ABSTRACT
Objective: to reflect on the care of the caregiver of elderly with dementia in the light of the National Policy for Health Care of the Elderly and the current legislation. Method: this is a reflection developed from the care of the caregiver of elderly with dementia and National Policy for Health Care of the Elderly, in which this care is built daily. Results: the challenges that caregivers face in their daily life take a reflection around their family and themselves were presented, articulating such issues with the policies. It is also discussed, from the economic impact of the care of elderly with dementia, the need to establish support networks. Conclusion: it was observed that the implementation of policies and relevant legislation presents advances to establish a network of care for the elderly, but does not include in its guidelines support to the family that takes care of the elderly with dementia. Descriptors: Caregiver; Elderly; Dementia; Health Policy.

RESUMO
Objetivo: reflexão acerca do cuidado com o cuidador de idoso com demência à luz das diretrizes da Política Nacional de Atenção à Saúde do Idoso e da legislação pertinente. Método: trata-se de uma reflexão desenvolvida a partir do cuidado com o cuidador de idoso com demência e da Política de Atenção à Saúde do Idoso, na qual este cuidado se constrói cotidianamente. Resultados: apresentaram-se os desafios que o cuidador enfrenta em seu cotidiano para cuidar do seu familiar e de si mesmo, articulando tais questões com as políticas. Discutiu-se ainda, a partir do impacto econômico do cuidado do idoso com demência, a necessidade de estabelecimento de redes de suporte. Conclusão: observou-se que a implementação das políticas e legislação pertinente apresenta avanços para estabelecer uma rede de atenção ao idoso, no entanto, não contempla em suas diretrizes o suporte à família que assume o cuidado do idoso com demência. Descriptores: Cuidador; Idoso; Demência; Política de Saúde.

CAREGIVER OF ELDERLY WITH DEMENTIA AND HEALTH CARE POLITICS OF ELDERLY
O CUIDADOR DE IDOSO COM DEMÊNCIA E A POLÍTICA DE ATENÇÃO À SAÚDE DO IDOSO EL CUIDADOR DE ANCIANO CON DEMENCIA Y LA POLÍTICA DE ATENCIÓN A LA SALUD DEL ANCIANO

ABSTRACT
Objective: to reflect on the care of the caregiver of elderly with dementia in the light of the National Policy for Health Care of the Elderly and the current legislation. Method: this is a reflection developed from the care of the caregiver of elderly with dementia and National Policy for Health Care of the Elderly, in which this care is built daily. Results: the challenges that caregivers face in their daily life take a reflection around their family and themselves were presented, articulating such issues with the policies. It is also discussed, from the economic impact of the care of elderly with dementia, the need to establish support networks. Conclusion: it was observed that the implementation of policies and relevant legislation presents advances to establish a network of care for the elderly, but does not include in its guidelines support to the family that takes care of the elderly with dementia. Descriptors: Caregiver; Elderly; Dementia; Health Policy.

RESUMO
Objetivo: reflexionar sobre el cuidado con el cuidador de anciano con demencia a la luz de las directrices de la Política Nacional de Atención de la Salud del Anciano y de la legislación pertinente. Método: se trata de una reflexión desarrollada a partir de la atención con el cuidador de anciano con demencia y de la Política de Atención a la Salud del Anciano, en que la atención se construye diariamente. Resultados: se presentaran los desafíos que el cuidador enfrenta en su vida diaria para cuidar de su pariente y de sí mismo, articulando tales cuestiones con las políticas. También se discute, desde el impacto económico del cuidado de anciano con demencia, la necesidad de establecer redes de apoyo. Conclusión: se observó que la aplicación de las políticas y la legislación pertinente presenta avances para establecer una red de atención a las personas mayores, sin embargo, no incluye en sus directrices de apoyo a la familia que cuida del anciano con demencia. Descriptores: Cuidador; Anciano; Demencia; Política de Salud.

1Nurse, Master Professor, PhD Student at School of Nursing, State University of Rio de Janeiro/UERJ. Rio de Janeiro (RJ), Brazil. E-mail: profmirianlindolpho@yahoo.com.br; 2Nurse, PhD Professor, School of Nursing, State University of Rio de Janeiro/UERJ. Rio de Janeiro (RJ), Brazil. E-mail: celpcaldas@gmail.com; 3Nurse, PhD Professor, School of Nursing, State University of Rio de Janeiro/UERJ. Rio de Janeiro (RJ), Brazil. E-mail: soniacioli@gmail.com; 4Nurse, PhD Professor, School of Nursing, State University of Rio de Janeiro/UERJ. Rio de Janeiro (RJ), Brazil. E-mail: omcvargens@uol.com.br.
INTRODUCTION

The world population aging has brought significant changes to society, requiring establishment of actions so that quality of life is maintained to this population. In order to meet the aging social demand, the following official documents were established: the National Policy for the Elderly, the National Policy for Health Care of the Elderly and the Statute of the Elderly.1,2 And the model of home care is based in these policies and the Statute, but, in their context, it is observed that these policies and the Statute reinforce the importance of family to bear social responsibilities in relation to aging.3 With this approach, the caregiver figure emerges with relevant role in the success of these guidelines, especially in caring for the elderly with dementia.

Dementia is a progressive neurodegenerative process, that leads to behavioral and cognitive changes.4 The person gradually loses their autonomy and independence, needing help to perform their care - a caregiver.

The caregiver is responsible for physical support - personal care, food, hygiene, safety and identification of signs and symptoms of illness, also seeks to take care of the psychological aspect of the elderly with dementia. Their care is direct and continuous, day and night. As the disease in the elderly progresses, caregiver’s responsibilities increase. With executive limitations, besides assuming the Activities of Daily Living (ADL), they must also perform the Instrumental Activities of Daily Living (IADL), such as medications, finances, and the care of their own lives. This provides an excess of activities and emotional overload that may trigger some diseases.5

The caregivers of elderly with dementia are more likely to develop psychiatric symptoms, health problems, and problems in family relationships and at work more frequently. They may have physical, social and financial, emotional and psychological problems, the most common are: high blood pressure, digestive, respiratory problems; inclination to infections, anxiety, insomnia and depression.5

With the possibility of occurrence of problems that affect physical and emotional aspects, strategies to minimize this overhead can constitute an alternative. Study indicates that the support from the social networks in society must become concrete to the caregiver of the elderly with dementia.6 This is a broad issue, since just as there is a strategic plan for the elderly, the caregiver also requires specific attention, due to the impact of this care in their lives.

OBJECTIVE

- To reflect on the care of the caregiver of elderly with dementia in the light of the National Policy for Health Care of the Elderly and the relevant legislation.

METHOD

It is a reflection about the care of the caregiver of an elderly with dementia, articulated the National Policy for the Elderly, the relevant legislation and from the economic impact of care for the elderly with dementia. Thus, this methodological approach allowed some considerations on the subject, in a move that tells about the legislation, articles published on the issue and gaps on caring for the caregiver of elderly with dementia.

RESULTS AND DISCUSSION

- Who are these caregivers and how are they?

The caregiver can be defined as a person, member or not of the family, who cares for the sick or dependent elderly in their daily activities, such as eating, hygiene, and other services required in daily life, by the National Policy for Health Care of the Elderly.1

Caregivers can be classified as informal and formal. The informal caregiver may be a family member or close friend who helps this old person, part time or full time, in their difficulties in performing activities of daily life; and the caregiver is a person hired to perform this care.7

Caring for someone, especially a person with dementia, is a stressful situation and its effects may be greater on the primary (or main) caregiver. As the disease progresses, the primary caregiver becomes increasingly overloaded and, consequently, the degree of difficulty to deal with the problem increases.8

This care generates on the caregiver, especially if female, backlog and overload in the physical, emotional, spiritual domains, which contributes to self-care deficit and, hence, jeopardizing general health.3

The hours of care, kinship and living with dementia carrier can also bring impact to the caregiver. Caring for a dependent elderly brings varied consequences, side effects and it is still recognized the existence of an emotional impact experienced by families. The emotional impact is characterized by several situations such as physical, psychological or emotional, social and...
financial problems. Thus, caregivers of elderly with suffer greater impact in relation to other types of caregivers. The quality of the caregiver's life will be reflected directly in the care that is provided to the elderly and, therefore, should be considered in the planning and implementation of assistance to the elderly with Alzheimer's Dementia.

These caregivers consult 46% more doctors, using more psychotropic medications - antidepressants and antipsychotics, worsening physical health and a loss in the immune system that can persist for more than four years after the death of the elderly. High rates of depression in caregivers of patients with dementia are recorded and documented in studies, reaching about 30% to 55% of caregivers, having, thus, their risk of developing the disease two to three times higher than the population in general. Therefore a close look from the multidisciplinary team to family caregivers of seniors with Alzheimer's is necessary. This is required in face of situations experienced and the implications arisen from the care to elderly patients with dementia. The situations generated by this care can contribute to psychiatric and physical illnesses of caregivers and increase the risk of death.

Findings recorded in the cited studies point to compromising consequences for the life of the caregiver of elderly with dementia and for the life of the elderly. And in these same studies we can identify the weaknesses to which they are exposed and, therefore, it is possible to draw attention to care plans for these subjects. When envisioning this scenario, it is observed that the caregiver is subjected to a chain reaction that will deepen gradually, with consequences that can exceed the lifetime of the elderly or even shorten the caregiver's lifetime, leaving the elderly entirely under State care, when that caregiver is solely responsible for the elderly with dementia.

There is need, then, of a support structure that goes along with care for the elderly with dementia, that works, is effective and comprehensive as regards the extent of the country, since the demands are consistent, and that compromises the functionality of the caregiver, making them as one more to be cared by the State. This type of work requires physical and professional structure, mainly because of sensitivity needed by who will care for caregivers, to realize in-between situations that they experience and the ability to intervene before the problem itself reach large proportions.

**Policies and the impact of dementia on caregiver family**

In 1994, the Law No. 8842 was approved on the National Policy for the Elderly, whose purpose was to promote healthy aging, maintenance and improvement of functional capacity, disease prevention, health recovery of those sick and rehabilitation of those who had their functional capacity impaired, to ensure them to stay in the environment where they live, acting their functions independently in society.

With this law, the establishment of the policies to the health of the elderly has started, since their expenditure brings much burden to the State with hospital medical treatments and so, in its writing mode, it can be understood that it directs the care of the elderly at home “... in order to guarantee them to remain in the environment they live in, ...”. This direction within the law comes after citation of rehabilitation of those who had their functional capacity impaired. Generally, those who have their functional capacity impaired have limitations that can be anything from a small degree or even complete dependence. Here there is a space for discussion of the types of dependence. If the law is not specific about the type of dependence, it is understood that any type of dependence will be under the responsibility of the family?

Therefore, the responsibility is passed on to the families, without warranty of any kind of support. How will the families sustain the care of a dependent elderly, if the synthesis of social indicators points out that “Just under 12.0% lived with a per capita household income of up to ½ minimum wage and about 66% were already retired”, if they have a low income? Similarly, it was registered that “higher levels of income allow acquisition of better monitoring services, support equipment and a more active social inclusion”. These data point to the helplessness that this clientele lives and if we think in terms of possibilities for change, rationally they are nonexistent, if the life cycle is observed.

This summary also states that there is a significant number of elderly (32.5%) whose homes were still not registered in the Family Health Program, neither had private health insurance. This situation of lack of protection does not change until the per capita household income of at most 2 minimum wages, amounting to two thirds of elderly without any public health coverage, by the program, or private, via medical insurance. If for these families, the health needs are managed by the current...
Family Health Strategy, is there any other way of support, if they were not yet reached by Strategy?

The last record of the synthesis of social indicators does not point very specifically to the situation of helplessness of the elderly as the previous one, but it still leaves recorded that “the poorest families have less access to health insurance and this situation can also be reflecting needs of coverage by Health System in these services”.13,222

To consolidate and facilitate the implementation of Law 8842, in 2002, it was proposed the organization and the implementation of State Networks for Health Care of the Elderly, based on the conditions of management and the division of responsibilities set by the Operational Norm of Healthcare.14 Reference Centers for Care to the Elderly were also created. Thus, these Reference Centers consist of a hospital that has the technical and physical facilities, equipment and adequate human resources to provide health care to the elderly.14 However, ten years went by and these networks have not yet reached the country, staying existent only in limited points.

It is up to Reference Centers to provide assistance to the elderly in the following ways: promotion of healthy aging; maintenance of autonomy and functional capacity; assistance to the health needs of the elderly; rehabilitation of the affected functional capacity and support the development of informal care. Reference Centers are also responsible for hospitalizations with 10% of general beds reserved, thus consisting the geriatric bed, that must be adequately adapted for this purpose.14

In an attempt to operationalize the actions in the area of attention for Elderly Care in Reference Centers, the SASMS Order no. 249 of April 12, 2002 approved the rules for the registration of Reference Centers for Health Care to the Elderly, in Article 1, it is established Home Care I in three modes: Short (30 days), Medium (31 to 60 days) and long-stay (attended for more than 60 days).15 This measure may provide welfare for one who was hospitalized away from their environment, experiencing institutional norms. Above all, it is a way to keep vacant beds and balance State expenditure.

The implementation of home care by the Unified Health System (Household Inpatient Program · HIP) has already been occurring and have been gaining a good acceptance of families that realize the concern of the Family Strategy team with the family itself.16 Comments are made about some difficulties concerning its operation: the HIP relationship with the Basic Health Units (BHU) is restricted to provision of care and material resources. For the reference and counterreference center is effective and efficient, it is necessary to build partnerships between public and private institutions.16 This means that the State alone cannot reach its goal. It is understood that this issue has great complexity, but when it reaches its peak, the Brazilian population will benefit.

One of the ways of Reference Centers to maintain the continued care of the elderly who was hospitalized and discharged is to be articulated with teams of Primary Care and Family Health Programs, where they are deployed.16 For this, the interlacing of health services needs to take place, not only on paper, but more effectively in care practice. And this situation has already been identified as a gap in assistance.8 But is this issue a misfortune? And how can this gap become a solution?

In Brazil, there are 74 reference centers, of these, 17 were registered to assist Alzheimer's dementia sufferers.16 The diagnosis, treatment and monitoring of patients with Alzheimer's disease should be given in Reference Centres for Health Care of the Elderly, defined by Ordinance GM/MS No. 702 and Ordinance SAS/MS No. 249, both of April 2002.16,15 It is interesting to note that the ordinance specifies the care protocol for the elderly with Alzheimer's disease by the Reference Center with its guidelines, but how do the elderly access the Reference Centers? By routing of the Municipal Health Centers, or the Family Health Strategy. Thus, this system of reference and counterreference needs to act fluently, as the continuous flow of a river that flows into the sea without dams augmenting the water level.

Of these 17 reference centers, 11 are university hospitals. Thus, it is expected a feedback in terms of experience reports on the operation of centers or research, since this is one of the functions of the University. On this issue, in a study, the interviewees’ speeches revealed a change in representations of old age as a result of creating social groups, the universities turning to the elderly, promoting redefinition of values, attitudes and behaviors.17 It is noticed that the proposal has good results when implemented, as can also be seen in a study on Day Center that it was configured as an important factor in the process of improving the quality of life of the family caregiver-dependent elderly binomial.18 But universities are usually located in big...
cities and it will become better when all urban and rural areas are reached. In other words, these actions are not yet proportional to the number of elderly population and incipient to the problems arisen by aging, since they consist of presentation of isolated cases.

Another action directed to the elderly was approved by Congress and the President - the Statute of the Elderly - which aims to promote social inclusion and ensure the rights of these citizens, but does not bring means to finance the proposed actions. In contrast, there are thoughts that reflect on these protective nuances and rely on the Constitution to argue that everybody has the same right to protection regardless of their age, giving differential treatment when the Constitution has its origin in equality. In other words, if this principle was followed, there would be no need for construction of other laws to safeguard it. In complementarity, references are made to the Statute of the Elderly, commenting that it contains the division of responsibilities with the elderly: family, society and the State, but role of the State is indispensable to the full realization of these guarantees through welfare policies.

So, since professionals who assist the elderly observe the difficulties of implementing these policies, the very National Health Policy for the Elderly, Ordinance No. 2528 of 19 October 2006, identifies its challenges, such as: the lack of qualified support structure for the elderly and their families to promote safe intermediation between the hospital discharge and going home; insufficient number of home care services to frail elderly provided for in the Statute of the Elderly and this poses the family as direct executor of this care, with the basic attention to the Family Strategy as a fundamental support. From what is recorded in the legislation, the State is the one that has in its hands the power to enforce the law and it is the one who experiences the difficulties of implementation and poor infrastructure of institutions. How then, can this issue be solved? Since life is a greater good, political ideals must not overwhelm the essential needs.

It is precisely in the passage of law that mentions “… in order to guarantee them…” that there is a bias. This structure depends on the structure of society as a whole, not only on the orientation and family training for care, but in the supply of trained professionals in elderly care and services that can assist them, referring, thus, to a change in the structure of health services, in terms of human resources and infrastructure.

The Interministerial Ordinance MPAS/MS No. 5153 of April 7, 1999 established the National Program for Caregivers of Seniors from the need to create alternatives that provide quality of life for older people, with comprehensive care to the elderly and the family in order to facilitate the institutionalization and training of human resources in the care of them. In an attempt to meet the demands of the needs of the elderly, provided by the growth of elderly population, it was then established the caregiver profession, through the Senate Project of Law 284/2011, with the rapporteur Senator Marta Suplicy. In the opinion of the report, it was expressed the Commission's wish that also the elderly care service is accessible to all aged people, of all walks of life, and not transforming the profession in a luxury for few.

In the original text of the Law Project 284/2011, in Article 1, the caregiver is defined as a professional who, in the home environment of elderly or long-term care facility, performs the following functions: providing emotional support and social life to the elderly; assistance in conducting and monitoring routines of personal and environmental hygiene and nutrition for the elderly; preventive health care, routine drug delivery and other medical procedures; assistance and monitoring in the elderly displacement.

But, is not observed in the Law Project a specification on, for example, what the routine medication is, which the caregiver will manage for the elderly. Insulin can be a routine medication for the elderly, but it needs a preparation and administration technique, and that this is nurses’ domain.

The profession of elderly caregiver may be exercised by a person over 18 years that has completed primary school and has completed with success the caregiver course. This profession can be exercised at home, residence for the elderly and care institution. There is also a concern in being a cheap professional for the healthcare institutions (nursing homes).

To move forward on the issue, it is relevant to put the elderly with dementia as a person who will be totally dependent on the care of a caregiver - family and, especially, with the expenses provided by the disease. Regarding global spending with dementia, one Swedish group, (Karolinska Institute) attempted to estimate global costs, these are estimated at around 315 billion dollars, of which 227 000
million (72%) were financed by higher income countries and 88 billion (28%) for low- and middle-income countries.\textsuperscript{24}

In the same study, what arouses the attention was that informal care are mostly used by less developed countries, where there are no formal elderly care services, which is the experience in Brazil. In low-income countries, informal care represent 56%, in middle-income countries, 42%, and in high-income countries, spending on informal care consist of 31%.\textsuperscript{25} There is an inversion, those most in need should get more, but in reality, it is the one who is most burdened in care of elderly with dementia.\textsuperscript{24} The Census has shown that there is a quantity of seniors who are not covered by the assistance of the Family Health Strategy, thereby strengthening the helplessness of the elderly with dementia and those who care of this elderly.\textsuperscript{13}

The annual expenditure for people with dementia is related to the income of the country. Thus, the higher the income, the higher the investment; the smaller the income, the less the country will dispense for this service. So, in developed countries, the investment is estimated at up to $4,588, while in low-income countries is up to $1,521.\textsuperscript{25} Study in Brazil shows that families spend 66% of their income on care for the demented elderly. And this spending differs depending on the stage of the disease, at the beginning it can reach 75%, and in a more advanced stage, 62%. This spending reaches higher values if the elderly with dementia have other comorbidities such as diabetes and hypertension. The high costs are justified by the growing need for care required by elderly patients with dementia associated with these diseases.\textsuperscript{26}

What we notice is that the family assumes all responsibility for the demented elderly. The home care is the responsibility of a single member, the family caregiver. This care burdens the caregiver and there is no recognition of their actions to the elderly and lack of formal support and the family support itself. These are some situations that generate large overhead to family caregiver, directly affecting their physical, mental and social health. It is understood that there is thus a burden on the caregiver and that this framework can compromise the quality of care provided to the elderly at home.\textsuperscript{3}

These demands could be met by the existence of a care network and, for many people this would be the only resource available to offer relief from daily overload experienced by the caregiver of the elderly.\textsuperscript{6}

The caregiver of elderly with dementia needs an effective social support so that they are not overloaded, thus setting another burden for the Health System. In Brazil, social support structures are still fragile and do not constitute an organized support network.\textsuperscript{27} It is observed that the monitoring of the growth of the elderly population by public policy is difficult. This difficulty is reflected in the distribution of responsibilities for dependent elderly people, whose family members take like an individual problem, when they should have the State support.\textsuperscript{3}

Study highlights the possibility of increased health spending on the elderly.\textsuperscript{26} It points to three factors that may contribute to the increase of the elderly population: the strong growth in the number of elderly people, considering their weaknesses, the progress of diseases, despite preventive measures and improved care practices; female status change will also affect the availability of family support for the elderly; and projections of seniors who will be cared by non-family (formal) caregivers will double by 2020 and will be 5 times higher in 2040 compared to 2008. It is highlighted further that the current model of health care for the elderly is expensive and not efficient, requiring creative and innovative structure.

It is noticed that there is an incipient legislation practice in the care of the elderly and that, despite its limitations, it provided benefits to over 18 million elderly people in the country, representing approximately 10.5% of the population.\textsuperscript{28} And this perception is not restricted only to researchers, but to professionals who perform this service and the population receiving and experiencing the limitations of policies.

The Policy for Health Care of the Elderly, in the body of its text, is broad and complex by the need for a restructuring of the whole society for its implementation. But there is in it only a recommendation that the caregiver receives special care because it is an exhausting task, and it is not described a specific attention to the elderly caregiver.\textsuperscript{29} Scientific studies on the caregiver for the elderly point to overloads and diseases to which they are subject. It is important also that there is a protocol care to caregivers of elders. But, can someone think that, in politics, this service to the caregiver is in secret; that the caregiver is most often is senior, also? But if the existence of the policy, which consists of a higher law to senior care, is no guarantee assistance, a call in secret to the caregiver, will they get what they need?
Health services will also increase their spending on the disease of this family member. It then becomes necessary a target of attention to caregivers, investment in human resources and infrastructure in care for the elderly with dementia and their caregivers also.

The World Health Organization and the Pan American Organization built a health care model, entitled Health Care for the Elderly - conceptual aspects, which addresses the conceptual aspects and also describes a model of care for the elderly. In this material, eight clinic interventions are proposed for geriatric care: Multidimensional Assessment, Action planning, Supported Self-Care, Monitoring, Motivational Strategies, Transitional Care, Education and support to the family, Community Resources (implementation of guided care). This proposal is in line with the System of Health policies and the health care for the elderly.

It is still observed in this document that it has a chapter on contextual factors such as socio-familial evaluation, the caregiver and the environment evaluation. About caregiver assessment item, what stands out is the realistic way that the caregiver issues are addressed, concerning the physical, emotional, financial conditions, which are also usually elderly, female, fragile, but do not point a strategy of care for them, limited only to an assessment.

It can be realized, therefore, fragmentation and discontinuity of care for this caregiver that, in most cases, is also a senior citizen. It is worth reflecting that the construction of this document is guided by a different reality from ours, and it is important that, for application in Brazil, an adjustment to the national reality is made.

Another point to be discussed concerns the training of professionals to serve seniors and caregivers. There is a need for knowledge of the subjects of geriatrics and gerontology, also there is a need of sensitivity and ability to listen toward this elderly clientele, due to the difficulties of aging that can provide social isolation, loneliness, difficulties in family relationships and living with diseases. This sensitivity is also needed toward caregivers who feel constrained in their lives, responsible for the care of their family member, overwhelmed and with no options of support.

When contemplating the existing laws and articles read, in a motion of distance and approach, thus have allowed reflecting that: this caregiver is also old aged, and if he is a senior, is not he also supported by the current legislation? On the other hand, we may ask: if the laws were made only to stand as a project, a dream, or as that which will reflect a characteristic of enforcing a nation committed to its greater purpose? We judge that the legislation was designed to really provide benefits and ensure compliance, but the acceptance of non-completion of its goals, is not only pitiful, but it makes us consider the situation of helplessness that one that depends on it lives.

**CONCLUSION**

The caregiver of elderly with dementia does not have support networks to minimize overhead and facilitate the care. It can be identified that, even with a limited population-wide, the National Policy for Health Care of the Elderly provides benefits and can even change the social representation of aging.

Through the studies, we identified the problems of the caregiver of elderly with dementia and thus representing a way of building guidelines for the care of the caregiver and for the implementation of such a complete and complex policy. Many changes in social contexts, structural and professional training will be required, however, a question still remains: why does it still represent a project to devise?

**REFERENCES**


Caregiver of elderly with dementia and health…

Lindolpho MC, Acíoli S, Vargens OMC et al.


DOI: 10.5205/reuol.6679-58323-1-ED.0811201425

ISSN: 1981-8963

J Nurs UFPE on line., Recife, 8(12):4381-90, Dec., 2014

4389
Lindolpho MC, Acioli S, Vargens OMC et al.

Submission: 2014/06/21
Accepted: 2014/11/09
Publishing: 2014/12/01

Corresponding Address
Mirian Da Costa Lindolpho
Departamento de fundamentos de Enfermagem e Administração
Escola de Enfermagem Aurora de Affonso Costa
Universidade Federal Fluminense
Rua Dr. Celestino, 74 / 4º andar / sala 41
Bairro Centro
CEP 24020-091 – Niterói (RJ), Brazil