Original Article

Supplementary home health care services and the inclusion of nursing in Belo Horizonte / Minas Gerais (Brazil)*

Serviços de atenção domiciliar na saúde suplementar e a inserção da enfermagem em Belo Horizonte/MG

Servicios de atención domiciliaria en la salud suplementaria y la inserción de la enfermería en Belo Horizonte/MG

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ABSTRACT

Objective: To evaluate modalities of home care services, discussing the inclusion of nursing. **Methods:** A qualitative case study conducted with four health plan providers in the city of Belo Horizonte / Minas Gerais (Brazil). Data were obtained from interviews and case management. **Results:** The home care services are grouped into three modalities: long-term care at home; temporary care at home; and, use of intensive technologies and care. In these modalities, nurses assume care actions, management of the care, and qualifying the care through the appropriate use of soft technologies. There is a trend towards outsourcing of nursing services to home care. **Conclusion:** The inclusion of the work of nurses in home care modalities represents both a component of cost reduction and contributes to the technological transition by establishing new forms of care at home.

Keywords: Home care services; Nursing care; Cost savings

RESUMO

Objetivo: Analisar modalidades de serviço de atenção domiciliar discutindo a inserção da enfermagem. **Métodos:** Estudo de caso qualitativo realizado em quatro operadoras de planos de saúde no município de Belo Horizonte/Minas Gerais. Os dados foram obtidos de entrevistas e acompanhamento de casos. **Resultados:** Os serviços de atenção domiciliar são agrupados em três Modalidades: Cuidados prolongados no domicilio; Atenção provisória no domicilio e Uso intenso de tecnologias e de cuidados. Nas modalidades, a enfermagem assume ações assistenciais e de gestão do cuidado e qualifica a atenção por meio do uso apropriado das tecnologias leves. Há uma tendência à terceirização do serviço de enfermagem na atenção domiciliar. **Conclusão:** A inclusão do trabalho do enfermeiro nas modalidades de atenção domiciliar representa ao mesmo tempo um componente de redução de custos e contribui para a transição tecnológica pelo estabelecimento de novas formas de cuidado no domicilio.

Descritores: Serviços de assistência domiciliar; Cuidados de enfermagem; Redução de custos

RESUMEN

Objetivo: Analizar modalidades de servicio de atención domiciliaria discutiendo la inserción de la enfermería. **Métodos:** Estudio de caso cualitativo realizado en cuatro operadoras de planes de salud en el municipio de Belo Horizonte/Minas Gerais. Los datos fueron obtenidos de entrevistas y acompañamiento de casos. **Resultados:** Los servicios de atención domiciliaria son agrupados en tres Modalidades: Cuidados prolongados en el domicilio; Atención provisional en el domicilio y Uso intenso de tecnologías y de cuidados. En las modalidades, la enfermería asume acciones asistenciales y de gestión del cuidado y cualifica la atención por medio del uso apropiado de las tecnologías leves. Hay una tendencia a la tercerización del servicio de enfermería en la atención domiciliaria. **Conclusión:** La inclusión del trabajo del enfermero en las modalidades de atención domiciliaria representa al mismo tiempo un componente de reducción de costos y contribuye a la transición tecnológica por el establecimiento de nuevas formas de cuidado en el domicilio.

Descriptores: Servicios de atención de salud a domicilio; Atencion de enfermería; Ahorro de costo

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INTRODUCTION

Use of the home as a space for health care has expanded all over the world as from the second half of the 20th Century, as a care space that responds to the increase in hospital attendance costs and unavailability of health services to meet the demand by the populations , especially in the face of aging and increment in the load of chronic diseases. Thus, use of the home as space for attention has sought to rationalize the use of hospital beds, reduce assistance costs and establish a logic of sustained humanization of care. [1-2]

The present organization of home health care in Brazil has visibility with the increase in the number of services offered by this care modality, especially in the private sector.

The supplemental health sector, which covers approximately 40% of the Brazilian population, is at present composed of 1630 companies and health care insurance operators, entities distributed among the modalities of self-management, medical, dental, philanthropic, medicine and dental group cooperatives, insurers specialized in health and plan administrators.[3]

It is pertinent to mention that Supplemental Health, as part of the health "market", is influenced by the economic dimension that has repercussion on the interest in cost reduction and reorganization of the models of care production found in the logic of home assistance, seen as a possibility of rationalizing spending and attempts to find substitutes for the production of care.[1-2, 4-6]

It is important to reflect that supplementary home health care finds itself in a field of tensions: On the one hand there is a logic of cost rationalization (and its consequent transfer) that appears to be central to the option for this modality of offer of assistance; on the other hand, home care has been shown to be a preferential modality of assistance under certain health conditions, either because it diminishes risks (of hospital infections, falls etc.),or promotes quality of life and approximates the care of the day-to-day life of families.[1, 7-8]

Moreover, there is evidence that the offer of this care modality responds to the movement of managed health care into the logic of management and financial rationality represented by the reduction in the costs of procedures, making the productive processes more flexible, and leading to precarious working relationships and conditions.[9]

When considering the extension and problems surrounding supplemental home health care services it is pertinent for us to reflect on the inclusion of the work of nursing in the care modalities.

Although other studies have demonstrated that nursing is included in the modalities of home care, in different degrees of participation and with different possibilities of action,[10-11] up to now, no elements have been revealed that define the option for the work of nursing, especially in those service that have traditionally, in the hospital environment, been centered on the role of the doctor. One presupposes that certain modalities have invested heavily in the inclusion of the nursing profession as an element of cost rationalization as well.

Therefore, the aim of this study was to analyze the modalities of home care service offered by the health plan operators, with the intention of discussing the inclusion of nursing, especially the nursing professional.

METHODS

This was research with a qualitative approach, with the referential use of Case Studies.[12] It was composed of the study of home care services connected with four health plan operators – identified in the text as ADSS1 to ADSS4 – in the municipality of Belo Horizonte/ MG intentionally selected among the 28 operators with headquarters and/or operations in the municipality. The choice took into consideration operators that had a program of home care service in operation in the year 2010, those with the widest coverage and at least one operator from each modality (self-management, medical cooperative, group medicine, insurer and philanthropist). With regard to the latter criterion, the only operator in the modality of philanthropy existent in the municipality is in the process of being disaccredited, and was therefore not included in the study.

Empirical data were obtained in interviews with the managers and/or coordinators of the home care services of the selected operators. The interview was guided by a semi-structured script, endeavoring to identify the scope of service, inclusion and discharge criteria, expression of the clientele profile, complexity and cost of care.

At the time of the interview, the operator's manager and/or coordinator of home care were asked to indicate a case to follow-up in the home, allowing contact with the team in "action" and with the family. The indication was made considering a case that would express the profile of complexity of the majority of cases attended by the operator and which was in progress.

Four cases were included, from which analysis of the record charge proceeded, seeking to identify the aspects of admission to the program, articulations and interactions to effectuate home care, actions developed in the home, professionals involved, and resources described in the actions performed), interview with the team members directed towards understanding the work process, organization for the visit, professionals that

participated in the care plan, resources and technologies used, logistics and travel for home care, and interviews with users, when possible, and family members, directed towards aspects of interaction with the professionals.

The data were treated by analysis of the thematic content[13], operationalized by putting the data into order and classifying it (reading and re-reading the material, identification and grouping of central ideas, enabling establishment of empirical categories) and final analysis (articulation between the empirical and theoretical) allowing characterization of the home care services offered by the health plan operators and inclusion of nursing in these services.

The study was approved by the Research Ethics Committee of the Federal University of Minas Gerais in Protocol ETIC 0555/07 – Ex01/09. All participants in the study signed the Free and Informed Term of Consent.

RESULTS

The findings of the study made it possible to reveal that operators organize the home care services in different modalities with a diversity of actions to respond to the specific needs of users, whether permanent or temporary.

Although the services had specific denominations in each of the operators, it was possible to verify that the home care services were grouped into three modalities: Modality of prolonged home care; Modality of temporary attention at home; Modality of intensive use of technologies and care.

Modality of prolonged home care

This modality is characterized by services that offered prolonged care in the home, generally in situations of chronic complaints, denominated by the operators as Management of Chronic Cases (ADSS1, ADSS2 and ADSS3) or Home Follow-up (ADSS4).

Generally speaking, the services are organized for prolonged home follow-up of users who have been hospitalized on various occasions, or decompensations, or in which the user and/or family do not know how to deal with the disease. It is a care modality that allows the organization of attention to certain population groups, by means of the continuous offer of actions in the home, in different degrees of complexity, including supervision of care in the user's access to the network of services. It is also shown to be an alternative for users who need multiprofessional attention in the long term, because they present difficulties with walking, or difficulties with ties to and resolution in ambulatory follow-up, or because they repeatedly use emergency services.

In the four service analyzed in the modality of prolonged care, scores were used in the classification of users by means of functional capacity criteria, and above all, history of expenses with hospital services that define the inclusion of users in follow-up at home.

With regard to organization of the work process, in this modality, definition of the number of home visits prevails according to the degree of classification of the user, with visits preferably being made by nursing professionals (technicians or nurses) for the lower degrees of clinical complexity, interspersed with doctor's visits for cases of greater complexity.

Modality of temporary home care

This modality is characterized by services that use the home visit to provide assistance for short periods of time, generally in acute situations for conclusion of therapy and/or to allow the user and family to adapt to new care situations. It is presented as the possibility for operators to offer care and/or support for delimited periods, when the user's complete or partial recovery is envisaged. At the operators it is represented by the following services: Specific intervention programs (ADSS1 and ADSS4); Curative Programs (ADSS1), Neonatal Monitoring (ADSS1), Rehabilitation Program (ADSS1), Home Attendance Program (ADSS2) and Home Support Program (ADSS3).

The Specific Intervention, Home Attendance, Rehabilitation and Home Support Programs are organized as temporary services in situations in which it is possible to complete treatment (medication or rehabilitation) at home. Typically, in these services the most frequent actions are antibiotic therapy, performed by nursing technicians or nurses, physical therapy attendance, and attendance by a nutritionist. In addition, guidance activities especially for care-givers are included, for the continuity of care, an action mainly assumed by nursing professionals.

The Curative Program is characterized by the treatment of users with chronic or acute wounds requiring special coverings, the majority of these in users with functional restriction arising from discharge from hospital, or conditions that become acute, in which hospitalization is not indicated. In this Program, the team is composed exclusively by nurses that construct a plan of care and take responsibility for the assistance.

The Neonatal Monitoring Program is characterized by discharge from hospital of newborns to gain weight and for phototherapy. This modality is organized by means of health education strategies in which the professional gradually makes a move to guarantee discharge from the program.

Modalities of attention with intense use of technology and care

This modality is characterized by services with the intense use of technologies and care, even of short du-

ration, such as the Program of Palliative Care (ADSS1, ADSS2, ADSS3), Program of Mechanical Ventilation (ADSS1); Program of Pediatric Monitoring (ADSS1) and Program of Hospitalization at Home (ADSS2).

The Palliative Care Programs are characterized by attention in terminal situations, the majority being oncological users at an advanced stage of the disease. The Mechanical Ventilation Program is characterized by invasive and non invasive ventilatory support at home, accompanied by transfer of the technological appliance and nursing care as in the hospital model.

The Pediatric Monitoring Program is characterized attendance predominantly to children with neurological or syndromic conditions with long periods of hospitalization, but that present clinical stability and demand some type of technology such as nasoenteric intubation, gastrostomy or tracheostomy for continuity of care . In this service there are also children assisted with mechanical ventilation at home.

The Home Care Program is not a frequent denomination in the studied operators, due to the implications it represents , with the supply of all the activities, means and ends for care as it would be provided in hospitalization. In this service there is no support for the home care team with assistential backup throughout the whole day. In these situations the unit cost per user at home could be higher than it is in hospital, attributed to the labor expenses in order to guarantee the nursing assistance. Thus, there is no saving on the pay scale as in hospital.

Discharge in the modality of care with intense use of technologies and care occurs in situations of death of the user, and in rare cases, with the complete or partial recovery of the patient. In addition, transfer to another modality may occur, such as those offering prolonged care.

In the analyzed cases, transfer of costs was identified (meals, light, medications, etc) to the family and the responsibility associated with care that it technically assumes. In situations in which the care-giver is a member of the family, the persons needs to give up his/her activities and is also deprived of social relationships because of staying with the patient full time.

Inclusion of Nursing in the different modalities of home care

The data revealed that nursing professionals are present in all the modalities of home care identified and are included with different degrees of participation, in some cases, assuming assistential actions as well as management of care and the administrative processes of the service. The mainly act in the management of chronic cases, with follow-up of the users by means of home visits or telemonitoring.

In the modality of temporary home care, the most frequent nursing actions are antibiotic therapies and application of dressings, performed by nursing technicians or nurses. They also develop guidance activities, especially of care-givers for continuity of the care.

In this model it was seen that there is need for developing the skills of nursing professionals, especially in two fields: Clinical evaluation, since the nursing visits take place with greater frequency than doctor's visits, and it is according to the demand identified by the nurses that referral to the doctor follows; and communication, to guarantee the tie to the Programs and adhesion to the proposed therapy.

It is important to point out that although the doctor continues to occupy a central position with regard to decision making – whether or not there will be inclusion in the program – the coordination of home care is the responsibility of the nurses who manage the care plans.

In the modality of care with intensive use of technologies, there is assistential backup of the nursing team throughout the entire day, with the presence of nursing technicians in the home 24 hours per day. In this modality, the nurse acts as coordinator of care plans, mobilizing the other professionals for assistance. The nurse also acts in the direct administration of care with extremely intense action, especially in the administration of medications and performing more complex dressings.

In the different modalities, some actions are almost exclusively the responsibility of the nurses, such as training the care-givers, supervising the nursing technicians, and identifying the demand for other health professions when defining the care plan.

Nevertheless, the results indicated the that work process in home care continue to be centered on the role of the doctor, expressed by clinical decisions in therapeutic treatments. In the services analyzed, although the nurse prepares the care plan in the first evaluation of admission of users to the different treatment modalities, there is a tendency for the doctor to centralize decisions that involve costs (it behooves him/her to confirm the need for treatments, mobilization of other professionals, permanence in programs etc.).

In the modality of temporary home care, the mode of organizing the work favors fragmentation of the assistance with centralization on specific professional nuclei. Thus, the action of different professionals is determined on a case-by-case basis: when the case demands rehabilitative assistance, the physical therapy professional interferes in a more active manner. Nevertheless, when there us a demand for performing procedures such as applying dressings and concluding medication therapy, in the cases of Specific Interventions or Home Support, nurses interfere in a more active manner.

On the other hand, organization of the highly intensive modality, such as Palliative Care, in which there is complexity in the cases, the action of nursing adds value to full time care, because remaining in the home for 24 hours represents the link in the team, necessary for the continuity of care.

In this modality it was possible to analyze the inclusion of nursing with skills for the biological, psychic and social aspects involved in the assisted situations. Above all, it revealed the intensity with which nursing and the other professionals of the team involve themselves in the problems of other members of the family, and not only those of the user attended. This relationship is also powerful when it is constructed in the modality of prolonged care.

In the modalities analyzed, the nursing professionals maintain labor ties, either by payment as autonomous employees, their own ties to the Consolidation of Labor Law regime (CLT-ties) or outsourced employees, the latter being the main labor tie identified. In the case of nursing technicians, hiring as autonomous employees prevails, by payment to the person, or to the work cooperative.

DISCUSSION

The findings of the study allowed one to affirm that the modalities of home care fulfill that which is expected of them in technological transition and productive re-structuring: impact the costs of operators and include new modes of care with take intensive advantage or relational technologies. In this sense, the different modalities contributed to the rationalization of costs, either by reducing the time and number of hospitalization episodes and the search for emergency services.

At the same time, the findings allowed one to analyze that the home care modalities, especially prolonged care, were shown to be an assistential alternative for more qualified care of users with functional dependence, such as patients with Alzheimer's, sequelae of cerebral vascular accident with or without being restricted to bed, sequelae of cranial-encephalic traumatisms, diabetics, hypertensive patients, those with severe coronary insufficiency, heart failure or Chronic Obstructive Lung Disease, among other chronic conditions that justify the large scale investment in this care modality.

In the different modalities, the nurse was presented as a central figure in the process of care production in home care, either by intermediating with other professionals, or by the link constructed with the family and users[4]. It is important to emphasize this protagonism advocated for nurses in the difference home care services, occupying the place of care plan management, especially as regards the logistics of services and mobilization of other professionals involved in the care, as well as in providing the necessary resources for the care.

Nevertheless, centrally conducted by the logic of cost reduction, prolonged home care is based on a set of main characteristics of managed attention, which favor the standardization of services; regulation of the relationship between health professionals and patients; basic attendance with restriction of access to specialized and hospital care; strict control of professional action which is defined in accordance with the parameters of the company, centered on the reduction of costs of procedures, and administrative efficiency in the production of services.[9]

In this sense, the teams use user classification scores, based on criteria of functional capacity, and above all on the history of spending on hospital services. It is the nurse's responsibility, after receiving the request for the user's admission, or the user him/herself promotes capture of hospitalization units to proceed with classification, according to the score adopted in the service, revealing that the action of this professional contributes to the rationalization of costs.

Allied to this cost rationalization, productive restructuring is shown in the context of home care by the modes and means of organizing the care. Thus, definition of the professionals that compose the home care team may signal an endeavor to reduce expenditure. In this sense, the study allowed one to analyze that in the different home care modalities, the option for professionals with generalist formation, such as the nursing professional, has configured.. On the one hand this option is justified because it presents a formation capable of performing multiple activities (management, supervision, procedures, identification of situations of risk or vulnerability, dialogic articulation with the family, etc.), and on the other hand, by representing cost reduction in relation to the medical professional.

The logic of cost rationalization in home care is expressive in the modality of temporary care arising from the abbreviation of hospitalization, even if there is a consequent transfer of costs to the families that assume responsibility for the inputs for continuity of care. Generally speaking, these comprise medications and dressing materials for which costs will be borne by the operator in cases of staying hospital.

It was also possible to analyze that in this modality the central role of doctors prevails in clinical decisions and the action of nursing, including the nurse, in the majority of cases, centered on carrying out the procedures. This mode of work organization makes it

difficult to qualify care from the perspective of integrality, since the fragmentation of actions is explicit, and few mechanisms were identified for sharing knowledge among the professionals in the teams. Therefore, action centered on the nuclei of specific professions appears to remain, fractioned by the different professionals that provide assistance mainly directed towards performing technical procedures.[14]

In the modality characterized by the intensive use of technologies and care, attention is drawn to the threshold between the reproduction of the locus of hospital care in the home and the substitutability of health practices. Substitutability was revealed in the study, by the construction of new forms of action in health which delimits the transfer of the medical-hospital appliance essential for the maintenance of life in this care modality , with the work marked by intense and close relationships between the team, family and user, which configures technological transition to home care.

The form of hiring nursing professionals for home care was revealed as an important element of analysis. Outsourcing of nursing service, especially of technical professionals, with its consequent transfer of costs of labor liabilities and the administration of conflicts to the outsourced agents hired [15] is an element of cost rationalization that defines the inclusion of nursing in the home care modalities .

From the research data it was evident that there is a predominance of contract for the provision of services in this modality which is compatible with a scenario of leading to precarious working conditions and structural unemployment characteristic of the present time of productive re-structuring.

It was seen that the micro-regulatory processes that fall on Supplemental Health as a whole[16], also imposes strategies of control on home care practiced by this system, which run through the relationships between the professionals that provide assistance, and from them to the users and families.

On the other hand, there are spaces for the creation of new relationships, and in this sense, inclusion of the work of nursing in the modalities of home care may represent a component of qualification of care when assuming new modes of care production that meet the health requirements of the user and family. Thus the inclusion of nursing is justified by the appropriate use of light technologies, which suggest more relational mechanisms of care construction.

CONCLUSION

It was concluded that the inclusion of nursing work in the different modalities responds to productive restructuring and technological transition in home care services, and is presented as a component of cost reduction to operators. In addition, the massive investment in hiring nurses, assuming functions performed by other professionals in the hospital space (such as clinical reference in the management of cases) could be analyzed, without however, acquiring the status of centrality in the definition of therapies in home care.

The inclusion of nursing in home care services in supplemental health is presented as an element that adds value to qualification of care, and at the same time, reduced the cost of the assistance provided. It indicates that qualification of the care by the inclusion of nursing is expressed in the construction of ties and in the guarantee of continuity that are attributed to these professionals. Therefore, the nurse is fundamental in health education and in the development of skills that guarantee adhesion to the therapies proposed.

Considering the limitations of the study, with reference to the number of cases analyzed and the reality of a single municipality, it is recommended that further studies should be conducted, which advance in analysis of the strategies and technologies that are designed in the micropolicy of the work process of nursing in home care in Supplemental Health, that may contribute to delineating the findings here presented.

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