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Why are our words so different from our actions?

One of the subjects of most interest to the **Revista Brasileira de Geriatria e Gerontologia** is the model of healthcare available to the elderly. We are all concerned. The discussion about population aging brought about by the new epidemiological and demographic reality has (or should) lead to the development of a resolutive and effective model of health care for this group[1].

The change in the age configuration in Brazil, with the growth of the elderly segment, is a recent phenomenon. On the other hand, we have already gone beyond the novelty stage and the clichés that are well known and today accepted by everyone – even by those who do not put them into practice. Discussing the theoretical frameworks or policies that aim to ensure healthy aging – which means maintaining functional capacity and autonomy, as well as quality of life, in line with the principles and guidelines of the Unified Health System (SUS) and focusing on disease prevention – is laudable. Major Brazilian and international health organizations have argued in favor of this idea for many years[2]. But the next step is yet to be taken.

While these words are well received by health managers and professionals, little or few of these ideas are applied. So here we must ask: if everyone is discussing the issue and the solutions are already available at the decision-making tables, why has the situation remained the same? Why does the theory not translate into everyday life? Why do leaders and managers not encourage change? Below we list some topics that will bring additional elements to the discussion.

In order for the health sector – particularly the elderly segment – to reorganize itself, one item to be considered is mistrust. Today's society is suspicious of what is offered to it. In this climate, any proposal for change is viewed with reservations. Entities that are multifactorial and have been constructed over many years are difficult to transform. Changing a culture is not simple. We are aware of this problem.

Another obstacle is quality of care, which remains undervalued. It is a subject of enormous importance, which demands greater awareness among health professionals and society. It is argued that it is expensive to apply instruments that improve and provide training in care, accreditations and certifications, but better qualified and trained services are more effective in terms of cost, create less waste and provide better patient care results. In some countries, accreditation and the evaluation of quality indicators are mandatory requirements. In Brazil, however, volume is valued and rewarded, while a policy that stimulates quality is lacking. Patients do not always recognize this characteristic as a necessity, and both public and private health perceive it as an additional cost.

Another issue is the general understanding that care for the elderly goes beyond health. In addition to diagnosis and prescription, social participation, physical and mental activities are important elements to maintain functionality. But we still have great difficulty in understanding these actions as an integral part of care, especially in supplemental health. There is a tendency to separate "social" from "curative" actions.

It is also of fundamental importance, especially today, that quality information and medical records are effectively used by physicians and health professionals, allowing constant customer monitoring.

The pay model of health professionals should also be discussed. If we accept that they are poorly paid, why do we not pay for performance? Associating the discussion of results with the form of remuneration is a powerful inductive tool in the search for what is right. Thus, "pay for performance" or "payment by results" are synonymous in the struggle for alignment between access and quality of care. The change in the remuneration model based on this new care framework, focusing on results and not volume, necessarily results in a win-win model, in which all involved benefit, but especially the patient themselves.

In order to put into practice all the strategies necessary for healthy aging and quality of life, it is necessary to rethink and redesign care for the elderly, focusing on the individual and their particularities. This will bring benefits, quality and sustainability not only for the elderly population, but for the Brazilian health system as a whole[3].

Now that we know what is required, it is time we concentrate our efforts on turning the theory into a quality health model for everyone, including the elderly. We do not want the SUS to be fragmented, or to increase the number of bankruptcies of private health care companies.

One thing is certain: every year, the cost of health increases while the quality of care worsens. It is time to put into practice what everyone believes, but which we have yet to do.

Renato Veras

Universidade do Estado do Rio de Janeiro, Universidade Aberta da Terceira Idade.
Rio de Janeiro, RJ, Brasil.

REFERENCES

1. Oliveira M, Veras RP, Cordeiro H. Supplementary Health and aging after 19 years of regulation: where are we now?. Rev Bras Geriatr Gerontol. 2017;20(5):624-33.
2. Veras RP. Caring Senior: um modelo brasileiro de saúde com ênfase nas instâncias leves de cuidado. Rev Bras Geriatr Gerontol. 2018;21(3):1-7.
3. Veras RP. Oliveira M. Envelhecer no Brasil: a construção de um modelo de cuidado. Ciênc Saúde Colet. 2018;23(6):1929-36.