

ELDERLY CARE IN PRIMARY HEALTH CARE FROM THE PERSPECTIVE OF HEALTH PROFESSIONALS¹

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ABSTRACT

The aging of the Brazilian population requires elderly care policies to be evaluated. **Objective:** To identify health professionals' perceptions about elderly care in Primary Health Care. **Method:** Case study with triangulation of data based on Ayres' vulnerability framework, conducted in the north of Paraná, Brazil. Data collection took place from January to March 2016 and was divided into: visit to and interview with the regional coordination, elderly care observation, documental analysis, and focal groups with 18 health professionals. **Results:** The analyses led to three categories: "Social and emotional vulnerability resulting in PHC dependence", "Network-organized services for comprehensive care" and "Poor human and financial resources". Primary Health Care evidences the elderly's social and individual vulnerabilities. Poor human and financial resources and a practice centered on curative, biologicistic and therapeutic actions reveal a programmatic vulnerability, forcing professionals to take on secondary- and tertiary-level roles. **Conclusion:** Changes in management planned according to local difficulties and characteristics could boost strategies that mitigate vulnerabilities by means of qualification actions and strengthening of the social network and existing services.

Keywords: Elderly Care. Primary Health Care. Health Vulnerability. Health Care Quality. Health Care Management.

INTRODUCTION

Brazil is aging rapidly, which means a need for ongoing assessments of social and health policies. Elderly care in Primary Health Care (PHC) aims to increase longevity by stimulating lifestyle changes and offering effective services, with highlight to the urgent need for identification of fragilities, as well as for prevention and reversion interventions⁽¹⁾.

Brazil's higher life expectancy does not mean quality of life, since aging is understood as a dynamic and progressive condition that brings biological, psychological, functional and social changes⁽²⁾.

In addition to the aging process, old-age vulnerabilities, which can manifest as functional decline, are the focus of geriatric and gerontologic interventions, regardless of the individual's age. In terms of functionality, this decline presents itself as a decisive factor for fragility, which is perceived as a clinical predisposition factor to risk of incapacities, institutionalization, hospitalization and death⁽¹⁾.

In this study, the service provided to the elderly

cared for by PHC was founded on the concept of vulnerability proposed by Ayres et al., which can identify causes and impacts of aggravations involving a number of characteristics, from individual organic susceptibilities to collective factors, such as health care programs, behaviors, culture, economy and politics, making the vulnerability proposal applicable to any health aggravation⁽³⁾.

Vulnerability analysis articulates three axes: individual, social and programmatic. The individual one refers to how a person receives proper information, understands it and is able to protect himself or herself when not in the presence of a health professional. The social one refers to acquisition of information and non-individual ability to incorporate them in order to enable changes and coping with health aggravations. Finally, the programmatic one has to do with optimization of social resources for injury protection, as well as with engagement of programs in planning, resources, management, assessment and care implementation

According to the elderly care guidelines of the

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Brazilian Unified Health System [*Sistema Único de Saúde*], care must be founded on the population's need and centered on the individual integrated with their family and community, as opposed to an illness-centered, prescriptive care. The specificities and singularities of the elderly population are a priority in humanized care and involves listening, accountability and problem solving through internal, external and multidisciplinary networks⁽⁴⁾. These aspects attach to the vulnerability axes, incorporating mutual accountability for coping with difficulties, recognizing social, political and cultural structures, allowing the citizen to make their own decisions and contribute to solving health aggravations.

In order to broaden and guide studies on vulnerability comprehension along with actions set forth by the Ministry of Health and elderly care, this study took into careful consideration the importance of establishing professionals' understanding of how the elderly are cared for on a primary level; therefore, it aimed to identify health professionals' perceptions about elderly care in Primary Health Care.

METHOD

This is a case study that seeks to comprehend individual, group, organizational, political phenomena and the like and used triangulation of data sourced through different collection techniques: interview, focal groups, observation, and documental analysis⁽⁵⁾.

The study place was a small town in the north of Paraná, which was chosen for having 100% of the elderly population registered in the risk of vulnerability stratification, with 462 seniors for 3,434 inhabitants⁽⁶⁾.

It was conducted in four stages: 1) Individual interview with the manager of the Regional Health Department that covers the municipality; 2) Observation of professionals' routine work in elderly care from January to March 2016; 3) Focal groups with elderly care professionals; and 4) Medical record analysis to assess the coherence between the observed reality and the records.

The interview with the manager aimed to provide a PHC management overview. As for focal groups, the first one was made up of seven professionals with a college degree, and the second one had 11 with a high school diploma; the entire

team received a printed invitation. They were requested to talk about their work, their healthcare practice, strengths, difficulties and challenges in elderly care. The interviews were recorded, the focal groups were recorded, filmed and fully transcribed, and the analysis of medical records was guided by a structured script.

Data were processed by means of content analysis, which "consists of discovering meaning cores that compose a communication and whose presence or appearance frequency" may contain meaningful content for the chosen analytical objective⁽⁷⁾.

The study had as participants PHC professionals identified by initials according to educational level – MP (1-11) for mid-level professionals, and HP (1-7) for high-level ones.

The informed consent form was approved by the State University of Londrina's Research Ethics Committee, CAAE: 51706115.2.0000.5231.

RESULTS AND DISCUSSION

The study municipality has 23 years of legal emancipation; the investigation included 18 municipal servers (Nurses, Technicians and Nursing Assistants, Psychologist, Physiotherapists, Odontologist, Nutritionist, Physician, Community Health Agents, and Health Care Manager) with 22 to 30 years of practice and 40 weekly working hours; seven were postgraduates, four worked in Public Health and none of them worked in Geriatrics or Gerontology.

Analyses of the interviews led to the construction of three categories: "Social and emotional vulnerability resulting in PHC dependence", "Network-organized services for comprehensive care" and "Poor human and financial resources".

Social and emotional vulnerability resulting in PHC dependence

The professionals' reports reveal the elderly's vulnerability caused by family issues and lack of support, which causes a dependence on the care provided by PHC professionals.

Her eyes ask for attention, kindness, someone to talk to. (MP9)

You can see that if she had a partner, she would not need a psychologist, a health center to receive a little love, a little attention. (HP2)

The professionals perceive that seniors that have family and emotional bonds with their caregivers are in better physical conditions compared to those who do not have it.

[...] You see bedridden seniors, for instance, who are poorly taken care of by caregivers who treat them like a burden [...] But the family that is dedicated does it properly, so they are always neat and well fed [...] It is what I always say, if caregivers are family, they do a good job. (HP1)

There was also a feeling of sadness when learning that families take advantage of the elderly for their pension or retirement money, putting them at situations of financial exploitation and institutionalization.

It breaks my heart when I see someone, usually a family member, wanting to take advantage of a senior, and families that put the elderly in one of those places. (HP1)

In addition to geriatric syndromes and other adverse conditions, the occurrence of abuses configures violence as a public health issue. Castro et al. (2018) showed that external factors, violence and accidents account for 6.3% of hospital admission causes among Brazilian senior citizens⁽⁸⁾.

Reduced social and family contact as part of the changes that happen with aging leads to the social isolation of elderly individuals, who, due to physical and intellectual losses, cease to be a reference for their families, take a back seat and, as a consequence of isolation, will seek friendships more often⁽⁹⁾.

In the study municipality, there was a decrease in social vulnerability when the elderly and health workers lived in the same neighborhood, thus being closer, which promoted to the former a greater confidence for them to seek the service. The analyses of household visits showed that strong family bonds reduced the search for PHC; on the other hand, where no emotional and social bonds were found, resorting to the health center was a more common behavior, which increased demand and programmatic vulnerability.

Analyzing the concept of family deficit among the elderly, a review study observed that this experience is, at the same time, a process of relations shaped by a number of factors, such as weakened family bonds, transformations in the family system over time, "intergenerational conflicts", psychological and functional health decline". It also found that family deficit among the elderly is caused by little family and social support,

and weakened family bonds, besides adding that the family is a senior's main source of support⁽¹⁰⁾.

The testimonies revealed an ethical dilemma as to PHC practice, whose professionals feel co-responsible and understand as inadequate some family members' indifference to the care to be provided. Research data have identified a "vulnerability derived from families not knowing how to care for their elderly members" and point out that as these members lose their independence and functional capacity, families transfer their responsibility onto caregivers and institutions⁽¹¹⁾. There are even situations in which the onset of disabling illnesses and their sequelae further hinder care within the family context, a situation that is oftentimes addressed during household visits^(12,13).

The analysis revealed that, despite the professionals identifying the elderly's social and emotional vulnerability, some attitudes do not reflect this perspective, with observations evidencing technical and routine procedures along with records of technical and biological nature that do not express the wholeness of the individual and their social context. There were few records in the nurses' advisement medical chart. It was possible to notice in the verbal communication within the team that these aspects are valued but not written down on medical charts. Resolution CNS No 553 of August 9th, 2017, which addresses medical charts, warns that verbal instructions provided by professionals must be recorded so that interventions can properly move forward⁽¹⁴⁾.

Data show a high demand for and replacement of the PHC role by urgency services (medium- and high-complexity). Replacement of basic services by those of higher complexity was also identified in a study that investigated how users and professionals see divergences and convergences between the Unit for the Family Health Strategy [*Estratégia Saúde da Família*] (FHS) and the traditional Basic Health Unit [*Unidade Básica de Saúde*] (UBS) based on components of the Primary Care Assessment Tool (PCAT). Concerning search for preventive actions, said study observed that ESF users rated the access positively; as for the UBS, it was better evaluated when it was resorted to for a health problem. The assessment instrument was intended for recognizing the existence of hierarchization in health actions, not their qualification.

In the study town, the workers did not have high-complexity services and therefore had to carry out

actions that were not related to their roles, which resulted in a biologicistic, fragmented practice and evidenced an array of inadequate human resources and a greater need for reflection on the part of managers about elderly care and hiring new professionals.

Performance of procedures on many care levels shows once again how elderly users become dependent and how vulnerability shapes the care network organization. This situation is represented in the counter-referral absence discourse and when the professionals express that no matter how busy the team is they will always seek a solution, even if partial.

I think that for us to be stronger, PHC should work more with prevention [...] We are operating more as an Emergency Care Unit [...] The service should be more organized, we should have a network functioning better, because how much time do you dedicate to prevention among the elderly? [...] We make referrals and do not have adequate services to help in elderly care [...] We lack this counter-referral. (HP2).

[...] I think that because it operates as an Emergency Care Unit, every patient that comes to us receives assistance; though incomplete, it is something. (HP2)

These conditions identified as generators of health care service dependence, absence of family support, abandonment, and a primary service running with poor resources in many aspects reveal an individual and social vulnerability that requires professionals to be able to comprehensively meet health, emotional and social needs in order to support health care actions and establish bonds and trust between the community, health care teams and PHC services. Programmatic vulnerability presents itself with great user demand affecting time availability for comprehensive care. Professionals with higher education show ethics, give quick diagnoses, are concerned about one's biological fragility as well as family and social aspects; however, no dialogues with users about possible ways to solve these issues were observed.

A 2017 household survey aimed at identifying programmatic vulnerability among senior citizens covered by the ESF found that those residing in areas of medium social vulnerability were more dependent on public health services, which signals an association between sociodemographic factors and the profile of used services⁽¹⁶⁾.

Provision of training on how to properly record

instructions could benefit future therapeutic and counter-referral measures. Family bonds could be strengthened and risks reduced by means of household visits supported by the presence of a nurse who would make referrals to other professionals in social care and psychology, contributing to division of responsibilities and to making health centers less overloaded.

Network-organized services for comprehensive care

In terms of reducing programmatic vulnerability, PHC prevention actions combined with social actions are of paramount importance; the town's "Seniors' Home" stands out with its great support to health units, as the elderly are assisted in their own house. The professionals state that this population has a special place in social and health care management proposals.

In the Seniors' Home [...] they exercise three times a week, and who goes there does not come here [...] They do not need to because all assistance they need they have there [...] And when an ESF doctor is at the house the exams are done there too. (MP1)

Management has been noticing the need for a special attention to the elderly, so much so that the town provided a house to receive these people. [...] So we look at an elderly person in a special way. (HP1)

Given all therapeutic advances and the higher number of chronic diseases, the elderly are required to have preserved cognitive conditions so that they can manage the use of multiple medications; in this sense, when helping senior citizens integrate with the UBS, community health care agents are a fundamental support to reduce programmatic vulnerability.

There is not one day that I do not receive an elderly person seeking guidance. When you get to the last pill, you do not even remember anymore which was the first one you prescribed, because they take so many others. (HP2)

We have patients here that cannot read, and their families do not help either, so we do everything for them, each one in their own department. [...] We even schedule the appointments, go to their houses, even our psychologist goes [...] If necessary, she drives to their houses to pick them up. That is how it works. (MP9)

Supporting the network care, nutrition professionals seek to deal with the patients'

difficulties with changes in their eating habits, encouraging physical activity and reduced use of medications, in addition to providing guidance as to cultural and traditional beliefs the elderly have and which stand as an obstacle.

I always think about prevention, about trying to eliminate the factors that are negatively affecting the life of these people; they depend on so many medications but with a better diet we could reduce cholesterol, we could dispense with the medication [...] They do not understand that they need to follow their diet plan, that it will work in combination with the medication. (HP5)

We let them know what might happen if they do not exercise, we explain to them the reason for physical activity, the benefits [...] Sort of encouraging prevention. (MP4)

The professionals consider that actions supported by intersectoral approach in public services are adequate for a small town with no private health care network.

For our town I think the service is good! [...] You have nowhere else to go but the health care center [...] The service in a big city is totally different [...] They do not even know whom they can complain to if someone treats them badly. Now, if they have to leave, then it is different. But here they talk to the mayor, to the deputy mayor, to the councilman, to the health secretary, but at least they have guarantee of a better service. (HP7)

Closeness between users and services was observed during the research, which signaled programmatic vulnerability. Management compositions need to be alert and implement actions towards privileging elderly care, as well as seek to inhibit negative closeness, which generates dependence, by subsidizing and strengthening health care units so they can provide the expected service. In order to support this operation model in which frontline professionals stand out with the fundamental role of guidance and sheltering, training teams are a priority need.

The social service referred to, the Seniors' Home, presented itself as a model to health care support, with physical activities, chronic illness control and recreational actions that involve residents and other elderly individuals from the community, evidencing the PHC concern about clinical matters, sharing responsibility with the social service as an incentive to a network care that

is coherent with the proposals of the National Primary Health Care Policy⁽¹⁵⁾.

The elderly's vulnerability is known by community health agents and deepened with inadequate use of medications and polypharmacy. Biological changes combine with hindering factors such as financial problems, and cognitive and comprehension deficits.

We go to the pharmacy, get the medication, cut it, put a tape on it [...] For those who cannot read we do not write "day" and "night", we draw a sun and a moon. (MP8)

A polypharmacy study involving seniors concluded that easy access to medication requires the creation of clinical protocols and greater control over medication usage⁽¹⁷⁾. As for professionals, they have taken on responsibility for pharmacological organization and administration, reinforcing the dependence situation. Polypharmacy is an indicative of fragilization risk, and iatrogenesis may occur when side effects are ignored and mistaken for new illnesses or linked to aging⁽¹⁾.

In this sense, means should be provided to make family members and caregivers aware of the risks of polypharmacy, and co-responsible for administering and controlling medications.

Poor human and financial resources

Need for adequate human and financial resources with the increasing number of seniors was observed, and this was also the understanding of the ESF team professionals, who further mention the need for creation of another UBS, pointing out that, despite all qualified professionals, there are limitations that prevent the objectives and goals of nursing assistance to be achieved, hindering proper care.

Unfortunately, it all has to do with finances [...] I cannot deny that our equipment and human resources do not meet the demand. (HP1)

The town is also growing a lot! But the team is still the same since the times I was not even thinking about going to college [...] You need to change the car's tire with the car still moving, it is impossible! (HP2)

[...] The team as a whole has to work together. I cannot do all this work alone, I do not have much time [...] I would like to have more time, to dedicate myself more, you know? (HP1)

Our greatest difficulty right now is that we do not have an ESF doctor. (MP4)

She [the nurse] is overloaded and ends up overloading the doctor too, so everyone is overloaded. (MP4)

The doctor is really good but now he is working as clinical physician at the health care center and does not have time to assist only elderly people (MP1)

The evidenced difficulty requires the adoption of intersectoral actions that contribute to informing the elderly about use of resources, social participation and coping with aggravations on the social and programmatic axes of vulnerability⁽³⁾. The complexity of the problem may derive from the role taken on by PHC and thematic networks, as stressed out by the authors of a study in which the discourse of managers is in line with national guidelines that cover PHC but, when it comes to citizens using these services, the context is different, showing that practices that reaffirm the fundamental role of PHC in health-related promotion, prevention and maintenance are identified as insufficient, which includes routine medical appointments, considering that PHC service is recognized for performing simple procedures only, such as blood pressure measurement or provision of medication⁽¹⁸⁾.

These professionals understand the elderly's situation and the poor structure into which they are immersed, expressing dissatisfaction between the job they do and the one they desire to do. However, their praxis reflects a victimization and tutelage condition that hinders a resolute social response, turning individuals that depend on health structures into passive ones. If the users' dependence on the services are sustained, there will be no contributions for them to take co-responsibility for measures that protect their health⁽³⁾.

By seeking solutions in a biologicistic, technical and immediate response, PHC maintains a one-sided responsibility, which manifests itself in mentions of overload and inadequacy. It is worth highlighting that, *a priori*, people are not vulnerable but become vulnerable to something, at some level, in some way and at some point in time and space. By victimizing or putting these seniors under tutelage and categorizing them as vulnerable, we disregard health care professionals, "the least affected ones, but still participants and victims equally"⁽³⁾.

Programmatic vulnerability presented itself in the absence of specialist physicians and endemic agents, since this role was increasingly attributed to

community health agents, as well as in the poor interaction between the latter and other professionals. The household visits evidenced the nurses' trouble with their care practice. Despite the actions recommended by the ESF, the community health agents were not aware of their important role, acting only as a visitor and deliverer of medical prescriptions.

The WHO preconizes 1 doctor per 1,000 inhabitants as the ideal health care parameter. According to the Brazilian Ministry of Health, each Family Health team should be responsible for a maximum of 4,000 people in a certain area. For the general health care team, the goal set by the WHO in 2006 was 22.8 professionals per 10,000 inhabitants⁽¹⁹⁾.

If we consider the diversity of professions in the health care team and make a calculation using only the number of interviewed professionals (18), we will have an average of 7.8 professionals per 3,434 inhabitants, with 10 professionals remaining in a positive proportion. However, if we recalculated it considering only medicine and nursing professionals, which totaled five, the result would be suboptimal. What the narrative of poor human resources, for both managers and professionals, actually revealed is a perception that is extremely centered on the doctors, disregarding the quality of the PHC multiprofessional team. Several authors address the importance of interdisciplinary teams so that the elderly can be comprehensively assisted^(20,21).

The decentralization of the Brazilian Unified Health System in 1990 interfered and keeps interfering with observed results; through it, "vertical relations were prioritized", and the decision power, management responsibilities and financial resources were all transferred to states and cities, which were then given an autonomy resulting from the decentralization, without structured health care services, without financial resource support and without the intersectoral and institutional structuration of the federal and state governments⁽²²⁾.

As for the ESF work management, there is a relevant study that have investigated the perspectives of local managers about difficulties and coping strategies, showing that the hierarchization and fragmentation of education and its practices nurtured a resistance to changes and moved health care professionals away from public service and Primary Care, which results in a specialized and

curative health care practice founded on mechanicism, biologicism and individualism⁽²³⁾.

Other studies have identified similar obstacles in PHC, including organization based on norms and protocols with productivistic, prescriptive and disciplining models, with highlight to the professional's technical formation and the conception of care for users accustomed to receiving types of care linked to routines and consumption of health procedures⁽²⁴⁾. This situation assigns health care workers with the important role of ensuring the quality of PHC services in order to protect more fragile seniors against aggravations, given the difficulties of programmatic vulnerability, without social resources available, herein represented by PHC human structures.

Better answers must arise through managers, provision of financial and human resources, new programs, or hospital care remodeling. This unique characteristic of small towns should not be lost; adequate reception must continue, and strategies for maintenance and appreciation of workers must be created.

Some limitations affected the study objective but did not result in drastic interferences. Absence of a medicine professional and an ESF nurse along with the low constancy of mid-level nursing professionals meant a longer time for observing the ESF activities and these professionals.

FINAL CONSIDERATIONS

These results show that, although the PHC professionals did not use Vulnerability concepts, the latter were identified by them in their reports and observed in their attempt to deal with the difficulties in providing senior patients with a comprehensive care. The workers see elderly individuals who are emotionally fragile, disconnected from their families and deprived of the support they need from them, so the professionals understand that the elderly meet their needs by using the services and the attention they find at the UBS, which favors this tutelage and victimization bond.

From a professional perspective, the characteristics of small towns favor a different treatment towards this population and enable network services for comprehensive care. The study subjects also perceive that poor human and financial resources contribute to increasing attributions for which they are not prepared. This investigation detected and analyzed all efforts made to encourage promotion, prevention and rehabilitation strategies, and that failure to hire human resources causes promotion and prevention actions to become actions of biologicistic and therapeutic nature.

The observed practice faces obstacles that reveal the programmatic vulnerability of the service. This type of work, if duly supported by means of qualification actions aimed at professionals and the community, and with the recognition of the value that each component of the multidisciplinary team has, along with proper investment, could be turned into effective network service strategies for comprehensive elderly care.

O CUIDADO DA PESSOA IDOSA NA ATENÇÃO PRIMÁRIA À SAÚDE SOB A ÓTICA DOS PROFISSIONAIS DE SAÚDE

RESUMO

Em decorrência do crescente envelhecimento da população brasileira, são necessárias avaliações das políticas de atenção à saúde do idoso. **Objetivo:** identificar as percepções dos profissionais de saúde referentes ao cuidado voltado à pessoa idosa na Atenção Primária à Saúde. **Método:** Estudo de Caso com Triangulação de dados embasado no referencial teórico de Vulnerabilidade de Ayres. Realizado no norte do Paraná, Brasil. A coleta ocorreu de janeiro a março de 2016 e dividiu-se em: visita à coordenação regional e realização de entrevista, observação da assistência ao idoso, análise documental e grupos focais com dezoito profissionais da saúde. **Resultados:** Após análise, emergiram três categorias: "Vulnerabilidade social e afetiva voltada para dependência da APS", "Serviços organizados em rede e voltados para o cuidado integral" e "Dificuldade de recursos humanos e financeiros". A Atenção Primária aponta vulnerabilidades social e individual da pessoa idosa. Dificuldades de recursos humanos e financeiros, prática centrada em ações curativas, biológicas e terapêuticas denunciam a vulnerabilidade programática, impelindo os profissionais a funções de nível secundário e terciário. **Conclusão:** Mudanças na gestão planejadas sob a ótica das dificuldades e características locais poderiam potencializar estratégias que diminuíssem as vulnerabilidades por meio de ações de capacitação e fortalecimento da rede social e serviços existentes.

Palavras-chave: Saúde do idoso. Atenção primária à saúde. Vulnerabilidade em saúde. Qualidade da assistência à saúde. Gestão em saúde.

EL CUIDADO A LA PERSONA ANCIANA EN LA ATENCIÓN PRIMARIA A LA SALUD BAJO LA ÓPTICA DE LOS PROFESIONALES DE SALUD

RESUMEN

Debido al creciente envejecimiento de la población brasileña, es necesario que ocurran evaluaciones de las políticas de atención a la salud del anciano. **Objetivo:** Identificar las percepciones de los profesionales de salud referente al cuidado a la persona anciana en la Atención Primaria a la Salud (APS). **Método:** Estudio de Caso con Triangulación de datos basado en el referencial teórico de Vulnerabilidad de Ayres. Realizado en el norte de Paraná, Brasil. La recolección fue hecha de enero a marzo de 2016, se dividió en: visita y entrevista a la coordinación regional, observación de la atención al anciano, análisis documental y grupos focales con dieciocho profesionales de la salud. **Resultados:** Tras el análisis surgieron tres categorías: "Vulnerabilidad social y afectiva dirigida para dependencia de la APS" "Servicios organizados en red y dirigidos para el cuidado integral" y "Dificultad de recursos humanos y financieros". La Atención Primaria señala vulnerabilidades social e individual de la persona anciana. Dificultades de recursos humanos y financieros, práctica centrada en acciones curativas, biólogos y terapéuticos, denuncian la vulnerabilidad programática; llevando a los profesionales a funciones de nivel secundario y terciario. **Conclusión:** Cambios en la gestión planificados bajo la óptica de las dificultades y características locales podrían potenciar estrategias que disminuyeran las vulnerabilidades por medio de acciones de capacitación y fortalecimiento de la red social y servicios existentes.

Palabras clave: Salud del anciano. Atención primaria a la salud. Vulnerabilidad en salud. Calidad de la atención a la salud. Gestión en salud.

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