

## Challenges and possibilities of health professionals in the care of dependent older adults

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**Abstract** *This study investigates the challenges and possibilities of health professionals in managing care for dependent older adults in PHC. We employed a qualitative approach based on dialectical hermeneutic fusion. Interviews were carried out with 38 health professionals, from June to December 2019, in eight cities in the five Brazilian regions, which resulted in themes about the challenges of professionals in the management of care for older adults, the strategies used, and their suggestions for improving the quality of care for dependent older adults. Management failures, structural factors, access barriers, scarce supplies, disrupted network, and lack of security, were pointed out as hardships in directing health protection, prevention, and promotion actions. The applied strategies are diverse and conflicting and aim to articulate the multiprofessional teams, which involve the Family Health Strategy and specialists to implement care. Strengthening reception, encouraging home consultation, mobilizing support groups, and carrying out health education were among the participants' integrative practices. Due to the complex study object, it was evidenced that professionals recognize the shortcomings in the health services and face undesirable situations due to the lack of qualified personnel in the teams and the defective materials and transportation.*

**Key words** *Health care, Health personnel, Dependent older adults, Primary Health Care, Qualitative research*

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## Introduction

Population aging is part of the demographic reality in Brazil and worldwide. The World Health Organization (WHO) warns that two billion older adults are expected in 2050, and, in the Americas, people over 60 will increase more than three-fold in the next 30 years, up from eight to thirty million<sup>1,2</sup>. Brazil will be the sixth highest ranked country in older adults by 2025, reaching 22.71% of the total population in 2050.

Chronic health problems arise with age. They often lead older adults to become dependent on care and challenges from health systems that demand more resolute lines of care and care networks<sup>3</sup>. The World Health Organization (WHO) spearheads the Decade of Healthy Aging 2020-2030 to promote longevity and healthy lives, in line with the Sustainable Development Goals<sup>4</sup>. In parallel with aging is an urgent need to care for this population to prevent dementia and physical and mental disabilities<sup>5</sup>.

The Ministry of Health developed from 1994 to the present the National Policy for Older Adults<sup>6</sup>. As of 2000, Policies have intensified – Statute for Older Adults<sup>7</sup>; National Health Policy for Older Adults<sup>8</sup>; Primary Care Policy<sup>9</sup>; Strategic Action Plan for Coping with Chronic Non-Communicable Diseases in the 2011-2022<sup>10</sup> period; National Active Aging<sup>11</sup> Policy; Guidelines for the Care of Older Adults in the Unified Health System (SUS); and Technical Guidelines for the Implementation of the Care Line for Comprehensive Health Care for Older Adults in the SUS<sup>12</sup>.

The increased life expectancy and the fragmented care in the care networks for older adults are a reality that influences the system's resolution and leaves dependent older adults receiving care at home unassisted. Depending on this fact, PAHO/WHO<sup>2</sup> expresses that disability-associated aging has increased by 12.6% since 2009. PAHO's Plan of Action on the Health of Older Persons, including Active and Healthy Aging for the period 2009-2018 report, showed that health workers are not prepared to meet the needs of older adults<sup>4</sup>.

Health care management must involve multiple dimensions, adjusting to each stage of life, searching for well-being, security, and autonomy, and can benefit from access to health resources available in the social environment<sup>13</sup>. In the SUS organizational scope, PHC is the main gateway to the system, as it is where users' first contact with health services and professionals should take place longitudinally, aiming at comprehensive

care, focusing on prevention and health promotion actions<sup>14</sup>. In the reorientation of the PHC health care model, Family Health Strategy (ESF) leads the care to the family and the community<sup>14</sup>.

From the perspective of Oliveira et al.<sup>15</sup>, the way of caring for older adults in Brazil, particularly dependent older adults, must be reworked to achieve a logical and coherent care path in the face of an articulated network of services and people. These transformations must be implemented in services, training of health professionals, support to the organization, and management of resources and financing.

However, it is necessary to clarify the strategies used to prevent risks and manage this population's health conditions. Understanding the challenges of professionals who address the care of these dependent older adults within PHC daily and investigating their care strategies and the suggestions for improvements to support coping with health problems of this frail population can open new avenues and strengthen comprehensive care in the SUS. This study aimed to investigate the challenges and possibilities of health professionals for the management of care for dependent older adults in Primary Health Care.

## Methods

This paper is nested in a multicenter study called *Situational study of dependent older adults living with their families to subsidize care and support policy for caregivers*, linked to the Jorge Careli Department of Violence and Health Studies, the Oswaldo Cruz Foundation.

A qualitative study was conducted from a hermeneutic-dialectic perspective, which anchors the comprehensive and critical processes of a social event<sup>16,17</sup>. Hermeneutics seeks to near the meaning established by professionals when they live the experience of caring for dependent older adults, emphasizing beliefs, values, objective actions, and subjective meanings. Dialectics allows confronting social components under critical lenses.

The study reported here was developed in eight municipalities in the five Brazilian regions, including Brasília, Teresina, Fortaleza, Manaus, Rio de Janeiro, and Belo Horizonte Porto Alegre, and Araranguá. These municipalities were chosen to understand the national realities due to the diverse and intricate aspects of social, cultural, and health conditions<sup>18</sup>.

Thirty-eight PHC professionals who provided some care to dependent older adults were

interviewed for this section of the study. Among the professional categories interviewed were doctors (8), nurses (18), psychologists (1), physiotherapists (1), social workers (3), dentists (2), biologists (1), physical educators (1), nursing technicians (1), pedagogues (1) and community health workers (1). Participants with at least one-year experience in PHC services were included to ensure the experience of caring for dependent older adults. Those who were on vacation or were removed for any reason from work activities were excluded.

Key informants from the municipal health departments indicated the participants, based on previous knowledge about the registration of households and UBS that attended older adults dependent on any type of physical, mental, or social care. The inclusion criteria considered health professionals who had worked, for at least a year, in PHC services and municipal programs that provided support to older adults and their families. The invited professionals were contacted in person, by phone, or social media. They received information about the study upon accepting the invitation.

Data were collected through semi-structured interviews to capture identification data, sociodemographic characteristics, facilities, and difficulties in receiving and monitoring the care of the dependent older adults and the support strategies used. Interviews were held from June to December 2019 after participants signed the Informed Consent Form (ICF), at reserved places in the respondent's work environments, with a mean duration of 20 minutes.

The data were sorted, classified, and analyzed following the steps of transcribing the interviews, reading, rereading the material, and separating the sets of signs that emerged from the text (sorting); grouping the sets of signs and their analytical classification (classification), and interpretation of the data, bringing to the fore the complementarities, convergences, divergences, and the unusual, from the empirical universe<sup>17</sup>.

The research follows the dictates of Resolution 466/2012<sup>19</sup>, having been approved by the Research Ethics Committee of Oswaldo Cruz Foundation. The abbreviations of the professions, followed by the name of the city where the collection was carried out, were used to protect the identities of the participants.

## Results

The results are presented in two themes that emerged from the collected empirical material. It is worth mentioning that the reference to "older adult" is extended to "dependent older adult" (DOA), since the research analysts of this study considered the principle of inseparability, since they belong to the same population group, only differing concerning the level or intensity of care demanded.

### Challenges for professionals in the management of care for dependent older adults

The participants' main challenges are related to inefficient PHC management, structural difficulties, territorial and access barriers, scarce supplies, counter-referral system bureaucracy, long waiting lines, and lack of public security. The inefficient management of PHC is evidenced by care lag and lack of priority resources and management.

*There's no such thing as primary care! All ends up staying much more at doctor's offices, losing the vital ability to identify inside people's homes. (Enf., Porto Alegre).*

*When talking about primary care, we think about prevention and health education. Today, we are doing 1% of education and health. The rest is just walk-in demand. So [the actions carried out] lost a little the meaning of primary care. (Med., Fortaleza).*

PHC structural difficulties are challenging and worthy of attention by responsible bodies. Professionals aim for spaces to conduct collective activities and establish a shared care network.

*In the health unit, we have NASF's room that does not even accommodate NASF professionals. Five professionals in there pack the place. So, we can't develop groups. (PSIC., Fortaleza).*

*How can I implement something different without having space for it? Without having a professional with me? Nothing is easy for primary care. Nothing is easy! It is difficult to establish a network! (Enf., Rio de Janeiro).*

The difficulties in assisting DOAs also exist in the health unit, due to territorial and access barriers:

*Not all units have good access or a lift, for example. You see a ladder here. We tried to put the doctors down there, tests, nursing. However, a female older adult has to climb stairs if she needs to go to the gynecologist. (As., Belo Horizonte).*

*The post was built in an area where the most significant demand comes from across the avenue. This is a hurdle for older adults because there are no buses, and they cannot cross. (Enf., Fortaleza).*

*Mobility is a barrier. Older adults have to come and get the medicine here. The frailest older adult cannot come here, you know? (Med., Belo Horizonte).*

Besides structural problems and DOA's access to services, professionals recognize the complaints of relatives:

*He has great difficulty taking the older adult to do any type of exam, except for home collection, which we also perform, but, generally, they are unable to take the user to any hospital to do simple radiography. (Enf., Rio de Janeiro).*

*The houses are not always close to the post. When they are, we accompany the older adult. (Enf., Porto Alegre).*

The particularities of some cities reveal the shortage of supplies for simple and biosafety procedures:

*We have difficulty in having material to treat an injury. Sometimes it takes a month or more for the order to arrive. The primary material is missing: gloves, serum, and dressing material. (Enf., Teresina).*

*Imaging and other tests that do not happen within the PHC unit and that the older adult has to do still take longer. Tests that require referrals to specialists are even more challenging. (Enf., Fortaleza).*

Other difficulties are the long waiting lines and bureaucracy in the counter-referral system for the monitoring or referral of DOAs, which hampers resolute care:

*The patient is registered, and there's a waiting list. Some people wait for several months, unable to perform tests or the appointment with the specialist. When he is more fragile and requires secondary care, we refer this patient and see several hurdles. (Med., Fortaleza).*

*There is a specialty that we can follow more quickly, like geriatrics. An Alzheimer's patient can be referred to a geriatrician, as neurology takes time. The referral remains here for a long time. (Enf., Teresina).*

*SUS bureaucracy is enormous, and regulation takes time. The number of older adults is enormous, and there's a long delay in meeting all needs. (Enf., Fortaleza).*

The lack of public safety in several territories expressed the reality of Brazilian cities.

*The health worker always accompanies the nurse, so as she doesn't go alone, we try not to make*

*home visits alone for the sake of safety in the area. (Enf., Porto Alegre).*

*Sometimes, in the territory, no one could visit because there was a shooting or something that prevented or hindered this visit. This has happened several times. (Enf., Fortaleza).*

### **Strategies and suggestions of professionals for the care of dependent older adults**

Interprofessional communication, hiring professionals and specialists, reception, therapeutic and community groups, training and continuing education actions with caregivers and relatives, and home visits, were necessary strategies for DOA care. The professionals stated that elderly healthcare requires interdisciplinary and multi-professional articulations to form a more efficient care network.

*It is necessary to reinforce the multiprofessional network to improve the quality of care for these older adults. (Med., Fortaleza).*

*NASF has several rehabilitation professionals, such as a social worker, psychologist, physiotherapist, nutritionist, pharmacist, occupational therapist, and we use this network to talk to them about the older adults' needs. (As, Belo Horizonte).*

*We have a supporter who is from the municipal health department. She reviews the entire structure of the ESF and seeks to remedy the problems regarding care to these families. (Enf., Teresina).*

The participants realized the lack of human resources in several areas, highlighting the need to hire specialists to strengthen ESF care.

*It is necessary to have more geriatricians in the team for better care to older adults because one cannot do much. (Med., Brasília).*

*The social worker would come to clarify what the role of the caregiver is, how far he can go when he can help [...], but we don't have a social worker, and we need it. (Enf., Rio de Janeiro).*

*It would be great if this team had more professionals, such as a psychologist, to provide better support for these older adults. (ACS, Manaus).*

The intention to receive DOAs in the health service was evident in the search for a resolute strategy for everyday problems.

*Receiving is the easiest part. Receiving, listening. We have a group and. We receive walk-in demand every day. You sit, listen, and see what you can do. (Enf., Fortaleza).*

*The initiatives employed must always be thought from the perspective of the patient's well-being. User reception plays a fundamental role in this process, as it is the moment to create bonds with the family and the patient. (Fisio., Manaus).*

The professionals recognized community groups as initiatives favorable to care to promote the health of DOAs. In some health services, complementary, integrative practices are valuable to this audience.

*A work coordinated by the social service once a week is focused on caregivers. Especially family caregivers for dependent older adults receive guidance and instructions. The most interesting thing is the conversation between them, one helping the other. It is the moment to vent. It is therapeutic.* (PSIC., Brasília).

*We have a group called "The Empowered" who are ladies making handicrafts. They are widows. Their children already left the house. It is compelling because you take away idleness, depression, and give this woman the means to earn money. She makes handicrafts and sells, socializes, makes friends. It's a great network!* (Enf., Rio de Janeiro).

*We already have community support in this support unit. This is expanded, and it is valuable for older adults! Here at the clinic, we also have community therapy for caregivers, who is sometimes more debilitated than the older adult. He is crying, more anxious, and tired from taking care of him day and night.* (Enf., Fortaleza).

Actions based on interdisciplinary practices stem from professionals to assist DOA's caregivers and relatives.

*One of the most significant initiatives is a course for caregivers, who are often other older adults. Some necessary information, mainly about hygiene, food handling, things that can prevent them from having any complications and bedsores.* (Enf., Teresina).

*Training of caregivers, mostly relatives, with mobility techniques in bed and transfers, which they can use daily.* (To, Fortaleza).

*We do so much education at school to talk about child care, talking to pregnant women, and a prenatal group. We should also have it for older adults, so the family knows that needs are different, and sometimes they have to receive some special care.* (Med., Belo Horizonte).

Professionals stressed home visits mediated by health education actions as a crucial care resource, especially for DOAs who do not attend the health center or live alone.

*When we go on a visit, we try to guide the questions about food, hydration, skincare, the issue of carpets (to avoid falls), the older adults' difficulty.* (Enf., Porto Alegre).

*We provide individual guidance here. When we go home, we give guidance to the family about specific care for older adults.* (Enf., Teresina).

## Discussion

As for the professional's challenges regarding the care of DOAs in PHC, the professionals' perception showed that the management of health services directed to this population is inefficient. Ravioli et al.<sup>20</sup> analyzed the management of services in the SUS, from 2005 to 2016, and detected administrative difficulties for managers, such as "[...] low operational capacity, lack of budgetary, financial, and administrative autonomy, poor quality controls, external political influence, excessive bureaucracy to hire staff, making adjustments to the structure and to buy supplies, medicines, and equipment".

In general, inefficient management actions challenge PHC's underpinning processes, from recruiting human resources to organizing services and purchasing supplies. Public managers need to know their problems, study health indicators so that they know how to plan, structure, organize and evaluate technical-scientific and political-institutional actions, and establish projects that can intervene on the health status of the population<sup>21</sup>. Managers and professionals providing health care must rethink their work<sup>22</sup> based on users' needs<sup>23</sup>.

Analyzing the elderly healthcare model, Veras and Oliveira<sup>24</sup> point out that, in current health systems, fragmented care and poor coordination issues can be solved from integrated care models. To this end, the authors suggest redesigning the care levels, which ensures a coherent flow of education, health promotion, and problem prevention actions, creating a care line favoring older adults' reception and the monitoring of palliative care.

The lack of space to develop work with DOAs was also identified in the research on the Brazilian Primary Health Care Structure Census<sup>25</sup>, which may be related to the use of houses adapted for health units' functioning, often without specific planning or project.

The territorial barriers and the lack of accessibility to health services identified in this study are reflected in care coverage, as they fragment the care cycle, break users' attendance, and weaken bonds with professionals<sup>26</sup>. In the Census carried out by Poças et al.<sup>25</sup>, the situations found are similar to the inadequate structure of physical environments and difficult transportation and access, especially for older adults and the disabled.

The scarce supplies for necessary procedures were among the difficulties associated with the

production of care in the ESF in different Brazilian regions. The lack of required materials for dressings in DOAs and bedridden patients becomes an unworkable task. Other studies<sup>25,27</sup> showed a macro problem of poor resource management in the country.

The multiple DOA's demands require intersectoral health care actions. However, challenges in the consolidation of comprehensive care for this public are pointed out, such as the difficulty of articulating with the care network and bureaucratization so that DOAs are accepted in all their complexity<sup>14</sup>. This articulation favors care comprehensiveness and must consider all the territory's resources, from health services, squares, churches, clubs, to professional centers and associations, in order to meet affective, health, social, economic, cultural, religious, educational, and leisure's demands for older adults<sup>28</sup>.

The bureaucracy of the referral and counter-referral system and the long and lengthy waiting lists for attending DOAs in medical specialties interrupts the continuity of care in the therapeutic itinerary. Schenker and Costa<sup>14</sup> characterize the referral to specialized care as fragmented and out of context, weakening the DOAs' care.

Kantorski *et al.*<sup>28</sup> show that the referral and the counter-referral system must be considered an essential resource in the line of care, since, if well structured, it promotes the efficient flow of referrals of users to the different levels of care and recommends the integration of services in a committed and effective manner.

Another factor is the lack of public security to carry out activities, especially home visits to older adults. Sturbelle *et al.*<sup>29</sup> emphasize that violence in health services increases by the day. In PHC, services are developed in the community, whether in health units, in other spaces, and their own homes. This brings professionals closer to the territory and can expose them to violence, especially in drug trafficking areas. This situation becomes more severe in the capitals due to urbanization, associated with crime escalation.

Brazilian police struggle with containing violence as they face the growing factions (organized and well-equipped criminal groups) and their insecure working conditions. Souza and Minayo<sup>30</sup> point out that the solution would not be just to provide the police with more armaments, but excellent training, daily support in conflicted areas, adequate rest, and emotional protection – not forgetting the need for investments in infrastructure in the police and health services for the safety of health workers<sup>29</sup>.

Concerning the strategies and suggestions of professionals for the DOA care in PHC, improving the articulation with the interdisciplinary and multiprofessional team stands out through an approach centered on comprehensive and continuous care. The repercussions transpose the biomedical model and configure the very users' involvement with their support network, bringing shared responsibility to the therapeutic care set<sup>31</sup>.

In China, researchers show that interdisciplinary care is beneficial to improve the performance of chronic DOA's conditions, exemplifying that patients with Alzheimer's disease have significant functional gains with this approach<sup>32</sup>.

The multidisciplinary team's valorization in the scope of DOA care management has been a significant challenge for public health policies, with an urgent need for expanded care that considers strategies for structuring and reorganizing services and changes in the work process<sup>33</sup>. In this sense, the clinical knowledge and technologies are still preferred and can be added to the commitment and bond, performing more integrated intersectorality and interdisciplinarity practices to expand and strengthen the daily lives of ESF teams<sup>34</sup>.

In the search for this type of care, the reports issue suggestions to put the professionals in the service and hire specialists to work with DOAs. The incorporation of professionals in the health care network is highlighted as the desire of the participants of this research, since its fixation consolidates the therapeutic bonds with the registered population, increasing territorial recognition and strengthening health practice, which enhances DOAs' resolute health care<sup>35,36</sup>.

It is noteworthy that it is necessary to observe factors such as the health unit's location, worker's age, function, level of expertise, pressure, and satisfaction in the work activity to hire a professional. Failure to observe these factors can lead to turnover, as highlighted by 42.3% of PHC doctors in a study developed in Chongqing, China<sup>37</sup>, whose researchers found the need to reformulate the incentives and work proposals for fixing and the continuity of professional care in PHC<sup>37</sup>.

From this perspective, the recruitment of specialists in Geriatrics and Gerontology can provide or consolidate more resolute care to DOAs, facilitating work in healthcare networks<sup>38,39</sup>.

User reception was highlighted as a diversified resource with multiple interfaces in the health of DOAs, which can interfere during the implementation of care, and is a challenge for health teams<sup>40</sup>. Regarding 'reception', profession-

als' statements are in line with the National Humanization Policy, as reception favors a space for listening and receiving DOAs and other users<sup>41</sup>.

In this study, the realization of community groups was highlighted as a reality in health services from several professionals' initiative. In contrast, the absence of groups focused exclusively on DOAs was also observed. The literature highlights support groups as methods to expand care for DOAs, emphasizing prevention and health promotion, even though older adults' participation in these groups occurs as adherence to treatment, when there is already a health problem<sup>14</sup>.

Elderly health requires a network-type care logic, comprehensive care, and macro or micro-management aspects. For the implementation of this care, management must make the necessary articulations for the network's composition and the priority care plan<sup>42</sup>.

Regarding family caregivers, the lack of support and guidance is sensitive. The professionals revealed the objective of intensifying the perspective for older adults' families, as they are the primary care providers. Araújo et al.<sup>43</sup> postulate the concept that actions for the family's empowerment are not sufficient and the family context must be understood to assist in relationships and care with DOAs. Public policies must promote care and feasibility so that families can provide care, observing how older adults see themselves in the family context, which interferes with the execution of practices that facilitate daily activities.

In care management, the family must be viewed in a multidimensional context, valuing the uniqueness of family interpersonal relationships, giving meaning to living, experience, religion, and culture<sup>33</sup>.

The idea that strengthening PHC is a global strategy is highlighted. In Thailand, training programs developed over a decade indicated that, once the multiple competencies of PHC members were established, the resolution of complex problems in different local contexts was expanded, enhancing the care outcomes of teams from low- and middle-income countries<sup>44</sup>.

Home visit is an excellent care strategy for DOAs in the professionals' perception. The consolidation of this strategy is highlighted as supporting a study conducted in rural Japanese communities, in which nursing students disseminate preventive actions, encompassing individual and environmental perspectives of well-being in community life<sup>45</sup>.

In effect, these findings corroborate the 'portrait' of Canadian PHC, highlighting the care

potential in the home context, highlighting the improved experiences for patients and caregivers, which leads to lower healthcare costs, mainly when care is provided by expanded interprofessional teams<sup>46</sup>.

## Final considerations

Elderly care associated with social, physical, or emotional types of dependence resulting from older adults' longevity requires institutions and professionals to adopt attitudes that determine effective care standards and promote a practice that can improve the quality of health and life for older adults and their relatives. This practice must be anchored in dialogue, interrelation of those involved, and in the incorporation of innovative actions that enable favorable conditions for the engagement of caregivers.

The management of DOA care is a unique, broad, and complex circumstance, where the health operator assumes challenging dimensions to make decisions involving protection, prevention, and health promotion, prioritizing resources and service management. The structural and administrative conditions of PHC services in the cities studied showed weaknesses in DOA care at home and the health unit, underscoring the inefficient management, hardships in the physical, territorial, and access areas, lack of care material, administrative bureaucracy in the counter-referral system, long waiting lists, and lack of public security.

The professionals revealed that the difficulties in health services are related to several factors, but they struggle to supply them, undertaking actions emphasizing greater integration of the multidisciplinary team, adaptations to improve the work environment, and the involvement of community resources. They stressed that community groups, complementary integrative practices, and health education are fundamental for the development of protective actions for DOAs and their relatives.

In the universe of elderly care in PHC, especially for care-dependent older adults, the challenges faced by professionals are diverse and complex, requiring an effective inter-professional and intersectoral articulation to expand resolute care. Thus, there is a need for reworking health practices geared to older adults, considering structural, administrative, social and political aspects, which promote changes in essential conditions to manage daily demand, in the health units and the homes.

## Collaborations

Our contribution was to design and plan the research project (RM Silva, CCP Brasil and MHAG Jardim); data collection, analysis and interpretation of results (IC Bezerra, JL Gonçalves, and MLF Figueiredo); writing of the manuscript (IC Bezerra, CCP Brasil, MCL Santos and RM Silva) and critical review of the manuscript (RM Silva, CCP Brasil, JL Gonçalves and MLF Figueiredo).



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