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PRIMARY CARE ATTRIBUTES IN TRADITIONAL UNITIES AND WITH FAMILY HEALTH STRATEGY, AN OLDEST-OLD PATIENTS PERSPECTIVE

ATRIBUTOS DA ATENÇÃO PRIMÁRIA EM UNIDADES TRADICIONAIS E UNIDADES COM ESTRATÉGIA DE SAÚDE DA FAMÍLIA, UMA PERSPECTIVA DE IDOSOS LONGEVOS

Joel Hirtz do Nascimento Navarro[1]
Cintia Cristina Sulzbach[2]
Angelo Jose Gonçalves Bós[3]

ABSTRACT - The objective of this study was to compare the presence and extent of the attributes of Primary Healthcare (PHC) in two different models of public of PHC services: Family Health Strategy (FHS) and traditional public PHC (THC), in the perspective of the oldest-old people (80 years and older). This is an observational, cross-sectional study with quantitative and analytical approach, in public PHC services in Porto Alegre, Rio Grande do Sul, with oldest-old users of public PHC (n=50). In the General Score, THC had higher degree for orientation of PHC than FHS. Observing the Essential Score, THC scored higher orientation for PHC, while FHS scored lower. Concerning Derivate Attributes, both models scored lower orientation. Although THC units showed better performance in almost all attributes, except Community Orientation, statistically significant differences were observed in Longitudinality (p=0.058), Coordination - Integration of Care (p=0.018) and Comprehensiveness - Services Available (p<0.001). This study leads us to reflect on the most appropriate way to assess long-term care in PHC. It also has the potential to contribute to the construction of comprehensive care lines aimed at the oldest-old population, which should include monitoring their therapeutic itineraries, programmed surveillance and care activities.

[1] Fisioterapeuta. Mestre em Gerontologia Biomédica pela Pontifícia Universidade Católica do Rio Grande do Sul (PUCRS), Doutorando em Saúde Coletiva na Universidade Federal do Espírito Santo (UFES).
[2] Nutricionista. Mestre em Gerontologia pela Universidade Federal de Santa Maria (UFSM).
[3] Médico geriatra. Professor Titular da Escola de Medicina da Pontifícia Universidade Católica do Rio Grande do Sul (PUCRS).

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Keywords: aged; aged 80 and over; aging; primary health care.

RESUMO - Este estudo teve como objetivo comparar a presença e extensão dos atributos da Atenção Primária à Saúde (APS) em dois modelos diferentes de serviços públicos de APS: Estratégia de Saúde da Família (ESF) e APS pública tradicional (THC), na perspectiva dos idosos longevos (80 anos ou mais). Estudo observacional, transversal, com abordagem quantitativa e analítica, realizada em serviços públicos da APS em Porto Alegre, Rio Grande do Sul, com idosos longevos usuários da APS (n = 50). No escore geral, o THC apresentou maior grau de orientação da APS do que a ESF. Observando o escore essencial, o THC obteve maior orientação para a APS, enquanto a ESF obteve menor. Em relação aos Atributos Derivados, ambos os modelos obtiveram menor orientação. Embora as unidades de THC tenham apresentado melhor desempenho em quase todos os atributos, exceto Orientação Comunitária, foram observadas diferenças estatisticamente significantes em Longitudinalidade (p = 0,058), Coordenação - Integração do Cuidado (p = 0,018) e Abrangência - Serviços Disponíveis (p <0,001). Este estudo nos leva a refletir sobre a maneira mais apropriada de avaliar os cuidados de longo prazo na APS. Também tem o potencial de contribuir para a construção de linhas de atendimento abrangentes voltadas para a população idosa, que deve incluir o monitoramento de seus itinerários terapêuticos, vigilância programada e atividades assistenciais.

Palavras-chaves: idoso; idoso de 80 ou mais; envelhecimento; atenção primária à saúde.

INTRODUCTION

Oldest-old, in developing countries, are those aged 80 years or older and have peculiar characteristics of aging process multimorbidity (SOLDERA; OLIVEIRA; BÓS, 2015). The presence of chronic diseases and decreased functional capacity, which require constant care, continuous medication and periodic examinations, results in greater demand and use of the older-aged group by health services (VERAS, 2009). Thus, health services should offer care based on the demands of specific age situations, such as chronic diseases, organic and social weaknesses (VERAS and OLIVEIRA, 2018).

The aging population refers to the change in the age structure of a population in which there is an increase in the weight of persons above a certain age regarded as defining the onset of old age (FREITAS and PY, 2011). This phenomenon has been accelerating worldwide. The forecast is that the number of people over 60 years in the

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world jump from 901 million (2015 value) to 1.4 billion in 2030 a growth of 56% (UN, 2019). In Brazil, projections indicate that oldest-old will increase from approximately 3 million in 2010 to 19 million in 2060, respectively, represented by 1.53% and 8.36% of total population (IBGE, 2019). This group also and increasing in proportion and accelerated manner, constituting the fastest growing segment in recent times.

From this perspective, the PHC is crucial in the health of the elderly, constituting as the contact preference with Unified Health System (UHS) in Brazil (GOMES et al., 2011). The FHS is the means by which PHC is reorganized through a new paradigm in health care, from the perspective of change and conversion of the mechanistic and biomedical care model into a collective health model, multiprofessional and family and community centered (GOMES et al., 2011).

The PHC model adopted by Brazil considers as its specific attributes the provision of first contact services, the assumption of longitudinal responsibility by the patient, the guarantee of integral care, the coordination of the various actions and services indispensable to solve health needs, the orientation for community, family centrality and cultural competence (PAHO, 2011).

The evaluation of the different PHC models based on their attributes is shown to be a fundamental element for UHS planning and health care for the oldest-old, as the appropriate use of these services is the result of the interaction of the behavior of the individual seeking care, of the professional who conducts it within the health system and the preventive, diagnostic and therapeutic resources available (TOMASI et al., 2011; OLIVEIRA et al., 2013).

Several studies have used and indicated the Primary Care Assessment Tool (PCATool) to evaluate PHS in Brazil (RIBEIRO; SCATENA, 2019; MELO et al., 2019; DOTTO, et al., 2016; ANTUNES; PADOIN; PAULA, 2018; PENSO, et al., 2017). The Brazilian PCATool version (PCATool-Brasil) measures the presence and extent of the attributes that must be present in the PHC model that was adopted in the country (BRASIL, 2010). Due to the lack of instruments to assess the attributes of PHC in Brazil, PCATool fills this gap in the measurement of aspects of the structure, process and results of national PHC services(BRASIL, 2010).

Accordingly, the aim of this study was to compare two different models of PHC, a FHS to non-FHS services designated in the oldest-old people perspective.

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METHODS

Observational, cross-sectional study with quantitative and analytical approach. The sample consisted of the oldest old, ascribed at the PHC services municipal in two sanitary districts of the city of Porto Alegre, Rio Grande do Sul, Brazil. The oldest-old were classified as: FHS group (users of PHC with FHS) and Traditional Health Care (THC) group (users of PHC without FHS).

Study participants were recruited using the convenience sampling technique. First, a meeting was held at the District Health Management of the two health districts with the PHC managers from both territories. On this occasion, according to the availability of the coordinators, 8 units were chosen for the study (4 with FHS and 4 THC). Then, through the registration of people aged 80 and older provided by health teams, the oldest were recruited via telephone or in person, in their homes. Data collection was performed between April and October 2015 in the homes of the elderly.

We included elderly people aged 80 years and over, of both sexes, enrolled in PHC with and without FHS from both health districts and who agreed to participate, regardless of cognitive status. In the case of cognitive impairment, evidenced during the interview (incoherent speech and memory lapses observed by the researcher), the information was obtained from the nearest caregiver or family member. Older people living in long-term care institutions were excluded from the study.

The study by Oliveira et al. (2013) observed differences in overall score PCATool between primary and non FHS through the Primary Evaluation Instrument. The score corresponded to 5.0 (95% confidence interval, 4.62-5.46) for units without FHS and 5.70 (95% confidence interval, 5.30-6.00) for with FHS.

In this study, to observe statistical difference between the two PHC models with a Statistical Power of 80% and an Alpha Error of 5% it would be necessary to interview 33 oldest-old subjects in each of the groups using the University of British Columbia Department of Statistics application (DEPARTMENT OF STATISTICS, UNIVERSITY OF BRITISH COLUMBIA, 2015).

The socioeconomic profile of the oldest old was analyzed using information such as sex, age, self-declaration of skin color, education, marital status, number of children, people living in the elderly's residence, presence of caregiver, frequency that usually leaves the residence, occupation during life, income monthly and source of income. Demographic data of the research participants were also obtained, such as neighborhood,

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city, among others.

The PCATool-Brazil was used to compare to the perception of oldest-old people in FHS and THC models. The instrument measures the presence and extent of four key attributes and the three derived attributes of the PHC and the degree of user affiliation to the health service (STARFIELD; XU; SHI, 2001; CHARLYN et al., 2000). It was adapted to the Brazilian reality by Harzheim et al., (2000) and Harzheim (2006).

The four essential attributes of PHC services measured by PCATool are: individual's first contact access to the health system; longitudinality; integrality and coordination of care (BRAZIL, 2010). The three derived attributes that qualify the actions of PHC services measured by the PCATool are: family-centered health care (family orientation); community orientation and cultural competence (BRAZIL, 2010).

The validated version of PCATool for adults (PCATool-Brasil Adult Version) contains 87 items (questions) divided into 10 components related to PHC attributes, namely: Degree of Health Service Affiliation; First Contact Access; First Contact Access - Accessibility; Longitudinality; Coordination - Care Integration; Coordination - Information System; Integrality - Available Services; Integrality - Services Provided; Family orientation; Community Guidance.

Each question enables, through Likert-type answers (4 = sure, yes; 3 = probably, yes; 2 = probably, no; 1 = sure, no, and 9 = don't know / don't remember) APS for each attribute, which are then transformed on a scale from 0 to 10 (OLIVEIRA, 2013). The average of the scores of attributes and their components produces the PHC General Score. This score allows the group of health services in a high degree of orientation to PHC when it assumes values greater than or equal to 6.7 and, in a low degree, when it assumes values less than 6.7 (OLIVEIRA, 2013).

The comparison between the means of the numerical independent variables and the two APS groups was tested by Student's t-test. The association of the level distribution of the categorical variables and the two groups was tested by Chi- square. Significance levels below 5% ($p < 0.05$) were considered statistically significant and between 10% and 5% as indicative of significance.

The research project was submitted to the PUCRS IGG Scientific Commission and the Research Ethics Committees of PUCRS. PUCRS and SMS, obtaining approval to be executed through opinions number 901,478 (CEP SMS / POA) and 852,070 (CEP PUCRS). Each survey participant received the Informed Consent.

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RESULTS

Of the total oldest old respondents (n=50), 62% were women and the average age was 83,4 years. Regarding self-declaration of skin color, the white color comprised 68% of the sample. The average of years of schooling was 3,5 years and the most cited marital status was widowed (48%). The average number of children was significantly higher among the group THC, corresponding to 3.5 children ($p = 0.041$). The average individual income in minimum wages of the participants was 1.5 for the FHS group and 1.0 for the group THC, which is a very significant difference ($p < 0.001$). Demographic and socioeconomic profile of participants are shown in Table 1.

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Table 1. Sociodemographic Profile of Participants According to The Type of Primary Health Care Service.

Sociodemographic profile	FHS	THC	Total	P
Gender				0,341
Female	17 (54,8%)	14 (45,2%)	31 (62%)	
Male	13 (68,4%)	6 (31,6%)	19 (38%)	
Idade	83,7±3,36	82,9±3,11	83,4±3,26	0,381
Ethnicity				0,893
White	21 (61,8%)	13 (38,2%)	34 (68%)	
Mixed	2 (50%)	2 (50%)	4 (8%)	
Black	7 (58,3%)	5 (41,7%)	12 (24%)	
Years of Study	3,0±2,37	4,0±3,37	3,5±2,9	0,243
Marital status				0,932
Married	11 (57,9%)	8 (42,1%)	19 (38%)	
Divorced,withoutpartner	2 (66,7%)	1 (33,3%)	3 (6%)	
Live with partner	2 (66,7%)	1 (33,3%)	3 (6%)	
Unmarried - single, without partner	1 (100%)	0	1 (2%)	0,932
Widow, without partner	14 (58,3%)	10 (41,7%)	24 (48%)	0,932
Number of children	2,5±1,52	3,5±1,57	2,9±1,60	0.041
People that live with				
Alone	6 (66,7%)	3 (33,3%)	9 (18,0%)	0,724
Spouse or partner	10 (52,6%)	9 (47,4)	19 (38.0%)	0,405
Children	15 (55,6)	12 (44,4)	27 (54,0)	0,487
Caregiver	1 (50,0%)	1 (50,0%)	2 (4,0)	1,000
Other people	5 (41,7)	7 (58,3)	12 (24,0)	0,182
Presence of Caregiver				
No	25 (61%)	16 (39%)	41 (82%)	0,851
Yes, familiar	3 (50%)	3 (50%)	6 (12%)	0,851
Yes, professional	2 (66,7%)	1 (33,3%)	3 (6%)	0,851
Frequency of leaving home per month	12,6±9,4	11,7±10,7	12,3±9,88	0,747
Time living in residence (years)	31,5±18,1	35,6±21,6	32,5±19,85	0,476
Individual income (in minimum wages)	1,5±0,87	1,0±0,32	1,3±0,78	<0,001

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The comparison of the PHC attributes between the two models in the perception of the oldest old was shown in Table 2. In the General Score, based on the 6.7 cutoff point used by Oliveira et al. (2013), THC model had a high degree orientation of PHC (6.7), while FHS model had a low degree (6.1), obtaining a statistically significant difference (p= 0.030). Observing the Essential Score, there was a statistical difference between the services (p= 0.006), in which THC model had a score indicating high orientation for PHC (7.2), while FHS model had low (6.5). Concerning Derivate Attributes, was found a low orientation, in the both models, FHS (4.6) and THC (5.0), there was not statistical difference. Although THC units showed better performance in almost all attributes, except Community Orientation, statistically significant differences were observed in Longitudinatity (p= 0.058), Coordination - Integration of Care (0.018) and Comprehensiveness - Services Available (p= <0.001).

Both models showed a high degree of PHC orientation for the Affiliation, with no significant difference between the two types of services. Three attributes had a high degree orientation of PHC in the both models. The best performance was First Contact – Utilization, FHS model score with 8.7 and THC model 9.2. Then followed by Longitudinality, scored by 8.3 in FHS and 8.8 in THC. The thirdly was Coordination - Information System, that the score was 6.9 in FHS and 7,4 in THC.

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Table 2. PHC AttributesAccording With The Model Care

PHC Attributes	FHS	THC	P
Affiliation	10±0,00	9,8±0,31	0,224
First Contact – Utilization	8,7±2,36	9,2±1,56	0,260
First Contact – Accessibility	4.3±1.27	4.6±1,17	0,361
Longitudinality	8,3±0,89	8,8±0,86	0,058
Coordination - Integration of Care	5,8±2,42	7,5±2,00	0,018
Coordination - Information System	6,9±1,80	7,4±1,40	0,278
Comprehensiveness - Services Available	3,6±1,73	5,4±1,67	<0,001
Comprehensiveness - Services Provided	4,2±1,13	4,7±1,51	0,157
Family Centeredness	4,5±3,07	6,0±2,48	0,093
Community Orientation	4,6±2,3	4,1±2,41	0,430
Essential Score	6,5±0,93	7,2±0,56	0,006
Derivate Score	4,6±2,39	5,0±1,82	0,491
General Score	6,1±1,12	6,7±0,89	0,030

DISCUSSION

The comparison of the degree of PHC orientation between the two types of services from the perception of the oldest old was analyzed. The results of this study revealed that from the perspective of the oldest old people, THC showed a high degree of PHC orientation compared to FHS services. It would be expected to be the opposite, because from the stand point of Peixoto, Carvalho and Vilasboas (2017), in Brazil, FHS model is the PHC's priority strategy and should focus on a broader health perspective. In addition to that, other studies have pointed to better FHS performance compared to THC with PCATool (NASCIMENTO et al., 2019; HERZHEIM et al., 2016), including elderly (DOTTO et al., 2016; CARVALHO et al., 2013; OLIVEIRA et al., 2013).

It is indicated that in the present study the PHC General Score was worse in FHS because they are inserted in an unfavorable context for the effectiveness of health actions, located in more vulnerable places, with less physical structure and directly interfere with the health disease process and the use of health services by this population segment.

Both BHU models showed a high degree of orientation for the Affiliation

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attribute, being the average of this higher in the units with FHS. It is assumed that the use of PHC with FHS as a source of care by the elderly may be greater because their teams have community health agents, who are assigned the articulation of actions between health professionals and the community (SALIBA et al., 2011).

Both FHU and non-FHU UBSs showed a high degree of orientation towards the First Contact Access attribute and its Utilization component, demonstrating that the first services sought by respondents when a new health problem arises or an already worsening condition occurs. existing are those services. The Accessibility component of this same attribute obtained low orientation in both PHC models.

The study by Araújo et al. (2014) evaluated the quality of PHC in FHS in a city in Northeastern Brazil from the perspective of the elderly and identified that the units studied had a high degree of orientation for the component Use of the First Contact Access attribute and low degree for the Accessibility component of this same attribute, corroborating the findings of this study.

Salway et al. (2017) verified in their study that the elderly access is unequal. Higher income and education were associated with the use and access to consultations (ZANESCO et al., 2018).

Considering that better access to PHC is related to the reduction of emergency visits, prioritizing long-term care and services may also decrease hospitalizations of PHC-sensitive conditions (BERG, LOENEN and WESTERT, 2016; BÓS and KIMURA, 2015).

Related the longitudinality, both models obtained a high degree of orientation. Lourenço (2014) identified that all units studied had a high degree of orientation for this attribute, which is similar to the present research with the oldest old.

Studies indicate that longitudinality is implicated with older age, due to the growing need to attend health services as a result of chronic diseases (KESSLER et al., 2018; ARAÚJO et al., 2014). Factors favoring longitudinality are time to develop interpersonal relationships, service organization, accessibility, user characteristics and the presence of chronic disease according with Kessler et al. (2018) and Paula et al. (2015). This evidence supports the appreciation of relationships in order to ensure an effective interaction aimed at the quality of health care.

When compared in relation to the attribute Coordination and its components, the FHS presented low degree of orientation for Care Integration and high degree for the Information System, unlike the THC that obtained high degree of orientation for both dimensions.

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The care Integration and referral and counter-referral approach involves interdependent aspects such as service regulation, conditions of access to services, human resources and logistical support systems. It is suggested that possible failures in some of these elements that make up care integration may have interfered with the health monitoring of a portion of the long-term UBS users with FHS, which led them to perceive this component more negatively.

A study realized in Sweden with elderly showed that most patients had not visited any health care facility during the month prior to the index hospital admission and had revealed a significant increase of health care utilization after hospitalization. They found that although most patients received written information at discharge, many of them felt insecure after discharge and lacked knowledge about which health care provider to consult in the case of deterioration or complications (SÄFSTRÖM, JAARSMA and STRÖMBERG, 2018). This research confirms the importance of coordination in the elderly care.

FHS and THC showed low orientation for the attribute Integrality and its two components Available Services and Services Provided. It is also noteworthy that the average of FHS was lower than that of traditional PHC services.

Another research focused on the health needs of older people in two health districts of Porto Alegre City, RS, found that only 23.9% of the PHC services evaluated were considered Integrality providers, according to the interviewees' perception (MARTINS et al., 2014).

From the perception of the interviewed elders, both PHC models presented low orientation for the Family Orientation derived attribute. This attribute refers to the fact that health teams consider individuals, whether elderly or not, in their living environments, assessing their needs for health actions within their family context and their exposure to health hazards, coordinating care through existing family resources (ALENCAR et al., 2014). Studies comparing UBS with FHS between UBS without FHS showed that Family Orientation appeared with low scores and below expectations for services with FHS (ELIAS et al., 2006; VAN STRALEN, 2008; BELISÁRIO et al., 2008). It is thought that the family as a central unit of care is going unnoticed within the work routine of family health team professionals because they still work with remnants of the biomedical, curative and health care model, leaving aside integral care and the concept of expanded clinic in PHC, establishing reductionist and disease-focused practices.

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Both PHC models presented low orientation for the Community Orientation attribute, although the average of this score was higher for services with FHS. In this attribute PCATool works mainly with issues related to Social Control, ie, community participation in PHC service management and decision-making, questions on conducting research to improve units and on possible invitations to participate by Local Councils. of Health are emphasized. It should be remembered that the legal framework for the beginning of SUS establishes community participation as the basic principle of health services management through article 7 of the Organic Health Law and Law 8,142 of December 28, 1990.

The study by Alencar et al. (2014) specifically used the PCATool Family Orientation and Community Orientation attributes to evaluate the FHS in the city of São Luís, Maranhão, from the perspective of three groups: users (adults and elderly), professionals and managers. The authors came up with very interesting results: the means that indicate the degree of PHC orientation to their attributes have gradually increased as they were evaluated. in the perception of health professionals and managers.

It is observed that in the scientific literature as in the present research attributes that are part of the ideological framework of the Brazilian Sanitary Reform and the ideals conquered through historical popular struggles for the right to health have not yet been universalized. There are few comparative studies between THC and FHS health care provided to elderly people and studies focused on the oldest-oldare unknown.

The oldest-old population is the fastest growing in Brazil and demand for specialized care, as they present high vulnerability. Long-term care in PHC is still incipient according to the data obtained in this study. According to Camacho et al. (2018), that verified the reason for decrease in the number of centenarians in Brazil, observed that the causes of death of nonagenarians and centenarians are inaccurate and poorly defined, verifying significant association of health care with lack of access to health services. Additionally, the authors point out a possible difficulty for health professionals in long-term care and the need for multidisciplinary care.

PHC was identified by the elderly as the main service they seek to obtain health care, however, accessibility has not been positively evaluated in both health models. It is suggested that PHC service managers plan measures to also consider the specific demands of older elderly people, such as the oldest old, as this group may have more physical limitations and chronic diseases that prevent them from going to health units in seeking care to prevent, protect or recover their health condition.

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Considering that PHC can be preferentially the first element of a continuous health care process, some suggestions can be mentioned to improve the comprehensive care of the long-lived, such as: the creation of devices that guarantee the widest possible inclusion of the long-lived in the units of health; the increase in the number and improvement of the working conditions of the community agents, since they play an important interlocutor role between the health services and the population of their territories; the evaluation and periodic qualification of teams and family health units; conducting training and qualifications for health teams addressing content related to the specificities of the long-lived population in the context of primary care; conducting research on the main demands of long-lived members of the PHC services; the creation of comprehensive care lines, which comprise the entire therapeutic itinerary and differentiated forms of access; that it is guaranteed that in the management of services there is a professional specialized in the field of gerontology; the implementation of participative management, in the form of Councils, which includes the elderly in these processes and that there is training to exercise this function.

In order to achieve the promotion of the health of the oldest-old in Brazil, the role of determinants on health conditions must be considered (BUSS, 2000). It is necessary to understand that health depends on a set of related factors such as quality of life, food and nutrition, housing, sanitation, good working conditions, lifelong education, social support, favorable possibilities for choosing healthy lifestyles, among others. In this sense, it is believed that only through a truly democratic society that strengthens the social rights of this population, as well as its public health system, in order to develop conditions favorable to the health of the oldest-old population.

The perception of the oldest old in relation to the essential attributes of PHC showed the need to qualify PHC actions in the city of Porto Alegre because, it still does not have the effectiveness of its proposed actions for health care for the oldest old.

CONCLUSIONS

This study leads us to reflect on the most appropriate way to assess long-term care in PHC. It also has the potential to contribute to the construction of comprehensive care lines aimed at the oldest-old population, which should include monitoring their therapeutic itineraries, programmed surveillance and care activities.

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We demonstrate that the attributes of PHC must be strengthened in both primary care models, especially in those with FHS. The more present the attributes of PHC in these services, the greater will be their ability to interact with the long-lived population, achieving comprehensive care.

Finally, this study showed the need to expand and strengthen the UHS to guarantee the right to health of the long-lived population in Brazil. In order to achieve better health conditions for the oldest-old, the public authorities and civil society must strengthen Social Security in the country, which corresponds to an integrated set of actions to guarantee the rights to health, social security and social assistance.

Considering that health is a right of all and a duty of the State, civil society, health professionals and other social actors involved and committed to the health of the elderly population should intensify their participation in the struggle to guarantee social and economic policies that aim at universal and equal access to health, as well as its promotion, protection and recovery and the strengthening of UHS in Brazil.

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