

## ACCESS OF THE ELDERLY TO PRIMARY HEALTH CARE UNITS

### ACESSO DE IDOSOS ÀS UNIDADES DE ATENÇÃO PRIMÁRIA À SAÚDE

### ACCESO DE ADULTOS MAYORES A LOS CENTROS DE ATENCIÓN PRIMARIA DE LA SALUD

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## ABSTRACT

**Objectives:** to evaluate the accessibility to Primary Health Care Units for the elderly in urban and rural areas. **Method:** descriptive quantitative study of 157 primary health care units in Ceará. An instrument with accessibility standards of the Brazilian Norm 9050/2004 for public streets and access to buildings was used in the study. **Results:** the assessment of the public streets shows uneven distribution with higher percentage in urban areas for crosswalks, wide sidewalks, traffic signs ( $p < 0.0001$ ) and lowered curbs ( $p = 0.0001$ ), while the rural area presented  $< 15\%$  of accessible units. Both had also inaccessible buildings. **Conclusions:** rural and urban health units have poor conditions of accessibility on public streets and no accessibility to buildings, jeopardizing the proper care for the elderly by difficult or lack of access.

**Keywords:** Health Promotion; Health Services for the Aged; Health Services Accessibility; Architectural Accessibility.

## RESUMO

**Objetivo:** avaliar a acessibilidade para idosos às Unidades de Atenção Primária de zonas urbanas e rurais. **Método:** estudo quantitativo descritivo em 157 unidades de atenção primária do Ceará. Utilizou-se instrumento com padrões de acessibilidade da Norma Brasileira 9050/2004 para via pública e acesso ao prédio. **Resultados:** a avaliação da via pública evidencia distribuição irregular com percentuais mais altos na zona urbana para faixas de pedestres, largura de calçadas, sinalização de trânsito ( $p < 0,0001$ ) e meio-fio rebaixado ( $p = 0,0001$ ), enquanto que a rural apresentou  $< 15\%$  de unidades acessíveis. Ambas foram igualmente inacessíveis no acesso ao prédio. **Conclusões:** as unidades de saúde rurais e urbanas apresentaram condições insatisfatórias de acessibilidade nas vias públicas e nenhuma acessibilidade aos prédios, comprometendo o atendimento aos idosos por dificuldade ou falta de acesso. **Palavras-chave:** Promoção da Saúde; Serviços de Saúde para Idosos; Acessibilidade aos Serviços de Saúde; Estruturas de Acesso.

## RESUMEN

**Objetivo:** evaluar la accesibilidad para adultos mayores a los centros de atención primaria en áreas urbanas y rurales. **Método:** estudio cuantitativo descriptivo de 157 centros de atención primaria del estado de Ceará. Se utilizó un instrumento con los estándares de accesibilidad de la Norma Brasileña 9050/2004 para vías públicas y acceso a edificios. **Resultados:** la evaluación de las vías públicas mostró distribución irregular con porcentajes más altos en las zonas urbanas para los pasos de peatones, ancho de las aceras, señales de tráfico ( $p < 0,0001$ ) y cordones rebajados ( $p = 0,0001$ )- la población rural presentó  $15\%$  de unidades accesibles. El acceso a los edificios era deficiente en ambas zonas. **Conclusiones:** las condiciones de accesibilidad en las vías públicas de los centros de salud rurales y urbanos eran insatisfactorias y la accesibilidad a los edificios nula, lo cual pone en peligro la atención a los adultos mayores por la dificultad o la falta de acceso a dichos centros de salud.

**Palabras clave:** Promoción de la Salud; Servicios de Salud para Ancianos; Accesibilidad a los Servicios de Salud; Estructuras de Acceso.

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## INTRODUCTION

The age structure of the Brazilian population has undergone changes in demographic patterns in recent years towards increasing longevity.<sup>1</sup> However, the increase in the number of years lived needs to be accompanied by investments in conditions to enjoy an active and healthy old age for as long as possible.<sup>2</sup>

The aspirations of the Health Promotion Policy aim at equity, autonomy and improvement of living conditions based on the recognition and respect for diversities to reduce vulnerabilities and health risks. In this context, it is important to build healthy environments conducive to human development and well-being through human mobility and accessibility.<sup>3,4</sup>

The standards established for urban and rural accessibility in buildings, spaces and urban equipment are set forth in the Brazilian Norm (NBR) 9050, of Brazilian Association for Technical Standards (ABNT), which considers several mobility conditions to provide autonomous, independent and safe use of the environment. Its applicability to the promotion of elderly health is pertinent, since aging implies declines in biological functions conducive to fragility, vulnerability and exposure to risks, being necessary to plan health actions to provide the elderly with a better quality of life.<sup>5</sup>

Elderly care is challenging because it encompasses issues peculiar to this stage, and should be based on the integral and continuous care to establish the link with the health services. Primary assistance for the elderly is offered in primary health care units, and it is essential to evaluate the conditions of operation of these services provided.<sup>6</sup>

The planning, implementation and enhancement of care for the elderly has stimulated studies on pertinent interventions applicable to clinical situations and life issues of this age group, such as accessibility. Such conditions contribute to multidimensional care with health promotion and disease prevention, especially by nurses, who are responsible for most of the actions structured by the health team in primary care.<sup>7</sup>

The evaluation of primary health care units regarding conditions of accessibility highlights the real context of the elderly population's access to these health services, which contributes to raising the awareness of managers and health professionals about the needs and benefits of facilities and adaptations in the physical structure of environments, in order to promote effective and efficient access, reception and care. This article aims to assess the accessibility for the elderly in primary health care units in urban and rural areas.

## METHOD

Descriptive quantitative study carried out in 16 municipalities in Ceará, located in the Baturité massif, from August 2014 to May 2015. As inclusion criterion, it was established that the health units

should be listed in the National Register of Health Establishments; and, as exclusion criteria: health units in public streets on repair at the entrance gate; closed and deactivated health units; or health units located in temporary sites, at the time of collection.

Sampling was performed for convenience, and all eligible units were selected, according to the inclusion and exclusion criteria established. Thus, among the 215 units found in the National Registry of Health Establishments, 157 were selected for analysis.

Data collection was carried out by members of the research group Person with Disability - Nursing Care Research, which is part of the Nursing course at the Federal University of Ceará (UFC), who were undergraduate and postgraduate students *stricto sensu*. All were trained to adequately fill the material, and had knowledge of the norm and of its applicability for carrying out the correct field measurements.

The team was divided into two pairs and one trio, which went to the municipalities twice a week during the period. The sites were accessed using transportation of the University of International Integration of Afro-Brazilian Lusophony (UNILAB) and private vehicle of the researchers. Data collection was carried out using photographic cameras, measuring tapes and an instrument addressing identification items of the health unit (institution name, zone and municipality), as well as the topics related to the public street and access to the building. The instrument items were elaborated according to accessibility conditions established in the NBR 9050.

The topic public street, with 10 items, evaluated the crosswalk, lowering of curb, sidewalks, avenues, traffic signs and indicative signs of the route to the units and traffic lights with visual and sound devices for crossing. Regarding access to the building, six items evaluated the lowering of doorsteps, parking, parking path to the entrance of the building and signs in entrances, exits, escape routes and elevators.

Each item was evaluated as accessible (A), if the structure was in accordance with the norm; and inaccessible (I), if the analyzed conditions had inadequate measures and/or were lacking the necessary objects.

The data identified were processed by the *Statistics Package for Social Sciences* (SPSS) version 20.0, organized into tables with absolute frequencies and percentages. The Pearson's coefficient, chi-square test and continuity correction were used for comparison between rural and urban health units and a significance level of 5% was established. National standards of ethics in research involving human subjects were obeyed.

The study was approved by the Research Ethics Committee of the University of International Integration of Afro-Brazilian Lusophony under number 652.134/2014 and complied with the principles of Resolution 466/2012 of the National Health Council. The authorization of the Health Secretaries of each municipality for research and access to health units was

requested and approved by means of the signature in the Informed Consent Term.

## RESULTS

The analysis was performed in 157 health units, 92 (58.5%) of them located in the rural area.

Table 1 lists data related to accessibility in the public street, showing the irregular distribution of accessible units, with higher percentages in the urban area in relation to crosswalks, sidewalks with a minimum width of 1.50 m, traffic signs in visible places ( $p < 0.0001$ ) and lowered curbs ( $p = 0.001$ ).

Table 2 shows the access to the buildings, in which inaccessibility predominated in all the items evaluated. There was no statistically significant difference between rural and urban areas.

## DISCUSSION

The health units evaluated presented unsatisfactory access conditions, demonstrating that primary care services have not adequately served as a gateway for the elderly. The trajectory from home to the health unit presents barriers, both in urban and rural areas. Although architectural accessibility is

mandatory and the norms that regulate it are in force, the accessibility to spaces in general is still very limited. Public streets are among the places that need improvement, since the impediments that the elderly face to reach the unit are already well-known in this route.<sup>8</sup>

Among the items evaluated in the public street, the urban areas showed the best structure for the safe displacement of the elderly regarding the presence of crosswalks, which help them crossing by indicating the appropriate place to do so. Other aspects were the presence of stop signs for vehicles to allow pedestrians to pass; sidewalks with a minimum width of 1.50 m so that the elderly can walk comfortably alone, accompanied and/or with their support instruments, such as walking sticks; traffic signs in visible places so that they organize and optimize the paths with flow of people and vehicles to promote a safe environment; and lowering of curbs for access of elderly to the health unit, by facilitating the disembarkation from vehicles as close as possible to the entrance, with less need for locomotion walking or with wheelchairs. Historically, urban environments have more socioeconomic diversity in the community and its spaces, with easier access to goods and services, while rural areas are more seriously missing infrastructure investments.<sup>9</sup>

Table 1 - Accessibility in the route to the units, according to the area

Items	Rural area		Urban area		P
	Accessible	Inaccessible	Accessible	Inaccessible	
Crosswalks	0 (0%)	92(100%)	14(21.5%)	51(78.5%)	<0.0001
Lowering of curbs	2 (2.2%)	90(97.8%)	13(20%)	52(80%)	0.001
Free sidewalks	1(1.1%)	91(98.9%)	1(1.5%)	64(98.5%)	1.000
Avenues without holes	4(4.3%)	88(95.7%)	10(15.4%)	55(84.6%)	0.35
Unevenness	7(7.6%)	85(92.4%)	11(16.9)	54(83.1%)	0.71
Sidewalk $\geq 1.50$ m	13(14.1%)	79(85.9%)	38(58.5%)	27(41.5%)	<0.0001
Visible traffic sign	1(1.1%)	91(98.9%)	16(24.6%)	49(75.4%)	<0.0001
Signaling indicating route	1(1.1%)	91(98.9%)	1(1.5%)	64(98.5%)	1.00
Semaphores with push-to-walk buttons	0 (0%)	92(100%)	0(0%)	65(100%)	-
Strategic semaphores	0(0%)	92(100%)	0(0%)	65(100%)	-

Table 2 - Accessibility for access to the buildings of the units, according to the area

Items	Rural area		Urban area		P
	Accessible	Inaccessible	Accessible	Inaccessible	
Lowering of doorsteps	1(1.1%)	91(98.9%)	5(7.7%)	60(92.3%)	0.88
Parking with ISA	0(0%)	92(100%)	0(0%)	65(100%)	-
Route	0(0%)	92(100%)	0(0%)	65(100%)	-
ISA on the floor	1(1.1%)	91(98.9%)	1(1.5%)	64(98.5%)	1.00
Vertical ISA	0(0%)	92(100%)	0(0%)	65(100%)	-
ISA on suspended board	0(0%)	92(100%)	0(0%)	65(100%)	-

\*ISA: International Symbol of Access.

The physical conditions of public streets in rural areas are worrying, since in this environment health units are sometimes located far from the elderly's homes, who need to travel to the institution, exposing themselves to risks along the way, as falls and traffic accidents. It should be noted that these risks are also related to the limitation of mobility caused by the physiological changes due to aging.<sup>10</sup> Conditions such pathways free of holes and unevenness, adequate traffic signaling, lowering of curbs, free and lowered sidewalks with a minimum width of 1.5 m are essential for mobility in the various spaces. These are strategic conditions for the inclusion of people with reduced mobility.<sup>11</sup> Furthermore, these measures imply quality of life for the population, economic displacement, better use of public spaces and health care.<sup>12</sup>

When older people reach the health unit, they face further architectural barriers. As observed in the study, both in the urban and the rural area, access was totally inadequate, with problems in the conditions outside the building, from the gates until the public street, with an inaccessible route.

These characteristics pose limitations and difficulties to access the health service, compromising the assistance. Accessibility to health services in primary care has been reported as one of the main problems related to care.<sup>13</sup> Adequate planning of health services, considering the available physical structure, contributes to a more efficient work process, providing more quality and accessibility to users who seek care.<sup>14</sup>

There was no significant difference between the areas regarding the access to the primary care units, although the urban area presented high percentage of accessibility. Urban accessibility makes it possible to achieve spaces that are free of physical barriers and involve the independent reach and use of spaces. In the case of the elderly, besides the difficulty in using the various inaccessible spaces, they may have limited social relations, and their personal space invaded by the need for help to guarantee their right to come and go.<sup>15</sup>

Still about access to the unit, we must highlight the importance of the aspects evaluated in this study. The lowering of doorsteps on the street allows the elderly to cross the streets safely, which avoids accidents caused if this movement had to be performed in spaces with stoppers. The parking lot should be close to the health unit and provide the route to the obstacle-free entrance for safe and autonomous traffic, with clear route for guiding the users.

In turn, the implementation of the International Symbol of Access indicates that the space is adequate to meet everyone satisfactorily, especially the elderly and other vulnerable groups; it indicates accessibility to the services and identifies usable and accessible spaces and equipment. Thus, these signs must be displayed in a way that allows them to be seen by individuals in different conditions, whether on the floor, vertical or suspended, and it is ideal to contemplate the three possibilities during the trajectory.

Health strategies should aim at improving the quality of life with public policies and actions in harmony with the environment, fostering community participation and social health promotion. Urban planning and the remodeling of the physical space are challenges for intersectoral actions that aim at the construction of healthy environments, with reduction of iniquities to allow safe access.<sup>16</sup>

Diverse social determinants should be in favor of healthy practices, including access to services, in order to achieve health promotion. Access can be considered the first step in meeting the health needs of the population, so that it must provide users with conditions to come and go, with independence, comfort and security.<sup>8,17</sup>

Nurses can contribute to quality of life by understanding and assisting the specific needs of this period, as well as the responsibilities of the health sector to develop health actions that include and promote the interaction of the elderly.<sup>18</sup> Understanding the accessibility conditions to the units allows them to act as disseminators of knowledge among other professionals and health managers in the search for change. It also demonstrates sensitivity to the benefits derived from this care strategy to favor the adherence of the elderly to the programs offered and their link with the service.

In practice, access to primary care is not universal, and actions that favor accessibility and equity are necessary, since any barriers or difficulties interrupt the continuity of care.<sup>19</sup> Physical adaptations as a complement to attitudinal strategies are important measures for structuring the society with inclusion and participation of all, in addition to inclusive awareness and sensitivity to meet the specific needs of individuals.<sup>20</sup>

As limitations of the study, the findings represent conditions of one region, which may compromise generalization to other sites. Thus, it is suggested to disseminate and evaluate the accessibility in future researches for comparison and increase of results, as well as to raise awareness among managers for this health necessity.

## CONCLUSION

The analysis of accessibility conditions of primary care units in urban and rural areas found unsatisfactory results in public streets and no accessibility to buildings. Notably, only the urban are presented an accessible item (width of sidewalks) in the public streets. As for access to the buildings, both areas were inaccessible. The results should alert and raise awareness of the need for public policies aimed at accessibility of services, since the elderly constitute a population that requires integral care.

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