



Estratégia Saúde da Família

Rede de Pesquisa em Atenção Primária à Saúde



Universidade Federal de Pelotas
Faculdade de Enfermagem
Programa de Pós-Graduação em Enfermagem



30 anos da ESF

Equidade no Acesso e na Qualidade da APS

Impacto na Sobrevivência de Idosos

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Rede de Pesquisa em APS

Programa de Pós-Graduação em Enfermagem - UFPEL

PROFSAÚDE - UFPEL - FIOCRUZ

11 de outubro de 2024



Estratégia Saúde da Família: promoção da equidade

Equipes multiprofissionais responsáveis por territórios e populações definidas

1994 - PSF - 328 equipes - piores indicadores de saúde, municípios pequenos e médio porte com oferta insuficiente

- 9 estados em 12 municípios

2002 - 15.201 equipes em 3.948 municípios - 50,3% de cobertura

2004 - PROESF - ESF em municípios com mais de 100.000 habitantes

2006 - PNAB - Pacto pela Saúde

2012 - 2018 - PMAQ - Programa de Melhoria do Acesso e da Qualidade

2013 - PMM - Programa Mais Médicos

2017 - PNAB - retrocessos - carga horária, número mínimo ACS,...

2023 (dez): 50.804 equipes - 5.524 (99,2%) dos municípios - cobertura - 70%

31.024 equipes de Saúde Bucal e 5.647 equipes AB, 278.209 ACS

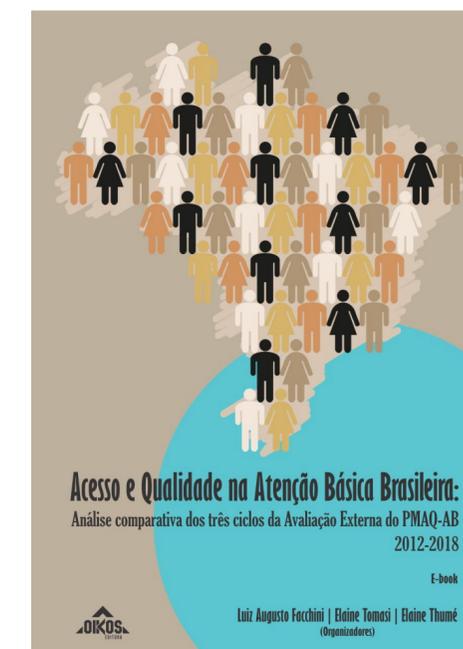
<https://atencaoprimaria.com.br/50-000-equipes-de-saude-da-familia-no-brasil/>

(Klitzke, 2024)

2024 - ESF - 52.000 equipes SF; 31.549 Eq SB; 402.777 ACS e ACE



Sousa Maria Fátima de, Ed Hucitec, 2002



Facchini, Tomasi, Thumé, 2021. Acesso e Qualidade na Atenção Básica Brasileira. Ed Oikos.

Qualidade da atenção à saúde da criança na primeira semana de vida

PMAQ, Brasil (2012-2018)

Houve aumento da qualidade ao longo do período em equipes que realizavam a busca ativa e o registro adequado do acompanhamento das crianças, visita domiciliar do ACS e consulta de puerpério.

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Tendências na qualidade da atenção à saúde da criança na primeira semana de vida na Atenção Primária no Brasil
Trends in the quality of child health care in the first week of life in primary care services in Brazil

TEMAS LIVRES FREE THEMES

1

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Abstract The aim of this study was to assess temporal trends in the quality of health care during the first-week child check-up in primary care services stratified by municipal, health team and maternal characteristics. We conducted a cross-sectional study using data from the three cycles of the National Program for the Improvement of Access and Quality (PMAQ) (2012, 2014 and 2018). Adult service users with children aged up to 2 were interviewed. The outcome was "good quality health care in the first week of life". Descriptive and time trend analyses were performed using variance-weighted least squares regression. The frequency of good quality care during the first-week check-up was 47.9% (95%CI 46.6-49.3) in 2012, 52.5% (95%CI 51.3-53.7) in 2014 and 53.3% (95%CI 52.2-54.4) in 2018, with an annual increase of 0.73 pp (p<0.001). The annual increase was greater in the Northeast (2.06 pp) and in municipalities with very low/low HDI (1.48 pp) and 100% family health strategy coverage (0.98 pp). Trends in the frequency of good quality health care during the first-week child check-up were favorable.

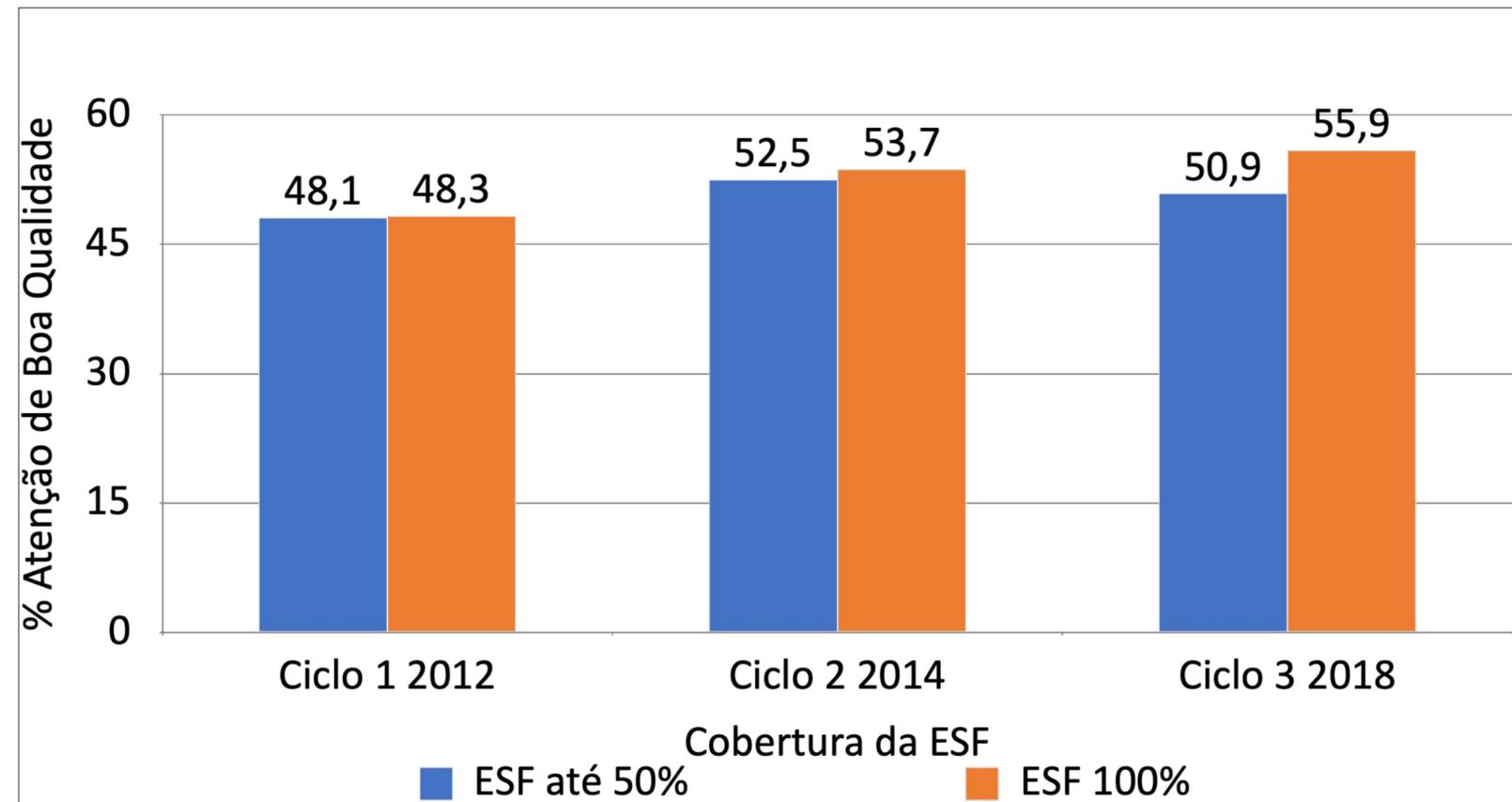
Resumo O objetivo deste estudo foi avaliar a tendência temporal da qualidade da atenção à saúde da criança na consulta da primeira semana de vida no nível da Atenção Primária à Saúde, segundo características dos municípios, do processo de trabalho das equipes e das usuárias responsáveis pelas crianças. Foram realizadas análises transversais com dados dos três ciclos do Programa Nacional de Melhoria do Acesso e da Qualidade (PMAQ) (2012, 2014 e 2018). Usuárias adultas com filhos de até dois anos foram entrevistadas. O desfecho foi a "boa qualidade da atenção à saúde na primeira semana de vida". Foram realizadas análises descritivas e de tendência temporal por meio de regressão de mínimos quadrados ponderados por variância. A frequência de boa qualidade na consulta da primeira semana de vida foi 47,9% (IC95% 46,6-49,3) em 2012, 52,5% (IC95% 51,3-53,7) em 2014 e 53,3% (IC95% 52,2-54,4) em 2018, com um aumento anual de 0,73 ponto percentual (p<0,001). O aumento anual foi maior na região Nordeste (2,06 pp) e com IDH muito baixo/baixo (1,48 pp) e com 100% de cobertura de ESF (0,98 pp). Ao longo dos três ciclos do PMAQ-AB houve uma evolução favorável na frequência da boa qualidade na atenção à saúde na primeira semana de vida.

Key words Health care quality assessment, Primary Health Care, Trends, Child Health

Palavras-chave Avaliação da qualidade do cuidado de saúde, Atenção Primária à Saúde, Tendências, Saúde da Criança

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Cien Saude Colet 2024; 29:e09192022



Flores-Quispe M del P, Duro SMS, Facchini LA, Barros NBR, Tomasi E. Tendências na qualidade da atenção à saúde da criança na primeira semana de vida na Atenção Primária no Brasil. Ciênc saúde coletiva [Internet]. 2024;29(1): e09192022. Available from: <https://doi.org/10.1590/1413-81232024291.09192022>

Family Health Strategy, Primary Health Care, and Social Inequalities in Mortality Among Older Adults in Bagé, Southern Brazil

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See also Miles, p. 762, and Galea and Vaughan, p. 787.

Objectives. To investigate the role of the Family Health Strategy (FHS) in reducing social inequalities in mortality over a 9-year follow-up period.

Methods. We carried out a population-based cohort study of individuals aged 60 years and older from the city of Bagé, Brazil. Of 1593 participants at baseline (2008), 1314 (82.5%) were included in this 9-year follow-up (2017). We assessed type of primary health care (PHC) coverage and other variables at baseline. In 2017, we ascertained 579 deaths through mortality registers. Hazard ratios and their 95% confidence intervals modeled time to death estimated by Cox regression. We also tested the effect modification between PHC and wealth.

Results. The FHS had a protective effect on mortality among individuals aged 60 to 64 years, a result not found among those not covered by the FHS. Interaction analysis showed that the FHS modified the effect of wealth on mortality. The FHS protected the poorest from all-cause mortality (hazard ratio [HR] = 0.59; 95% confidence interval [CI] = 0.36, 0.96) and avoidable mortality (HR = 0.46; 95% CI = 0.25, 0.85).

Conclusions. FHS coverage reduced social inequalities in mortality among older adults. Our findings highlight the need to guarantee universal health coverage in Brazil by expanding and strengthening the FHS to promote health equity. (*Am J Public Health.* 2021;111:927–936. <https://doi.org/10.2105/AJPH.2020.306146>)

Socioeconomic inequalities in mortality are a major public health issue because the associated burden is on a grand scale¹ and persists at older ages.^{1–3} Monitoring the magnitude of socioeconomic inequalities in mortality among older adults has become even more important because of worldwide population aging.² Such inequalities indicate the need for improvements in life expectancy among lower socioeconomic groups² as well as policies that address both social and medical determinants of health.^{4,5}

Policies toward universal public health systems⁵ framed by the values and principles of primary health care (PHC) represent the main strategy to achieve the World Health Organization's stated goal of health for all.⁶ PHC was introduced in the Brazilian public health system during the 1980s and implemented after the creation of the Unified Health System (Sistema Único de Saúde [SUS]), which made considerable progress toward delivering universal and comprehensive health care during the last 30 years.⁷ During the 1990s, the Family Health

Strategy (FHS) was developed to reorganize and restructure the health system, aiming to strengthen primary care.^{7–9} The FHS has multidisciplinary teams including community health workers, that are responsible for meeting the health care needs of approximately 10 households in a defined geographical area.^{10,11} By contrast, traditional primary health care (TPHC) teams do not have a fixed structure; contain more medical professionals, sometimes including specialists such as pediatricians, obstetricians, and gynecologists; do not

Research Peer Reviewed



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A ESF minimiza o impacto das iniquidades sociais na mortalidade de idosos?

- Estudo de Coorte
- Município de Bagé, RS
- 2008 - 1593 indivíduos com 60 anos ou mais
- 2016/2017 - 1315 acompanhados após 9 anos (82.5%)

Kessler M, Thumé E, Marmot M, Macinko J, Facchini LA, Nedel FB, Wachs LS, Volz PM, de Oliveira C. Family Health Strategy, Primary Health Care, and Social Inequalities in Mortality Among Older Adults in Bagé, Southern Brazil. *Am J Public Health.* 2021 May;111(5):927–936. doi: 10.2105/AJPH.2020.306146. Epub 2021 Mar 18.

RESEARCH ARTICLE

Open Access

Cohort study of ageing from Bagé (SIGa-Bagé), Brazil: profile and methodology



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Abstract

Background: The Bagé Cohort Study of Ageing is a population-based cohort study that has recently completed the first follow-up of a representative sample of older adults from Bagé, a city with more than 100,000 inhabitants located in the state of Rio Grande do Sul, Brazil. This is one of the first longitudinal studies to assess the impact of primary health care coverage on health conditions and inequalities. Our aim is to investigate the prevalence, incidence and trends of risk factors, health behaviours, social relationships, non-communicable diseases, geriatric diseases and disorders, hospitalisation, self-perceived health, and all-cause and specific-cause mortality. In addition, we aim to evaluate socioeconomic and health inequalities and the impact of primary health care on the outcomes under study.

Methods/design: The study covers participants aged 60 or over, selected by probabilistic (representative) sampling of the urban area of the city of Bagé, which is covered by Primary Health Care Services. The baseline examination included 1593 older adults and was conducted from July 2008 to November 2008. After eight to nine years (2016/2017), the first follow-up was conducted from September 2016 to August 2017. All participants underwent an extensive core assessment programme including structured interviews, questionnaires, cognitive testing (baseline and follow-up), physical examinations and anthropometric measurements (follow-up).

Results: Of the original participants, 1395 (87.6%) were located for follow-up: 757 elderly individuals (47.5%) were re-interviewed, but losses in data transfer occurred for 22. The remaining 638 (40.1%) had died. In addition, we had 81 (5.1%) refusals and 117 (7.3%) losses. Among the 1373 older adults who were followed down, there was a higher proportion of female interviewees ($p=0.042$) and a higher proportion of male deaths ($p=0.001$) in 2016/2017. There were no differences in losses and refusals according to gender ($p=0.102$). There was a difference in average age between the interviewees (68.8 years; SD ± 6.5) and non-interviewees (73.2 years; SD ± 9.0) ($p<0.001$). Data are available at the Department of Social Medicine in Federal University of Pelotas, Rio Grande do Sul, Brazil, for any collaboration.

Keywords: Cohort study, Epidemiology, Population based, Old health care, SIGa-Bagé, Brazil

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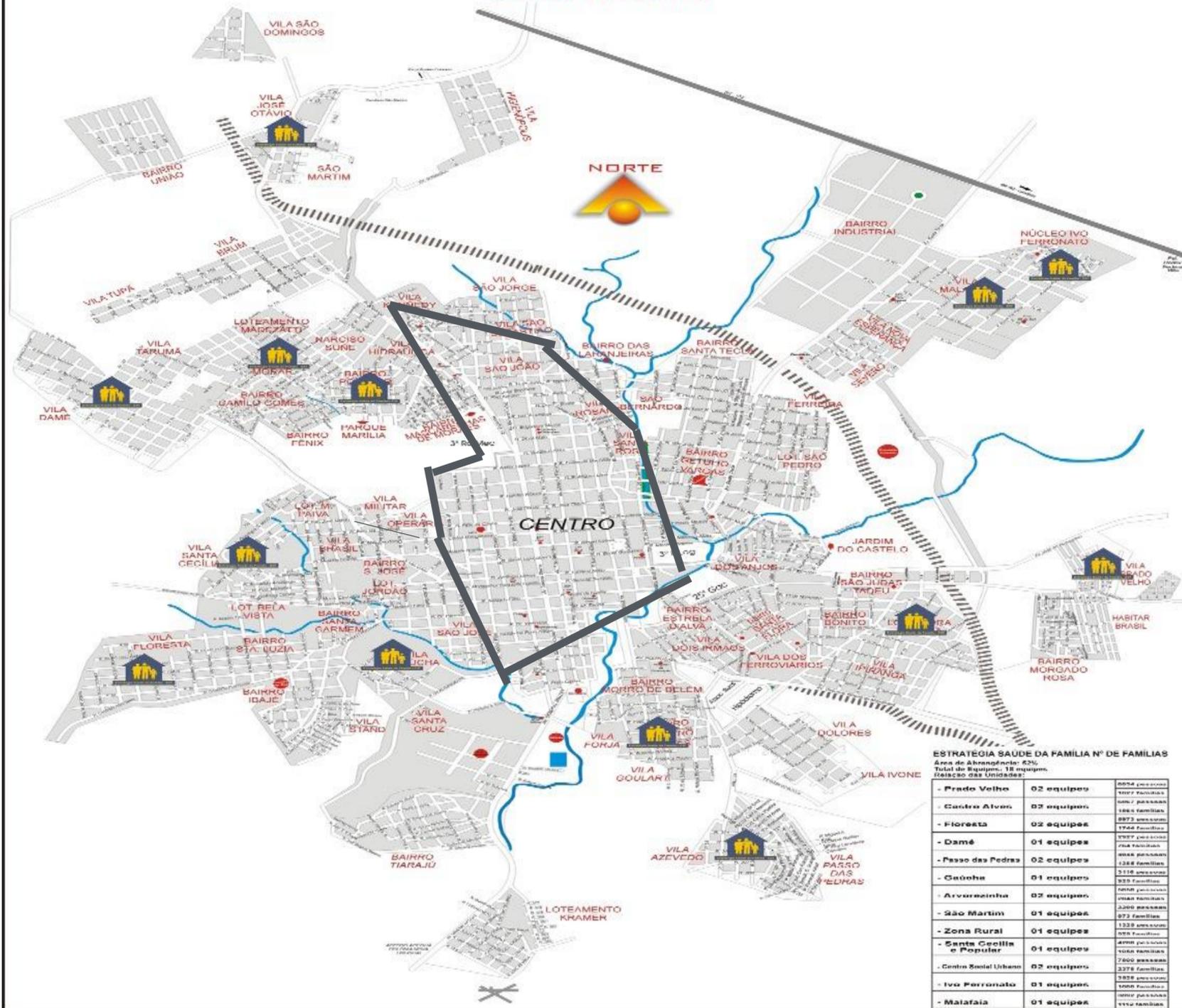


Coorte SIGa-Bagé



- 2008 - População total - 122.461 habitantes (82% taxa de urbanização)
- População com 60 anos ou mais - 14.792 idosos (zona urbana 12.050 - IBGE, 2006)
- Expectativa de vida ao nascer - 72 anos (PNUD, 2003)
 - 2010 - 75,86 anos (IBGE)
- 2003 - Implantação das 1as equipes ESF

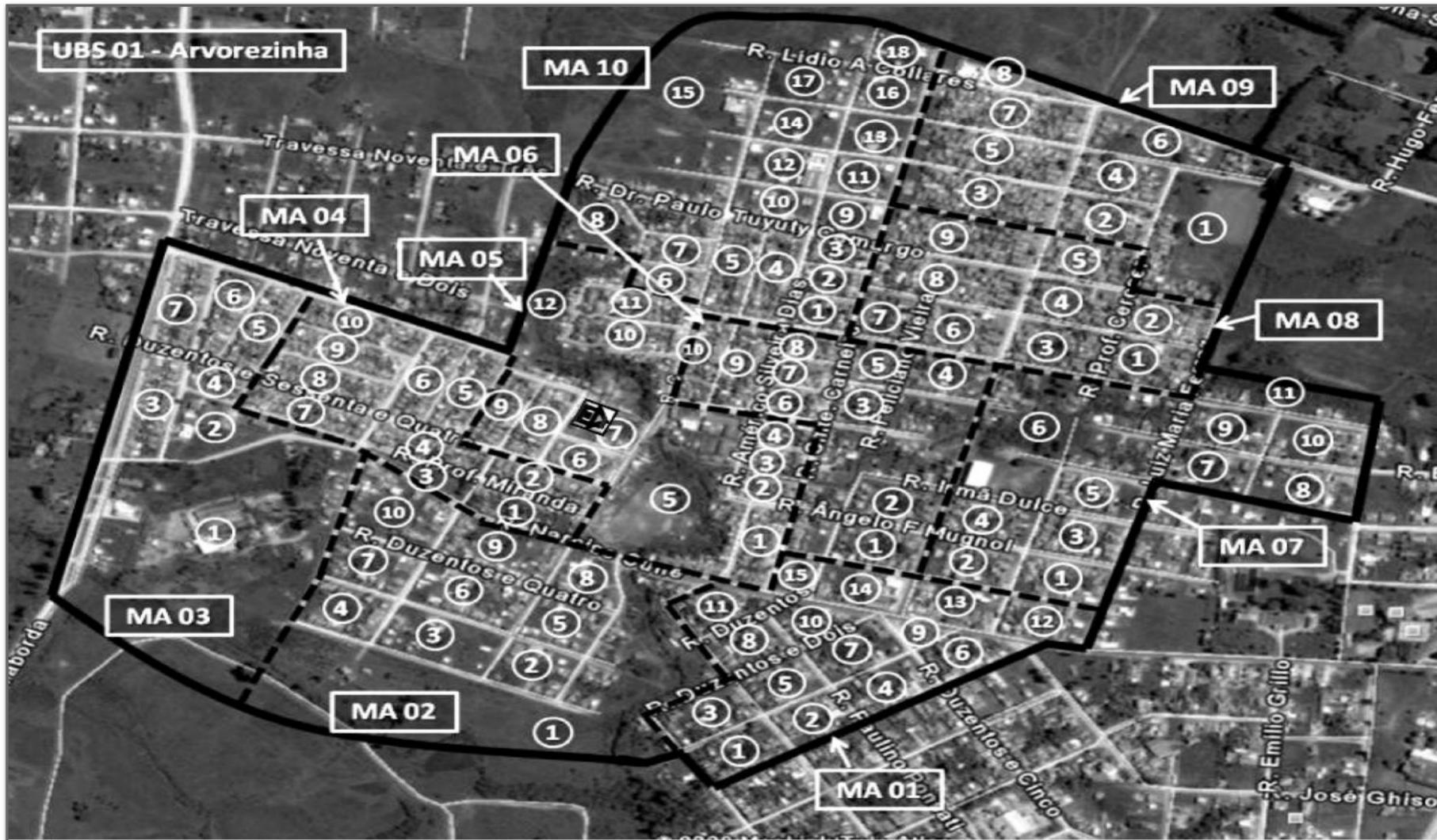
Estratégia Saúde da Família - ESF



Linha de Base - 2008

- 15 Unidades de Saúde da Família
 - 20 equipes
 - Cobertura Populacional SF - 52%
- 5 Unidades Básicas Tradicionais





Localização da Amostra

- Localização das UBS
- Delimitação da área e micro-áreas
- Numeração das quadras
- Sorteio do ponto de início - na quadra
- Pulo sistemático de domicílios



Variáveis em estudo

Dependente

- Óbitos - Sistema de Informações de Mortalidade
- Causas - CID 10 (classificadas como evitáveis ou não) (n= 579)

Independentes

- Sociodemográficas - Idade, sexo, cor da pele, situação conjugal, domicílio multigeracional, renda per capita, escolaridade, classificação econômica, plano de saúde
- Comportamentais - fumo, atividade física
- Morbidades - diagnóstico médico de hipertensão e/ou diabetes, depressão (GDS), capacidade funcional (AVD e AIVD)
- Auto-percepção de saúde
- Utilização de Serviços de Saúde - hospitalização no último ano, consulta médica ou atendimento domiciliar nos últimos 3 meses
- Modelo de atenção da área

Procedimento analítico

Descritiva - distribuição da amostra por modelo de atenção e teste qui-quadrado para verificar diferenças estatisticamente significativos ($p <$ ou igual a 0,05).

Kaplan-Meier - curvas de probabilidade de sobrevivência dos grupos em estudo, ao longo tempo, ajustada para sexo, idade e riqueza.

Regressão de Cox - verificar associação entre modelo de atenção e mortalidade, ajustado para as variáveis em estudo e examinando a interação do modelo de atenção com riqueza (ABEP).

Variables	TPHC (605)		FHS (709)		p
	46.04%		53.96%		
	n	%	n	%	
Sex					0.072
Female	391	64.63	424	59.80	
Male	214	35.37	285	40.20	
Age					0.011
60 to 64	124	20.50	188	26.52	
65 to 74	260	42.98	307	43.30	
75 or more	221	36.53	214	30.18	
Having children					0.237
No	71	11.75	69	9.73	
Yes	533	88.25	640	90.27	
Marital Status					0.378
Partner	295	48.76	363	51.20	
No partner	310	51.24	346	48.80	
Ethnicity					<0.001
White	521	86.12	543	76.59	
Black, brown, yellow, indigenous	84	13.88	166	23.41	
Per capita income					0.146
≥129.7 USD	520	86.24	590	83.33	
<129.7 USD	83	13.76	118	16.67	

Variables	TPHC (605)		FHS (709)		p
	46.04%		53.96%		
	n	%	n	%	
Schooling years					<0.001
≥8 years	183	30.25	87	12.27	
4-7 years	194	32.07	210	29.62	
<4 years	228	37.69	412	58.11	
Wealth					<0.001
AB (richest)	206	34.22	134	19.09	
C	246	40.86	260	37.04	
DE (poorest)	150	24.92	308	43.87	
Private Health Insurance					<0.001
No	343	56.88	521	74.00	
Yes	260	43.12	183	26.00	
Current Smoker					0.004
No	530	87.60	580	81.81	
Yes	75	12.40	129	18.19	
Sedentary					0.008
No	329	54.38	437	61.64	
Yes	276	45.62	272	38.36	
Hypertension					0.611
No	273	45.12	310	43.72	
Yes	332	54.88	399	56.28	

Variables	TPHC (605)		FHS (709)		p
	n	%	n	%	
Diabetes					0.039
No	525	86.78	586	82.65	
Yes	80	13.22	123	17.35	
Depression					0.026
No	483	84.29	531	79.37	
Yes	90	15.71	138	20.63	
Disability (ADL + IADL)					0.001
No	409	67.60	418	59.12	
Yes	196	32.40	289	40.88	
Self-perception of health					0.511
Good/very good	339	58.25	387	56.41	
Regular/bad/worse	243	41.75	299	43.59	
Hospitalization**					0.729
No	495	81.82	574	81.07	
Yes	110	18.18	143	18.93	
Visited a doctor***					0.241
No	265	43.87	334	47.11	
Yes	339	56.13	375	52.89	

Mortality

- SIGa-Bagé: 579 deaths - mean follow-up of 6.4years (SD 2.6).

Unadjusted mortality rate:

- SIGa-Bagé: 67.6 (62.3-73.3) deaths/1,000 person-years
- TPHC= 69.0 (61.2-77.7)
- FHS= 66.3 (59.4-74.2)

* TPHC: Traditional Primary Health Care; FHS: Family Health Strategy. **Hospitalization during the last year, before the interview. ***Visited a doctor during the last three months before the interview.

Mortalidade por todas as causas e por causas evitáveis pela APS conforme o modelo de atenção - 60 aos 64 anos (n=309). Bagé, 2008-2017

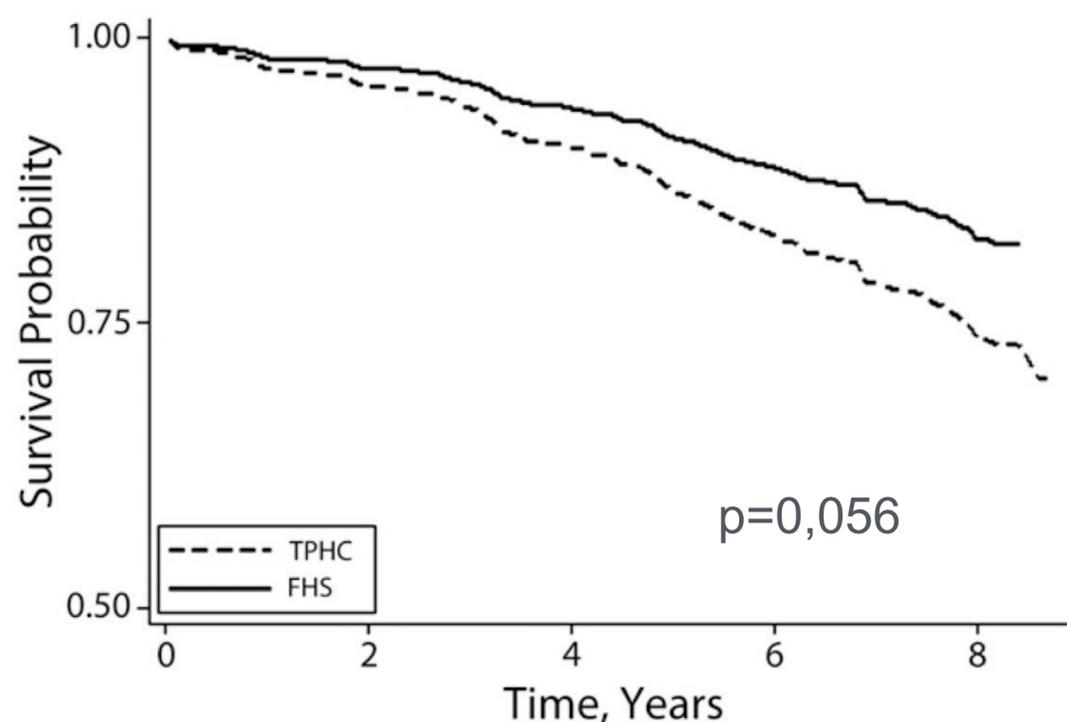


FIGURE 1— All-Cause Mortality by Primary Health Care Coverage in Age Group 60–64 Years, Adjusted for Gender, Age, and Wealth: The SIGa-Bagé Cohort Study, Bagé, Rio Grande do Sul, Brazil, 2008–2017

Note. FHS = Family Health Strategy; TPHC = traditional primary health care. The sample size was 309 observations and 83 failures.

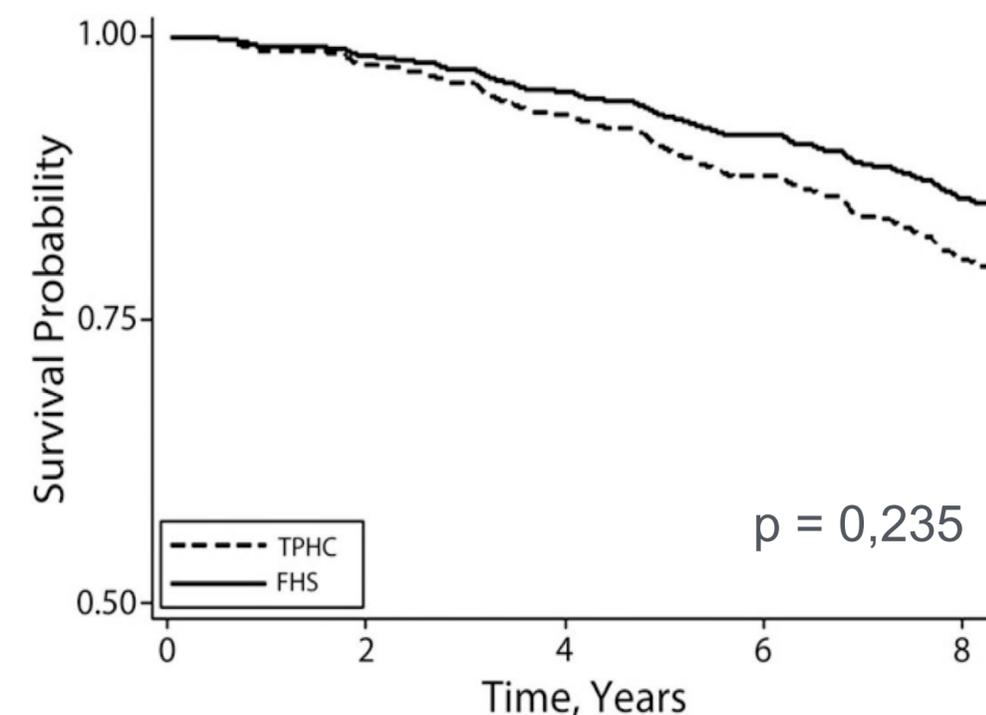


FIGURE 2— Avoidable Mortality by Primary Health Care Coverage in Age Group 60–64 Years, Adjusted for Gender, Age, and Wealth: The SIGa-Bagé Cohort Study, Bagé, Rio Grande do Sul, Brazil, 2008–2017

Note. FHS = Family Health Strategy; TPHC = traditional primary health care. The sample size was 309 observations and 55 failures.

Todas as Causas de Mortes

Final adjustment model^b

PHC type (Ref: TPHC)

1.77 (1.19, 2.63)

Wealth (Ref: richest)^a

1

Middle

2.07 (1.46, 2.93)

Poorest

1.75 (1.16, 2.61)

PHC type##wealth (Ref:
richest)

FHS#middle^c

0.44 (0.27, 0.71)

FHS#poorest^c

0.59 (0.36, 0.96)

Causas de Mortes Evitáveis

2.54 (1.37, 3.57)

1

2.21 (1.37, 3.57)

1.75 (1.00, 3.06)

0.31 (0.17, 0.58)

0.46 (0.25, 0.85)

b: Final adjustment model for all-cause mortality included the following: marital status, per capita income, school, inactivity, disability, SPH, age, gender, home health care, visited a doctor, hospitalization, and interaction between PHC type and wealth.

Final adjustment model for avoidable mortality included the following: marital status, per capita income, school, inactivity, disability, SPH, age, gender, PHC type, home health care, private health insurance, visited a doctor, hospitalization, and interaction between PHC type and wealth.

c: Reference level is richest in FHS. Test of proportional-hazards assumption with a robust variance-covariance matrix used the following: all-cause mortality—level 2: inactivity $P = .003$, and level 5: home health care $P = .022$; avoidable-cause mortality—level 2: inactivity $P = .001$, and level 4: gender $P = .011$.

Discussão e Conclusões

- A ESF teve um efeito protetor na mortalidade entre indivíduos de 60 a 64 anos, um resultado não encontrado entre aqueles cobertos pelo modelo tradicional
- A análise de interação mostrou que a **ESF modificou o efeito da riqueza na mortalidade.**
- **A ESF protegeu os mais pobres** da mortalidade por todas as causas (razão de risco [HR] = 0,59; intervalo de confiança [IC] de 95% = 0,36, - 0,96) e da mortalidade evitável (HR = 0,46; IC de 95% = 0,25, - 0,85).
- **A cobertura da ESF reduziu as desigualdades sociais na mortalidade entre idosos.**
- Nossos achados destacam a necessidade de garantir a cobertura universal da ESF no Brasil, de modo a promover a equidade em saúde.

A ESF aumenta a sobrevivência dos idosos mais pobres, minimizando as iniquidades sociais!

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