

From real to ideal - the health (un)care of long-lived elders

Do real ao ideal - o (des)cuidar da saúde dos idosos longevos
El real a lo ideal - el (des)cuidado de la salud de los más ancianos

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ABSTRACT

Objective: to analyze similarities and dissimilarities in the meanings assigned to health care by long-lived elders and nursing professionals in a healthcare setting. **Method:** ethnographic qualitative research, based on the Spradley-McCurdy method and the interpretive anthropology of Geertz and Kleinman. The sample consisted of 20 key informants. Data were collected through participatory observation and ethnographic interviews from March to October 2013 and analyzed in domains, taxonomies and cultural themes. **Results:** Six domains and cultural taxonomies emerged and revealed reasons, attributes, and resources in providing care in relationship to long-lived elders and nursing professionals; finally, the following cultural theme emerged: the real to the ideal - the health (un)care of long-lived elders. **Conclusion:** The study showed the distance between the desired and actual health care provided to aged people in the scenario studied.

Key words: Aged, 80 and over; Geriatric Nursing; Nursing; Culture; Health Services for the Aged.

RESUMO

Objetivo: analisar semelhanças e dessemelhanças nos significados do cuidado à saúde de idosos longevos atribuídos por eles e pelos profissionais de enfermagem no cenário de uma unidade básica de saúde. **Método:** pesquisa qualitativa etnográfica, alicerçada no método de Spradley e McCurdy e na antropologia interpretativa de Geertz e Kleinman. Participaram 20 informantes-chaves, as informações foram coletadas por meio da observação participante e entrevista etnográfica no período de março a outubro de 2013 e analisadas em domínios, taxonomias e tema cultural. **Resultados:** emergiram seis domínios e taxonomias culturais que mostraram razões, atributos e recursos para cuidar, na perspectiva dos idosos e dos profissionais de enfermagem e, por fim, o tema cultural: do real ao ideal - o (des)cuidar da saúde dos idosos longevos. **Conclusão:** o estudo mostrou o distanciamento entre o cuidado almejado e o realizado à saúde das pessoas com idade mais avançada no cenário estudado.

Descritores: Idoso de 80 anos ou mais; Enfermagem Geriátrica; Enfermagem; Cultura; Serviços de Saúde Para Idosos.

RESUMEN

Objetivo: analizar las similitudes y diferencias en los significados del cuidado de salud para los más ancianos asignado por ellos y los profesionales de enfermería en un unidad básica de salud. **Método:** investigación cualitativa etnográfica, basado en método de Spradley y McCurdy y la antropología interpretativa de Geertz y Kleinman. Participaron 20 informantes clave y los datos fueron recolectados a través de la observación participante y entrevistas etnográficas en período de marzo a octubre de 2013 y analizados en dominios, taxonomías y tema cultural. **Resultados:** surgieron seis dominios y taxonomías culturales que mostraron las razones, atributos y recursos para cuidar, en perspectiva de los más ancianos y profesionales de enfermería; finalmente, el tema cultural: el real a lo ideal - el (des)cuidado de la salud de los más ancianos. **Conclusión:** el estudio demostró la distancia entre el cuidado de la salud deseado y real de las personas con edad avanzada en el escenario estudiado.

Palabras clave: Anciano de 80 o Más Años; Enfermería Geriátrica; Enfermería; Cultura; Servicios de Salud para Ancianos.

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INTRODUCTION

Human existence is closely associated with taking care of the self and the other; this care is considered to be action and sustains life in the world. Regarding health care, people develop different means of providing care, as happens in complex societies. This reality can be surveyed in the light of anthropology.

Concepts of care are considered universal in human life and are present in all societies; however, groups develop unique knowledge and practices⁽¹⁾, depending on the culture to which they belong. This study adopted the concept of culture as a “system of inherited conceptions expressed in symbolic forms, through which humans communicate, perpetuate and develop their knowledge and activities in relation to life”⁽²⁾. Health care is considered to be a local cultural system whose internal structure is made up of the popular, professional and traditional sectors⁽³⁾.

Throughout life, individuals develop and use a system of conceptions related to health care that guides their everyday practices. Some of those conceptions are learned in families and are consistently reworked and reproduced through social interactions in the community and health services. Health services are producers and disseminators of disease-related knowledge and behaviors⁽⁴⁾ and, as such, influence values, beliefs and ways of taking care of health.

The dialogue between the professional and popular sectors in health services is emphasized in the literature as a strategy for concretizing health promotion⁽⁴⁾ practices by means of congruent care delivered to the elderly. However, few studies have approached the specifics of health care provided to the population aged 80 years or older, and there is little knowledge about professional care for long-lived elders in health units.

This study aimed to analyze the similarities and dissimilarities in the meanings assigned to health care by long-lived elders and nursing professionals in a basic health unit scenario.

METHOD

A qualitative, ethnographic survey grounded in the work of Spradley and McCurdy⁽⁵⁻⁶⁾ that was carried out with long-lived elders and nursing professionals in a basic health unit (UBS, in Portuguese) in the Boa Vista Sanitary District, northeast of Curitiba in the State of Paraná.

The survey subjects were individuals who were part of the study scope: UBS users, professionals and general staff. Twenty key informants participated, of whom 10 were nursing professionals (3 nurses and 7 nursing assistants) and 10 were long-lived elders (5 men and 5 women).

Nursing professionals were selected based on the following inclusion criteria: having worked in health care for the elderly in the UBS for at least six months; and being open to dialogue. The following inclusion criteria were used to select the elders: being 80 years old or more; obtaining a score on the adapted Mini-Mental State Examination⁽⁷⁾ above the cut-off points⁽⁸⁾; being registered at the UBS; having used the UBS services for at least 6 months; and being open to dialogue.

Information was collected through participatory observation and ethnographic interviews conducted from March to October

2013. Data were analyzed simultaneously with collection, following the ethnographic method⁽⁵⁻⁶⁾. In a cyclical process, one of the researchers visited the survey field, and then gradually distanced herself to analyze information in pursuit of theoretical deepening and to draft the ethnography. The process was halted when information was repeated in the most significant cultural domains and disclosed the cultural theme.

The ethnographic interviews started with descriptive questions from a semi-structured script designed for long-lived elders and nursing professionals, followed by structural questions. The formal ethnographic interviews with key informants were recorded to capture words and expressions in the raw data, after agreement by the participants. Data were transcribed after the end of each interview.

The cultural domains were identified in the ethnographic records of participatory observation and ethnographic interviews through the selection of semantic relations to link the terms approached and the terms included. Then, lists of hypothetical domains were drafted and further tested and deepened through observations and interviews. The selection of domains for deeper analysis was based on the proposed objective, and they were chosen from among those with more information that proved to be more significant in the field work.

The taxonomic analysis observed the links between the terms included, and additional terms to be included were identified. Next, structural questions were formulated to test the taxonomies and clarify new terms. The thematic analysis involved the broader features of the scenario under study and expressed recurrent principles in the domains that related the subsystems of the cultural meaning of health care to long-lived elders.

The study conformed to the ethical principles for research involving human beings, and was approved by the Committee of Ethics in Research under opinion no. 11373112.0.0000.0102. The study was explained to invited participants, and the key informants signed Free and Informed Consent Forms prior to the ethnographic interviews.

RESULTS

The ethnographic analysis yielded six cultural domains and taxonomies based on three semantic relations, disclosing the reasons, attributes and resources in providing health care to long-lived elders from their perspective and that of nursing professionals. It also yielded a cultural theme: from real to ideal – the health (un)care of long-lived elders. Chart 1 shows the cultural domains and taxonomies and describes the results.

Cultural Domain and Taxonomy 1 – Old age and vulnerability: reasons to provide health care to long-lived elders according to nursing professionals

Advanced age fosters in nursing professionals the intention of including long-lived elders in monitoring programs in the UBS. Specific programs for individuals of that age group are recommended, since they are considered to be more prone to presenting health problems and being victims of violence in the community. Nursing professionals showed recognition of and concern about the social vulnerability of long-lived elders, as in cases of physical violence and vulnerability, when referring to chronic illness.

Chart 1 - Cultural domains and taxonomies of the meanings assigned to health care by long-lived elders and nursing professionals in a UBS, Curitiba, 2013

Nursing Professionals	Long-Lived Elders	Semantic Relations
<p><u>Cultural Domain and Taxonomy 1</u></p> <p>Old age and vulnerability: reasons to provide health care to long-lived elders</p>	<p><u>Cultural Domain and Taxonomy 2</u></p> <p>“Because we are older”: reasons to provide health care to long-lived elders</p>	<p>Racional</p> <p>$\frac{X \text{ is a reason to do } Y}{}$</p>
<p><u>Cultural Domain and Taxonomy 3</u></p> <p>Deficits in proper care: attributes of health care for long-lived elders</p>	<p><u>Cultural Domain and Taxonomy 4</u></p> <p>“Being well served” and more help at home: attributes of health care for long-lived elders</p>	<p>Atributo</p> <p>$\frac{X \text{ is a reason to do } Y}{}$</p>
<p><u>Cultural Domain and Taxonomy 5</u></p> <p>Responsibility of families and guidance: used to provide health care to long-lived elders</p>	<p><u>Cultural Domain and Taxonomy 6</u></p> <p>Health services and practices that do good: used to provide health care to long-lived elders</p>	<p>Function</p> <p>$\frac{X \text{ is used for } Y}{}$</p>

[They] should be included in the program for their age, and not only for having high blood pressure or diabetes. Being evaluated every three months, even if they have no pathology – only because of age. (AE 5)

These are elders with more co-morbidities and they become bedridden more easily than the others. There is family negligence with elders, mainly the long-lived ones, because they are weaker. Violence is reported, but there is nothing to do with that elder. (E 2)

Achievement of the objectives that led long-lived elders to go to the UBS was construed as a reason to take care of their health by the nursing professionals. Among these objectives we could mention medical appointments and measurement of blood pressure and blood glucose. Sometimes this is the reason to go to the health unit to talk with professionals.

The care should be based on their complaints. It depends on the object of their visit to the unit. If they come to book an appointment we will book the appointment, if they come to check blood pressure, it is an issue we can solve. (AE 1)

Care for them is the same as that for those with chronic diseases, mainly high blood pressure and diabetes. Their nutrition and medication need are cared for and they have periodic visits to physicians and nurses. (E 3)

According to nursing professionals, biomedical knowledge, care focused on diseases and age-related dependence are among the prevailing reasons to provide health care to long-lived elders.

Cultural Domain and Taxonomy 2 – “Because we are older”: reasons to provide health care to long-lived elders

Long-lived elders spoke about some limitations related to age that demand care, such as forgetting things, deafness, pain, weak bones and slower recovery.

I want to get better because some minor problems we have, due to age, I sometimes forget things, but I try to fix it. Because older people always have some minor problems, because of age. Things don't work as well they work with younger people. (IL 3, 88 years old)

Because we are older, if we fall and break a bone, it's hard. Mainly me, I have diabetes and if a person with diabetes gets a fracture, it takes more time to heal and the bone sometimes doesn't heal, depending on the bone you broke. (IL 5, 82 years old)

Informants expressed their vulnerability in a real way, and their physical condition was emphasized. They indicated that care is needed for disease conditions like high blood pressure, diabetes and breathing difficulties, and they perform care actions at home or go to the health service.

The person has problems like me, for example, the physician examined me, made a diagnosis about what I'm feeling and the care I must have. If I don't take care as the physician said, my health will get worse. (IL 5, 82 years old)

Elders perceive their physical vulnerability as a reason to take care of health and attribute diseases, limitations on daily life, and health conditions to aging. They show biomedical knowledge, like nursing professionals, and take care of themselves as a way to survive in old age.

Cultural Domain and Taxonomy 3 – Deficits in proper care: attributes of health care for long-lived elders according to nursing professionals

The UBS does not offer any program to develop actions specifically focused on long-lived elders, who receive the same care as elders in general. Priority for health care services was frequently mentioned by informants, including elders and people with disabilities in general. One informant, however, explained that wisdom is required to prioritize services, since sometimes the long-lived elders are not the ones who need more care.

We always try to attach higher priority to elders. Sometimes a person of 80 years old is doing well, while a person of 20 years old has a health condition. For example, in a medical visit we use wisdom to provide services, to check who has higher priority in the case. (AE 5)

According to nursing professionals, long-lived elders rarely go to the UBS, and those who do go are in better physical condition. Many are dependent and do not receive care for several reasons, like locomotion and transportation difficulties. The UBS lacks the proper structure to provide home visits and the human, material and professional resources to make up a multi-professional team, jeopardizing services for all age groups.

From 80 years old onward, some are not in good shape to come, sometimes they even want to have care, be evaluated, but they can't do it because they can't come. This isn't the Family Health Strategy yet; physicians sometimes provide home care, but it is not routine. (AE 6)

He has high blood pressure and came to get enalapril [medication], but we don't have it. It is very common, unfortunately. Some medications are not provided to the unit for four months. (AE 1)

Moreover, according to nursing professionals, the aging population and longer life expectancy demand knowledge and learning to provide health care to long-lived elders, which is in line with the perspective of geriatric nursing. This specialty considers the specific traits of health care to elders, and the required preparation and training of professionals to work with that population.

The symbols employed by nursing professionals disclose attributes of health care for long-lived elders involved in nets of meaning, and showed gaps for nursing professionals in providing care in a way closer to that considered adequate for that age group.

Cultural Domain and Taxonomy 4 - "Being well served" and more help at home: attributes of health care for long-lived elders

Long-lived elders expect to get good service when they go to health services, and that means being served with attention, patience and affection by health professionals.

Every aged person that comes to the doctor's office is a little nervous, afraid, says: I'm feeling this, that. Physicians should have patience and affection with the people they are examining. A friendly word, understanding, a smile to a person who is upset or sad is the most important medicine in life. (IL 2, 82 years old)

However, they said they had to wait a long time to be served, which made them suffer. In the face of such long waits for care, and not just at the UBS under study, long-lived elders feel the priority for old age is not fulfilled, and believe that the number of physicians should be increased.

We receive good services at many sites. But some places don't provide good service, we face difficulties, have to stay sitting on hard benches, long times in line. You get there, the doctor didn't come that day, you have to book another appointment. (IL 2, 81 years old)

I come here for an appointment and wait for three hours. There is no single time I have come here when my blood pressure hasn't gotten higher; I guess I get angry. Where is the priority on old age? At least above 80 years old. I'm 87. (IL 3, 87 years old)

There is no doctor today; they are no longer helping sick people. You book an appointment today, it takes 90 days, 6 months; it took 2 years for me. If it is a lethal condition, you die and it is not yet time to get care. (IL 4, 84 years old)

The long-lived elders referred to the need for resources to provide health care to them and, among these, they hoped to find physicians, nurses and medicines at the UBS. However, they didn't always have at home or find at the UBS the resources they needed for health care for their chronic diseases.

Health depends on medicines; when they don't have the medicines, some individuals can't buy them. So, at the health unit, if there are physicians, nurses and medicines, there is nothing missing. The person leaves fulfilled, served and has nothing else to say. (IL 4, 84 years old)

The physicians, nurses teach us right, but we must have good memory to recall everything, sometimes the person has no one to help her. My sister is an example, she took too many medicines and it harmed her, she lived by herself. (IL 1, 82 years old)

The attributes of health care for long-lived elders were translated by the relationships they built with professionals and by the conditions of service. The scarcity of materials and human resources limits the delivery of health care. Similar aspects were referred to by the nursing professionals. When seeking care at health services, long-lived elders often find that the expected care is nonexistent, to the contrary of the care intended.

Cultural Domain and Taxonomy 5 – Responsibility of families and guidance: used to provide health care to long-lived elders according to nursing professionals

Nursing professionals recognized that family care for long-lived elders is crucial for health, and it was explained based on family values and life experiences. Families take care of elders in several different ways. Assigning the responsibility for care to younger family members, who are then obliged to make every effort to protect and support elders, is a cultural tradition.

All sons and daughters must take care of their parents of more than 80 years old. Fortunately this law exists, otherwise they forget to give care at the end of their lives, to give more comfort, regardless of what the father or mother had been, it is a responsibility. (AE 2)

According to the nursing professionals, care at the UBS for long-lived elders should start earlier, preventing illness. Regarding the control of co-morbidity, they emphasized monitoring at the UBS and guidance, mainly regarding medications, nutrition and falls. Nursing guidance is used to teach long-lived elders and their families to take care of health.

Elders that already have co-morbidity are mainly cared for with medications. Some are illiterate, others have impaired vision, and they end up being responsible for their own medication. Falls make things even worse; they forget that motor coordination is reduced, as well as visual and hearing acuity. If there is a caregiver, we also instruct them. (E 3)

Instruct about nutrition because most of them are at risk for high blood pressure, or have high blood pressure or diabetes, to reduce the intake of salt and sugar, avoid fat, and eat more fruits and fiber. (AE 3)

According to nursing professionals, family responsibility and guidance in self-care, based on the biomedical model, are crucial to health care for long-lived elders. Although they value disease prevention among younger individuals, this practice is little emphasized at the UBS.

Cultural Domain and Taxonomy 6 – Health services and practices that do good: used to provide health care to long-lived elders

Long-lived elders must seek health services when they need care. Therefore, they go to the UBS to seek resources like appointments and medications for them or their families. They call medications as drugs, but emphasize that they should be taken in the right way, otherwise they can damage health. Medications, nutrition and falls are emphasized in the guidance provided for nursing professionals, and are learned and often incorporated into the daily practices of long-lived elders.

Sometimes consuming too much fat can block veins, and salt can also cause some problems. Excess of sugar can cause diabetes, so when we avoid it we are taking care. (IL 4, 84 years old)

Some people sometimes take uncontrolled medications. We ourselves must have this care. In this regard, I'm more careful, I even take note not to forget, if it is to be taken at night, I'll take it right, as prescribed. (IL 2, 82 years old)

Care starts at home; for example, no carpet because we slip and fall. Sometimes there are stairs in the house, we come down the steps and fall; all that is care. Many elders fall and break a leg. (IL 3, 87 years old)

The practices passed down to families by their predecessors are used by long-lived elders, as they believe these do good, like teas, actions to prevent colds, and religious practices like praying, reading the Bible and going to church. These practices include psychosocial and spiritual elements fundamental to their understanding and concepts about health.

We were not raised this way, we were extremely protected in my time! If I put my hand in hot water, I couldn't put it in cold water; so, things must remain the same. I learned that from my grandmother. (IL 3, 87 years old)

I try to keep myself in line, do the right things, because if we do wrong everything goes wrong. Keeping in line means not doing evil to others, and trying to help. (IL 3, 88 years old)

I pray to God for the strength not to lose heart, to be courageous and face it. I've read in the Bible: Fear nothing, be faithful. Maybe faith heals diseases that we sometimes think we have. (IL 2, 82 years old)

Families are considered to be priceless, and taking care of and supporting them is another kind of care. Work is a source of income to cope with expenses for them and their families.

I take care of my wife. I fix food and buy whatever she wants. That's important to me. When our sons were about

to get home from the service, I worried about them. (IL 2, 81 years old)

I have five daughters. Sunday I came back from her home at 10 pm. So, that's our lives. I worry about my son, if my grandson is sick I go there, but this cataract bothers me. (IL 4, 81 years old)

To take care of health, long-lived elders use the scientific knowledge they get from health professionals at the UBS, and reproduce the nursing instructions at home in the form of care with nutrition, medications and falls. Moreover, they use the traditional knowledge passed down from one generation to the next, like religious practices, avoiding colds, and drinking tea. Similar to what nursing professionals said, families play a core role in the provision of health care to long-lived elders, who develop everyday actions to support their families. They want to keep on supporting their families regardless of advanced age; moreover, this is a way to keep them healthy.

Cultural theme – From real to ideal: the health (un)care of long-lived elders

This cultural theme expresses the distance between what nursing professionals and elders want regarding health care and what is effectively developed in everyday practices. "Real" stands for what effectively exists, while "ideal" belongs to the imagination of the subjects in this study.

The term "ideal" means exactly right, decent, required, responsible, broad care, an optimistic way of facing care as professionals and elders would like it to be. "Real" describes the hegemonic model of care that impoverishes the locations of health production, and its meanings are grounded in the biological, regulatory, prescriptive perspective and that of pharmacolization.

Political institutions draft laws, guidelines and rules to guide the work of the nursing professionals in charge of complying with them. However, implementation is not fostered, due to lack of sufficient and properly skilled human and material resources. No resources are provided to enable care to take place and, thus, long-lived elders remain unassisted. Nursing professionals are accustomed to facing situations where they must vehemently deny services, and they are impaired in performing intended actions like disease prevention and health promotion.

Health policies assign to families the responsibility for care of the elderly, in collaboration with professionals and community members. Care provided by family members could lapse into imposing health practices that disregard local reality and what people desire. Families have knowledge passed down from one generation to the next, and have their own particularities regarding prevention and treatment of diseases and health care for long-lived elders. Appropriation of the discourses of health professionals takes place in a perennial field of reflection that articulates a consensual plan, the assignment of meanings, construing, building and manipulation of strategies in the face of the realities of social life.

Therefore, both health professionals and long-lived elders experience a set of difficulties strongly influenced by moral and disciplinary speech that disregards the concreteness of social realities and the psychosocial and spiritual perceptions

of elders and their families. Cross-sectoral actions aiming at integral health care for long-lived elders should be promoted, considering local realities.

DISCUSSION

Human beings are vulnerable in all dimensions – physical, psychological, social, cultural and spiritual – and awareness of that vulnerability causes them to seek ways to fight or deny it. The care of suffering, vulnerable subjects is a crucial motivation in the work of nursing professionals⁽⁹⁾.

To fight their own vulnerability, long-lived elders reproduce biomedical knowledge in health care, and take on responsibility for diseases. Such reproduction was also observed among elders in the community of Bambuí (state of Minas Gerais), who related old age to diseases and disabilities, and assumed the idea of self-inflicted disease resulting from physical abuse⁽¹⁰⁾.

The biomedical model is focused only on biological issues, and lacks the proper strategies and tools to effectively work on vulnerability. Professional culture is focused on diseases, addressing complaints, and establishing therapeutic conduct. Professionals are trained to recognize diseases and treat them and, although they often cannot heal, they are not trained to provide care⁽³⁾.

In health care for long-lived elders based exclusively on the biomedical model, the actions performed by nursing professionals are focused on biological processes and reinforce scapegoating individuals for their health conditions as, for example, attributing falling to neglect. On the other hand, there is no care-technology-based support for incorporating instructions, which is left to the subjects, like the installation of protection bars at home.

Health professionals consistently instruct people about what to do and how to take care of themselves, and thus contribute to instituting knowledge and behaviors based on scientific knowledge⁽¹¹⁾. However, in the biomedical model the perspective of care based on disease experience is limited⁽³⁾.

In this study, health care for long-lived elders proved to be similar to that defined as a process of human relations that positively changes the individuals involved. This reciprocity allows people to build themselves up and improve in both the physical and spiritual sense. Care is developed through presence and dialogue that enable human beings to recover when sick, and find ways and the will to live⁽⁹⁾.

Traditional basic care is characterized as being detached from the reality of users and families, while care is focused on spontaneous demand with no investment in prevention, resulting in late diagnosis of diseases⁽¹²⁾. Today, after implementation of the Family Health Strategy, the focus of health professionals is oriented toward families⁽¹³⁾. Families are tasked with the duty of being caregivers for elders, as it is assumed that personal relationships and mutual affection are part of the family setting.

In a study carried out with families that had experienced hospitalization and dependence on family members for daily basic care, the relationship with specialized public health services was characterized as neglect. Participants disclosed lack of access to services, great difficulty in getting them, and little problem-solving when fulfilling family care needs⁽¹¹⁾. The

authors stated, “There is a strong decorrelation between public health policy and the concrete reality of work and production of care in health services”⁽¹⁴⁾.

Guidance based on the biomedical model assumes that nurses must learn and know how elders should take care of their health. This vision is not favorable to empowerment and could lead to practices that disregard traditional knowledge and the ways to take care of their health that people develop in their lifetimes.

The use of methodologies like cultural curricula that enable participation and enhancement of the technical and political power of communities is in line with proposals for health promotion. These methodologies enable the convergence of professionals and users, where both are considered to be subjects, thus enabling the educational and preventive character of groups⁽¹⁵⁾.

Traditional therapies based on empirical experiences acquired during subjects’ lives and taught to family members are used in combination with professional therapies like the use of medications⁽¹⁶⁾. Religious aspects are part of the health care practices learned from predecessors, exercised during life, and they take on the connotation of the backbone of life⁽¹⁷⁾. Religious faith is a strategy to cope with problems encountered in older people’s ways of living⁽¹⁰⁾; it contributes to adjustment to hardships; feeds hope and is good for the soul and brain⁽¹⁶⁾.

Rather than being sets of similarities differentiated by consensus, cultures have several implications in collective life. Differentiation of cultural ruptures and continuities demands ways of thinking that involve contrasts and individualities, comprising differences⁽¹⁸⁾. Breaking with the individual health model and establishing dialogue between professionals and users is a challenge⁽¹⁵⁾.

The biological, pathologizing, prescriptive, ruling and generalizing focus imperceptibly detaches individuals from their sociocultural realities. However, there is discourse that opposes anything that detaches individuals from their sociocultural realities, as there are reactions against the contradictions between the real and the ideal, except if the UBS routine is compromised.

The discursive ideal is contrasted to the everyday reality, rejects genuine and creative human knowledge, and discloses everyday frustration in health units⁽¹⁴⁾. However, discourse about the ideal could be shifted into real practice grounded on principles of an anthropological and ethical nature, which could serve as guidelines for the actual conduct of providing care to long-lived elders. These principles would allow for re-reading of the actions themselves to submit them to self-criticism under intellectual standards and conceptions that could be consistently reformulated and instructed by the contributions of the world of experience⁽⁹⁾.

FINAL CONSIDERATIONS

The similitude of meanings of health care for long-lived elders occurred in light of their vulnerability, age-related diseases, and the distance between intentions and what is actually accomplished in health care for aged people. That distance can be partially attributed to lack of material resources, capacity-building and permanent education in geriatrics care, and lack of action in prevention and health promotion. Moreover, the biomedical model has limitations such as the homogenization

and imposition of care, in opposition to negotiation, and the reduction of human beings to their biological aspects with weak emphasis on other aspects – like culture – and the integration of dimensions, which leads to lack of care.

Regarding health care for long-lived elders, discourses converged on practices oriented to medications, nutrition, and fall prevention, grounded in the model of scapegoating individuals for their diseases.

Dissimilarities in the meaning of health care for long-lived elders appeared when they perceived their own vulnerability, and nursing professionals perceived the other's vulnerability.

Likewise, family is assigned to support the care of long-lived elders, while to them it is the opposite, as they want to support their families. Traditional practices of health care for long-lived elders were not part of the professionals' discourse.

Ethnographic studies could contribute to health care for long-lived elders by revealing the perspectives of elders and professionals. Health care that approaches that desired by long-lived elders could contribute to improving the well-being of that population, promoting more autonomy in self-care, and strengthening individuals in their families, communities, and professions, and in nursing and health services.

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