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REVISIONES

Quality of health care for the elderly in primary care: an integrative review

Qualidade da atenção à saúde do idoso atençãoprimária: uma revisão integrativa

Calidad de la atención a la salud de las personas mayores en la atención primaria: una revisión integradora

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ABSTRACT:

Objective: To investigate, through an integrative literature review, the quality of health care for the elderly in primary care.

Material and Methods: Integrative literature review conducted in MEDLINE/PubMed, SciELO, LILACS and BDENF databases between April and May 2020, which generated 780 references. After removal of the duplicates and use of inclusion and exclusion criteria, the final sample consisted of 15 articles.

Results: The quality of health care for the elderly in primary care was associated with potential and weaknesses that involved the availability and training of human resources, adoption of evaluation protocols, monitoring and follow-up, supply of inputs and structural variables linked to infrastructure and intersectoral support network. The effectiveness of actions to the elderly in primary care was related to the implementation of the Family Health Strategy, combined with the active action of the community health agent in the territory and the participation of the elderly in the decisions.

Conclusion: Strengthening the health care of the elderly in primary care involves short, medium and long-term efforts related to education, human and material resources management, networking, and the formation of ties with the territory and the elderly person.

Keywords: Health of the Elderly; Primary Health Care; Quality of Health Care.

RESUMO:

Objetivo: Investigar, por meio de uma revisão integrativa da literatura, a qualidade da atenção à saúde do idoso na atenção primária.

Materiais e Métodos: Revisão integrativa da literatura realizada nas bases de dados MEDLINE/PubMed, SciELO, LILACS e BDENF entre os meses de abril e maio de 2020, as quais geraram 780 referências. Após remoção das duplicatas e emprego dos critérios de inclusão e exclusão a amostra final foi composta por 15 artigos.

Resultados: A qualidade da atenção à saúde do idoso na atenção primária esteve associada a potencialidades e fragilidades que envolveram a disponibilidade e treinamento dos recursos humanos,

adoção de protocolos de avaliação, acompanhamento e monitoramento, oferta de insumos e variáveis estruturais ligadas à infraestrutura e à rede de apoio intersetorial. A efetividade das ações à pessoa idosa na atenção primária esteve relacionada à implantação da Estratégia Saúde da Família, conjugada com a atuação ativa do agente comunitário de saúde no território e a participação do idoso nas decisões.
Conclusão: Fortalecer a atenção à saúde do idoso na atenção primária envolve esforços a curto, médio e longo prazo relacionados à educação, gestão de recursos humanos e materiais, atuação em rede e a formação de vínculo com o território e a pessoa idosa.

Palavras-chave: Saúde do idoso; Atenção Primária à Saúde; Qualidade da Assistência à Saúde.

RESUMEN:
Objetivo: Investigar, a través de una revisión integradora de la literatura, la calidad de la atención en salud del adulto mayor en atención primaria.
Materiales y Métodos: Revisión bibliográfica integradora realizada en las bases de datos MEDLINE / PubMed, SciELO, LILACS y BDENF entre abril y mayo de 2020, que generó 780 referencias. Después de eliminar los duplicados y utilizar los criterios de inclusión y exclusión, la muestra final fue de 15 artículos.
Resultados: La calidad de la atención en salud del adulto mayor en atención primaria se asoció con fortalezas y debilidades que involucraron la disponibilidad y formación de recursos humanos, adopción de protocolos de evaluación, seguimiento y seguimiento, suministro de insumos y variables estructurales vinculadas a la infraestructura y red de apoyo intersectorial. La efectividad de las acciones para el adulto mayor en atención primaria estuvo relacionada con la implementación de la Estrategia Salud de la Familia, combinada con el desempeño activo del agente comunitario de salud en el territorio y la participación del adulto mayor en las decisiones.
Conclusión: El fortalecimiento de la atención a la salud del anciano en la atención primaria implica esfuerzos a corto, mediano y largo plazo relacionados con la educación, la gestión de los recursos humanos y materiales, el trabajo en red y la formación de vínculos con el territorio y el anciano.

Palabras clave: Salud del Anciano; Atención Primaria de Salud; Calidad de la Atención de Salud.

INTRODUCTION

The aging population has been the agenda of managers, professionals, academics and public policy makers in order to ensure that old age is well assisted and cared for. In the field of gerontological care, it becomes necessary to plan and implement resolute and quality services that offer social responses to the challenges imposed by the increase of longevity elderly[1], with functional limitations, chronic non-communicable diseases (NCD), greater risk of fragility and adverse health outcomes[2].

For this, one of the bets of the health care models has been the adoption of long-term care combined with Primary Health Care (PHC) and anchored by an integral and comprehensive view of the elderly person, their resources and predisposing conditions of the health process and disease[3].

In Brazil, efforts have been undertaken in the Brazilian Unified Health System (UHS) with the objective of reorganizing the care practice and health of the elderly. The PHC is defined by the National Policy on Health of the Elderly (NPHE) as the gateway to health care for the elderly and the reference for the network of specialized services of medium and high complexity[4]. Later, the National Primary Care Policy (NPCP) establishes actions such as health promotion and protection, prevention of illness, diagnosis, treatment, rehabilitation and maintenance of health[5].

The NPHE deliberates relevant guidelines for comprehensive health care for the elderly, such as the promotion of healthy and active aging, support for the development of informal care, as well as rehabilitation and maintenance of functional capacity being responsible for guiding all actions in the health sector and indicating the responsibilities of institutions to achieve the proposal. In addition, it guides on the continuous process of evaluation that must accompany its development, taking into account possible adjustments coming from the practice. Its implementation includes the definition and/or readjustment of projects, programs, plans and activities in the health sector directly or indirectly related to its object[6,7].

According to research conducted in Brazil, the implementation of care for the elderly in the context of PHC includes as challenges the lack of integrality of actions, the defragmentation of care, the absence of interprofessional teams and difficulties in using and accessing the health system[8]. Data from the Brazilian ELSI study indicated that the population aged 50 years or older and attending the traditional Basic Health Units (BHU) had a higher prevalence of access difficulties, continuity of care, communication with the medical professional, coordination and resolution of care when compared to the population assisted by the Family Health Strategy (FHS) and users of the supplementary health system[9].

In this sense, investigating the factors that enhance and weaken the quality of care for the elderly in PHC can help professionals and managers to act in the planning and improvement of care offers. This theme is of great relevance, because 75.3% of the Brazilian elderly depend exclusively on the UHS to have access to health services and 70% have one or more CNCD. Of the services accessed by this population, 83.1% made at least one medical consultation in the last 12 months and 10.2% of the elderly were hospitalized one or more times[9].

Therefore, the objective of the present study was to investigate, through an integrative review of the literature, the quality of health care for the elderly in primary care.

MATERIAL AND METHODS

This is an integrative review of the literature carried out in seven stages[10]: 1) delimitation of the guiding question for the review, 2) definition of inclusion and exclusion criteria, 3) extensive search of the literature, 4) identification of potential studies through evaluation of the title and abstract, 5) selection of articles based on the full text, 6) evaluation of the quality of the studies included, and 7) synthesis of the studies included.

In view of the first phase of the review, the research guiding question was elaborated based on the PICO strategy: P - population and problem, I - intervention, C - comparison and O - outcome. Thus, we considered P: elderly users in PHC, I: quality of care, C: any comparison regarding the factors related to the quality of care for the elderly and O: health care. In this direction, the question was: what are the potential and fragility factors for the quality of care of the elderly in PHC?

The search for the articles was conducted between April and May 2020 in the electronic databases MEDLINE/PubMed, Scientific Electronic Library Online (SciELO),

Scientific and Technical Literature of Latin America and the Caribbean (LILACS) and Nursing Database (BDENF).

In order to define the search terms, the Health Sciences Descriptors (DeCS) were consulted. The descriptor "health of the elderly" and its correlates were chosen and combined with the search term "primary health care" and "quality of health care" and their respective expressions in English. The Boolean operators "AND" and "OR" were used for combination. The strategies constructed with the search terms and their results are presented in Box 1.

Chart 1: Search strategies and results of identified productions. Brasília, Distrito Federal, 2020.

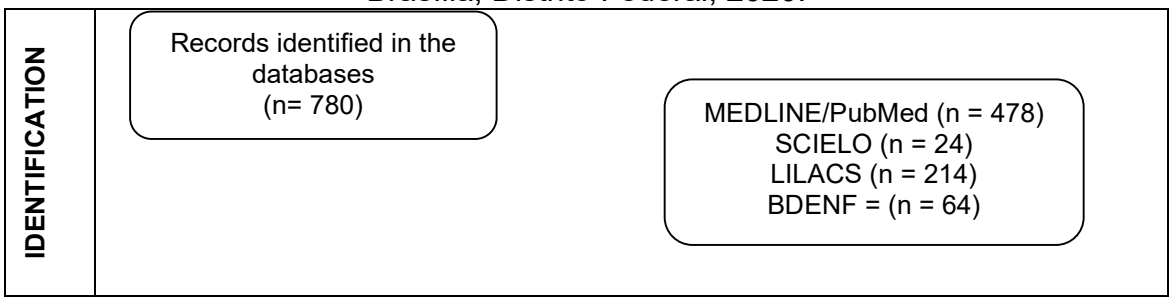
Information sources	Search Expressions	Results
MEDLINE/PubMed	"health services for the aged" OR "aged" OR "older adult" OR "elderly" OR "older persons" AND "primary health care" AND "quality of health care"	478
SCIELO	"health of the elderly" AND "primary health care" AND "quality of health care"	24
LILACS	"health of the elderly" AND "primary health care" AND "quality of health care"	214
BDENF	"health of the elderly" AND "primary health care" AND "quality of health care"	64
Total		780

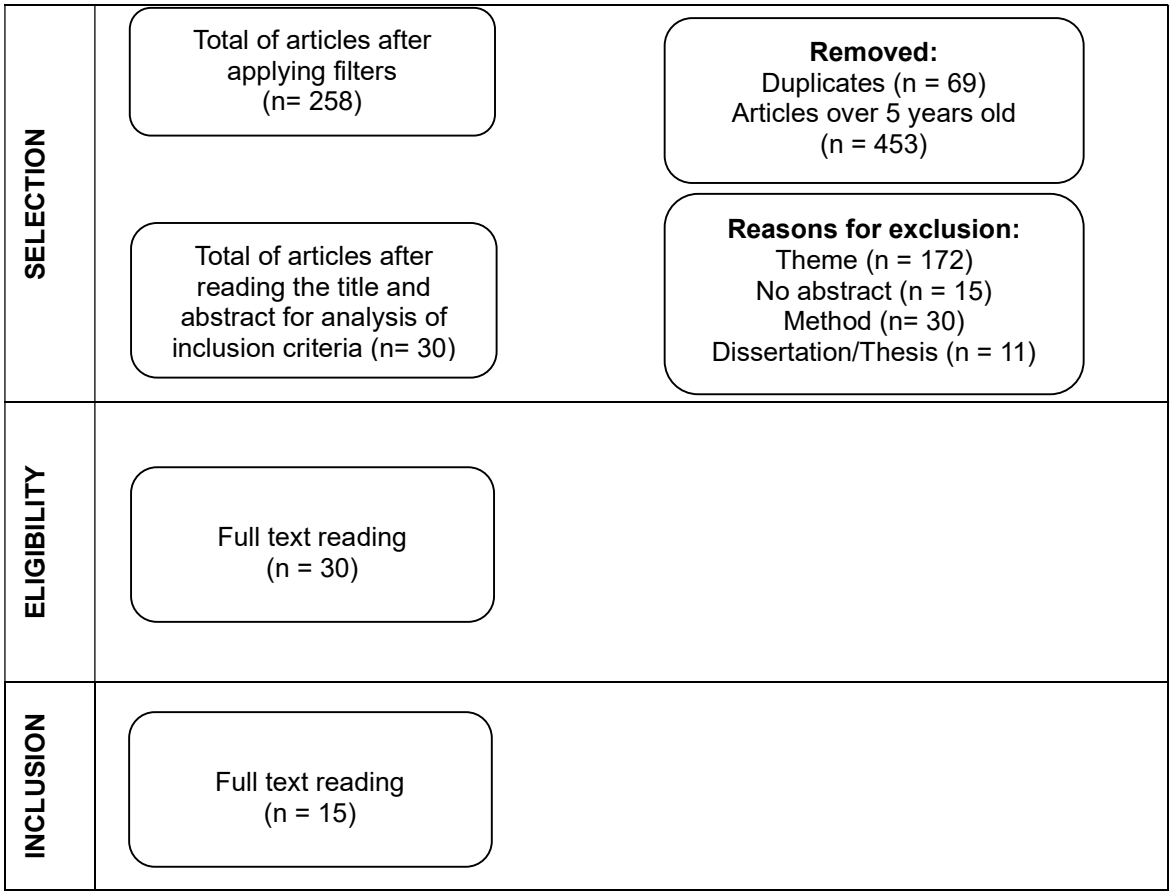
Elaboration: Aguiar RS, Silva HS, 2020.

The inclusion criteria for the sample were: studies with people aged 60 years or older, health professionals and managers; studies addressing the quality of care for the elderly in PHC; studies with qualitative, quantitative and mixed methods design; articles published online in the last 5 years (2015 to 2020), available in Portuguese, English or Spanish and in full. Literature reviews, congress abstracts, proceedings, editorials, dissertations and theses were discarded.

The database search generated 780 references. The selection of studies was conducted by exporting the results of searches in the electronic databases to the EndNote desktop® reference manager. With the program, 69 duplicates were removed and 453 in the temporality (last 5 years), which resulted in 258 for evaluation of other inclusion criteria through the reading of titles and abstracts. Of these, 228 were excluded depending on the theme (n= 172), method (n=30), not having an abstract (n=15) or being a dissertation and thesis (n=11). At the end, 30 articles presented potential for inclusion in the sample and, among these, 15 were chosen after full reading (Figure 1).

Figure 1: Database search flowchart according to PRISMA recommendations. Brasília, Distrito Federal, 2020.





Elaboration: Aguiar RS, Silva HS, 2020.

The evidence for the articles was classified into six levels: Level I - studies related to the meta-analysis of multiple controlled studies; Level II - individual experimental studies; Level III - quasi-experimental studies, such as the non-randomized clinical trial, the single group pre- and post-test, in addition to time series or case-control; Level IV - non experimental studies, such as descriptive, correlational and comparative research, with a qualitative approach and case studies; Level V - program evaluation data obtained in a systematic manner; and Level VI - expert opinions, experience reports, consensus, regulations and legislation[11].

In order to facilitate the extraction and synthesis of data, a synthesis matrix described in an Excel® spreadsheet has been prepared. Data was collected such as: journal; country and year of publication; author(s); title; study design; main results, factors related to the quality of attention and level of evidence. We tried with the instrument, besides forming a database, mapping relevant points, integrating data and characterizing the revised sample. Thus, part of these data are represented in Chart 2.

Chart 2: Final sample of articles. Brasília, Distrito Federal, 2020.

Study	Journal	Author(s)	Year	Title	Study design	Level of evidence
E1	Public Health Journal	Placideli N et al. [12]	2020	Evaluation of comprehensive care for the elderly in primary care services	Cross-sectional study	IV
E2	BMC Health Services Research	Vestjens L, Cramm JM, Nieboer AP[13]	2019	Qualidade da prestação de cuidados primários e interações produtivas entre pessoas idosas frágeis que	Quasi-experimental	III

				vivem na comunidade e seus médicos de clínica geral e enfermeiros de clínica geral		
E3	BMC Geriatrics	Kelly G, Mrengqwa L, Geffen L[14]	2019	"They don't care about us": older people's experienes of primary healthcare in Cape Town, South Africa	Qualitative	IV
E4	African Journal of Primary Health Care & Family Medicine	Naidoo K, Wyk JV[15]	2019	What the elderly experience and expect from primary care services in KwaZulu-Natal, South Africa	Qualitative	IV
E5	Rene Journal	Meireles VC, Baldissera VDA[16]	2019	Quality of care for the elderly: risk of pressure injury as a marker condition	Multiple Case Study	IV
E6	Latin American Journal of Nursing	Silva LB et al. [17]	2019	Estratos de risco e qualidade do cuidado à pessoa idosa na atenção primária à saúde	Estudo transversal	IV
E7	Gaúcha Nursing Journal	Andrade LAF et al. [18]	2019	Evaluation of the quality of primary health care according to the level of satisfaction of the elderly	Quantitative	IV
E8	Epidemiology and Health Services	Augusto DK et al. [19]	2019	Factors associated with the evaluation of the quality of primary health care by elderly residents in the Metropolitan Region of Belo Horizonte, Minas Gerais, 2010	Cross-sectional study	IV
E9	American Journal of Hospice & Palliative Medicine	Hamayel NAA et al. [2)0	2018	Older patient's perspectives on quality of serius illness care in primary care	Qualitative	IV
E10	BMC Health Services Research	Vestjens L, Cramm JM, Nieboer AP[21]	2018	An integrated primary care approach for frail community-dwelling older persons: a step forward in improving the quality of care	Mixed method	IV
E11	*Phisys*: Collective Health Journal	Coelho LP, Motta LB, Caldas CP[22]	2018	Elderly care network: facilitators and barriers to implementation	Qualitative	IV
E12	Kairós Gerontology Journal	Placideli N, Castanheira ERL[23]	2017	Elderly health care and aging in a network of primary care services	Quantitative	IV
E13	Plural Science Journal	Souza AMG et al. [24]	2017	Evaluation of care for the elderly in primary health care: users' perspective	Quantitative	IV
E14	British Journal of General Practice	Van de Pol MHJ et al. [25]	2015	Quality care provision for older people: an interview study with patients and primary healthcare professionals	Exploratory study	IV
E15	Interface	Medeiros SG, Morais FRR[26]	2015	Organization of services in health care for the elderly: user perception	Qualitative	IV

Elaboration: Aguiar RS, Silva HS, 2020.

The compiled data was then analyzed by means of thematic analysis[27], being organized and presented in thematic categories obtained from the following stages of analysis: 1) familiarization of the data (results of the studies that composed the sample

and related to the research question), 2) generation of initial codes, 3) search by themes, 4) revision of the themes, 5) definition and titling of the themes and 6) production of the report.

RESULTS

The final sample of this review consisted of fifteen articles, as described in Table 4.

A large portion of the publications refer to the year 2019 with seven articles (46.7%), followed by 2018 with three (20%), 2017 and 2015 with two each year (13.3% each year) and 2020 with one article (6.7%). Qualitative design was the most prevalent among the searches (five articles, 33.3%). As for the place of publication and development, nine studies (60%) were conducted in Brazil, three (20%) in the Netherlands, two (13.3%) in South Africa and one (6.7%) in the United States (USA). Regarding the level of evidence of the articles, there was a higher prevalence of non-experimental studies, such as descriptive, correlational and comparative research, with qualitative approach and case studies (93.3%).

The thematic analysis of the results of the articles allowed the organization in two main thematic categories: 1) potentialities associated with the quality of care for the elderly in PHC and 2) weaknesses in the quality of care for the elderly in PHC.

Potentialities associated with the quality of care for the elderly in PHC

In general, the articles brought aspects identified and/or executed by health professionals, managers and the elderly as necessary for the quality of care for the elderly in PHC. Thus, the typology of the service in the FHT model, the high coverage of PHC and the availability of the primary health care service free of charge were highlighted by articles E1, E11 and E3, respectively[12,22,14].

The E11 study identified the figure of the community health agent (CHA) as a strong point for the improvement of the follow-up processes of patients due to the capillarity of the FHT in the municipality, performance in family guidance, home visits to the elderly after discharge for continuity of care and investment in technical training in Nursing to professionals for a better monitoring of users in the territory[22].

Among the clinical processes of monitoring the elderly in PHC, the attention to CNCD was the one that stood out the most, as found in studies E1, E3 and E12[12,14,23].

In the perception of elderly people, it was identified that they value the discussion on the impact of diseases or treatments on their quality of life(E9)[20], the service adapted to their wishes(E10)[21] and the maintenance of its autonomy for decisions that impact its monitoring and health treatment (E14)[25]. Additionally, the continuity of care by the same health professionals was identified as a positive aspect in the E14 study[25], this fact corroborates the one identified in the E13 study, which demonstrated the existence of a link due to the small turnover of health professionals. Furthermore, patient-centered communication was raised as an important marker for the quality of care [24].

Still according to the elderly, the quality of PHC was associated with the perceived productivity of their interactions with the doctor and the nurse in the E2 study[13] and the construction of a relationship of trust and affection with the elderly allows for more effective actions in therapeutic practices (E11)[22]. The PHC physician was identified as a professional with a central role in the coordination of elderly care according to the E9 study[20], but the E10 study brought that multidisciplinary collaboration in the care of the elderly allows a more satisfactory follow-up[21].

Regarding the work processes of professionals, the E9 study values the provision of health education to the elderly for better decision making and accountability of their care, as well as the provision of reliable brochures or websites for research and health education[20]. In the E15 study, discussions on health care in elderly groups are encouraged[26].

Additionally, the E11 study approached the follow-up of requests for referrals by health professionals to avoid absenteeism in care, resizing of vacancies of specialists and/or exams regulated according to the demands of the APS and the hiring of services not available in the municipality to ensure better health care, aiming at the completeness of the care[22]. Furthermore, the E3 study pointed out the delivery of medicines at home for fragile elderly as a factor for increasing access and accessibility[14].

The E1 study demonstrated the need for constant evaluation of the care processes for monitoring and evaluating users, in addition to the need for the use of epidemiological data for a better performance in comprehensive care for the elderly[12].

The relationship between professional and user was an aspect highlighted in the E9 study in which the elderly highlighted aspects necessary for the quality of care, namely: detailed explanation about the diagnoses, relevance of the evaluation, treatment and presentation of treatment options focusing on patient preference, timely communication with the doctor, listening to patients and translating their concerns as important aspects of communication, perception of comfort and confidence when the doctor is receptive to learn new information about their disease and care, in addition to listening, respect, humility and punctuality as positive characteristics in the care of the elderly[20].

Weaknesses in the quality of health care for the elderly in PHC

PHC is seen as the preferential gateway for users to the UHS due to the possibility of lifelong follow-up and the completeness of care, but according to the E11 study it was possible to identify the absence of a model of care for the elderly in the services, since care is provided based on adult care, without taking into account the needs of the elderly person[22]. Corroborating this finding, the E10 study presents a reactive, fragmented PHC that is not able to effectively deal with the complexity of the health needs of elderly people in the community[21]. In addition, the elderly consider the quality of services provided in PHC to be of low quality, and their expectations regarding the service attributes are usually higher than their perceptions, according to the E7 study[18].

The work and formation of an intersectoral network are fundamental in the care of the elderly, but studies E1, E11 and E12 demonstrated the absence of intersectoral and

interdisciplinary support network, besides the low performance of intersectoral work, even in services with positive assessment of PHC[12,22-3].

Although it has been identified that the attention to CNCD was the most prominent among the clinical follow-up of the elderly person, the risk stratification is still underused in the practice of care for the elderly, as demonstrated in the studies E6, E11 and E12[17,22-3]. In addition, there was an association between chronic health conditions and a worse perception of PHC performance in the attributes of care coordination, family counseling and community orientation in the E8 study[19].

Additionally, the evaluation of the degree of fragility and the multidimensional evaluation of the elderly person was another aspect neglected by health professionals in the E5 and E8 studies[16,19]. In addition, the E1 study identified incipiency in the development of actions aimed at active and healthy aging[12]; an attention not patient-centered or inappropriate for age (E3)[14]; the lack of knowledge of the aging process and its implications in the health demands by the professionals, besides difficulties of performance with elderly people with functional decline or fragile elderly people (E11)[22]. These facts may be associated with the perceptions of the elderly identified in the E4 study in which they report that health professionals are trained to see the elderly as diseases to be treated rather than individuals with health needs[15]. In addition, studies E5, E11, E12 and E14 demonstrated deficiency and/or lack of permanent training/education aimed at health professionals[16,22-3,25].

Regarding health promotion and prevention actions, studies E7, E11, E12 and E15 showed in their results little incorporation, inefficiency of actions contributing to the increase of emergency care, difficulty of access to information materials and non-prioritization and/or lack of health education during consultations[18,22-3,26].

Table 3 shows a compilation of other weaknesses described by the studies that make up the final sample of this integrative review, as well as the possible outcomes. Intervening in the complaints system requires planning actions anchored in the adoption of evaluation protocols, follow-up and monitoring of elderly people; use of management indicators and quality of care; supply of inputs, expansion of infrastructure and better articulation of the intersectoral support network; continuing education actions for professionals who work at BHU, as well as expansion of reception actions, formation of links and health education for users.

Chart 3: Synthesis of the negative factors and possible outcomes described by the studies included in the integrative review. Brasília, Distrito Federal, 2020.

Complaints	Possible outcome
Unavailability and/or eventual lack of medication (E3, E12, E15)[14,23,26] Delays in meeting the needs for mobilization devices (E5)[16] Failure to meet the scheduled dates for medical appointments (E7)[18]	Several visits to the health service (E4)[15]
Lack of infrastructure and material and human resources (E5)[16] Lack of doctors (E11, E13)[22,24] Lack of structure to support the acute conditions attended in the PHC, as well as to transport these emergencies to the hospital emergency room (E11)[22]	Overload of other professionals (E11)[22] Development of basic demands in PHC (E15)[26] Perception by health professionals that the increase in the number of elderly results in a longer consultation time, especially for doctors, greater demand for home visits, increased work for professionals, and an increase in the queue for

Lack of important information in the referral of the patient to specialists via regulation system (E11)[22]	medical appointments (E11)[22] Old age was associated with loss of productive capacity, dependence and uselessness from the social point of view (E11)[22] Low priority care for the elderly (E3, E4, E15)[14-5,26]
Lack of support to family caregivers by health professionals (E5, E12)[16,23]	Exposure of the caregiver to overloads in the activity, with damages to the quality of life and higher risk of illness (E12)[23]
Scheduling of inquiries on a first come, first served basis (E15)[26]	Long wait for healthcare professionals (E4)[15] Delays in scheduling appointments and exams (E15)[26]
Incipient use of clinical protocol (E6, E10)[17,21] and/or unavailability of the same in the services (E14)[25] Insufficient medical records (E6)[17] Poor communication between PHC and other health care network services (E11)[22]	Failure of health professionals to know the patients' clinic in advance (E13)[24] Quick inquiries (E15)[26] Fragmentation of services offered to the elderly (E4)[15] Multiple adverse effects were observed with the prescribed medication (E4)[15] Hurried consultations and lack of physical examination (E3)[14] Lack of continuity of care (E3)[14] Over-prescription of drugs (E3)[14] Difficulty in working with multidisciplinary assistance plans (E14)[25] Unnecessary referral to specialists by PHC (E11)[22]

Elaboration: Aguiar RS, Silva HS, 2020.

Another outstanding factor identified in studies E3, E11 and E14 was the physician's performance in which the absence of interpersonal relationship between the professional and the elderly person was verified, centralization in the medical consultation and in the model based on the production and not in the resolution of the demands of the users, besides little medical availability for the care directed to the elderly in the territory, respectively[14,22,25].

About the performance of nurses, the E3 study showed a negative reputation of professionals by the elderly due to disinterest, judgment of value, rudeness and even aggression by nurses due to non-follow-up of treatment by the elderly[14]. In addition, the E6 study demonstrated that the nursing consultations were directed to complaint-conduct during the reception, with consequent referral for medical evaluation[17], in addition to the existence of problems related to decision making by nurses in the E14 study[25].

DISCUSSION

The health care of the elderly must be based on the provision of care practices aimed at achieving old age with independence, autonomy and productivity, as well as having a network of services articulated, integrated, referenced and with information systems constituted[12,18].

In the contemporary model of care with a focus on aging and, especially, on the elderly person, it becomes necessary to gather a continuous flow of educational actions, health promotion, prevention of preventable diseases, postponement of aggravation and maintenance of functional capacity[12,16,23].

Therefore, investments in human resources, permanent education, standardization and implementation of behaviors related to the health of the elderly are necessary to qualify health care so that there is an improvement in the implementation of clinical guidelines in the practice of health professionals, aiming to promote alignment of health care with the needs of the elderly person[16-7].

Furthermore, the work process of the health teams needs to be organized in order to offer an equitable and integral care, welcoming the user and linking him/her to the services offered according to his/her real needs, because when the health demands are not identified and/or stratified, the necessary care under-supply to elderly people with higher risks and/or the over-supply of unnecessary care to those with lower needs may occur, which consequently produces ineffective and inefficient care[17].

For this, risk stratification, the use of epidemiological indicators, and the evaluation of the quality of PHC services need to be institutionalized as a process of transformation of PHC practices. In addition to this need, the expectations and perceptions of the elderly are identified as a determinant for the organization of the model of care for the elderly that allows for flexibility and organization of care actions based on the needs of users in order to value and influence therapeutic adherence[17-8,20,22,24].

The elderly person has biopsychosocial demands and particularities that differentiate him/her from a young and middle-aged adult user; thus, the importance of breaking with the idea of a generalized elderly care is stressed [22] to invest in a person-centered, integral, proactive and inter-rational care[14-5,21,26].

In view of this, the institutionalization of the process of permanent education in health tends to be an alternative for the qualification and improvement of the work processes within the scope of PHC[14,25] and the creation of partnerships with educational institutions may serve as support for the realization of this measure[17].

However, besides the regular institutionalization of training for professionals to expand knowledge on specific issues of aging and health of the elderly, it is necessary to reflect that for a more substantial change in the model of care may require new structures, materials and equipment, which points to the reorientation in the allocation of public funds[26].

Therefore, exploring the potential of PHC services in managing care and maintaining the functional capacity of the elderly associated with networking and with the participation and co-responsibility of the elderly may overcome the fragmented system still in place in UHS[14,24-5].

CONCLUSION

From the data obtained in the review, it is identified the existence of fragilities in the health care of the elderly in PHC that directly impact on the quality of care offered and perceived by the elderly person. Aspects that involve lack of training, protocols, inputs, human resources, infrastructure and intersectoral network were identified.

In addition, by making the association with the attributes of PHC, access and completeness are the most impacted in the provision of care for the elderly within

PHC. Parallel to this, the effectiveness of the FHT model was identified as an important aspect for the health care of the elderly in the PHC, besides the active action of the CHA in the territory, as well as the need for valorization and participation of the elderly in discussions about their follow-up and treatment.

Thus, this review suggests the need for future research in order to improve the understanding of the factors associated with the quality of care for the elderly in PHC, because despite the efforts to qualify PHC through the implementation of the book of the elderly, care for CNCDs, strengthening of the FHT, provision of courses by the Open University of the UHS (UNASUS) and forums for continuing education, it has not been sufficient or is not applied comprehensively to direct care professionals. These challenges become even greater with Constitutional Amendment No. 95, which limited public spending for 20 years and with the difficulty of operating the NPHE in the last decade. There is a lack of broad and mobilizing actions to promote healthy aging, as well as the use of technical and relational devices aimed at the territory and the elderly person.

Therefore, a broader and more comprehensive view of the aging process is needed, as well as the commitment of professionals to the subject, given that aging is a growing reality in PHC and that it will be increasingly so in the coming decades.
Regarding the limitations of the study, it is believed that they are related to the use of a single international database, a fact that may have limited the expansion of the supply of scientific articles in languages other than Portuguese.

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