

Policies of attention to the elderly according to the voice of the municipal managers of health



Políticas de atenção a idosos na voz de gestores municipais de saúde

Políticas de cuidados a los ancianos en la voz de los gestores municipales de salud

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ABSTRACT

Objective: To analyze the understanding of municipal managers of health about public policies destined to the elderly population and the way they are effected in the city.

Method: Qualitative study, developed with 14 municipal managers of health. Data were collected through a semi-structured interview and analyzed according the precepts of content analysis.

Results: The results show the lack of knowledge of the municipal health managers, related to public policies of attention to the elderly. Also, the attention given to the elderly in the studied municipalities focuses on measures to control health problems.

Conclusion: The municipalities do not have specific health care policies for the elderly population. Thus, these results can support reflections about care for the elderly in health services, their relationship with legislation, and the applicability of public health policies.

Keywords: Aged. Public politics. Resources management. Health policy.

RESUMO

Objetivo: Analisar o entendimento de gestores municipais de saúde acerca das políticas públicas destinadas a população idosa e a forma de como elas são efetivadas no município.

Método: Estudo qualitativo, desenvolvido com 14 gestores municipais de saúde. Os dados foram coletados por meio de entrevista semiestruturada e analisados conforme os preceitos da análise de conteúdo.

Resultados: Os resultados evidenciam a carência de saberes dos gestores municipais de saúde, relativos a políticas públicas de atenção aos idosos. Também, a atenção prestada a idosos nos municípios estudados centra-se em medidas de controle dos agravos à saúde.

Conclusão: Os municípios não possuem políticas específicas de atenção à saúde da população idosa. Assim, estes resultados podem subsidiar reflexões acerca da atenção a idosos nos serviços de saúde, sua relação com a legislação e a aplicabilidade das políticas públicas de saúde.

Palavras-chave: Idoso. Políticas públicas. Gestão de recursos. Política de saúde.

RESUMEN

Objetivo: Analizar la comprensión de los gestores municipales de salud acerca de las políticas públicas para la población de ancianos y la forma como ellas entran en vigor en la ciudad.

Método: Estudio cualitativo, que se llevó a cabo con 14 gestores municipales de salud. Los datos fueron recogida a través de entrevistas semiestructuradas y analizados de acuerdo con los preceptos de análisis de contenido.

Resultados: Los resultados muestran una falta de conocimiento de los administradores de salud locales, en relación con la atención política pública para los ancianos. Además, la atención a las personas mayores en los municipios estudiados se centra en las medidas de control de problemas de salud.

Conclusión: Los municipios no tienen cuidado de la salud específica de las políticas de población de edad avanzada. Por lo tanto, estos hallazgos pueden subvencionar reflexiones sobre la atención a las personas mayores en los servicios de salud, su relación con la ley y la aplicación de políticas de salud pública.

Palabras clave: Anciano. Políticas públicas. Gestión de recursos. Política de salud.

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INTRODUCTION

Populational aging is a worldwide phenomenon. While European countries took nearly 100 years for the elder population to increase from 7% to 14%, Brazil is going through the same meaningful change in less than 30 years. In face of that, the country has less time to organize the necessary infrastructure to answer to the demands from this population⁽¹⁾.

It stands out that until 2020, Brazil will have a higher number and predominance of adults, a diminished population of children, and an increase in the number of elders, albeit without a great impact in the total number of people. However, according to estimates, from 2030 on, the age pyramid will reverse, with a steady diminution of people in productive age and a number of elders that is greater than that of children, and may reach, in 2040, 23.8% of the total population⁽²⁾.

The factors that are responsible for the longevity of the population were created by society and result, in part, from public policies and social incentives anchored on technological progress. Their consequences, although, are concerning, since they imply in changes in the standards of public and private resources transference, and also due to the association between old age and the independence to perform daily activities.

The population aging is simultaneous to changes in the epidemiological setting. That happens because, in the Brazilian population, most elders suffer from chronic diseases, and some have functional limitations. In less than 40 years, Brazil went from a mortality setting that was common for a younger population, to a situation of complex and expensive diseases, typical in countries where people have long lifespans, and characterized by multiple and chronic diseases that last for years, demanding constant care, continuous medication and periodic exams.

One of the results of this dynamic is a greater number of elders seeking health services. Hospitalizations are more frequent and the time in the hospital bed is greater when compared to other age groups. In addition, the growing demand of attention to the elderly population in the health system demands a health team that is trained in this field of knowledge⁽³⁾.

Nowadays, the Brazilian demographic and epidemiological reality requires urgent changes and innovations to the models of health care for the elderly population, represented by different and creative actions, to improve the effectiveness of the system, allowing for elders to integrally enjoy the extra years science managed to provide them with. Therefore, due to the increase in the propor-

tion of elders, their extra years of life, and consequently, the more frequent use of health services, the expenses in the service will substantially increase in Brazil, tending to emerge as one of the greatest financial challenges of the next decades. Thus, it is paramount to invert the current logic of the system, whose focus is much more on the treatment of previously installed diseases than in preventive actions⁽⁴⁾.

As a consequence of an older population, health promotion, education, prevention, and the treatment of diseases and vulnerabilities, the maintaining of independence and autonomy, are initiatives that must be amplified, aiming to ensure a higher quality of life for the elders and a greater well-being to the population as a whole⁽⁴⁾.

The demographic Brazilian revolution is an achievement and a responsibility for public managers and for society itself. Investing in the promotion of autonomy and of a healthy lifestyle is decisive for this populational contingent of elders, as is providing adequate attention to their needs. This new moment requires planning, logistics, training of caretakers, and above all, sensibility, since this population will continue to increase until the decade of 2050⁽⁵⁾.

It is necessary to prepare elders, families and communities to face the reality that is confronts them. Therefore, it becomes necessary to count on quality health services in primary care, services of medium and high complexity or supplementary ones. Thus, the health sector must be apt, both in public and private spheres, to promote health, aiming at a healthy aging process⁽⁶⁾. To do that, the Unified Health System (SUS) must consider these aspects and guarantee care for all people.

In the search for effective actions, the country, the states and the municipalities use public policies - directives, guiding principles, rules or procedures - which maintain the relationship between public power and society. These are systematized or formulated in documents (laws, programs, financing programs), guiding actions that normally involve the application of public resources. Public policies bring, in their elaboration and implantation, and especially in their results, ways to exert political power, involving the distribution and redistribution of power, the minimization of the social conflict in the decision process, and the sharing of costs and social benefits.

In this setting, the Pact for Life is a compromise between managers of the Unified Health System (SUS), concerning the priorities that have an impact upon the health situation of the Brazilian population, including the elders. In addition, the decentralization process extended the points of touch between the system and the social, political and administrative reality of the country, increasing its complexity and presenting challenges for the managers to organi-

ze an attention network that is regionalized, hierarchic, and provided with qualified administration.

Confronted with the aging process of the Brazilian population, the question that guided this research was: what do the municipal health managers know regarding the public policies focused on the elder population and their applicability in the municipality? Therefore, the objectives of this study were: characterizing the municipal health managers and analyzing their understanding of public policies destined to the elder population, and the way they are brought to effect in the municipality.

■ METHODOLOGY

This is a qualitative study, in which participated the municipal secretaries of 14 municipalities that make up the 19th Health Region, headquartered in Soledade/RS. According to the Decree 7,508, from the state of Rio Grande do Sul (RS), from June 28, 2011, a Health Region is a continuous geographic space formed by a group of municipalities that share borders. It is demarcated according to cultural, economic and social identity, taking into account shared networks of communication and transportation infrastructure, to generate the integrated planning and execution of actions and health services. They belong in the 6th Regional Health Coordination (CRS) of Rio Grande do Sul.

It is worth to highlight that there are 62 municipalities in the territory under the responsibility of the 6th CRS, which are divided in four health regions, whose headquarters are in the following municipalities: Passo Fundo, which includes 21 municipalities; Sananduva/Lagoa Vermelha, with 20; Soledade, 14; and Carazinho, with seven. The inclusion criteria for participants was: being a municipal secretary for one of the municipalities in the 19th Health Region. The exclusion criteria included only secretaries who did not agree to participate in the research.

The data collection instrument was a semi-structured review composed of close-ended questions (to characterize the managers) and open-ended ones (regarding the themes of the research). The questions were: What do you know regarding public health policies for elderly care? What actions targeted at this age group, considering the public policies, are implemented in this municipality? What services of health care for the elderly are there in your municipality? Are there public intersectoral actions for the elderly? If so, which? If no, why? Are there municipal policies focused on the elderly population? Talk about them. The interviews were conducted in the spaces of the Municipal Health Secretariat of each municipality, and were previously scheduled. The average length of each interview was

one hour. Data were collected from February to May 2015, digitally recorded, and transcribed unabridged. To guarantee the anonymity of the participants, the interviews were codified with the letter E, followed by a number, according to the order in which the interviews were conducted.

To analyze the data, theoretical constructs from the legislative knowledge of the national policy of health care for the elders were used, as well as the methodological references of content analysis. From the perspective of this study, these are techniques to analyze communication, aiming to describe the content of messages and allow for the deduction of the knowledge regarding policies of attention to the elderly according to the words of municipal managers of health. Therefore, three stages were contemplated: the first was the pre-analysis, in which data was organized and skimmed. The second was the re-reading of the data generated and its classification in categories. The third one was constituted by the exam of the data obtained and its interpretation, whose meaning was considered according to the investigated context. Therefore, different interpretations were found, starting from the elderly health care policies, in addition to inferences that contributed to clarify the findings of the research⁽⁹⁾. After readings and re-readings of the content of the interviews, two analytic categories emerged, which were: the knowledge of municipal managers regarding public policies of attention to the elderly; and attention to the elderly according to the words of municipal health managers.

Ethical aspects were respected, including Resolution CNS 466/12. The project was approved by the Research Ethics Committee of the institution (CAAE): 39022114.4.0000.5346/2014, under Protocol N° 909.980/2014. It should be highlighted that all participants signed a free and informed consent form.

■ RESULTS AND DISCUSSION

14 municipal secretaries from the cities that belong to the 19th Health Region of Rio Grande do Sul (RS) participated in the research. The age of the participants varied between 23 and 64 years of age; four were female, and the others, male. Regarding education, five have completed high school, four have an incomplete undergraduate course, five are graduated (one in pharmacy, one in nursing, and the others in business administration), one of which has a post-graduation. Regarding how long they exercise the activity of public health manager, it varied from one to 17 years, and most of them have been in the position for more than five years.

Concerning the municipalities in which the managers work, the most populated has nearly 30 thousand inhabitants, while the least, 1,800. The total of residents of the

Health Region being researched is 115,495. All municipalities have a percentage of elders which is above the national average of 12.6%⁽¹⁰⁾. Regarding health services, five of the cities have a hospital, two of them capable of sheltering more than 100 beds. Nine do not have hospitals, and among these, two only have emergency services.

Municipal managers knowledge regarding policies of attention to the elderly

In the current context, in which populational aging is a reality, and the need for assistance and treatment continuously grows, it is necessary to think about public policies that can offer health, independently of age, including the promotion of a healthy lifestyle, healthy environments, disease prevention and the perfecting of assistance technologies. That, in addition to rehabilitation and other types of care, can, throughout time, minimize the inabilities related to old age, which impact the financial budget of the government⁽³⁾.

Through an analysis of their speech, it can be noted that the managers have difficulties in expressing what is a public policy of health care for the elderly population. Considering this issue, their answers were generic, incongruous and tried to evade the subject. Also, most of them mentioned actions they develop or not, instead of directly discussing what is a public policy.

Generally we don't have that policy, not that we're not interested, there's no specific policy, but we're always interested in these situations of observing statutes and people's rights. So the elder, for us, receives special attention. (E3)

Although they find it difficult to describe public policies for the health care of the elderly, the managers recognize that this group of the population demands a specific look regarding their care, and that is considered in their perspectives. Since they are small municipalities, and due to their difficulties, they admit that the policy of attention to the elderly is not very discussed, and therefore, not implanted.

It's a policy that in our town, actually I think that if you think rigorously in all small towns, even if you consider the difficulty of the team, it's a policy that's not promoted, that's the reality. (E4)

This understanding is not on par with the strategies recommended by the World Health Organization, according to which the old age population must be a priority. Such strategies are: a compromise with healthy aging, which demands sensibility regarding the worth of getting old, com-

promise, and the adoption of sustainable measures to formulate policies that reinforce the capabilities of the elders; adaptation of the health system to the needs of the elders; the establishing of health systems to chronic situations; the creation of spaces adapted for the elders; and the improvement of the follow up and of the investigations related to populational aging⁽¹⁾.

Also, a part of the interviewees mentions the existence of legislation focused on the care for the elders. They, however, cannot describe them with clarity, even though they state to know the programs destined to this group of people.

I think I know... there are many programs, but I think it's not enough, little access, because there's no organization, the elder needs to be more valued, needs more follow up. (E5)

According to the managers, it was found that the legislation regarding attention to the elderly has not been efficiently applied. That is, partly, due to the fact that its content is not known, and to the traditional, centralized and segmented form of public policies, which favors the disarticulated superposition of programs and projects targeted at this populational group. This study indicates that the implementation of the National Health Policy for the Elderly must happen in the Primary Health Care (APS) to answer the growing needs of the elders, and contemplate their specificities. Whence the need for the managers to have domain over the theme, as they should make viable and systematize these and other policies in primary care, aiming to integrate the work of the network⁽³⁾. On the other hand, some subjects clearly admitted that they do not know the policies, or are not performing any specific actions focused on the elderly population.

I know little about... (E10)

With elders we're actually not working, elder policies, we still don't have that segment. (E9)

Even considering the unquestionable significance of the Statute of the Elders in the Brazilian legal framework, which establishes the directives of attention to the elders to prevent diseases and keep their health and autonomy, only two managers mentioned its existence. It must be highlighted that, even though, the Statute of the Elder was the only policy mentioned.

Routinely we've always tried to care more for the status, you know? We try to care, to pay specific attention to these cases. (E3)

We know that there's the statute of the elders, which involves many situations that are for the elder, but we are in this administration for two years. (E2)

When questioned about their knowledge regarding policies focused on the elders, many mentioned the actions developed in the prevention and control of chronic diseases, making it clear that they relate these activities to policies of care for the elderly. The managers confuse the domains "health promotion" and "disease prevention" with the monitoring of groups and specific morbidities⁽¹¹⁾.

Considering the hypertensive and diabetic, I consider that as a policy for elders, because let's think like: '95% of the hypertensive and diabetic are elders.' I understand it as a policy for chronic diseases, yeah, but it doesn't change that. (E4)

We have groups of elders, as we have other groups, of hypertensive, diabetic, and so, the coordination of the ESFs end up working in this policy for the elders. (E11)

Although most managers do not know the public policies of care for the elders and few know any fragments of them, it is evident that they are aware of the progressive populational aging, and express the responsibility that is due to the health sector.

We need to prepare, with the municipalities, to have many elders, build a team structure that's linked to the health of the elder, because in a few years we'll have much more elders than young people. We feel that the concerns about the elders are big. (E2)

The need to prepare and qualify the public managers, especially in health, to and for the issues involving aging, is notorious. A study shows that the perception of the manager is the perspective that permeates local health practices. Thus, it becomes necessary for the managers to be trained in the perspective of Health Promotion, and prepared to operationalize public policies, for them to provoke changes that positively impact in the quality of life of the population⁽¹¹⁾.

Culturally, the population is not used to looking for the health service as a measure to improve their well-being or prevent aggravations. Therefore, in order to effect health promotion actions that overcome the model that is in place, managers and a multiprofessional team need to be mobilized in order to direct their efforts to the field of elderly health.

Sometimes people say 'ah there's no money'. No! There is, but it has to be better invested, because you often end

up spending in things that aren't needed and don't bring anything good to the city. (E2)

Most participants mention monetary difficulties, as well as the existence of a certain distance between the municipality and the state. It becomes evident that the managers expect, from the Regional Health Coordination, training about the policies and the areas in which they should invest. They also expect, from other federal entities, funds to make the programs become financially viable. Thus, even aware of the populational aging and of the needs of health promotion actions, they are not convinced enough to financially invest in the area.

I think that we're still under a deficit, the connection is very far, from the city to the state. Always with the support of the state, but I see the difficulties of the state in getting to these regions. (E2)

We know that our values, the funds that come, are few, there's almost nothing for the elders. (E5)

Although they show concern with health promotion, the contents of the interview with most managers points to the supremacy of a biomedical health care model, since in their municipalities the collective actions are diminished, the focus is on chronic diseases and investments in individual actions are prioritized, among which are the payment of exams, specialized consultations, medication, hospitalizations, and the purchase of prosthetics and orthotics. It should be highlighted that these investments are expensive, and their results immediate and limited, since they only solve specific situations.

It's the welfare, we're known for accepting anything. The elder entered here, the problem wasn't solved, send him to do exams, or, if you have to refer to medium, high complexity, out of the SUS, we have an agreement, we authorize. (E8)

Even if the current model of health care prescribes the articulation of actions for health promotion and prevention, and for the treatment of diseases and rehabilitation, the hegemonic model in health institutions is still the biomedical. Health practices focus on the complaints of individuals and on the treatment of diseases. Therefore, the promotion of health is not a priority, work is fragmented, and hierarchic practices predominate⁽¹²⁾.

As to the inter-sectoral enabling of actions of health care for the elders, most managers mentioned that they have a greater connection to the Municipal Secretary of Social Ac-

tions (SMAS). This happens because the National Policy of Health Care for the Elder states, and the Statute of the Elders reinforces, that attention to the elder is a competence of the fields of social assistance (LOAS) and health (SUS). Thus, the systems must conduct the actions between themselves. The coordination of the service of health care to the elder in a network implies in the possibility of guaranteeing the continuity of attention in the service network, through integrative mechanisms, clinical management techniques, and instruments for communication among professionals⁽¹³⁾.

It can be noted that the health managers consider the SMAS to be the main responsible for the actions destined to the elderly population, in which cases the health secretariat would be a secondary figure.

It's more linked to social assistance, because they work more with the elders. So that part's on them, and we give support. (E1)

Several managers made it clear that the actions conducted by the SMAS are limited to activities that are considered entertainment - socialization and recreation -, and do not consider them to be part of the work in the health field. That makes clear that they do not relate these activities to health promotion, active aging and to the protection of autonomy.

There's a group of very organized elders here, but it's actually more like an entertainment thing. (E14)

It can be noted that the interviewed have little knowledge regarding the policies of health care for the elders. Even though they are aware of the increase of the elderly population, they are not prepared and mobilized to act in such a reality. The health care model is predominantly biomedical, and the knowledge of the elder, in many cases, is limited to actions of control of chronic disease, which, in most cases, are highly specific.

Attention to the elderly according to the words of the municipal managers of health

When inquiring the elders about the actions of care for the elders that take place in their municipalities, only one of them stated that the city had a Municipal Council for the Elders, an organ to formulate, organize and control the public policies and the actions targeted at the elderly population.

We have a Council of the Elders in the city, it's a policy that's not adequately... how can I put it... regulated, but it happens. (E4)

Regarding the assistance to the elders by the health services, most respondents mention that the elders are a priority in care, as indicates the Statute of the Elder⁽¹⁴⁾.

In face of the growing number of elderly people, it becomes necessary to reflect on how is it that this populational group is prioritized. That is due to the fact that most attendees of health institutions are elders, and therefore, this criterion will not be enough to adequately answer the demands. This situation is considered when the managers change the way to offer treatment, and instead of prioritizing start to evaluate the severity of the health condition of the user, that is, to work through admission and risk classification.

We don't have a policy that prioritizes the elder, our policy is to admit. So, the individual is admitted in the health unit according to a classification of the risk they're under. (E12)

Admitting elders in a health service is not merely taking them out of a queue, but to offer them a space where they can be listened to and cared for, ethically. The person who admits the elder assumes the responsibility to care for the other and his or her demands. Therefore, admittance is different from a simple triage, since it is inclusive, and does not end during reception, but happens in all places and moments inside the health service⁽¹⁵⁾. This implies professionals that listen and assume an empathetic, ethical and political posture, aiming to intervene with resolute actions to solve the demands of the users.

Concerning the actions targeted at the elders, those who care for chronic diseases, especially groups of hypertensive and diabetic, are prevalent. This is according to the Decree 371/2002 from the Ministry of Health, regarding the plan of reorganization of the care to arterial hypertension and diabetes mellitus, and the National Program of Pharmaceutical Assistance in Brazil, once it is destined to the entire population, including elders⁽¹⁶⁾.

Although education group activities might be questioned because, most of the times, they focus on the pathology, this is an important modality of intervention aiming at promoting active aging. In addition, it is necessary to adequately manage morbidities such as the systemic arterial hypertension and the diabetes mellitus, since they affect a high percentage of adults and elders, and their aggravations are expensive for both the patient and the health system.

The World Health Organization (WHO) points out that, in order to promote active aging, health institutions must see from the perspective of the course of one's life, aiming to promote health, prevent diseases, and offer an equal access to the primary and long term care. The policies and programs for health promotion that aim to prevent chronic

diseases and minimize the level of inability among elders contribute for them to live independently and autonomously for more time⁽¹⁷⁾. Through these perspectives it can be noted that such policies are according to the directives of the Unified Health System, the policy of health care for the elder and of the Pact for Health^(8,15).

The interviewed mentioned that they try to implement actions contained in the different programs and policies to the attention of the elder, but that those are not the ones with focus on this populational stratum, and the emphasis remains on arterial hypertension and diabetes mellitus:

Here I developed with the pharmacist the pharmaceutical assistance not to the elder, but to the hypertensive and diabetic, which I also consider as a policy for the elders. (E4)

We created groups which we call senior groups, which have meetings once a week, with a nurse and a teacher, and there they check the diabetes, pressure, do exercises, talk. (E13)

The findings allow to understand that the managers recognize the power of collective actions for education and health promotion, especially through the creation of groups. In these spaces, health professionals develop actions of health promotion and prevention, for those situations where a disease is already affecting the patient. Most chronic diseases that affect the elders, however, have their age as the main risk factor. Thus, several challenges need to be confronted, from the restructuring of primary health care, to the offer of care in the different services that compose the health network, the record of information in a clear and objective way, to outline viable goals of prevention and control for the main chronic diseases, and even to perform professional interventions with the elders, developing health promotion and prevention actions, including their family⁽¹⁸⁾.

Some managers know a group of actions that favor the preservation of the functional capabilities in elders and stimulate their realization, also acting together with the other municipal secretariats.

We have therapeutic workshops with guitar, music and dance classes, through the Municipal Secretariat and Social Assistance. Workshops of handcrafting, where elders also can participate. The last workshop that took place, and that has the participation of elders, involves informatics. So they have, through the secretariat of education, a music teacher and an aerobics teacher. (E3)

A practice that is not recommended, but is still used in some municipalities, is that of inserting the elders and

requiring their participation in groups of health education, so that they can obtain the medications that the Unified Health System offers them.

People who do not participate in the group, do not get the medication. So, even the diabetics, we offer the HGT, but if they don't go to the group, they don't get the HGT. Of course, this is a way to negotiate, to have them in our hands. But the participation is really good, we even take there together the medication of the hypertensive, diabetics, all the prescriptions, the people who go to the group take everything ready. (E14)

This type of imposition denies the production of attention guided by the recognition of the individual, the person and the subject, to which the overcoming of a biomedical model contributes. It is recognized that the individual has rights, in this case, regarding the therapy with medication. When a person is recognized, they are more valued by their belonging to an *ethos*, to a culture, to a group that defines the meaning of "I", and in this perspective, of disease and of the search or lack thereof for alternative therapies. The notion of subject refers to the ethical discourse of autonomy, of choices and decisions. Thus the importance of the reflection regarding who enjoys the status of person and of subject in the care offered by health services, as well as the relevance of the questions regarding the points of authority and autonomy of the different actors involved in the production of care, as well as the margins and mechanisms of negotiation and expansion of these borders⁽¹⁹⁾.

Therefore, linking actions of health promotion with health prevention is a continuous task, full of challenges. The socialization in the groups of old age is an important space to trigger, both in the elders and in their community, a change in the mentality that enables the insertion and strengthening of the social role of the elder, and also minimizes the environmental or personal risks that can predispose them to diseases.

Among the municipalities studied, four managers stated to have a health team linked to the Center for the Support of Family Health (NASF). This support has been presented as an important way to operationalize actions of health promotion, to amplify and strengthen the actions developed in the primary health care.

We have an academy with the teacher from NASF. (E1)

With the NASF agreement we managed to hire a nutritionist, who helped us a lot. Because that's a difficulty many cities have: hiring. (E2)

It stands out that primary health care needs more investment in actions and in the definition of the criteria of caring for the elder population, allowing for equal access, interventions in the specific demands of these clients, and professional training, whilst it is understood that this type of care delineates the path of these individuals in the different levels of health care⁽²⁰⁾.

Still, as a part of the programs and policies of elderly health care, it can be noted that four of the managers mentioned that, in their municipalities, there are Long Permanence Institutions for Elders. Among these, one is public and four are philanthropic, although all of them receive municipal investments. The participants recognize that these institutions are important, and a responsibility of the Municipal Secretariat of Health.

In the city there's a home for the elderly, the municipality itself directs some of the budget to this institution, and makes available the diapers that are used in the institution. The follow up with the elders in the institution is conducted by the health unit. We are the ones who offer medication, not to mention all the assistance, psychologists, social assistants, physical therapy, everything necessary, the city offers attention in the institution that shelters the elders who are in a situation of social vulnerability. Because of that, the municipality also contributes financially, to help maintaining this institution. (E12)

In face of what was found in this category, it is clear that public policies of health care to elders are restrict, due to the lack of efficiency of the managing and administrative organs, not to mention the lack of training of professionals and assistance sectors to answer the needs of this group of people.

FINAL CONSIDERATIONS

The actions for the health care of the elders in the municipalities studied are not systematized and there is little articulation between the sectors. Possibly, this is because the elders and the interviewees do not know, at least in part, the existent policies of care for the elder population.

It is understood that these actions of care for the population, especially to the elders, must be intersectoral, involving different professionals. The study shows that health actions for this group of people are restricted to the control and prevention of the worsening of chronic diseases, and do not aim to tie together the dimensions of physical and mental health, functionality, social interaction and socio-economic aspects.

In this context, it can be found that the municipal health managers have a limited knowledge regarding the policies of health care for the elders, as they are not aware of the specificities that characterize the elderly and do not operate as to qualify their actions to give responses to the demands of the aging population.

The limitations of this study are related to the participants, since the only ones listened to were managers linked to the health secretariat of municipalities in a health region. Therefore, it is suggested that other investigations be conducted approaching the same subject, but giving a voice to managers from other areas or sectors of society that act together with the elderly population. Also, it is necessary to listen to the elders, and get to know how they understand and experience public policies of elder health care in their municipalities.

The contribution of this work is focused on the advance of discussions regarding public policies directed at the elderly, in the words of managers. It can be considered that such a debate favors the identification of how this takes place in the day-to-day practice of municipalities, and allows for the sharing of strategies of intervention that can be operationalized in the different spaces of elderly health care.

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