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ORIGINAL ARTICLE

OLDER ADULTS' KNOWLEDGE ABOUT THE BRAZILIAN HEALTH SYSTEM: SIGA-BAGÉ STUDY

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ABSTRACT

Objective: to investigate knowledge about the Unified Health System and the Right to Health in the traditional model and in Family Health, in a cohort of older adults in the city of Bagé, Rio Grande do Sul. **Method:** a cross-sectional study, carried out with older adults residing in the area covered by Primary Health Care services in the urban area of Bagé. Fisher's exact statistical test was used in the analyses. **Results:** in the statement about the constitutional guarantee of access to health, 46.8% of older adults in areas of the traditional model and 23.8% of older adults residing in areas covered by FHS were in full agreement. Access to health services was verified in the statement "the Brazilian Health System should assist all people"; 24.5% of older adults in the traditional area totally agreed and in the FHS area; 17.6% strongly agreed. A pattern of older adults who did not know how to give an opinion was also observed, with a significant number in the FHS area. **Final considerations:** the analysis of older adults' knowledge about the SUS can contribute to the implementation of educational actions, in order to strengthen health as a fundamental right.

Keywords: Aged. Right to Health. Primary Health Care. Unified Health System. Universal Access to Health Care Services.

INTRODUÇÃO

The Alma-Ata conference that took place at the end of the 1970s, after a series of conferences organized by the United Nations (UN), proposed Primary Health Care (PHC) as a model for organizing the health system worldwide, and reaffirmed health as a fundamental human right[1]. In Brazil, the right to health was an achievement achieved by the Health Reform movement that guaranteed the creation of the Brazilian Health System (SUS - *Sistema Único de Saúde*) in the Federal Constitution (FC), enacted in 1988[2].

The constitutional precept of health as a right for all and a State's duty requires the implementation of social and economic policies that reduce the occurrence of diseases and injuries, guaranteeing universal and equal access to health services, in order to promote equity and reduce historical social inequalities[3].

The complex networks of providers and purchasers of services that form the Brazilian health system promote a public-private combination with three subsectors: the public, in which services are financed and provided by the State at the federal, state and municipal levels, including military health services; the private (for-profit or not), which are services financed in different ways with public or private resources; finally, the supplementary, with different types of health insurances and insurance policies, in addition to tax subsidies[4].

PHC plays an important role in reducing health inequalities, favoring equity in access to health services. According to the literature, the

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Family Health Strategy (FHS), in general, performs better compared to the traditional model, promoting the quality of primary care, equity in the health system and the reduction of vulnerability, as it guarantees access to poor populations[5-9].

In Brazil, PHC is organized into two models of Basic Health Units (BHU), the traditional ones, aimed at meeting the community's momentary demand, generally allocated in areas with better socioeconomic index, and the BHU of the FHS model that focus their services on programmatic actions and have community health workers (CHW) in the teams. FHS show improvements in access and are important linkers between the health service and the community. In general, FHS is allocated in regions of greater social vulnerability, aiming to ensure that these populations are assisted[10].

FHS is a reference for the application of SUS principles and a way to oppose the biomedical model of care focused on curative actions. PHC is the preferred gateway to the SUS, aiming at promotion and prevention, guided by the principles of longitudinality, comprehensiveness and coordination of care over time[11].

It is known that social and economic characteristics, the so-called social determinants of health, are strongly linked to the health-disease process[9]. Despite the guarantee by law of universal and equal access to health services aimed at promoting, protecting and recovering health, the numerous inequalities in the SUS and in FHS consolidation are recognized[12]. This study is relevant to promote discussions on the subject, in order to disseminate the premise of health as a fundamental human right.

The aim of this article is to investigate knowledge about SUS and the right to health, in the traditional model and in family health, in a cohort of older adults in the city of Bagé, Rio Grande do Sul.

METHOD

This is a population-based cross-sectional study, in the area covered by PHC services, with older adults participating in the SIGa-Bagé cohort study, with data from the follow-up carried out in 2016/2017.

Bagé is a municipality located in the south of the state of Rio Grande do Sul (RS), according to the last census of 2010, it had a population of 116,794 people, of which 83.7% lived in the urban area of the municipality. The Human Development Index (HDI) of Bagé in 2010 was 0.740, which characterizes it as high, and the dimension that most contributed to this index was longevity. Life expectancy at birth averaged 70.68 years. In Bagé, 3.34% of the population lives in extreme poverty[7].

In 2008, the year the baseline study was carried out, the municipal health system was formed by 20 BHU located in the municipality's urban area, 15 were Family Health Units (FHU) and five Traditional Basic Units. The sample was composed respecting BHU's coverage area, being divided into micro areas and blocks, and the starting point for locating the households was randomly defined through drawing lots. For further information on criteria and sample selection, see macro-study[13].

Older adults who received help to answer the questionnaire were excluded from the analyses. A total of 735 older adults were interviewed, of which 161 received partial or total help to answer the questionnaire and, therefore, were removed from analysis. Data collection for the second follow-up was carried out by trained interviewers from September 2016 to August 2017, at the older adults' own homes, using the Personal Digital Assistant (PDA) electronic device.

The outcome "Older adults' knowledge about the Brazilian Health System and the right to health" was investigated through the operationalization of eight affirmative sentences, namely: 1 - The FC of Brazil guarantees access to health as a right of all and a State's duty; 2 - Health care is an exclusive responsibility of each person; 3 - The government has no responsibility for caring for people's health; 4 - Having health insurance is a must for all people; 5 - Those who have health insurance are not entitled to use the SUS; 6 - The SUS was proposed to serve only those who do not have health insurance; 7 - The SUS guarantees assistance to all people; 8 - The SUS can only treat more serious health problems.

These had five response options (totally disagree = 0; disagree = 1; neither agree nor disagree = 2; agree = 3; totally agree = 4), in

which older adults should choose only one alternative.

Independent variables included were demographic, socioeconomic, morbidities and health status, such as gender (female and male), age (68 to 74 years, 75 years or older), self-reported skin color (white, black/brown/yellow/indigenous), education in complete years (none, 1 to 7, 8 or more), economic classification according to the Brazilian Association of Research Companies (ABEP) - (A/B, C, D/E), retired (yes or no), marital status (single married, widowed, separated/divorced), health insurance or insurance policy (yes or no), self-perceived health (very good/good, fair, very poor/poor).

Initially, a descriptive analysis was performed to characterize the sample, and later a bivariate analysis was carried out to analyze the relationship between the outcome and exposure to care models (traditional/FHS), using Fisher's exact test for heterogeneity and adopted a significance level of 5%. Data analyzes were performed using the Stata 12.0 statistical program (StataCorp/College, United States).

The study has a favorable opinion from the Research Ethics Committee of the Faculty of Medicine of the *Universidade Federal de Pelotas* (UFPel), approved under Opinion 678.664 on May 29, 2014, according to the precepts of Resolution 466/12 of the Brazilian National Health Council of the Ministry of Health, registered on *Plataforma Brasil* CAAE (*Certificado de Apresentação para Apreciação Ética* - Certificate of Presentation for Ethical Consideration) 31497314000005317.

RESULTS

The analysis included responses from 574 older adults, with a loss of 23 responses in the statement about knowledge of the constitutional right of access to health (n=551). The sample consisted mostly of females in both health care models, white skin color was self-reported by 73.3% in the FHS area and 85.2% in the traditional one. Of the respondents, 38.5% had 8 years of study or more in the traditional model, a proportion that reached 16.2% in the area covered by FHS. As for economic classification, 39.7% of older adults residing in the FHS area were in category D/E (lowest socioeconomic classification), approximately 80% of older adults were retired in both health care models and 26.7% had health insurance in the FHS area and 50% in the traditional model, as shown in Table 1.

Table 1. Description of the population sample of older adults according to demographic and socioeconomic characteristics and care model, Bagé, 2017 (n = 574).

Variables	N			
	FSH	**%**	**Traditional**	**%**
Sex				
Male	107	36,1	89	32
Female	189	63,9	189	68
Age				
68 to 74 years	260	87,8	230	82,7
75 or older	36	12,2	48	17,3
Skin color				
White	218	73,3	237	85,2
Black, brown, yellow, indigenous	78	26,7	41	14,8
Education				
None	62	21	27	9,7
1 to 7 years of study	186	62,8	144	51,8
8 years and older	48	16,2	107	38,5
Socioeconomic classification (n=572)*	**n=295**		**n=277**	
A/B	62	21	127	45,8
C	116	39,3	100	36,1
D/E	117	39,7	50	18,1
Retirement (n=572)*	n=295		n=277	
Yes	244	82,7	215	77,6
No	51	17,3	62	22,4
Marital status				

With partner/married	175	59,1	147	52,9
No partner/single	29	9,8	31	11,1
Separate	26	8,8	18	6,5
Widow	66	22,3	82	29,5
Health insurance				
Yes	79	26,7	139	50
No	217	73,3	139	50
Self-rated health (n=571)**	**n= 293**		**n=278**	
Very good/good	185	63,1	183	65,8
Fair	92	31,4	82	29,5
Very poor/poor	16	5,5	13	4,7
Total	**574**		**100**	

Source: SIGa-Bagé study. 2017. Pelotas. 2021.
*Loss of two answers; **Loss of 3 answers.

Table 2 shows the percentages of older adults disagreeing and agreeing with statements about the SUS and the right to health. The results highlight the important percentage of older adults who did not know how to give an opinion on the statements presented to them, being practically twice the number of older adults who did not know how to give an opinion in the FHS area when compared to older adults in the traditional model.

In the statement about health as a constitutional right, a low percentage of older adults who totally disagreed was found, regardless of the care model. The percentage of total agreement was higher among older adults in the traditional care model (traditional=46.8%; FHS= 23.8%). Half of older adults in FHS areas agreed with this statement, highlighting the higher percentage of older adults who neither agreed nor disagreed when compared to the older adults in the traditional model.

When stating to the older adults that health care is the exclusive responsibility of each individual, 46.1% of older adults in the traditional model and 28.4% in the FHS area totally agreed. When it was stated that the government is not responsible for caring for individuals, 1.3% of older adults in the traditional model and 16.9% of older adults in the FHS area strongly disagreed. In the statement about the SUS having been proposed to serve only individuals who do not have health insurance, it is observed that 31.6% of older adults in the traditional model and 28.0% in the FHS area disagreed with this statement, with no statistical difference when comparing the models of care. Regarding the obligation to have health insurance, 18% of older adults residing in the traditional health care model strongly disagreed, and, for this same category, in FHS areas, 10.5%. When it was stated "those who have health insurance do not have the right to use the SUS", 37.4% of older adults in the model and 39.5% in the traditional FHS area disagreed.

Access to the health system, verified in the statement that SUS guarantees care to all people, it is observed that 24.5% of older adults in the traditional model and 17.6% in the FHS area totally agreed. The principle of comprehensiveness in the SUS was represented by the statement: "*The SUS can only deal with more serious health problems*". Regarding the complexity of the problems treated in the SUS, 44.6% of older adults in the traditional model and 25% in the FHS area totally disagree.

Table 2. Percentage of older adults disagreeing or agreeing with statements about the SUS and the right to health in a cohort of older adults in the municipality of Bagé in 2016/2017.

	TRADITIONAL (N=278)					FHS (N=296)					*p value*
	TD	D	NAD	A	TA	TD	D	NAD	A	TA	
	N %	N %	N %	N %	N %	N %	N %	N %	N %	N %	
The Brazilian Federal Constitution guarantees access to health as a right for all and a State's duty.*	6 (2,2)	20 (7,2)	12 (4,3)	110 (39,5)	130 (46,8)	9 (3,3)	25 (9,2)	37 (13,5)	137 (50,2)	65 (23,8)	<0,001
Health care is the exclusive responsibility of each	9 (3,2)	17 (6,1)	16 (5,8)	108 (38,8)	128 (46,1)	6 (2,0)	24 (8,1)	27 (9,1)	155 (52,4)	84 (28,4)	<0,001

person.											
The government has no responsibility for caring for people's health.	87 (31,3)	74 (26, 6)	11 (3,9)	67 (24,1)	39 (14,0)	50 (16,9)	99 (33,4)	28 (9,5)	99 (33,4)	20 (6,8)	<0,001
Having health insurance is a must for everyone.	50 (18,0)	62 (22,3)	14 (5,0)	113 (40,7)	39 (14,0)	31 (10,5)	87 (29,4)	37 (12,5)	111 (37,5)	30 (10,1)	<0,001
Those who have health insurance are not entitled to use the SUS.	57 (20,5)	104 (37,4)	22 (8,0)	71 (25,5)	24 (8,6)	44 (14,9)	117 (39,5)	23 (7,8)	91 (30,7)	21 (7,1)	0,335
SUS was proposed to serve only those who do not have health insurance.	46 (16,5)	88 (31,6)	19 (6,9)	90 (32,4)	35 (12,6)	44 (14,9)	83 (28,0)	22 (7,4)	124 (41,9)	23 (7,8)	0,101
The SUS guarantees care to all people	14 (5,0)	54 (19,4)	16 (5,8)	126 (45,3)	68 (24,5)	18 (6,1)	45 (15,2)	29 (9,8)	152 (51,3)	52 (17,6)	0,059
The SUS can only deal with more serious health problems.	124 (44,6)	110 (39,6)	8 (2,9)	29 (10,4)	7 (2,5)	74 (25,0)	118 (39,9)	22 (7,4)	63 (21,3)	19 (6,4)	<0,001

* Fisher's exact statistical test for heterogeneity, p<0.005 were considered significant.
*n=551 / FHS (n=273)
TD: totally disagree; D: disagree; NAD: neither agree nor disagree; A: agree; TA: totally agree. Source: SIGa-Bagé Study, 2017. Pelotas, 2021. *Loss of 23 responses in the statement about the Federal Constitution of Brazil.

DISCUSSION

The answers indicate that older adults have knowledge about the constitutional right of access to health, and there is greater confidence in this statement among the older adults who reside in the areas of the traditional care model.

Brazil has consolidated itself as the only capitalist country in Latin America to offer a public health system with the principle of universality, since the promulgation of SUS after the FC of 1988[6].

A study carried out in the Federal District with 14 older adults states that they were satisfied with FHS services. FHS has potential in care for bonding and qualified listening[14]. SUS users' satisfaction is associated with obtaining access to health services, using highly complex services and receiving home visits. Dissatisfaction is associated with the delay in service, the flow of referrals and counter-referrals and the precariousness of some institutions[15].

In this study, it is observed that, in the statements about responsibility of care, almost half of older adults in the traditional model showed total agreement that care is an exclusive responsibility of each person, but when stated that the government has no responsibility in caring for individuals' health, disagreement occurred. It is noticed that most older adults, despite recognizing that they have the right to access health services, still think that responsibility for health care is exclusive to each individual and only part of them hold the government accountable. It should be noted that, since 2011, the charter of the rights of health users has been published, but with little dissemination and transfer of information to the population.

Observing the pattern of participants' answers, a problem emerges: the answers point to the direction that older adults are not recognizing the responsibility that the government should have in relation to access to health services. It is possible that part of older adults think of health only in the absence of disease, without recognizing the other dimensions included in health, such as leisure, accessibility, inclusion, housing, food, dignity, intrinsic factors for well-being.

Another problem raised is that of the participants answering that it is mandatory to have a health insurance. In the national territory, a survey carried out in 2015 estimates that 49.1% of the population is covered by some health insurance[16]. As expected, the logic of the private market is profit. Thus, older adults and chronically ill people end up being excluded from the system in a certain way due to the fact that they burden it with more costs, implying their migration to the SUS, or the judicialization to assert their right[17]. Criticism of this functioning occurs due to the fact that older adults end up entering the system only from a curative perspective, dismantling the idealization

of actions to prevent health problems, where many times they will access the SUS in other ways, not through PHC, which guides the care of individuals.

Bagé has a significant presence of the military army, which can influence the number of individuals covered by health insurances, making it necessary a more specific analysis of the profile of older adults who use the private network and how this use can contribute to the generation of health inequities.

In this way, FHS aims to reorganize the work process in PHC according to SUS' principles and guidelines. It uses expansion, qualification and consolidation strategies, expanding and seeking to generate an impact on the health situation of the population covered in the territory, in addition to providing a positive relationship between costs versus effectiveness, since it should act firmly in injury prevention.

PHC is characterized by a set of health actions, at the individual and collective levels, in order to provide adequate assistance to individuals[18]. In addition to dedicating itself to promoting and protecting health, assisting in diagnosis, treatment and maintenance of health, PHC is consolidated with the objective of impacting individuals' autonomy as well as their health situation and social determinants. In this regard, considering care as a continuous action, PHC should be the preferred contact for users, the main gateway and coordinator of the Health Care Network (RAS - *Rede de Atenção à Saúde*). Moreover, it must carry out development with the highest degree of decentralization and capillarity, be a link-former, solve problems and exercise its main role, coordinate care and organize networks[19].

A repetition factor was observed in the responses of non-opinionated older adults in the FHS area, when compared to older adults in the traditional area, the older adults residing in the FHS areas were twice as likely. Attention is drawn to this fact, as older adults residing in FHS areas generally have fewer resources and use SUS health services more, but were unable to maintain a position.

Research shows us that older adults residing in areas covered by FHS are in the lowest income categories and attended school for a shorter period, this fact is intriguing, because we did not look for a direct association with the outcome variables, however the results point to a possible association. The findings of this study provide subsidies for important discussions, contributing to the local health system, showing that, despite more than 30 years after the promulgation of SUS, there is still a lack of information about how this system works.

It identifies the need for services that are closer to the community to be informing and encouraging users to occupy spaces of struggle to ensure the rights guaranteed by law, according to what appears in SUS users' charter of rights, which points out the principles for guaranteeing universal access to actions and services aimed at promoting, protecting and recovering health[20].

FINAL CONSIDERATIONS

The article presents older adults' opinion regarding the SUS, with significant statistical differences being verified when comparing the PHC models in the statements: the FC of Brazil guarantees access to health as a right of all and a State's duty; health care is the exclusive responsibility of each person; the government has no responsibility for caring for people's health; having a health insurance is an obligation for all people; SUS can only treat more serious health problems.

It was observed that older adults residing in areas covered by the traditional model had more favorable responses regarding knowledge of their right to health and access to health services. The studies used for discussion indicate a strong relationship between knowledge about rights and education, however this analysis was not carried out in our study. However, when we look at the answers about the right to health being a constitutional precept, older adults from the areas of the traditional care model had a higher percentage of agreement; in these areas, education is also higher.

It is suggested that new analyzes be carried out in order to verify the relationship between socioeconomic factors and knowledge of rights, which is a gap in this article as well as new research aiming to identify issues related to the permanent education of professionals working in PHC. It should be noted that the generalization of these findings to other realities may not be

applicable.

CONHECIMENTO DOS IDOSOS A RESPEITO DO SISTEMA ÚNICO DE SAÚDE: ESTUDO SIGA-BAGÉ

RESUMO

Objetivo: investigar o conhecimento sobre Sistema Único de Saúde e Direito à Saúde no modelo tradicional e na Saúde da Família, em uma coorte de idosos do município de Bagé, Rio Grande do Sul. **Método:** Estudo transversal, realizado com idosos residentes na área de abrangência dos serviços de atenção básica à saúde na área urbana de Bagé. Nas análises foi realizado o teste estatístico exato de Fisher. **Resultados:** Na afirmação sobre a garantia constitucional ao acesso à saúde, 46,8% dos idosos de áreas do modelo tradicional e 23,8% dos idosos residentes em áreas de atenção da ESF estavam totalmente de acordo. Acesso aos serviços de saúde foi verificado na afirmação "o Sistema Único de Saúde deve atender todas as pessoas", 24,5% dos idosos da área tradicional concordaram totalmente e na área da ESF 17,6% concordaram totalmente. Foi observado ainda um padrão de idosos que não souberam opinar, sendo um número expressivo na área ESF. **Considerações finais**: a análise do conhecimento dos idosos sobre o SUS pode contribuir para a implementação de ações educativas, de modo a fortalecer à saúde como direito fundamental.

Keywords: Idoso. Direito à saúde. Atenção primária à saúde. Sistema único de saúde. Acesso universal aos serviços de saúde.

CONOCIMIENTO DE LOS ANCIANOS ACERCA DEL SISTEMA ÚNICO DE SALUD: ESTUDIO SIGA-BAGÉ

RESUMEN

Objetivo: investigar el conocimiento sobre Sistema Único de Salud y Derecho a la Salud en el modelo tradicional y en la Estrategia Salud de la Familia (ESF), en una cohorte de ancianos del municipio de Bagé, Rio Grande do Sul-Brasil. **Método**: estudio transversal, realizado con ancianos residentes en el área de cobertura de los servicios de atención básica a la salud en el área urbana de Bagé. En los análisis se realizó la prueba estadística exacta de Fisher. **Resultados**: en la afirmación sobre la garantía constitucional al acceso a la salud, el 46,8% de los ancianos de áreas del modelo tradicional y el 23,8% de los ancianos residentes en áreas de atención de la ESF estaban totalmente de acuerdo. El acceso a los servicios de salud fue verificado en la afirmación "el Sistema Único de Salud debe atender a todas las personas", el 24,5% de los ancianos de la zona tradicional estuvo de acuerdo totalmente y en el área de la ESF el 17,6% estuvo de acuerdo totalmente. Se observó también un patrón de ancianos que no supieron opinar, siendo un número expresivo en el área ESF. **Consideraciones finales**: el análisis del conocimiento de los ancianos sobre el SUS puede contribuir para la implementación de acciones educativas, de modo a fortalecer a la salud como derecho fundamental.

Palabras clave: Anciano. Derecho a la salud. Atención primaria de salud. Sistema único de salud. Acceso universal a los servicios de salud.

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