Hospitalizations of older adults due to chronic conditions sensitive to primary care in a Ceará region

Hospitalizaciones de personas mayores por Condiciones Sensibles de la Atención Primaria en una región de Ceará

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INTRODUCTION

The indicator of Hospitalizations due to Primary Care Sensitive Conditions (HPCSCs) is widely used in several countries to verify the performance of Primary Health Care (PHC). Two studies\(^1\)\(^-\)\(^2\) contribute a well-established relationship between decreased rates of HPCSCs in older adults and improved access and resoluteness of the first-level health care services.

The socioeconomic profile can also exert an influence on the HPCSC rates. According to Amorim et al.\(^3\), the social determinants of health can be considered as external influencers of the HPCSC rates, especially those related to education, income, and housing conditions. Therefore, the resolutive capacity of the first level of care and the socioeconomic profile directly impact on the quality of life of the aged population and on the maintenance of their functional capacity, affecting their health, disease, and need or not for hospitalizations.

Older adults have a seven times higher risk of hospitalizations due to these conditions compared to the general population\(^4\), which reflects the relevance of analyzing and monitoring this indicator in this population. In addition, the Brazilian Northeast region is marked by social characteristics that make its population vulnerable\(^5\)-\(^6\), although it is a pioneer in the development of programs to access the basic health network, which makes it relevant to explore the correlation between the Family Health Strategy (FHS) coverage, the socioeconomic indicators, and the HPCSC rates in this region.

The objective of this study is to analyze the time evolution of chronic HPCSCs in older adults and its correlation with the Family Health Strategy (FHS) coverage and socioeconomic indicators in a health region of Ceará.

METHOD

This is a descriptive and ecological study, in which the time cutout comprised the period from 2012 to 2017 and the units of analysis were the 24 municipalities that make up the 11th Health Region of Ceará, which recorded chronic HPCSCs in older adults aged from 60 to 74 years old in the network convened to the Unified Health System (Sistema Único de Saúde, SUS), through notification of the responsible institution, which fed the database of the Hospital Information System (Sistema de Informação Hospitalar, SIH/SUS).

The groups of causes in this research were selected from the Brazilian list of HPCSCs\(^7\), the groups of chronic conditions being considered, namely: Asthma (group 7), Lung Diseases (group 8), Hypertension (group 9), Angina (group 10), Heart Failure (group 11), Cerebrovascular Diseases (group 12), and Diabetes Mellitus (group 13).

Data collection occurred between April and June 2018, having Hospital Information System (SIH) from the Ministry of Health, available at the SUS Informatics Department (DATASUS), as the source of the data on hospitalizations. This data were compiled using the Tab software for Windows – TabWin, which assisted in the fast tabulation of files in “dbf” format.

The data regarding the history of FHS coverage were extracted from the e-Gestor Information System, via public reports stratified by year and municipality of interest. For this extraction, it was necessary to choose the “period per unit” option, which allowed for the selection of a specific time interval.

The socioeconomic indicators were obtained from the Atlas of Human Development in Brazil (Atlas Brasil). As they are calculated only for census years (1991, 2000, and 2010), the linear interpolation technique was applied between 2000 and 2010, as well as linear extrapolation from 2010 to 2017. Subsequently, the period of interest (2012-2017) was selected. By using this technique, the annual estimated values for each indicator selected were estimated: Municipal Human Development Index (MHDI), Gini index, illiteracy rate in people over 15 years old, percentage of the population in households with a bathroom and running water, percentage of individuals vulnerable to poverty, and proportion of extremely poor population.

To find the number of aged residents in the age group of the study in the municipalities, a search was performed in the DATASUS for the data of the last 22 years (1990-2012) and a projection of this population until 2017 was made in the Excel program with the formula “=PROJ(YEAR,X;Y)” where “year” referred to the years of interest of the projection, “X” is the population, and “Y” is the interval of the years already collected.

The rate of chronic HPCSCs in older adults was calculated for each municipality by the ratio of the total number of chronic HPCSCs in the resident aged population aged from 60 and 74 years old in the year of interest, multiplying the final value by 1,000.

Likewise, the rate of chronic HPCSCs in older adults by cause group was calculated through the ratio between the total number of chronic HPCSCs for each cause group on the Brazilian list of sensitive conditions and the resident aged population aged 60-74 years old, considering the year and municipality of interest, multiplying the result by 1,000.

The numerical variables were subjected to the Shapiro-Wilk (SW) normality test in the STATA 13.0 software, which verified nonparametric distribution of the data for all the variables tested, opting to use the median. The statistical test used was Spearman’s coefficient. In this study, coefficients above ±0.75 were considered satisfactory.

For the analysis of the hospitalization trends, a graph was generated in the Microsoft Excel program, version 2016, in which the trend line (dotted line), the straight line equation, and the R-squared value (R\(^2\)), available in the program, were inserted.

The research used secondary data sources in the public domain, with no requirement for submission to and appreciation by any Committee of Ethics in Research with Human Beings.
RESULTS

A total of seven 7,245 HPCSCs were recorded in aged individuals up to 74 years old, with 4,650 (64.18%) belonging to the chronic conditions groups. Chronic HPCSCs were more frequent in aged males, with 2,578 (55.44%), and in the 70-74-year-old age group, with 1,673 (35.98%). The three prevalent groups of causes were Heart Failure with 1,666 hospitalizations (35.83%), Cerebrovascular Diseases with 1,048 (22.54%), and Angina with 754 (16.22%). The years that recorded the highest and lowest number of these hospitalizations were 2012 with 920 (19.78%) and 2017 with 675 (14.52%), respectively, indicating a reduction in this indicator during the observation period. Sobral (83.74%) obtained the highest number of hospitalizations, followed by Mucambo (35.36%) and Santana do Acaraú (3.20%). Seven municipalities of the health region did not record any HPCSC rate in the period.

Table 1 – Profile of the hospitalizations of older adults due to chronic conditions sensitive to Primary Health Care in the 2012-2017 period, in the 11th Health Region of Ceará. Sobral, Ceará, Brazil, 2019.

| Health Region        | Chronic HPCSC in older adults | 2012  | 2013  | 2014  | 2015  | 2016  | 2017  | Total | %    |
|----------------------|--------------------------------|-------|-------|-------|-------|-------|-------|-------|------|
| Gender               |                                |       |       |       |       |       |       |       |      |
| Male                 |                                | 489   | 386   | 400   | 488   | 421   | 394   | 2,578 | 55.44|
| Female               |                                | 431   | 382   | 365   | 357   | 256   | 281   | 2,072 | 44.56|
| Total                |                                | 920   | 768   | 765   | 845   | 677   | 675   | 4,650 | 100  |
| Age group (in years old) |                              |       |       |       |       |       |       |       |      |
| 60-64                |                                | 271   | 225   | 205   | 238   | 214   | 194   | 1,347 | 28.96|
| 65-69                |                                | 307   | 254   | 246   | 301   | 243   | 279   | 1,630 | 35.05|
| 70-74                |                                | 342   | 289   | 314   | 306   | 220   | 202   | 1,673 | 35.99|
| Total                |                                | 920   | 768   | 765   | 845   | 677   | 675   | 4,650 | 100  |
| City*               |                                |       |       |       |       |       |       |       |      |
| Cariri               |                                | 0     | 2     | 9     | 1     | 2     | 3     | 17    | 0.36 |
| Catunda             |                                | 2     | 10    | 6     | 3     | 0     | 5     | 26    | 0.55 |
| Coreá               |                                | 1     | 4     | 1     | 0     | 2     | 4     | 12    | 0.25 |
| Frecheirinha        |                                | 6     | 7     | 1     | 2     | 0     | 1     | 17    | 0.36 |
| Groaíras            |                                | 1     | 2     | 0     | 1     | 1     | 2     | 7     | 0.15 |
| Hidrolândia         |                                | 9     | 13    | 14    | 6     | 5     | 4     | 51    | 1.09 |
| Ipu                 |                                | 27    | 26    | 23    | 23    | 9     | 15    | 123   | 2.64 |
| Irauçuba            |                                | 7     | 6     | 0     | 0     | 1     | 6     | 20    | 0.43 |
| Massapê             |                                | 16    | 0     | 8     | 10    | 6     | 5     | 45    | 0.96 |
| Meruoca             |                                | 4     | 3     | 1     | 2     | 1     | 2     | 13    | 0.27 |
| Moraujo             |                                | 2     | 1     | 0     | 1     | 0     | 2     | 6     | 0.12 |
| Mucambo             |                                | 45    | 38    | 33    | 21    | 16    | 13    | 166   | 3.56 |
| Reriutaba           |                                | 9     | 6     | 4     | 3     | 0     | 3     | 25    | 0.53 |
| Santana do Acaraú   |                                | 67    | 32    | 14    | 12    | 12    | 12    | 149   | 3.20 |
| Santa Quitéria      |                                | 9     | 8     | 9     | 4     | 2     | 7     | 39    | 0.83 |
| Sobral              |                                | 701   | 595   | 638   | 753   | 617   | 590   | 3,894 | 83.74|
| Varjota             |                                | 14    | 15    | 4     | 3     | 3     | 1     | 40    | 0.86 |
| Total               |                                | 920   | 768   | 765   | 845   | 677   | 675   | 4,650 | 100  |
| Chronic conditions  |                                |       |       |       |       |       |       |       |      |
| Asthma              |                                | 60    | 104   | 65    | 36    | 9     | 17    | 291   | 6.25 |
| Pulmonary diseases  |                                | 139   | 110   | 83    | 54    | 35    | 22    | 443   | 9.52 |
| Hypertension        |                                | 20    | 12    | 10    | 6     | 5     | 4     | 57    | 1.22 |
| Angina              |                                | 154   | 2     | 52    | 216   | 158   | 172   | 754   | 16.21|
| Cardiac insufficiency|                               | 338   | 355   | 342   | 263   | 194   | 174   | 1,666 | 35.82|
| Cerebrovascular diseases |                             | 100   | 109   | 154   | 215   | 240   | 230   | 1,048 | 22.53|
| Diabetes Mellitus   |                                | 109   | 76    | 59    | 55    | 36    | 56    | 391   | 8.40 |
| Total               |                                | 920   | 768   | 765   | 845   | 677   | 675   | 4,650 | 100  |

Source: Hospital Information System (SIH)/DATASUS. *The cities of Alcântaras, Forquilha, Graça, Pacujá, Pires Ferreira, Senador Sá and Uruoca were removed from the table because their data were null in the years researched.
Graph 1 represents the behavior of the sensitive hospitalizations over the years, showing a tendency of reduction in the number of these hospitalizations in the 11th HR of Ceará (Graph 1).

Graph 1 – Trend of chronic HPCSCs in the 11th Health Region of Ceará, 2012-2017. Sobral, Ceará, Brazil, 2018.

Graph 2 – Rate for the groups of chronic causes in older adults, in a set of 1,000 aged individuals from the 11th Health Region of Ceará, 2012-2017. Sobral, Ceará, Brazil, 2018.

Despite the downward trend in these chronic HPCSCs, a rise in cerebrovascular diseases was noticed to the detriment of the others, with a linear regression line angle coefficient of +0.58. Another observation was regarding the time evolution of the hospitalizations due to angina, which showed great oscillation in the studied period (Graph 2).

Graph 3 – Comparison of the population covered by the Family Health Strategy and the rates of chronic HPCSCs in older adults of the 11th Health Region of Ceará, 2012-2017. Sobral, Ceará, Brazil, 2018.

The correlation between the study variables by means of the Spearman’s coefficient showed a significant correlation between FHS coverage and the rate of chronic HPCSCs ($r = 0.80$, $p$-value = 0.0301) and with the Gini index ($R = 0.80$, $p = 0.0291$). The other socioeconomic indicators presented no association with the HPCSC rates.

DISCUSSION

The higher prevalence of chronic HPCSCs in aged males can be explained by behavioral attitudes related to lifestyle and health care patterns, as men expose themselves to greater risks throughout life, seek less prevention and health promotion services, and have a smaller support network for daily care compared to women.(8)

One of the most consistently observed associations with the occurrence of hospitalizations is age, with higher occurrence in older age groups.(9) This study evidenced that older adults aged 70-74 years old presented a higher rate of hospitalization due to chronic conditions, being prevalent in the heart failure and cerebrovascular disease groups.

Regarding the relative share of chronic conditions in the rates of HPCSCs in the older adults surveyed, heart failure presented the highest contribution (35.83%). This is the cardiovascular disease that causes the most hospitalizations in Brazil, affecting men more frequently and, among the main causes of heart failure in the Northeast region are myocardial ischemia, idiopathic dilated cardiomyopathy, and arterial hypertension.(10)

Unlike heart failure, hypertension was the condition with the lowest relative share among chronic HPCSCs. Due to inherent characteristics of the natural history of the disease, it is less prone to hospitalizations. Even so, data from this study pointed out that this condition was more prevalent among women, which, according to the study(11), can be associated with income inequality between the genders.
Another factor that may have exerted an influence on the low relative share of hypertension compared to other chronic conditions was the implementation of the “Hiperdia Program” in 2012. Besides being a prevention program, it provided new strategies for the control of the modifiable risk factors, such as smoking, alcohol abuse, sedentary lifestyle, and inadequate diet\(^{(12)}\).

A Brazilian study\(^{(13)}\) that analyzed the trend of HPCSC rates in Santa Catarina evidenced that the three groups with more expressive rates were the following: cerebrovascular diseases, heart failure and Chronic Obstructive Pulmonary Disease (COPD), that is, all were chronic disease groups, which corroborates with this study.

The estimation of care coverage is a relevant indicator in the evaluation of PHC and primary care teams in Brazil\(^{(14)}\), and it influences indicators that are sensitive to improving access to primary health care services, such as HPCSCs. Corroborating the findings of this study, in which a strong inverse association was evidenced between FHS expansion and chronic HPCSC rates, a study by Busby et al.\(^{(15)}\) showed that improved continuity of primary care was more strongly associated with lower emergency admission rates for chronic conditions.

The study by Pimenta et al.\(^{(16)}\), which evaluated the period from 1998 to 2015, found a correlation between increased FHS coverage and reduced rates of hospitalization due to cardiovascular conditions and asthma. The coverage in the years researched, in the analyzed region, was always above 85%, which shows that the FHS teams are advancing in the sense of promoting access to health care in the territories and enabling older adults to have greater access to basic health care services. This expansion of the FHS may have contributed to sensitive chronic conditions in general being less and less present in hospital contexts.

However, despite the downward trend in the chronic HPCSC rates in older adults, this study identified, in 2017, an expressive increase in these hospitalizations when compared to the other years of the period studied, even in the face of the progressive consolidation of the FHS in the municipalities analyzed. Possible explanations for this phenomenon can be related to economic issues that Brazil has experienced in the last few years.

Therefore, the increase in the number of people who lost their health plans and started to use only the SUS, called SUS-dependents, added to the reduction in funding in the health sector, may have contributed to the increase in the rates of HPCSCs in older adults during 2017, both by the direct increase in the demand for hospitalizations in public beds, and by the per capita dilution of resources, compromising the quality of primary services. Associated with this is the active population aging and the relative increase in chronic conditions, which are more costly.

Another important point to highlight was the relative rise in cerebrovascular diseases, which has care longitudinality as a protective factor\(^{(17)}\). The various factors that interfere with the work processes of the health team within PHC are limiting the effectiveness of the care provided to older adults. Examples include the geographical characteristics of the territory, violence in the territory, assisting a population beyond what is recommended, excess demand and productivity, adherence to the treatment of diverse conditions, multiple demands exhibited, dysfunctional family dynamics of the older adults and also the establishment of connections with the aged individuals\(^{(18)}\). All this makes it a great challenge for the FHS professionals to promote comprehensive, longitudinal and multidimensional care to older adults.

Cerebrovascular conditions impact on the lives of the older adults and, according to Lopes et al.\(^{(19)}\), the rates of hospitalizations due to these conditions have reduced nationally, contrary to the data found in the 11th Health Region of Ceará. Thus, it becomes imperative to invest in prevention and management strategies, to qualify the professionals, and to develop intersectoral policies to control these health conditions.

Northeastern states have the worst socioeconomic indicators in the country\(^{(20)}\). Older adults with higher schooling levels and greater wealth power have lower prevalence of undiagnosed diseases\(^{(21)}\). HPCSC rates in aged individuals are sensitive to the indicators related to income. Social inequalities exert a negative influence on the access to goods and services, including health. The low-income population receives fewer preventive services, suffers greater delays in their care, and tends to seek assistance already in acute crises\(^{(22)}\), which promotes impairments in their health status and reduces the resolutive capacity of the FHS, which does not act in a timely manner. Thus, people with lower schooling levels and limited access to information are less likely to adopt self-management behaviors, as they have limited understanding of their health condition and of attitudes that would promote good control throughout the course of the disease\(^{(23)}\).

In this study, only the Gini index was significantly correlated to the variation in the HPCSC rates. This is probably due to the fact that income and social inequalities exert greater impact on people’s daily lives than the other socioeconomic indicators analyzed. Income in old age is a factor that can have favorable or unfavorable repercussions on the quality of life of these individuals. Low-income seniors who require specific health care may have difficulty maintaining their health status because more financial resources are needed to ensure a healthy diet, access to medications, and alternative treatments.

In this perspective, it is believed that the other indicators such as MHDI, illiteracy rate in people over 15 years of age, percentage of the population in households with a bathroom and running water, percentage of individuals vulnerable to poverty, and proportion of extremely poor population may not have presented a significant correlation due to the initiatives of assistance programs at regional or national level, in addition to the initiatives of health education actions strongly directed to the older adults within PHC.
The model proposed by the FHS directly contributes to the improvement of health indicators because, in addition to cure, rehabilitation and prevention, the FHS acts in health promotion and health education\textsuperscript{(24)}, expanding the critical sense and awareness of self-care management. However, the economic and political agenda imposed on Brazil in recent years have weakened the counter-hegemonic health reform movement, compromising the overall quality of the health services\textsuperscript{(25)}. The economic measures and political decisions, including the Proposal for Constitutional Amendment (Proposta de Emenda Constitucional, PEC) 241 and the review of the National Primary Care Policy (Política Nacional de Atenção Básica, PNAB), move towards ensuring the effective implementation of the PCH attributes and the achievement of a Universal, Comprehensive and Equal public health system, with broad social participation.

In this sense, to worsen the dismantling process of the SUS, the new review of the PNAB in 2017, with emphasis on the biomedical and medicalizing model, changes the number of Community Health Agents (CHAs), which will be according to the population base, as per the current legislation, creating vulnerability in the populations\textsuperscript{(26)}.

Thus, monitoring the effectiveness of PHC brings to light consequences of the set of political decisions that involve social sectors, including health. By evaluating the quality of primary services, the HPCSC indicator allows for the expansion of the FHS not to override its qualification. In the informational set generated by the analysis of this indicator, it is possible to make evidence-based decisions, efficient resource management, rationalization of technologies, and, consequently, improvement of the epidemiological profile of the population, especially the most vulnerable populations, such as older adults.

The following are to be noted as the study limitations: the significant heterogeneity of the analysis units with different health care profiles, considering the significant discrepancy of the technological contribution of each municipality, especially when compared to Sobral, a reference of medium- and high-complexity services in the health micro- and macro-region. This limitation did not allow for a comparative analysis of the hospitalization rates across the analysis units, which guided the evaluation of the HPCSC indicator for the 11th Health Region.

Small municipalities have problems feeding the SIH database, which led to the exclusion of seven municipalities that did not present data on the hospitalizations of interest in the DATASUS system, making it impossible to obtain a reliable number of hospitalizations in the region, underestimating the HPCSC rate, and compromising the analysis of the indicator.

However, this study contributes to the Nursing practice as it provides subsidies for nurses who assume positions in assistance, coordination or management of public policies to expand their ability to analyze the health problems of the older adults, susceptible to preventability, enabling the planning of programs and actions that can ensure timely and resolute care for aged individuals in PHC, following the guidelines of intersectoral articulation and interprofessionalism in the face of social vulnerabilities involved in the process of illness and hospitalization of the older adult.

**CONCLUSION**

The expansion of FHS coverage was strongly correlated to the reduction in the rates of chronic HPCSCs in older adults. Thus, it is appropriate to urge professionals and managers to develop strategies that contribute to the consolidation of the public policies that strengthen PHC in the Brazilian territory, especially in the municipalities of the Northeast region, favoring effective health care mainly focused on the most vulnerable populations.

In addition, the correlation analysis performed in this study does not allow inferring causality. Therefore, individual-level longitudinal studies are recommended to analyze the risk of hospitalization due to sensitive chronic conditions in this population, as well as its relationship with access and quality of care.

**REFERENCES**

1. Pinto LF, Giovanella L. Do Programa à Estratégia Saúde da Família: expansão do acesso e redução das internações por condições sensíveis à atenção básica (ICSAB). Ciênc. Saúde Colet. 2018;23(6):1903-13. Available from: DOI: 10.1590/1413-81232018236.0592018

2. Santos LPR, Castro ALB, Dutra VGP, Guimarães RM. Internações por condições sensíveis à atenção primária à saúde, 2008-2015: uma análise do impacto da expansão da ESF na cidade do Rio de Janeiro. Cad. saúde coletiva. 2018;26(2):178-83. Available from: DOI: 10.1590/1414-462X201800020230

3. Amorim DNP, Chirello MD, Vianna LG, Maures CF, Vilaça KEC. Interactions through conditions sensitive to primary attention of elderly persons in Brazil 2003 to 2012. Rev. enferm. UFPE on line. 2017;11(2):576-83. Available from: DOI: 10.5205/revol.10263-91568-1-RV.1102201712

4. Previto GF, Nogueira IS, Acorsi CRL, Baldissera VDA, Mathias TAF. Diminuição de internações por condições sensíveis à atenção primária em idosos no estado do Parânam, Espac. saúde (Online). 2017;18(2):15-24. Available from: DOI: 10.5433/15177130-2017v18n2p15

5. Filho DBF. Desigualdade de renda e vulnerabilidade social em Pernambuco: uma análise exploratória. Ci. &Tropico. Recife. 2019;43(1):49-57, 2019. Available from: DOI: 10.33148/CeTropical-v.43,n.1(2019)_1829

6. Costa MA, Santos MPG, Marguti B, Pirani N, Pinto CVS, Curi RLC, Ribeiro CC, Albuquerque CG. Vulnerabilidade social no Brasil: Conceitos, métodos e primeiros resultados para municípios e regiões metropolitanas brasileiras. Texto para Discussão 1ed. Brasília: Rio de Janeiro, 2018, 84 pág.
http://bvsms.saude.gov.br/bvs/saudelegis/sas/2008/prt0221_17_04_2008.html

8. Santos KMR, Oliveira LPBA, Fernandes FCGM, Santos EGO, Barbosa JR. Hospitalizations due to primary care sensitive conditions in a population of older adults in the state of Rio Grande do Norte from 2008 to 2016. Rev. Bras. Geriatr. Gerontol. 2019;22(4):e180204. Available from: DOI: https://doi.org/10.1590/1981-22562019022.180204

9. Rodrigues MM, Alvarez AM, Rauch KC. Tendência das internações e da mortalidade de idosos por condições sensíveis à atenção primária. Rev. bras. epidemiol. 2019; 22:e190010. Available from: DOI: https://doi.org/10.1590/1980-5497201900100.

10. Albuquerque DC, Neto JDS, Bacal F, Rohde LEP, Pereira SB, Berwanger O, Almeida DR. I Registro brasileiro de insuficiência cardíaca: Aspectos clínicos, qualidade assistencial e desfechos hospitalares. Arq Bras Cardiol. 2015; 104(6):433-42. Available from: DOI: 10.5935/abc.20150031

11. Lucumi DI, Schulz AJ, Roux AVD, Kaylor AG. Income inequality and high blood pressure in Colombia: a multilevel analysis. Cad. saúde pública (Online). 2017;33(11):1-13. Available from: DOI: 10.1590/0102-311X00172316

12. Maranhão STDP, Ramos APC, Silva LGS, Silva, MMF. Hiperdia: grandes demandas e desafios para o enfermeiro. Saúde coletiva (Barueri). 2021, 11(60): 4736-41. Available from: DOI: https://doi.org/10.36489/saudecoletiva.2021v11i60p 4736-4747

13. Rodrigues MM, Alvarez AM, Rauch KC. Trends in hospitalization and mortality for ambulatory care sensitive conditions among older adults. Rev. bras epidemiol. 2019;22:1-11. Available from: DOI: 10.1590/1980-549720190010

14. Ribeiro AF, Barbosa GFA, Alves TM, França IF, Lima AM, Sales MSM, et al. O impacto da estratégia saúde da família sobre os indicadores da atenção básica no Brasil. Rev. Eletr. acervo saúde. 2020;12(11):1-9. Available from: DOI: https://doi.org/10.25248/rees.e4730.2020

15. Busby J, Purdy S, Hollinworth W. How do population, general practice and hospital factors influence ambulatory care sensitive admissions: a cross sectional study. BMC Fam Pract. 2017;18(67):1-9. Available from: DOI: 10.1186/s12875-017-0638-9

16. Pimenta LS, Dutra VGP, Castro ALB, Guimarães RM. Analysis of conditions sensitive to primary care in a successful experience of primary healthcare expansion in Brazil, 1998-2015. Public health. 2018;162:32-40. Available from: https://doi.org/10.1016/j.puhe.2018.05.011

17. Xavier AJ, Reis SS, Paulo EM, D’orisi E. Tempo de adesão à Estratégia de Saúde da Família protege idosos de eventos cardiovasculares e cerebrovasculares em Florianópolis, 2003 a 2007. Ciênc. Saúde Colet. 2008 [cited 2020 jan 10];13(5):1543-1551. Available from:

18. Shenker M, Costa DH. Avanços e desafios da atenção à saúde da população idosa com doenças crônicas na atenção Primária à Saúde. Ciênc. Saúde Colet. 2019;24(4):1369-80. Available from: DOI: 10.1590/1413-81232018244.01222019

19. Lopes JM, Sanchis JB, Medeiros JLA, Dantas FG. Hospitalization for ischemic stroke in Brazil: an ecological study on the possible impact of Hiperdia. Rev. bras. epidemiol. 2016;19(1):122-34. Available from: DOI: 10.1590/1980-549720160010011

20. Teixeira KH. Uma análise da estrutura espacial dos indicadores socioeconômicos do nordeste brasileiro (2000-2010). EURE/Santiago. 2018 [cited 2020 feb 15];44(131):101-24. Available from: http://www.eure.cl/index.php/eure/article/view/1 923/1058

21. Arakiasamy P, Ummacharya, Kowal P, Capistrant BD, Gildner TE, Thiele E, et al. Chronic Noncommunicable Diseases in 6 Low-and-Middle-Income Countries: Findings From Wave 1 of the World Health Organization’s Study on Global Ageing and Adult Health (SAGE). Am. J. epidemiol. 2017;185(6):414-28. Available from: DOI: https://doi.org/10.1093/aje/kwx125

22. Huang Y, Meyer P, Jin L. Neighborhood socioeconomic characteristics, healthcare spatial access, and emergency department visits for ambulatory care sensitive conditions for elderly. Prev Med Rep. 2018;12:101-5. Available from: DOI: https://doi.org/10.1016/j.pmedr.2018.08.015

23. Dimitrová K, Costa C, Santana P, Perelman J. Evolution and financial cost of socioeconomic inequalities in ambulatory care sensitive conditions: an ecological study for Portugal, 2000-2014. Int. j. equity health. 2017;16(1):2-11. Available from: DOI: 10.1186/s12939-017-0642-7

24. Farias JM, Minghelli LC, Soratto J. Promoção da saúde: discursos e concepções na atenção primária à saúde. Cad. saúde colet. 2020;28(3): 381-9. Available from: DOI: https://doi.org/10.1590/1414-462x202028030351.

25. Machado CV, Lima LD, Baptista TFW. Políticas de saúde no Brasil em tempos contraditórios: caminhos e tropeços na construção de um sistema universal. Cad. Saúde Pública (online). 2017;33(Suppl 2):143-61. Available from: DOI: 10.1590/0102-311X00129616

26. Pinheiro FTS, Tavares NBF, Aaraujo AF, Silva JPX. Reflexões sobre o sistema único de saúde: da gênese à crise contemporânea. Sanare (Sobral, Online). 2018 [cited 2020 jan 20];17(2):82-90. Available from: https://sanare.emnuvens.com.br/sanare/article/view/1265/673
Hospitalizations of older adults due to chronic conditions sensitive to primary care in a Ceará region. Rev Enferm UFPI [Internet] 2021 [cited: dia mês abreviado ano]; 10:e883. doi: 10.26694/reufpi.v10i1.883