DESCRIPTIÓN DA REDE DE ATENDIMENTO AO IDOSO SOB O ENFOQUE DA INTEGRALIDADE

RESUMO

Objetivo: compreender a assistência de enfermagem ao idoso considerando os sistemas de referência e contrarreferência nos serviços de saúde. Método: estudo exploratório-descritivo realizado com 10 enfermeiros gerentes de serviços da rede de atenção à saúde em um município da Zona Norte do Ceará, Brasil. A produção de dados ocorreu por meio de entrevistas, submetidas à Análise do Conteúdo. O estudo foi aprovado pelo Comitê de Ética em Pesquisa da Universidade Estadual Vale do Acaráu (UVA), sob o Certificado de Apresentação para Apreciação Ética (CAAE) n. 0058.0.039.000-10. Resultados: na atenção primária, as ações em saúde do idoso são programáticas. No nível secundário, as ações são de cunho mais gerencial. E no nível terciário há uma lógica de assistência ao idoso por prioridades e especialidades, dissociada dos demais níveis de atenção à saúde. Conclusão: foram constatadas deficiências na rede de atendimento ao idoso.

Descritores: Idosos; Assistência de Enfermagem; Assistência Integral à Saúde.

ABSTRACT

Objective: to understand elderly nursing care considering the referral and counter-referral systems in health services. Method: exploratory and descriptive study conducted with 10 nurse managers of services within the health care network in a municipality in the North Zone of Ceará, Brazil. Data production took place through interviews, which underwent Content Analysis. The study was approved by the Research Ethics Committee of the State University Acaraú Valley (UVA), under the Certificate of Submission for Ethical Appraisal (CAAE) 0058.0.039.000-10. Results: at primary care, actions in elderly care are programmatic. At the secondary level, actions have a rather managerial nature. And at the tertiary level there is a rationale of elderly care by priorities and specializations, dissociated from the other health care levels. Conclusion: weaknesses were found out in the elderly care network. Descriptors: Elderly; Nursing Care; Comprehensive Health Care.

RESUMEN

Objetivo: comprender la atención de enfermería al anciano considerando los sistemas de referencia y contra referencia en los servicios de salud. Método: estudio exploratorio y descriptivo realizado con 10 enfermeros gerentes de servicios de la red de atención de salud en un municipio de la Zona Norte del Ceará, Brasil. La producción de datos se realizó a través de entrevistas, sometidas al Análisis del Contenido. El estudio fue aprobado por el Comité de Ética en Investigación de la Universidad Estatal Valle del Acaráu (UVA), bajo el Certificado de Sumisión para Evaluación Ética (CAAE) 0058.0.039.000-10. Resultados: en la atención primaria, las acciones en salud del anciano son programáticas. En el nivel secundario, las acciones tienen un carácter más gerencial. Y en el nivel terciario hay una lógica de atención al anciano por prioridades y especialidades, dissociada de los otros niveles de atención a salud. Conclusión: se encontraron deficiencias en la red de atención al anciano. Descriptores: Ancianos; Atención de Enfermería; Atención Integral de Salud.

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INTRODUCTION

The research problem involving this research evokes the health service aimed at the elderly as a key issue. Aging is characterized by the increased proportion of elderly population since 60 years of age. An indicator of this process is the aging index, which is the ratio between the population over 60 years and that under 15 years multiplied by 100.1

The impact of this process may be evidenced by an increase in this index: in 1991 it was 21.0%; in 1996, 25.0%; in 2000, 28.9%; and in 2005, 33.9%. Within 15 years, we came from the category intermediate country in the population aging process to that of aged country, whose ratio is above 30%. The percentage of elderly people in 2009 was 9.9%, ranking Brazil as the 79th most aged country in the world.3

The demographic transition process in Brazil has begun due to the introduction of new technologies, such as vaccines, antibiotics, and medicines, representing, between the decades 1940 and 1960, a significant decline in mortality. In addition to this factor, in the late 1960s there was a reduction in fertility, first initiated in the most privileged populations and in more developed regions. This fact has triggered a reduction in the young age group, characterizing what is named aging from the base.3

Aging provides significant changes within health, where an epidemiological transition has set up with vigor: progressive, dynamic, and irreversible. It is characterized by decreased functional body reserves and biological changes, this is a period of intense psychological and social changes. This leads to a need for support from family members, caregivers, and health professionals, due to the great weakness it can cause the subject.4

Comprehensiveness, as organization and connection between the services, sets up in order to have a system that is interconnected at all complexity levels. Thus, it is understood as a network of services that works to enable access conditions and solves the problems faced and the risks affecting the population’s quality of life.5

Regarding protection for the health of a human being who gets older, the principle of comprehensiveness stands out. An elderly person is a complex human being due to the functional, anatomical, social, and psychological changes coming along with the aging process. So, including the elderly in the agenda of the Brazilian National Health System (SUS) is required in order to adapt to the new profile of health needs among this population.

Organizing services into a network, in order to establish comprehensiveness, enables access for the elderly at the various health care levels, tending to reverse the characteristic of a disconnected system, a discontinued provision of care for the elderly, fragmented and driven by the inertia observed in services. Thus, the following question arises: “How is set up the nursing care provided for the elderly at the various health care levels in the municipality under study?”. To answer such a question, this study aims to:

● Understand the nursing care provided for the elderly at the various health care levels.

METHOD

This is an exploratory and descriptive study, with a qualitative approach, whose scenarios were the local levels of health care: primary care, secondary care, and tertiary care. The subjects were 10 nurse managers, 6 from primary care, 1 from secondary care, and 3 from tertiary care. Its inclusion criteria were working as a nurse and service manager, besides agreeing with the research proposal by signing the free and informed consent term. To preserve secrecy, respondents were designated by the letter “R” and numbered according to the sequence of interviews: R1 to R10.

Information were produced, within the period from March to May 2011, by means of a semi-structured interview with the following questions: “How does nursing care for the elderly work in this service?”; “In which cases does referral occur?”; “Under which circumstances does referral occur?”; “Is there counter-referral?”; “Under which circumstances does counter-referral occur?”; “How do you rate the efficiency of referral and counter-referral services for the elderly in the municipality?”. The information were fully transcribed and analyzed by using the thematic Content Analysis technique as proposed by Minayo6, a Content Analysis mode (AC). To do this, the following steps were taken: 1) Phase previous to approaching the material or fluctuating readings of the corpus of interviews; 2) Selection of units of analysis (or units of meaning); and, 3) Categorization and sub-categorization process.

This study was approved by the Research Ethics Committee of the State University Acaraú Valley (UVA), under the Certificate of
Nurses’ speeches have provided information portraying elderly nursing care at the various health care levels. Data were grouped and categorized by making content in subjects' responses alike, with the emergence of three categories: Health promotion groups - a strategy at the primary care level; Elderly secondary care - reflecting the specialties; Elderly tertiary care and the disconnected network.

- Health promotion groups: a strategy at the primary care level

The collected information allowed understanding some aspects of elderly nursing care, outlining characteristics inherent to each care level. At the primary level, we notice a care particularly aimed at the health promotion groups (HPGs), which work as strategies that help in the treatment of chronic non-communicable diseases (CNCDs), besides working as entertainment.

So, we have the walking group, with meetings, but they are rather playful, promenade, walking, it is particularly focused on this goal. They also fall within the hypertension and diabetes group due to the very situation. (R1)

There are the groups, certain groups involving the elderly, we perform dynamic physical education practices, aimed at entertainment. So, elderly care is more related to this issue of groups within the FHS. (R3)

The increased number of elderly people, among other factors, evoked the need to resume the discussions permeating the crisis in the health sector. From this perspective, aiming to implement the principles and guidelines of SUS, the Ministry of Health established, in 1994, the Family Health Strategy (FHS), which focuses on the family as a programmatic action unity, and not only the individual anymore.7

The FHS has the potential to stimulate community organization and families’ autonomy. The proposed technical care model favors the establishment of a bond through health promotion, based on encouragement and support so that social groups to take greater control over their health.8 This aspect is corroborated in respondents’ speeches, when they emphasize elderly care is particularly aimed at the health promotion groups.

Group activities represent an opportunity to discuss issues of importance for the collectivity, aiming to solidify reflections that may resonate positively in members’ lives.9 We notice through the subjects’ speeches that the HPGs are allied for treating chronic diseases, such as in the case of hypertension and diabetes mellitus, as well as mechanisms to provide the elderly with fun and entertainment, making them get their focus out of the illness process and seek the practice of activities that promote their quality of life.

Based upon the broad concept of health, the HPGs cover the biopsychosocial dimensions related to the binomial health-disease and an active aging. They contribute to the elderly life satisfaction and facilitate the establishment of emotional bonds with health care providers, providing exchange of experiences and fight against social isolation.10 From this viewpoint, in 2006, the National Primary Care Policy was implemented through Portaria GM 648, which defines primary care as a set of actions encompassing health promotion and protection, health problem prevention, diagnosis, treatment, rehabilitation, and health maintenance.7

Regarding elderly health actions at primary care, the subjects’ speech express they are restricted to the programs proposed by the Ministry of Health:

It is based on programs of the Ministry of Health, but in a rather shy way, because the very elderly health policy leaves much to be desired. (R2)

Well, […] the primary care level, any assistance that she/he needs, she/he is provided with here, in most cases it is hypertension and diabetes. (R4)

There is a lack of more support. (R5)

The municipality works with programs, right? […] Programs of the Ministry of Health. (R6)

The Ministry of Health has, through the National Elderly Health Policy, in line with the National Primary Care Policy, established goals for a population aging with quality of life, according to strategies and protocols that ground the actions taken by health professionals; among these protocols, it is worth highlighting the clinical ones. Clinical protocols guide the therapy and care management for the most prevalent diseases, helping in clinical behavior and care flow management.11

- Elderly secondary care: reflecting the specialties

In Brazil, the FHS was designed to guide the population health care, stimulating quality of life, for instance, by promoting an active aging. As aging is not a homogeneous process,
the elderly needs and demands vary, and it is necessary to strengthen networking to provide with care those elderly individuals with minor limitations and meeting the needs of those with various degrees of disability or illness, including home care. Thus, elderly care requires an interconnected health system, where each domain contributes to the others.

When the elderly individual is in need of evaluation by a more specialized health care level, in the local context of this study, she/he is referred to the Medical Specialties Center (MSC). This service covers the following specialties: cardiology, dermatology, infectious diseases, mastology, neurology, neurosurgery, pediatric neurology, high-risk obstetrics, oncology, pulmonology, clinical and surgical pediatrics, proctology, and urology, with a specific care for the elderly; these services are aimed at patients from the municipality, as well as the entire North Zone in the state, totaling 54 municipalities.

Regarding secondary care, the subjects mention the service under analysis is a reference in the local health network, with the presence of several specialized professionals:

*We are a reference in secondary health care, so [...] we are along with all municipal specialty services. All appointments provided here are elective. [...] Here at the MSC we have a specific elderly care, which is provided by the geriatrician, once a week.*

(R7)

People mentioned that nurses' task is only the managerial act, without rather specific elderly care procedures:

*Elderly nursing care, elderly care does not fit our service, indeed; the nurse here is rather managerial.*

(R7)

Secondary health care has the duty of providing with care those referred due to problems identified at primary health units that have not been solved or required a more specific care. However, in order to solve elderly health problems, the secondary care level must ensure user access to appointments with specialists and specialized examinations, indispensable for the completion of diagnosis by primary care.

At elderly secondary care, we observe the inclusion of geriatricians, working with their own identity. This care level provides specialized professionals and technological resources for the diagnostic and therapeutic support, with the purpose of avoiding complications pointed out by primary care.

In order to allow clients to reach secondary care, there is a need to use the referral and counter-referral systems, regarded as a mutual referral mechanism between the various complexity levels of services. This system is organized by regulation systems, such as the Appointment Scheduling Center.

The average outpatient complexity operates at a specialized level, which requires a stronger structure to put its regulation into effect, since its demand is not restricted to geographical references, such as primary care. It is also at this level that emerge the referral procedures between municipalities, causing all studies that address health care needs and flow to deal with variability within the regional care process, which generates demands on which regulation is not always able to work, because they arise outside the operation area of the regulatory complex management.

The biggest regulation challenge of the average outpatient complexity lies on the management of medical agenda and equipment, the structure of communication to patients, the control of absenteeism in the organization, the access grounded in the use of protocols, the determination of need and prioritization, the management of referred flows, as well as the construction of referral and counter-referral grids. Through care regulation, the actual and effective hierarchy of the health services network will be made possible, with qualified management and contribution to ensure comprehensiveness and equity in care.

- **Elderly tertiary care and the disconnected network**

In hospital care there is a rationale of elderly care by priorities and detached from the other elderly health care levels, especially the Family Health center:

*Viewing elderly care at the hospital level is regarded, let us say, not complete, but organized. There is an organization of physicians and residents, who make a daily visit to these patients, a large amount of exams, which, although taking a while, are provided, both when regarding these patients as effectively treated or not, in addition to nursing, which, even having few professionals, strive hard to provide an adequate care.*

(R8)

*It is based on priorities, and she/he comes as a priority already regulated.*

(R9)
When the problem is solved here, that is it. (R7)

There is no connection, counter-referral, in my view, does not occur. (R10)

The aging process involves new forms of illness, which are often characterized as the CNCDs, such as hypertension and diabetes mellitus. So, we see a need for readjustments also in the hospital care provided for the elderly population, where this is not just a priority, but regarded as a current reality in health services.

The rapid increase in the elderly population results in an increasing demand for health services and it is among the biggest challenges for public health practices, generating major economic impacts on the country, because in hospitalization, the average stay of the elderly was around two days longer than the average stay shown by the other age groups.17 Besides, elderly diseases can last for several years and they require a continued follow up by physicians and multidisciplinary teams, in addition to continuous interventions.

The current Brazilian epidemiological status is faced with a triple burden of diseases, because it involves at the same time: an incomplete agenda of infections, malnutrition, and reproductive health problems; strong growth of external causes; and the challenge of chronic diseases and their risk factors, such as smoking, overweight, obesity, physical inactivity, stress, and inadequate diet.18 Thus, the high prevalence of CNCDs added with a multiple pathogenesis (evidence of more than one concurrent disease), the lack of a more coherent response by health systems, since they are the deliberate social responses to the population health needs.18

Being aware that these attitudes involve a whole network of health services, we get into the hospital environment, especially due to the longer stay at this service and the progressive loss of autonomy among the elderly, an aspect arising from the increased number of diseases that affect the elderly, associated with poor health systems concerning the elderly population’s health, because of the fragmented care. So, there is a need to think of devices to connect the hospital to the network of health services, thinking through the hospital as a station, from the viewpoint of comprehensiveness. Any clientele, specifically the elderly one, can benefit from the organization of services into a network, with comprehensive care flows, which cover everything the elderly individual needs, relating the services needed. Around 70% of the elderly individuals depend on the services provided by SUS, ranging from outpatient to inpatient care, in order to meet their health care needs.19

Hospitalization represents, for many elderly people, a moment of weakness and fear, because besides suffering and unpleasant sensation, and the lack of confidence brought by the disease, these patients will require care from a set of health workers to intervene in this process. The health team, when providing the elderly with care, must be aware of a number of physical, psychological, and social changes that usually occur among these patients and they justify a different care.20

The hospital is realized as a transitional space that might refer to other services. In order to emphasize the idea of the importance of networking, thinking of the hospital as a station through which the most varied types of people, showing the most varied needs at different times of their own lives. Another starting point to consider is the time of hospital discharge, as this is a privileged occasion to reach the continuity of treatment in other services, not only in a bureaucratic way, playing a counter-referral role, but due to the construction of the care line needed by a specific patient.19

To enable elderly care within a network of health services, there is a need to use continued learning strategies, in addition to proper functioning of the referral and counter-referral system and horizontalization of elderly health care actions. This will imply an organized and comprehensive flow, which drives the elderly throughout the health care network, from the gateway, primary care, going through the specialties, and reaching the levels with higher technological density, tertiary care.

Working within a health care network implies knowing each care level and its functionality as a strategic point to achieve an organized and good quality care. This organizational context of networks has not emerged due to their complexity, or, much less, as a representative imagery that is drawn when it comes to health care levels.

On the contrary, it came from the discussion on the health status experienced by the user, who always came and went from/to the services without solving problems. So, a health care network aims to implement an organized flow, dynamic, without hierarchical power, and driven by communication between members, so that the elderly, faced with the specific characteristics of aging, do not constitute a salutary demand, which leaps from service to service with no connection.
CONCLUSION

This study enabled an in-depth theoretical approach to SUS, the health care networks, and comprehensiveness, as well as the weaknesses of a health system that still does not accompany the aging process at the same speed, where emergency actions are frequently mentioned both in practice and in literature. The latter, in turn, was a limiting factor of this study, since it is scarce and outdated, something which became a significant bias to the survey, as the theoretical foundation enables a move away from simple empiricism.

It was found out that health professionals recognize the shortcomings of networking in elderly health care, where this becomes diluted in programmatic actions taken by the Ministry of Health. Failure is not related to one point or another in the system, but to the procedures underlying the health care network. It is a duty of health professionals, managers, and politicians to seek real solutions for the problem concerned, instead of just creating utopian policies, humanly inapplicable to reality. Thus, there emerges a need for encouragement, ranging from the academy to practice, to an elderly nursing care based on evidence, appreciating its practice, asking questions, seeking and implementing strategies with real applicability; then, we should educate health agents, who turn the practice they experience into a trigger of human solutions to the population’s health, especially the elderly.

Understanding referral and counter-referral in elderly health will enable the nurse to work in order to meet the actual elderly health needs, as well as it will foster new strategies that promote health at any care level within the network. When providing health actions that guarantee the elderly a comprehensive care promotes a strengthening of the SUS principles by means of an effective referral and counter-referral system, besides improving the quality of life of the elderly and their families.

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Description of the elderly care network...