Managers’ strategies in caring for dependent elderly at home in Brazil

Estratégias de gestores no cuidado com idosos dependentes em domicílio no Brasil

Estrategias de gestores en el cuidado a domicilio de adultos mayores dependientes en Brasil

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Abstract

Objective: To investigate the strategies Brazilian health managers employ to supply dependent elderly home care.

Methods: This is qualitative hermeneutics-based research with a comprehensive perspective on elderly home care. Sixteen managers working in Primary Health Care and specific elderly healthcare programs from the five Brazilian regions participated in this study. Data were collected from June to September 2019 with semi-structured interviews, and later systematized and consolidated into two themes in light of hermeneutics.

Results: Managers articulated health education practices, mapped vulnerabilities, implemented care flows and protocols, and organized community support and health promotion groups, besides integrative and complementary practices to consolidate and improve elderly home care.

Conclusion: Multiple strategies in dependent elderly home care stand out, such as individual and collective health education actions and work management processes, in which the manager plays a crucial role in developing services for the elderly.

Keywords
Primary Health Care; Health strategies; Aging; Elderly; Health manager

Descritores
Atenção Primária à Saúde; Estratégias de saúde; Envelhecimento; Idoso; Gestor de saúde

Resumo

Objetivo: Investigar as estratégias utilizadas por gestores da saúde no Brasil para o cuidado com o idoso dependente atendido no domicílio.

Métodos: Pesquisa qualitativa, com aporte na hermenêutica, numa perspectiva compreensiva acerca do cuidado com o idoso em domicílio. Participaram 16 gestores atuantes na Atenção Primária à Saúde e programass específicos da saúde do idoso das cinco regioes brasileiras. A coleta de dados ocorreu entre junho e setembro de 2019, com entrevistas semiestruturadas, e os dados foram sistematizados e consolidados em duas temáticas, à luz da hermenêutica.

Resultados: Para a consolidação e a melhoria do cuidado domiciliar com os idosos, os gestores articularam práticas de educação em saúde; mapearam as vulnerabilidades; implantaram fluxos e protocolos de atenção e realizaram grupos de apoio comunitários e de promoção à saúde, além de práticas integrativas e complementares.

Conclusão: Destacam-se múltiplas estratégias no cuidado com o idoso dependente em domicílio, como ações de educação em saúde, individuais e coletivas, tais como processos gerenciais do trabalho, em que o gestor desempenha papel fundamental no desenvolvimento das ofertas à população idosa.
Introduction

Aging is challenging governments and health system organizations worldwide.\(^{(1)}\) Equal access to health services requires adjusting the reorientation of elderly care and health management.\(^{(2)}\) A significant age pyramid transformation has been observed despite asymmetric public policies.\(^{(3,4)}\) The Pan American Health Organization (PAHO)\(^{(5)}\) points out that longevity is a concern for policymakers, as income growth may decline in countries with a large number of elderly individuals. Equalizing the increase in life expectancy, healthy aging, and the health needs of this population is more complex in low- and middle-income countries, given the socioeconomic vulnerabilities.

An additional issue facing policymakers is the multidimensional nature of aging populations since it includes biological, chronological, psychological, and existential aspects, although it can occur naturally and healthily. However, elderly individuals are susceptible to living with chronic physical and mental health conditions, besides being care-dependent, which affects health services.\(^{(6,7)}\)

In this context, the World Health Organization (WHO) reaffirms Primary Health Care (PHC) as the preferred contact in the health system.\(^{(8)}\) Primary health care provides integrated, accessible, resolutive, territorially-based, and culturally competent care. In Brazil, PHC is crucial in providing comprehensive healthcare to the elderly, emphasizing those who are vulnerable.\(^{(9)}\)

The WHO\(^{(10)}\) considers the following as vulnerable elderly: age over 80; living alone; single women or widows; residents of Long Term Care Facilities for the elderly; socially isolated; without children; with severe limitations; with physical, motor, psychological and neurological disabilities; couples over 65, when one of the spouses is disabled or ill; and living with scarce resources.

In public policies on dependency, elderly subjects are assessed according to the severity of their loss of autonomy. The vulnerable live with biopsychosocial repercussions that range from social isolation to the lack of health services. Dependency levels are observed to plan how to overcome, scale up, or reorient healthcare for this population.\(^{(10,11)}\)

The Brazilian National Elderly Health Care Policy (PNSPI - Política Nacional de Saúde da Pessoa Idosa) aims to “recover, maintain, promote autonomy and independence of the elderly with collective and individual health measures under the principles and guidelines of the Brazilian Health System (SUS – Sistema Único de Saúde)”. Thus, PHC is responsible for reorganizing health practices but needs help with implementing them. Given this complexity, management in the SUS plays a role in planning and implementing elderly care strategies, especially for vulnerable elderly. Thus, managers are responsible for implementing and consolidating public health policies and reducing care provision disparities.\(^{(11,12)}\)

Based on the above, the question arose: What strategies are Brazilian health managers adopting to provide dependent elderly with home care? This study aimed to investigate the strategies Brazilian health managers employ to supply dependent elderly home care.

Methods

The data derive from the multi-center project “Situational Study on Dependent Elderly Living with their Families, Aiming to Subsidize a Policy...
of Care and Support for Caregivers”, coordinated by Fundação Oswaldo Cruz (Fiocruz), in Rio de Janeiro (RJ).

This is a qualitative study\(^{13}\) from a hermeneutic perspective, which incorporates comprehensive processes of care for dependent and vulnerable elderly subjects, according to the WHO.\(^{10}\) Hermeneutics seeks to understand the practice and meaning of care strategies offered by health managers for dependent elderly.\(^{14}\)

Sixteen managers invited by convenience participated, considering the subjective accumulation linked to the health management experience’s materiality delimited by theoretical saturation.\(^{13}\) The informants were responsible for managing PHC and specific programs linked to it in eight Brazilian municipalities in the five regions of the country: Araranguá (Santa Catarina, 4), Brasília (Federal District, 1), Fortaleza (Ceará, 2), Manaus (Amazonas, 2), Porto Alegre (Rio Grande do Sul, 1), Belo Horizonte (Minas Gerais, 4), Rio de Janeiro (Rio de Janeiro, 1), and Teresina (Piauí, 1). The municipalities had different economic, social, and cultural backgrounds but shared the responsibility of being hub regions for health services. Managers were contacted through the Municipal Health Departments. All those invited agreed to join the research and signed the Informed Consent Form, with no refusals during data collection.

We included managers responsible for organizing elderly care in each municipality from PHC Units and specific programs for the elderly with at least six months of management experience. Managers on sick leave were excluded.

The interviews were held with a team of researchers in each state from June to September 2019. After prior scheduling and presentation of the study’s objectives, they were conducted by university-educated professionals in a private location to avoid embarrassment. Interviews were flexible and individual, lasting approximately 30 minutes. The question was: What dependent elderly care strategies are provided by health management in your municipality?

The interviews were transcribed in full to preserve data reliability. The information was then thoroughly read, sorted, and interpreted using a hermeneutic approach\(^{13,14}\). Thus, the following thematic axes were chosen: Dependent Elderly Care Management Strategies and Dependent Elderly Care Practices in PHC. We proceeded with random coding, using the word “Manager”, the interview order number, and the corresponding location (Manager 1 – Fortaleza; Manager 1 – Manaus) to preserve anonymity.

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The study used the Consolidated criteria for Reporting Qualitative research (COREQ).\(^{15}\) It was approved by the Research Ethics Committee of a university under Opinion 1,326,631 (Certificate of Presentation of Ethical Appreciation (Certificado de Apresentação para Apreciação Ética) 44615315.0.0000.5240), respecting the ethics of studies in the human and social sciences.\(^{16}\)

Results

Dependent Elderly Care Management Strategies

The strategies were plural actions incorporated in most municipalities with no differences inherent in their economic, social, and cultural contexts. They all shared strategies to promote care, such as health education, home care with support for caregivers, support between care levels, organizing elderly groups, and providing spaces for bodily practices.

Health education was a qualifying technology for services for the managers, whose broader vision of health guided, organized, and facilitated elderly care.

Health education is what we need: teaching, not increasing the number of psychologists in the office. More people are at the front door to talk to, bring to the unit, organize, and guide. (Manager 2 - Araranguá)

We organize and receive these elderly individuals and families into groups. (Manager 1 – Rio de Janeiro)
Providing home care services was a decisive strategy in supporting family members/caregivers and professionals at the secondary care level. Primary health care managers acknowledged that Specialized Care’s training promoted learning and understanding of the dependent elderly’s demands under PHC’s shared responsibility. Moreover, the information provided instrumentalized the work of caregivers, who needed practical knowledge to address elderly subjects.

We see the satisfaction when it’s a training day between the family and the elderly. We see a behavioral change. (Manager 1 – Manaus)

Caregiver training occurs through the service organization that recruits caregivers in the service. (Manager 4 – Belo Horizonte)

Primary health care programmatic actions evidenced that health promotion groups predominantly targeted elderly individuals with chronic conditions. However, some focused on the demands inherent in healthy aging and health problem prevention, working with a specific group of elderly and bringing them to participate in group activities.

Work with a specific group for the elderly, bringing them to participate in group activities. (Manager 1 – Fortaleza)

We have an elderly group with more than 30 elderly individuals. Most of them are women. This group works with physical activity and other activities. (Manager 1 – Rio de Janeiro)

Community Health Workers lead a group in a square, which becomes a cooperative group. The professional sits down with them. They talk and ask questions. (Manager 1 – Fortaleza)

We also had strategies to increase PHC resolutivity: managing the queue for specific care, referrals to specialties, and bodily practices facilitated by the Health Academy Program.

There are health gyms with pain-free back groups, and there are some elderly individuals. This activity took them off the physiotherapy waiting list. (Manager 4 – Araranguá).

We used to hold events for the elderly at local venues. It increases every year, and the population is growing. (Manager 1 – Belo Horizonte)

Dependent Elderly Care Practices in PHC

The managers suggested implementing care practices centered on the biological dimension, which suggests preserving the curative model. The care adjustment justifies this model, especially in preventing complications in bedridden elderly subjects.

He had terrible bedsores. So, they have healed, and he has improved. It’s just a care adjustment. (Manager 4 – Araranguá).

At the same time, some managers pointed to implementing care practices geared to the comprehensive elderly care model, such as screening for vulnerabilities of dependent elderly and their caregivers. Screening was relevant, especially when elderly individuals were isolated and without care.

We managed to map some neighborhoods in the face of isolation. We discuss the case. We conduct an inclusion assessment, considering social assistance and vulnerability issues. Once the assessment has been performed, elderly subjects scoring the required points are included or not in the program. (Manager 2 – Belo Horizonte).

Managers also offered training to qualify the Community Health Workers (CHW), enabling them to identify and stratify the elderly’s health risks, covering Activities of Daily Living and Instrumental Activities of Daily Living, which, in turn, guided the service’s demands.

A risk stratification is done using a scale. The Community Health Worker fills in a form and asks whether elderly subjects can come to the unit in-
dependently or can look after their lives and those who cannot. (Manager 2 – Fortaleza)

With the flows and protocols, I’m working on a well-cared-for family program, signposting the vulnerable elderly. (Manager 1 – Manaus)

The implementation of care flows and protocols supported person-centered care. The statements emphasized the importance of programmatic actions to reduce the healthcare gaps in this population, recognizing the breadth of the elderly’s health demands.

The Elderly Health Protocols also assess the social aspect because the elderly’s vulnerability is not just physical. (Manager 1 – Brasília)

Everything we have or need is a possibility to make life easier, regardless of the order, not to limit ourselves to one action, everything we work on, not health, to think of the whole. (Manager 1 – Porto Alegre)

The managers also ensured the implementation of Integrative and Complementary Health Practices, which enhanced care in PHC. However, these practices still depended on volunteers and were offered unsystematically.

On Fridays, a nursing technician who has retired continues her voluntary work. She does Pa Tuan Chin. (Manager 1 – Rio de Janeiro).

So many people do massage therapy. We have started making a schedule: massage therapy day and Reiki day. The professionals make referrals. Therapies are open to the public. Anyone can join in. (Manager 1 – Fortaleza)

Discussion

The interviews revealed that managers adopt a set of strategies to promote care and support the implementation of care practices for the dependent elderly that cover dimensions of aging and its dynamics. They addressed the promotion of healthy aging, which is maintaining functional abilities and correlating them with physical and mental health; maintaining human functionality; assisting with specific needs; functional recovery; training human resources; and supporting the development of formal care and research, all of which are the PNSPI’s objectives. (11)

Although managers cover policy topics, they show little structured care for dependent elderly. It should be noted that PHC is unable to assist those in need of permanent care on a daily basis. The statements referring to longer-term follow-up reveal, between the lines, the difficulties in assisting and integrating care.

Managers’ conception revealed that the strategies launched by the dependent elderly care management in PHC settings are diverse and specific, not institutionalized, and manager-sensitive. More effective actions and a comprehensive view of longevity and the manager’s role are revealed where the services are more oriented and organized, such as the Maior Cuidado Program in Belo Horizonte. Based on international experiences, such as European models, some countries corroborate that it is necessary to develop policies to insure the elderly and their caregivers besides specific care. (17)

Health systems emphasizing PHC can respond to people’s multiple demands, implementing intersectoral and effective public policies to achieve equitable and resolutive healthcare. (8) However, these authors need to discuss the effectiveness of actions when there is no specific permanent care program for dependent elderly subjects.

Given the health models in developed countries, such as some European ones (17), health systems need a specific law or strategy to address the elderly who lose their basic and instrumental autonomy and become dependent. This is especially true in the Brazilian reality, which differs from European examples due to the lack of an effective policy and support for dependent elderly and their caregivers. Otherwise, this population could be left unattended and invisible to the State and society, leaving the responsibility to families or charities.
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In general, the managers reposition the role of education as a strategic and essential act for promoting health and improving care, converging towards training that considers comprehensive and interprofessional care. Managers’ narratives highlight the need for PHC to transpose physical structures, communicating with families and neighborhoods to understand and monitor the situation of people aged 60 and older, not necessarily those dependent. According to the Israeli Quality Indicators for Community Health Services (QICH), elderly subjects should be increasingly monitored due to their greater susceptibility to chronic diseases. The assessments of this program show that the early elderly age healthily if adequately monitored.

Some managers are concerned about linking CHW’s proposals with actual practice. Studies in Finland and Sweden point to a disconnection between the perceived ideal, the actual experience, and the multidisciplinary experience. Managers’ discourses practically show efforts to establish complex, interprofessional and interactive protocols and programs to the detriment of curative and specific practices. Thus, health promotion groups and training are used as strategies.

In Germany, the United States, the United Kingdom, and the Netherlands, PHC care management focusing on dementia requires collaborative care, interprofessional education, early diagnosis and planning for caring for the elderly and their caregivers to provide resolutive care. In Brazil, a pilot study conducted in Fortaleza highlights that CHW training to support elderly care in health or social assistance helps to mitigate the challenges faced by low- and middle-income countries in the face of aging issues.

All participants agree that PHC is confirmed as the care organizer when it follows a logic of network and comprehensiveness, interlocution, interdisciplinary training, and interaction with families and the community. The Chinese experience of an aging pyramid reaffirms the need for protection and strengthened research and technological innovation to meet the diverse needs of the elderly population, improving the capacity to guarantee access to several care environments.

Faced with a greater centrality for PHC when it comes to pondering on policies and the organization of health services, the scope of allocations remains reduced to the possible imputable attributes, especially when considering users. Low-autonomy and highly dependent people need more care continuity support in PHC. These situations reveal its limitations and call into question its resolutive and ability to be the “Health Services network organizer”.

Thus, we noted a gap since PHC should allow care continuity in other situations. It requires adequate funding, human resources, and training for all those involved to mitigate and expand the forms of care. As a result, caring for dependent elderly and their caregivers is incipient, especially for those who need continuous care. We underscored the vital task and the need for a policy for the care of the elderly and the other players involved in this care. Training, management, and interprofessional education within PHC are needed to consolidate elderly care.

Managers need to address the daily care of elderly people who always need a caregiver by their side. Primary health care can offer a lot, but not everything. However, although it expands outside its walls and reaches society, its performance reveals the Health Services’ limitations. A specific policy is, therefore, urgently needed to address this segment of the population, especially caregivers of dependent elderly.

The study is limited because it only used interviews and did not employ focus groups among managers. Its contributions, given that it took place at the national level, subsidize public policies, underscore managers’ care strategies, and produce new evidence about comprehensive care.

Conclusion

Managers’ multiple strategies to provide dependent elderly home care and PHC care practices stand out,
which include individual and collective health education, caregiver training, functional assessment, health gyms, work management processes (flows and protocols), and integrative practices.

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Collaborations

Gonçalves JL, Silva RM, Minayo MCS, Vieira LJES, Bezerra IC, Brasil CP contributed to study design, data analysis and interpretation, article writing and critical review. Saintrain MVL and Guimarães JMX collaborated with the critical review and with the other authors in the final approval of the version to be published.

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