

Access for the Elderly to Primary Health Care Services: an Integrative Review

REVIEW

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Abstract

Background: With the aging of the population, there is a trend of increase in the number of elderly people with greater needs for assistance in health. The challenge is to ensure access to all of them.

Objective: Discussing on access of older persons to primary health care services from an integrative review.

Method: Integrative review of literature through the databases CINAHL, LILACS, Medline, and Web of Science. The descriptors used were health services accessibility, elderly and primary health care. The instrument of data collection included: article title, journal name, year of publication, database, country, type of study, level of evidence, objectives and key results. There were met 111 published articles, 13 of which were selected for filling the inclusion criteria.

Results: The difficulties of access faced by seniors include: limited offer; insufficient number of professionals; quick queries without identifying their needs; opening hours and inadequate, excessive wait time to be answered. The elderly still face external barriers to path-related service, and internal, non-adapted environments to their visual, auditory and limitations. Home care and over the phone, however, can facilitate access. The elderly should also receive information about your health problem and have the opportunity to clarify doubts.

Conclusion: It is necessary to recognize the elderly as an individual with distinctive needs for improved access to health care.

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Keywords

Access to Health Services, Elderly; Primary Health Care.

Introduction

The concern about health care to the elderly person arises from the projection of the growth in the number of elderly in the coming decades in Brazil and in the world. The gradual ageing of the population tends to increase the absolute number of elderly fragile, which in turn requires an offer of care that meet their health needs. The developed countries are already experiencing a few decades ago this problem and have carried out initiatives to meet the needs of the elderly [1-3].

The Brazil, however, has been showing a rapid aging of the population and, if the problems of access to health for its younger citizens already existed, these have been added to the difficulties of meeting the health needs of elderly individuals who are ever more frequent users in health services. In this perspective, access to the population to health services appears as a challenge that needs to be understood by management and health workers to guarantee health care for the elderly.

Access is a complex concept that varies between authors and that changes over time and according to the context. It is related to a set of characteristics of the offer that facilitate or limit the ability of people to use health services when they need [4-5]. As part of the health system, it can be considered as the absence of financial, geographical, ethnic, gender, social, cultural and organizational barriers to receive health care, and evaluated by the availability (obtaining elective or emergency care), acceptability (approval of users regarding the location and appearance of the service, services provided, and health professionals) and convenience (waiting time to get attendance, opening hours of service, ease of contacting a health professional) [6].

Access is also how we see accessibility which in turn constitutes the structural part that enables people to have access to health services. The term is used to describe the accessibility features that facilitate the use of health services by users and is divided into two dimensions: social and organiza-

tional (resources which facilitate or hinder access to the service, such as opening hours or consultation fees) and geographic (distance and time required to reach the service). Accessibility can also be geographic (provision of transportation and distance); psychosocial (existence of linguistic and cultural barriers between the professionals, professionals and users and on the premises); and time related (Office hours). Is still one of the requirements to measure the potential and scope of attributes of primary care (attention to first contact, longitude, coordination and completeness) [7-8].

Problems in access to health services can encompass political dimensions (agreement between the spheres of Government, social participation and monitoring of actions), social-economic (financial investment by municipal and State authorities, social, economic, cultural and physical barriers), organizational (geographical barriers, customer service, hospitality stream), technical (completeness, greeting, bond, competence and ability, commitment) and symbolic (health-disease process, culture, beliefs, values and subjectivity) [9].

Despite the creation of the Unified Health System (SUS) in Brazil have allowed substantially larger access of the population to health services that once, much still has to be done to remedy the inequalities of access. One of them is related to the fact that the private health system retains control of the larger share of hospital beds and medium and high complexity, which makes users more affluent can resort to covenants and private services, while the majority of the Brazilian population has to face a great competition to receive health care in public institutions [10].

Another inequality of access that can be cited is the difference in the provision of services between the regions of Brazil, as Southeast and Northeast, although there has been improvement [11-2]. An example of this regional contrast is the fact that the residents of poorer municipalities have less chance of being admitted into a hospital to the residents of wealthier cities [13].

It is important to highlight also the influence of schooling on inequality of access. A survey conducted by researchers at the Oswaldo Cruz Foundation (FIOCRUZ) pointed out that people with a few years of study who perceive their health as being bad utilize fewer health services, while people with higher level of education and who perceive their health as being good seek more often for health assistance. This can be partially explained by the influence of the private health plans that allow greater access to their insured and by meeting the health needs of the population that seeks public services. In addition, the higher the socioeconomic level, the greater the demand for preventive services, while low-income people tend to seek medical help when the disease already installed [14].

Many developed countries offer a health care system of quality [15], but also presents difficulties for the population's access to health services, although these problems are smaller in scale when compared to those of Brazil. One of the challenges that these Nations present are: establish a schedule of operation of primary care clinics that meet the needs of the population, avoiding the unnecessary use of emergency departments [16]; ensure access to residents of distant regions of major centers [17] and for low-income citizens, in the case of countries which finance only part of health services, such as the Japan [18]; and deal with the increasingly reduced number of health professionals, especially nurses [19].

In this way, it is acknowledged that the bigger the barriers of access to primary health care services for the elderly, the greater the risks and damage to your health. Front of the preoccupation with access to primary health care and the aging of the population, this article aims to discuss the access of older persons to primary health care services from an integrative review.

Method

The present study is an integrative review of the literature. This is a method that seeks to find and synthesize theoretical or empirical data present in the literature on a particular topic, with the goal of understanding a phenomenon in particular [20]. For its implementation, the following steps were followed: drafting of the guiding question; search or sampling in the literature; data collection; critical analysis of included studies; discussion of results; and, presentation of integrative review [21].

Drafting of the guiding question

The guiding question of this integrative review was: what are the scientific evidences in the literature about the elderly access to primary health care services?

Search or sampling in literature

Searches were carried out in pairs from June 2015, 1:30 of articles published in national and international journals indexed in the databases: Cumulative Index to Nursing and Allied Health Literature (CINAHL), Latin American and Caribbean Literature in Health Sciences (LILACS), Medline (Medical Literature Analysis and Retrieval System Online) and Web of Science. Using health sciences descriptors (DeCS) and Medical Subject Headings (MeSH): health services accessibility, elderly and primary health care, using the Boolean and.

The selection of the articles had as criteria's of inclusion: full papers published between 2005 and 2015; treat the elderly access to primary care services; and, be in the Portuguese, English or Spanish language. After reading the titles and abstracts, it was selected articles that addressed the guiding question. It was excluded: publications that were not in paper format (books, dissertations, theses, book reviews, letters and editorials), review articles (integrative and systematic) and those who were not in full online access.

Applying the intersection of descriptors were found 111 articles, 33 in CINAHL, LILACS, 21 in

41 on Medline and 16 in Web of Science. Among them, 13 publications were selected to compose the sample for filling all the inclusion criteria (2 in CINAHL, 2 in LILACS, 3 in Medline and 6 in Web of Science).

Data collection

The data collection was done via an instrument containing the following items: article title, journal name, year of publication, database, country, type of study, level of evidence, objectives and key results.

Critical analysis of included studies

Classification by a level of evidence serves to assess the quality of the evidence pointed to by studies, assisting in decision-making about their incorporation in clinical practice. On completion of this step, the evaluation of the level of evidence of articles selected was made as it follows [22]:

- Level 1: evidence resulting from systematic review or meta-analysis of all relevant controlled randomized clinical trials or clinical guidelines based on systematic reviews of randomized controlled clinical trials;
- Level 2: evidence of at least one randomized controlled well delineated;
- Level 3: evidence of well-defined clinical trials without randomization;
- Level 4: evidence from cohort studies and case-control study well delineated;
- Level 5: evidence of systematic review of descriptive and qualitative studies;

- Level 6: evidence derived from a single descriptive or qualitative study;
- Level 7: evidence and opinion or expert committees report.

Then there were in-depth reading of each article and descriptive analysis of the data found.

Discussion of Results

With the interpretation and synthesis of the results, the data highlighted in the analysis of the articles was compared to the theoretical framework of the research object, in order to expose concordant and discordant information on the subject, based by the authors of the articles. It also enabled to identify knowledge gaps and define priorities for future studies.

Presentation of the integrative review

The results are presented in table 1 and 2 the following categories that subsidized the discussion: Access to care; Facilitators in access to health services; Access to information; and, Access to the service.

Results

Thirteen publications were selected that focused on the subject of elderly access to primary care services. Eight articles were made in Brazil; the other occurred in European countries and the United States. **Table 1** presents the distribution of the number of articles found in the databases searched in the period from 2005 to 2015.

Table 1. Distribution of articles found according to the year of publication and databases searched.

Year/Database	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Total
	N	N	N	N	N	N	N	N	N	N	N	N
CINAHL	-	-	1	-	-	-	1	-	-	-	-	2
LILACS	-	-	-	-	-	1	-	-	1	-	-	2
MEDLINE	-	-	1	-	-	1	-	-	-	1	-	3
Web of Science	-	-	-	-	-	-	-	-	-	5	1	6
Total	0	0	2	0	0	2	1	0	1	6	1	13

In general, the studies discussed the difficulties and facilities of access to health care for the elderly; characteristics of the care provided to the elderly in primary health care; and perception, experience and satisfaction of older persons with primary care services to meet their health needs. There was a pre-

dominance of studies with quantitative approach. In relation to the level of evidence, all the articles were classified as level 6 for being a single quantitative descriptive study (9) and qualitative (6) (**Table 2**).

Table 2. Distribution of items according to the title, objectives, journal name, study design and level of evidence.

N	Title	Objective	Journal	Design/Level of evidence
1	Older people's preferences for involvement in their own care: qualitative study in primary health care in 11 European countries [23]	Explore the vision of older people with more than 70 years on the involvement in their care from primary care in 11 European countries	Patient Education and Counseling	Qualitative/Level 6
2	Use and access of the elderly to primary health care services in Porto Alegre (RS, Brazil) [24]	Describe the use and geographic access of the elderly to primary healthcare (PHC) in Porto Alegre (RS), and to analyze the association between variables of interest to the study and access to PHC.	Science & Public Health	Quantitative/Level 6
3	Service for elderly in primary care health: social representations [25]	Evaluate the service offered to the elderly in primary care from the perspective of social representations	Revista de Pesquisa: Cuidado é fundamental online	Qualitative/Level 6
4	The Elderly's Look Regarding the Access to a Basic Health Unit in Porto Alegre -RS [26]	Describe how to give the elderly access to health services in a Basic Health Unit in Porto Alegre	Revista da Faculdade de Odontologia de Porto Alegre	Quantitative/Level 6
5	Characteristics of general practice care: What do senior citizens value? The qualitative study [27]	Improve the understanding of the preferences in relation to attributes not primary care physicians	BMC Geriatrics	Qualitative/Level 6
6	Does the patient-centered approach help identify the needs of older people attending primary care? [28]	Investigate the effect of patient-centered care in identification of unmet needs in the elderly	Age and Ageing	Quantitative/Level 6
7	Better Access, Quality, and Cost for Clinically Complex Veterans with Home-Based Primary Care [29]	Check the quality and perceptions as to the restrictions of the primary service in home (HBPC)	Journal of the American Geriatrics Society	Qualitative/Level 6
8	Elderly Health: perceptions related to the care provided [30]	Understand how the elderly perceive the care provided in primary healthcare services	Esc Anna Nery	Qualitative/Level 6
9	Evaluation of the quality of primary health care from the perspective of the elderly [31]	Assess the quality of Primary Health Care (PHC) provided to the elderly from their viewpoint	Ciência & Saúde Coletiva	Quantitative/Level 6
10	Humanization in primary health care from the viewpoint of elderly [32]	Analyze the perception of the elderly population on how humanized is primary health care, focusing on aspects of outpatient services that affect the quality of care	Saúde e Sociedade	Quantitative/Level 6

N	Title	Objective	Journal	Design/Level of evidence
11	Satisfaction of the elderly population attended in the Family Health Strategy in Santa Cruz, Rio Grande do Norte, Brazil [33]	Identify the satisfaction of the elderly population in relation to the health care received in the Family Health Strategy, in Santa Cruz, in the State of Rio Grande do Norte (RN)	Texto & Contexto Enfermagem	Quantitative/ Level 6
12	Expectations and user experiences of older Roma women with health services in primary care [34]	Know the expectations and user experiences of older Roma women with health services in primary care (PC)	Atención Primaria	Qualitative/ Level 6
13	Primary healthcare geared to the needs of the elderly: from theory to practice [35]	Establish a confrontation between theory and practice with respect to healthcare for the elderly	Ciência & Saúde Coletiva	Quantitative/ Level 6

Source: CINAHL, LILACS, Medline, Web of Science, 2005-2015.

Discussion

Reading the selected articles made it possible to identify the scientific evidence related to the access of the elderly to primary health care which will be discussed by means of the following categories.

Access to care

Among the issues to be discussed are the obtaining of care, the duration of the query, the time and the waiting time to be answered. The limiting factors for access to the service include the limited offer; insufficient number of professionals; quick queries not patient-centric and based on medicalization by the population without listening and correct identification of their health needs; and, opening hours that caters exclusively to the interests of professionals and managers [36-8].

These factors are responsible for the generation of a pent-up demand, formed mainly by older people, who will return home without assistance, with risk of worsening of your clinical condition; or will look for private medical services; or, still, that will address emergency departments for situations that could have been circumvented in the basic attention. Thus, the user becomes a true seeker, begging attendance by health centers aside from [39].

As for the duration of the query, you must take into account the time required for the elderly clari-

fy your doubts, assimilate the information received and tell about your health problems, as well as for professional conduct interview and physical examination with quality [32]. The query time is associated with the degree of interest of health professionals on your client, but also disproportionate ratio between demand and number of professionals, which requires them to consult more quickly [40]. This represents a risk to the health of users, since if they are not examined thoroughly, there could be omission of any health problems that, consequently, will not be treated, causing worsening of health status, diagnosis, complications, and even death, in addition to burdening the costs with an injury that could have been detected early.

The insufficient consultation time interferes with the professional-user interaction by inhibiting the client to clarify your doubts and concerns about his illness and prevent identification of their real needs. A study conducted in Germany questioned elderly patients about the health problems that they thought more relevant, and doctors about what were your processing priorities. There was divergence in the responses of the patients and the doctors (treatment priorities differed from what the elderly perceived as being important), pointing out the need to improve the communication between the parties, which will contribute to the accession of

the elderly to the indicated therapy and attendance expectations [41].

Regarding the opening hours, users complain of the short period of functioning of health services, especially those sites that provide specific days for attendance of the population according to your health problem, for example, diabetics and hypertensive [23, 31]. Scheduled demand benefits of priority service due to his health problem, however, other users should not be deprecated by not being in the priority group. On the contrary, health professionals should listen to the user about what reason he sought the job and forward it to the requested sector (vaccines, for example) or, if your problem is acute, use the rating system (immediate priority or day). If the problem is not urgent, may be made: query, scheduling specific guidance or on unit offerings, stock advance provided for in the protocols, inclusion in programmatic actions, discussion of the case with the user reference or referral to other points of attention [42].

To establish the hours of operation, the needs and the profile of the population answered should be considered, providing care at convenient periods for users and not only for the health care professional or for managers, obeying the principle of centralization in the patient. The period of service and appointments, namely, access to health care must not hinder the user bureaucratic. As he has no obligation to know what is an emergency situation, your complaint should be heard and considered by qualified professional, ensuring your constitutional right to receive health care [43].

The establishment of an ideal opening for primary care services is not a unique difficulty of the Brazilian health care system. Countries such as Canada, known for providing high standard health care, also face this challenge: offer primary care services within a schedule that meet the needs of users, avoiding overcrowding of emergency services [44].

Some alternatives were created to deal with this problem. In Spain, the primary care services have

longer opening hours (up to 20 hours), facilitating access to workers and, even after being closed, users can get in touch with general practitioners in their offices or call to ask questions [45]. In England, in 2000, were created so-called service walk-in centers conducted by nurses that meet cases of low gravity (fractures, cuts, allergies, burns) 24 hours a day [17].

Similar to the walk-in centers of developed countries, emergency room units (UPA) were created in Brazil to unburden the emergency services of the hospitals to meet cases of average complexity, but come back to also serve the primary care services. These locations become more attractive to users, once they find in one place health care team (doctors and nurses), diagnostic tests and treatment. However, the use of the emergency room unit as gateway has been criticized since it promotes the medicalization and centralization in medical care, at the expense of the exploitation of the potential of other health professionals; does not follow patients with chronic diseases (only treats symptoms and signs); in addition to working with disease and social determinants of collective interest. And more than that, does not establish linkages, generating only complaints resolution [46].

Another complaint of the elderly relates to the excessive time that is spent in waiting rooms [25,33]. Advanced age and the weakened state because they need to be prioritized in attendance. However, some services still use the system of distribution of passwords in order of arrival, contrary to the principle of equity of SUS and making these people, already weakened by old age and illness, lay-up lines in front of the health units during the early hours, facing rain and cold [36]. When the chips are down that day, the user finds himself forced to go home without having your problem solved or seek emergency services, overloading them.

To listen and the identification of user needs in the host and require training of health staff to put it into practice. Without adequate training, the host is

seen only as a friendly and polite way of answering the user, whichever is a fragmented and bureaucratic assistance, physician-centered, based on signs and symptoms and in order of arrival, within days and timetables stipulated by the health team until the vacancies of the day [47].

When it comes to the elderly, the health professional must be doubly qualified. The elderly person does not have the same facility that the youngsters to express what you feel. In addition to the physical problems, it is common to the existence of depression in this population. The signs and symptoms of diseases may present differently than in younger individuals. Thus, the interview with the elderly should include a careful evaluation of the signs and symptoms that he presents, but also as important, their social and psychological situation. The elderly face the distancing of the sons (who left home and have their own affairs), the physical and psychological changes that come with aging, disease and death expectancy, which can lead to mental illness and be reflected in your physical state. Therefore, these changes must be identified by health professionals, which will help you to deal with these issues (or forward to another professional most qualified to do so) and promote measures that contribute to their quality of life [48].

In the face of all these difficulties, users seeking health services only when the disease manifests itself, and not for prevention and monitoring [24]. That looks more heavily on low-income population, which leads to another factor: the financial system exclusive. Thus, the poorest people are who else needs the health system due to the absence of prevention and control of diseases, and is the one that least can access, because coming up in an inadequate supply of health services. Those with better financial conditions will seek private services for care, inequality of access, which is a contradiction in a country like Brazil that ensures universal access to health care to its population [49].

Facilitators in access to health services

Home care and the phone can be facilitators in access to health services by avoiding accessibility problems, such as distance to the services, difficulty of transport and weakened state beyond the way to these locations [27, 30].

Brazil, the home visit is planned on the family health strategy and can be applied to health teams for community health Agents (ACS), by the user, family, neighbors and other services [50]. The elderly are the main applicants for presenting more diseases associated with functional and cognitive disability (stroke, dementia and functional incapacity to instrumental activities of daily living) that the younger individuals [47].

This service mode is also used as an alternative to developing countries to contain health spending by reducing the number of hospitalizations. In Japan, nurses make home visits to seniors who have health insurance. Although these visits are subsidized by the Japanese public, not all low-income seniors can have access to the service [18].

In Brazil, unlike, the House call is a free service funded entirely by the Government. However, some difficulties common to the Japan, such as the limited number of professionals in relation to demand, costs and lack of professional conduct shuttle visits and problems to reach the most remote areas (such as rural communities) [51]. This is because, although the SUS guarantees free health care to the entire Brazilian population, cannot be universal in practice by the inability to offer access to all citizens, sets up in violation of a right guaranteed by law [52].

Another route of access to the service used by citizens of developed countries is the phone, through which users can clarify questions of health, receive medical and nursing consultation and be sorted and forwarded to the appropriate services, which avoids the user having to scroll unnecessarily until the service. In Denmark, the queries can be made by email, which does not exclude face-to-face customer service if necessary [45].

In Canada, the phone service works 24 hours a day, seven days a week, and is performed by trained nurses. Most of the links are related to questions associated with symptoms [53]. However, the use of the telephone and the internet for senior citizens to access to health services should be studied more thoroughly, checking the familiarity and the disposition of elderly person in handling these apparatuses, as many still prefer face-to-face contact with health professionals.

In Brazil, some initiatives in the area of long-distance service have been made to improve access of the population, even if indirectly. In Porto Alegre, most primary care services have consultation phone scheduling, which is also used for prioritization of elderly [35]. In Minas Gerais, in 2005, Telehealth Network was implemented (as part of the program "Brazil Telehealth networks" of the federal Government), in which basic health care professionals can ask questions about diagnosis, treatment and medical procedures, with experts from various fields of university hospitals. The "Minas Telecardio Project" allows doctors of health units of the most remote regions send electrocardiograms to cardiologists of university hospitals for interpretation. In spite of the consultations to the distance patients being prohibited in Brazil, these initiatives assist in better access to the population by allowing more qualified and quick answers to your health problems [54].

Access to information

One aspect of access that should be assessed is whether the patient has the opportunity to discuss your health problems and questions about his illness and attendance [8]. The information is essential for the individual to understand and make choices about their health. Users should know the range of services offered by the health system, to require those who are not covered by the system and use the ones available, given their needs. The lack of information is a form of exclusion of the individual health services [55].

Studies show that elderly people would like to receive information about your health condition, treatment options and preventive measures. However, communication between the health professional and the elderly still need to be ripened [27-8]. The professional should take into account some features of aging that can interfere with this interaction. The elderly must be included in decision-making about their treatment, considering their autonomy and ability to make decisions; must receive guidelines without using technical terms, according to their degree of education, in a bright environment and with little noise, considering the possible reduction in visual and auditory. It is important to not yet infantile it and show no hurry while talking [56].

Health professionals should be available to listen to the old user. Elder hopes that doctors do not act as if they were superior and they are kind, concerned about your health, that establish trust and listen to them [34]. The communication should still be an exchange of biological and psychosocial information to be effective. The elderly seem to value their everyday problems, related to the loneliness, the fear of death, to the prejudice suffered by being old, the loss of functional capacity and autonomy that once owned and the difficulty in dealing with the limitations imposed by age, then their actual health problems during a health consultation. The socioeconomic problems interfere with your quality of life and mental health that reflect on their physical health. All these factors should be considered for elderly care, leaving room for him to express [41].

Considering the psychosocial needs of older persons contributes to the opening of a communication line, establishment of bond and confidence in professional, most interest of the elderly in the knowledge of your medical condition and treatment adherence [46]. In addition, you must pay attention to communication difficulties of the elderly concerning the change of cognition and memory, gender

(women tend to talk more than men), ignorance of the language (in the case of European countries, for example) and even in linguistic variation in the own country [57].

Access to the service

Besides the difficulties discussed earlier, which the elderly face to have access to health care, there may be barriers to reach the health service about the challenges of getting carriage and use it, the cost of the course and distance of their residence [29].

In Brazil, the primary care services in general are strategically located in order to avoid the problems cited. The challenges faced by the elderly in urban centers refer to the bad conservation of sidewalks and streets, the risk of assault and the lack of respect for traffic laws by the population (disrespect to the crosswalk and the light) [26].

However, for people who are far from big cities, such as the Riverside population, who lives on the edge of rivers or in flood plains, the difficulties are related to the costs and the limitation of displacement caused by seasonal rivers. These people are dependent on the arrival of boats or ships-hospitals of non-governmental Organizations, army or health departments to receive assistance [58]. A study conducted in Canada in rural communities pointed out the complexity for residents to access health services outside of their region that also involves costs and obtaining transportation and unsafe conditions on the roads, as bad weather and conservation [59].

When access problems are not external to services, many times they are internal, such as: presence of steps; lack of handrails, ramps and toilets adapted for wheelchair users; inadequate waiting rooms; and, unmarked facilities for people with visual and auditory limitations. In fact, they end up encountering unfriendly environments, especially for the elderly more fragile, such as examination rooms with narrow doors, precluding or hindering the passage of wheelchairs or walkers. The services are often

noisy, poorly ventilated and have uncomfortable seating, no signs on the doors and hallways, with professionals who do not use identification badges, or when they do, it is difficult to read, and that do not orientate users where they should go [57].

The access of older persons to health services is a comprehensive theme starting from the physical access to the service to the attendance of their health needs. With the world trend of increase in the elderly population, and consequently, with the increased need for health care, the services must be prepared to deal with the various issues related to this phenomenon that involves ensuring access to health care, empower professionals and suit your physical structure. It is a complex process, because it involves other sectors not only of health to improve access, as public policies to improve public transportation, hiring more health professionals to handle the existing demand and creation of strategic actions for dealing with the economic barrier with regard to the financing of all these actions.

Even the developed countries face problems in providing health services to their citizens, especially the elderly. Brazil has a public health system sought by many countries, free to its population as few. However, it presents several obstacles to the implementation of its guidelines and principles that need to be overcome so that universal access can come out of the paper and turn reality.

Conclusion

The elderly represent a major portion of the pent-up demand in the health public services with increasing tendency, because with the ageing of the population in Brazil and in the world, the demand for care tends to be larger, in view of the increase of chronic diseases present in old age. This fact requires rapid and efficient responses of managers to meet these new demands, especially in developing countries like Brazil that experience this demographic transition of an accelerated rate.

The difficulties of access for the elderly are not very different from those of other age groups, however, their needs differ from younger individuals, because many have difficulty of locomotion, vision and hearing impaired, usually need more health care, and tend to have more psychological and mental disorders such as depression. The lack of family and social support can put them at risk of falls, hamper the demand for health care and adhere to the recommended health treatment.

The problems of access to services for the elderly have some similarities to the problems faced by developing nations. One of them is the exclusion of the elderly with low income and low education. In rich countries this happens due to the inability to afford health services, even though subsidized by the Government, or the transport. In Brazil, even the health care being free, not all seniors receive assistance.

However, countries such as Canada, Japan, Spain, England and Denmark are examples of accessibility related to infrastructure such as public transportation, public roads in an excellent state of conservation, in addition to health services organized and with excellent physical structure. In Brazil, except for few cities, the difficulty of the elderly already starts to get out of their houses and wait at inappropriate bus stops (no seat and no protection from rain, cold or sun), catch bus overcrowded with high steps; or, if he's going to walk up to the nearest unit, often face a lack of sidewalks or defective driveways that are real obstacles even for the youngest.

In developed countries in Europe and North America, the difficulty of access in urban areas occurs especially after the closure of the primary care units. In Brazil, demand for emergency services for non-urgent reasons happens during the hours of operation of the basic units, often guided by professionals of these places, driven by the lack of customer service, reception and resolution of needs.

Lack a real and more comprehensive inclusion of elderly health care network and its recognition as

an individual with distinctive needs. However, no responsibility can be only by health professionals as they face the lack of sufficient staff to meet the demand, supplies, adequate physical structure and training. There must be joint efforts between the Government, managers, professionals and even users who must complain to the responsible organizations, so there is substantial improvement in the quality of the access, not only for the elderly, but for the entire population, to health care.

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