

Comprehensive and integrated care in healthy aging policies: comparison between Portuguese and Brazilian health systems

Larissa Weber¹ (Orcid: 0000-0002-5278-245X) (issaweber@hotmail.com)

Isabel Craveiro² (Orcid: 0000-0003-4348-1986) (isabelc@ihmt.unl.pt)

Cláudia Flemming Colussi³ (Orcid: 0000-0002-3395-9125) (claucolussi@hotmail.com)

¹ Secretaria Municipal de Saúde. Guaíba-RS, Brazil.

² Universidade Nova de Lisboa. Lisbon, Portugal.

³ Universidade Federal de Santa Catarina. Florianópolis-SC, Brazil.

Abstract: This study investigated how comprehensive and integrated care is expressed in the legislation of the Portuguese National Health Service and the Brazilian Unified Health System, especially in healthy aging policies. This qualitative and exploratory study was based on documentary research and included laws, decrees, ordinances, and plans, published until 2020. Twenty-four documents were selected, 12 from Portugal and 12 from Brazil. The data was subjected to content analysis. The findings indicated that Primary Health Care is the level of care responsible for integrating care in both countries. Both invested in the formation of care networks, intersectoral coordination, and the adoption of information and communication technologies to facilitate integration. Healthy aging policies have emphasized the importance of care at the community level, integrating users, their families, health equipment, and other sectors, promoting autonomy, and preventing chronic diseases and violence. The transformations in both countries follow scientific evidence published by the World Health Organization and research centers focused on healthy aging that contributes to making their systems more efficient and problem-solving. It is hoped that the aspects discussed will contribute to the development of successful ways of overcoming current challenges, such as those imposed by the COVID-19 pandemic.

► **Keywords:** Integrality in health. Comprehensive health care. Aging. Health systems.

Received on: 8/24/2023

Revised on: 10/2/2023

Approved on: 11/16/2023

DOI: <http://dx.doi.org/10.1590/S0103-7331202434042en>

Editor: Francisco Ortega

Reviewers: Vanessa Trintinaglia and Marcelo Azambuja

Introduction

The advancement of scientific knowledge and the development of new technologies in the health area have contributed to the increase in the quality of life and longevity of populations. As a result, there are transformations in the demographic and epidemiological profiles, phenomena known as demographic and epidemiological transition, respectively (Mendes, 2011).

Brazil is in an accelerated demographic transition. People over 65 years represented 10,5% of the population in 2022 (IBGE, 2023). A transformation can be seen in the Brazilian age pyramid. The base narrows as the top widens, characteristic of countries with a marked aging population (Mendes, 2011), as is the case of Portugal, where the elderly represented 22% of the population in 2019 (European Commission, 2020).

Changes in the demographic profile are followed by changes in the epidemiological profile, with a decline in infectious and parasitic diseases and an increase in non-communicable diseases, associated with lifestyle (Mendes, 2011; Araujo, 2012). In Portugal, oncological and cardiovascular diseases are the main causes of death before age 70 (Portugal, 2018). Brazil shows the persistence of infectious and parasitic diseases, while morbidity and mortality rates from chronic-degenerative diseases are increased (Araujo, 2012).

The elderly population is a group that faces great difficulties in accessing continuous care for their varied and complex health needs, whether due to communication difficulties between services or even the lack of attention to the special needs of the most vulnerable groups. Therefore, fragmented care models do not serve well this population (Oliver; Foot; Humphries, 2014; Ellins *et al.*, 2012). On the other hand, integrated care shows good results among the growing number of elderly people. By focusing care on the person, the integration of care is an effective way of qualifying care and support for the elderly (Briggs *et al.*, 2018).

For the World Health Organization (WHO), integrated health services are those that offer people a continuum of care – health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation, and palliative care – coordinated at different care levels and places, within and outside the health sector, according to their needs throughout life (WHO, 2018).

Comprehensive care, or integrality – a term coined within the Brazilian Unified Health System (Sistema Único de Saúde - SUS), presupposes that people have access to the necessary care, from the least to the most complex, from understanding the human being as a whole and not in separate parts. It permeates the practices of professionals, the organization of health programs and services, and the construction of health policies (Mattos, 2006).

Faced with the above and considering the validity of the Decade of Healthy Aging 2020-2030, whose base document commends the provision of integrated care to elderly people (WHO, 2020), this study investigates how comprehensive and integrated care is expressed in the public health systems of Portugal (Serviço Nacional de Saúde - SNS) and Brazil (SUS), especially analyzing the interface of this theme with healthy aging policies. SNS and SUS established health as a fundamental right and responsibility of the State, differing, among other aspects, because the SUS is free, while the SNS established moderating rates in certain situations (Portugal, 1979;1990; Brazil, 1990).

Method

This qualitative and exploratory study begins with documentary research (Severino, 2007), conducted in 2020 and 2021, that supports the comparative analysis between SNS and SUS legislation, focusing on integrated and comprehensive care in aging policies. Documents' selection considered the following inclusion criteria: (I) having been published between 1979 (creation of SNS) and 2020, in the case of Portugal, and between 1990 (creation of SUS) and 2020, in the case of Brazil; (II) to deal with the organization of care in the health system and (III) to address health care for the elderly. Documents that did not mention the terms “integrality”, “globality” or “integrated care” were excluded.

A total of 24 documents were analyzed, 12 from each country. The documents consist of laws, decrees, ordinances, and plans. Data sources were accessed on the websites of the Directorate-General for Health (www.dgs.pt) and the *Jornal Eletrónico da República* (www.dre.pt) of Portugal, from the Virtual Health Library (bvsm.saude.gov.br) and the Federal Government site (www.gov.br/planalto/pt-br) of Brazil.

Data were submitted to content analysis, which enabled a broad understanding of systems' organization from the mechanisms of integration of care, especially in aging policies. First of all, the material was freely explored (pre-analysis). Afterward, the

data were separated into “Operationalization of comprehensive and integrated care in SNS and SUS” and “Characterization of integrality in SNS and SUS’s Healthy Aging Policies”. In part 1, data were grouped into four categories, in which each system's operational aspects of comprehensive and integrated care are compared. In part 2, the comparison took place within the scope of elderly care policies, especially from pre-established analysis units (axes) (Bardin, 2009).

Results

The selected documents are shown in Chart 1.

Chart 1. Documents from Portugal and Brazil selected for analysis

Country	Documents
Portugal	Law N° 56/79. National Health Service (1979)
	Decree-Law N° 74-C/84. Creates, within the Ministry of Health, the Directorate-General for Primary Health Care (1984)
	Law N° 48/90. Basic Law of Health (1990)
	Decree-Law N° 281/2003. Creates the network of continuous health care (2003)
	National Health Plan 2004-2010 (2004)
	National program for the health of the elderly (2006)
	Decree-Law N°101/2006. Creates the National Integrated Continuing Care Network (2006)
	Decree-Law N° 28/2008. Establishes the regime for the creation, structuring, and operation of groups of health centers of the National Health Service (2008)
	National Strategy for Active and Healthy Aging 2017-2025 (2017)
	Law N° 95/19. Approves the Basic Health Law and repeals Law N° 48/90, of August 24, and Decree-Law No. 185/2002, of August 20 (2019)
	National Strategic Plan for Telehealth 2019-2022 (2019)
National Health Plan - Review and Extension to 2020 (2015)	
Brazil	Law N° 8.080/1990. Provides for the conditions for the promotion, protection, and recovery of health, the organization and functioning of the corresponding services, and provides other measures (1990)
	Ordinance N° 1.395/1999. Approves the National Health Policy for the Elderly (1999)
	Ordinance GM N° 2.528/2006. Approves the National Health Policy for the Elderly (2006)*

continue...

Country	Documents
Brazil	Operational Guidelines of the Pacts for Life, in Defense of the SUS and Management (2006)
	National Health Promotion Policy (2006)
	Ordinance N° 4.279/2010. Establishes guidelines for the organization of the health care network within the scope of the Unified Health System (2010)**
	Decree N° 7.508/2011. Regulates Law 8,080, of September 19, 1990, to provide for the organization of the Unified Health System, health planning, health care, and inter-federative articulation, and makes other provisions (2011).
	Strategic action plan to tackle chronic non-communicable Diseases in Brazil 2011-2022 (2011)
	Ordinance GM N° 2.546/GM/2011. Redefines and expands the Telessaúde Brazil Program, which is now called Programa Nacional Telessaúde Brasil Redes (2011)
	Ordinance GM N° 2.446/2014. Redefines the National Health Promotion Policy (2014)*
	Ordinance N° 2.436/2017. Approves the National Primary Care Policy, establishing the review of guidelines for the organization of primary care, within the scope of the Unified Health System (2017)
	Law N° 13.989/2020. Provides for the use of telemedicine during the crisis caused by the coronavirus (SARS-CoV-2) (2020)

* The ordinance is no longer in effect, but its content is consolidated, inserted, and published in Consolidation Ordinance N° 2, of 2017.

** The ordinance is no longer in effect, but its content is consolidated, inserted, and published in Consolidation Ordinance N° 3, of 2017

Source: produced by authors.

The terms “integrated care” and “integrality” have been present in the SNS and SUS, respectively, since the promulgation of their founding laws. In the Organic Law of the SNS (Portugal, 1979), the understanding of integrated care permeates the promotion and surveillance of health, disease prevention, diagnosis and treatment of patients, and medical and social rehabilitation. The first Basic Law stipulated that the SNS should “provide comprehensive care or ensure its provision” (Portugal, 1990, p. 3456), while the second Basic Law stressed the imperative of focusing care on the person (Portugal, 2019). In Portugal, the term comprehensive care is also used to refer to person-centered care (Portugal, 1979; 1990) and is provided by Primary Health Care teams (Portugal, 2008).

In Brazilian legislation, the integrality of care was given the status of a principle of SUS. According to its Organic Law, integrality refers to the articulated and

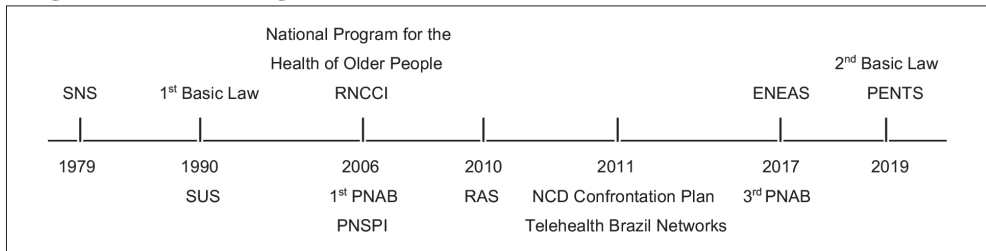
continuous set of preventive and curative actions and services, individual and collective, at all system levels (Brasil, 1990). Subsequently, the National Health Promotion Policy (Política Nacional de Promoção da Saúde - PNPS) added new dimensions to integrality, such as the analysis of health needs, their determinants and conditions, and the action on the effects of falling ill, concerning people's living conditions (Brasil, 2006b).

The effectiveness of integrality in its various aspects occurs in the scope of Primary Health Care. The latest revision of the National Primary Health Care Policy (Política Nacional de Atenção Básica - PNAB) proposed the most robust concept of the integrality of Brazilian legislation, presented as

the set of services performed by the health team that meet the needs of the assigned population in the fields of care, promotion, and maintenance of health, disease prevention, healing, rehabilitation, harm reduction, and palliative care. It includes accountability for the provision of services at other points of health care and the adequate recognition of the biological, psychological, environmental, and social needs that cause diseases, and management of the various technologies of care and management necessary for these purposes, in addition to the expansion of the autonomy of people and collectivity (Brasil, 2017, p. 68).

A chronology of the main legislative milestones concerning comprehensive and integrated care in both countries is presented (Figure 1).

Figure 1. Chronology of the main legislative milestones concerning comprehensive and integrated care in Portugal and Brazil



Caption:

RNCCI= National Integrated Continuous Care Network

ENEAS= National Healthy Aging Strategy

PENTS= National Strategic Plan for Telehealth

PNSPI = National Policy of Health of Elderly People

RAS= Health Care Network

NCD= non-communicable disease

Source: produced by authors.

The other results will be presented in two parts. The first covers the operationalization of the object in both countries. The second refers to integrality in healthy aging policies.

Operationalization of comprehensive and integrated care in SNS and SUS

Based on data analysis, four categories were established to elucidate how comprehensive and integrated care are operationalized in the two health systems: Primary Health Care; Care networks; Intersectoral actions; Information, and Communication Technologies.

Primary Health Care

In Portugal, the prerogative of integrating unscheduled care practices with public health interventions, articulating promotion, prevention, and treatment actions, was entrusted to Primary Health Care services shortly after the former Health Centers merger with the posts of the Pension Funds (Portugal, 1984). The legislation regarding Health Centers underwent successive transformations until 2008, when the Health Centers Clusters (*Agrupamento de Centros de Saúde - ACES*) was established – whose constituent units must act in cooperation with each other, and articulate with other intra and intersectoral services (Portugal, 2008).

In Brazil, Primary Health Care addresses different aspects of integrality and responds by identifying users' needs, building unique therapeutic projects, and accountability for continuity of care. In addition, the teams mobilize the necessary resources in the service network, assuming the coordination of care to users and the ordering of the service network (Brasil, 2017).

Care networks

Another strategy adopted by the SNS to integrate care was the organization of health services in the network (Portugal, 2019). The formation of networks understood as mechanisms for rationalizing the provision of care (Portugal, 2004), occurred in combination with the implementation of intermediate services to primary health care and hospital care aimed mainly at diseases that cause limitation (Portugal, 2003). The Portuguese National Network for Long-term Integrated Care (*Rede Nacional de Cuidados Continuados Integrados - RNCCI*) emphasized the centrality of integration of care (Portugal, 2006).

While in SUS, the Health Care Network (Rede de Atenção à Saúde - RAS) was created to horizontalize a model of care originally fragmented and hierarchized. RAS are organized within one or more Health Regions. According to the established covenants, integrality is effective by referencing the user in the local, regional, or interstate network (Brasil, 2010; 2011a).

Intersectoral action

In Portugal, the model proposed by the RNCCI is based on the integration between health and social security (Portugal, 2006), in accordance with Law nº 56/1979 (Portugal, 1979). Intersectoral action was expanded in the first Basic Law, which established the need to involve sectors such as education, economics, and urbanism in the formulation of health promotion policies (Portugal, 1990).

In Brazil, the implementation of the RAS and the redefinition of the National Health Promotion Policy (PNaPS), which revoked the PNPS, raised intersectoral cooperation to a new level in health promotion, recognizing it as a guideline to expand action on health determinants and conditions. It is expected to strengthen comprehensive care through humanized action, in a network, based on local needs, which encourages social participation (Brasil, 2010; 2014).

Information and Communication Technologies

Portugal elaborated the National Strategic Plan for Telehealth 2019-2022 (Plano Estratégico Nacional para a Telessaúde - PENTS) in search of new solutions to the challenges faced by the SNS. This plan proposes forms to advance the coordination and integration of care; health monitoring; sharing of knowledge and experience among professionals in case management; and intra- and inter-institutional flows (Portugal, 2019).

SUS also uses Information and Communication Technologies and has a Telehealth Program, which offers Tele-consultation, Tele-diagnosis, and Tele-education. Named Telessaúde Brasil Redes, the program aims to support the consolidation of the RAS through integrated actions, with the coordination of Primary Health Care (Brasil, 2011c). The use of Telemedicine was authorized on an emergency and temporary basis during the COVID-19 pandemic (Brasil, 2020).

Chart 2 summarizes the comparisons presented.

Chart 2. Comparison of the conformation of integrated care between Portugal and Brazil

Categories	Portugal	Brazil
Primary Health Care	<ul style="list-style-type: none"> - Main gateway to the health system; - Integrates unscheduled care practices with public health interventions; - Articulates the actions of promotion, prevention, and treatment; - Personalized care; - Multi-professional teams. 	
Care networks	<ul style="list-style-type: none"> - RNCCI; - Aimed at providing integrated continuous care, including comprehensive assessment of the needs of the person, rehabilitation, re-adaptation, reintegration, maintenance of comfort and quality of life, in an interface with social care; - Access is determined by the hospital where the user has been hospitalized or by the health center of his/her geographical area. 	<ul style="list-style-type: none"> - RAS; - Aimed at promoting the systemic integration of health actions and services with the provision of continuous, comprehensive, quality, responsible, and humanized care, and at increasing the performance of SUS in terms of access, equity, health effectiveness, and economic efficiency. - User is referenced in the regional or interstate network.
Intersectoral action	<ul style="list-style-type: none"> - Law nº 56/1979 established that health care also includes social support. Health and social security are linked to other sectors in the formulation of health promotion policies. 	<ul style="list-style-type: none"> - RAS attribute and PNaPS principle, which highlighted the need to articulate the health sector with others in the formulation of health promotion policies.
Information and Communication Technologies	<ul style="list-style-type: none"> - PENTS 2019-2022; - Tele-consultations, telemonitoring, telediagnosis, telerehabilitation, tele-screening, tele-training; - SNS24 Line provides screening, counseling, and telecare services. 	<ul style="list-style-type: none"> - Brazil Network Telehealth Program integrates education and service and provides teleconsultation, telediagnosics, tele-education; - Law nº 13.989/2020 authorizes telemedicine on an exceptional and temporary basis.

Source: produced by the authors.

Characterization of integrality in SNS and SUS's Healthy Aging Policies

In Portugal, the National Program for the Health of Older People proposed a concept of healthy aging based on the execution of preventive and health-promoting actions throughout the life cycle, guided by the National Health Plan (Portugal, 2004). It prioritized interventions focused on the promotion of active aging, with

emphasis on health education; adequacy of care to the needs of elderly people; and organization of environments, to prevent domestic/leisure accidents and detect cases of violence, abuse, or neglect, wagering on

[...] an integrated conceptual model, substantiated in the RNCCI, which aims to promote the maintenance of elderly people in their habitual form of life and improve equitable access to quality, flexible, transitional, or long-term care, ensuring continuity (Portugal, 2006, p. 14).

The creation of the National Network for Long-term Integrated Care, whose purpose was to expand long-term and palliative care, resulted in one of the main strategies to expand comprehensive care to the elderly population. The network operates through the individualized and humanized provision of interdisciplinary care, through comprehensive needs assessment and goal setting in conjunction with users and family members (Portugal, 2006). The National Health Plan review identified the reduction of premature mortality, improvement of healthy life expectancy, and reduction of risk factors related to non-communicable diseases as priorities. The interventions, gathered in four transversal axes (citizenship; equity/access; quality; and healthy policies), should be intersectoral and result in a better match between needs and services (Portugal, 2020)

The National Strategy for Active and Healthy Aging 2017-2025 (*Estratégia Nacional para o Envelhecimento Ativo e Saudável - ENEAS*) was elaborated in line with the assumption that the determinants for aging act throughout life. ENEAS proposes the approach to health in all public policies, enabling the population to gain quality of life with advancing age and reducing the burden on the health system (Portugal, 2017).

In Brazil, the first National Health Policy for Older People (*Política Nacional de Saúde do Idoso - PNSI*) was drawn up and published in 1999. It is aimed at the promotion of healthy aging, the maintenance and improvement of the functional capacity of elderly people, disease prevention, recovery, and rehabilitation of those who fall ill, and the effort to keep them in the environment in which they live. Its focus was on measures promoting healthy habits and preventing functional losses (Brasil, 1999).

In 2006, the health of elderly people was considered a priority in the Health Pact legislation, which proposed the reformulation of the policy in effect at that time with the following guidelines, namely: to promote healthy and active aging; comprehensive and integrated health care to elderly people; encouraging

multi-stakeholder actions; implementation of the home care; social participation; continued education; national and international cooperation; and support to study and research (Brasil, 2006a). Thus, a new National Health Policy for Elderly People (Política Nacional de Saúde da Pessoa Idosa - PNSPI) was launched, while PNSI was revoked (Brasil, 2006c).

The PNSPI considers that the health of this population traverses the interaction between physical health, mental health, financial independence, functional capacity, and social support. This policy has established among its priorities the control and prevention of non-communicable diseases (Brasil, 2006c).

Given the progress of these diseases in Brazil, a strategic actions plan was developed for addressing it in 2011-2022, based on three axes: surveillance, information, evaluation, and monitoring (of risk factors, morbidity, mortality, and health system responses); health promotion (a model of care for active aging with interventions aimed at the entire life cycle); and comprehensive care (with diversification of interventions, including the implementation of a line of care and the expansion of telemedicine and home care) (Brasil, 2011b).

Chart 3 presents a comparative analysis between four axes of the main HA policies of Portugal (ENEAS) and Brazil (PNSPI) based on assumptions related to integrality.

Chart 3. Comparison between four axes of the main HA policy developed by Portugal and Brazil based on the assumptions of integrality

Axis	ENEAS (Portugal)	PNSPI (Brazil)
Objectives	<p>To raise awareness of the importance of active aging and solidarity between generations, promoting change in attitudes towards aging and elderly people; to promote cooperation and intersectoral action; to contribute to the development of policies that improve the quality of life of elderly people;</p> <p>To promote health and autonomy throughout all phases of the life cycle;</p> <p>To integrate governance and inter-ministerial cooperation.</p>	<p>To recover, maintain, and promote the autonomy and independence of elderly people, directing collective and individual health measures for this purpose, in accordance with the principles and guidelines of the SUS;</p> <p>Focus on elderly people, acknowledging that healthy aging requires the formulation of health promotion actions at all ages;</p> <p>To instigate intersectoral action, avoid duplicity of actions, correct distortions, and enhance the solidarity network.</p>

continue...

Axis	ENEAS (Portugal)	PNSPI (Brazil)
Health	<p>The actions are divided between those aimed at people with high and stable levels of intrinsic capacity, to increase or maintain these levels over time, and others aimed at the population with reduced intrinsic capacity, to stop, reverse, and manage this situation.</p> <p>Prioritizes the prevention of chronic diseases and physical and mental incapacitation and the reorientation of the health system in meeting the needs of elderly people, in conjunction with existing programs and strategies;</p> <p>Adoption of Individual Care Plans as integrated intervention instruments to be contracted between different levels of care.</p>	<p>2 guiding axes: coping with frailties and promoting health and social integration, at all levels of care;</p> <p>Promotion of autonomy and independence, with stimuli to self-care; prevention actions – primary, secondary, tertiary; rehabilitation; autonomy and health recovery; social reintegration;</p> <p>Structuring a care line, focusing on the user, and facilitating access to care levels through bidirectional flows;</p> <p>Proposes the adoption of mechanisms that expand the resolution of Primary Health Care, such as home care, and the implementation of State Health Care Networks for elderly people.</p>
Participation	<p>Includes education throughout the life cycle, creation of home care networks, identification and regular evaluation of external factors that contribute to the vulnerability of elderly people, creation of living spaces, support and activities in neighborhoods, encouragement of telemonitoring and e-inclusion to facilitate “aging in place” and elimination of architectural mobility barriers.</p>	<p>Stimulates the participation of elderly people in social facilities, councils, and health conferences where they present their demands and priorities;</p> <p>Encourages the formation of links between health services and their users, giving priority to family and community groups, creating conditions for the effective participation and social control of the elderly part of the population.</p>
Safety and well-being	<p>Proposes measures to prevent and address situations of violence, such as conducting campaigns and training for security, health, and legal professionals, and monitoring and supporting isolation situations.</p>	<p>Proposes actions to prevent accidents at home and on public streets; integrated actions to fight domestic and institutional violence against elderly people; and actions that counteract prejudiced attitudes.</p>
Measurement, monitoring, and research	<p>Focused on the survey of needs and the dissemination of good practices.</p>	<p>Focused on assessing the quality and impact of the policy and improving care.</p>

Source: produced by the authors.

Discussion

Considering the scope of the present study, one of the main convergent aspects observed in the comparison between the two health systems legislation concerns the Primary Health Care role in the operationalization of integrated care. This fact converges with international publications that place integrality as one of the attributes of Primary Health Care (Starfield, 1998; Haggerty *et al.*, 2007)

Investments in training teams at this level of care are particularly necessary in the context of aging observed in Portugal and Brazil. Knowing that multimorbidity is common in the elderly and that patients with multimorbidity seek more clinical consultations, it is essential to ensure the coordination of care for these patients, which is the responsibility of the Primary Care teams. Thus, to deal with multimorbidity, Primary Health Care teams must be prepared to act from a generalist, holistic, and continuous approach, developing preventive actions at different levels and avoiding unnecessary medication burden and polypharmacy (Gusmão *et al.*, 2022; Akintayo-Usman, 2021).

Both countries created networks to integrate the different levels of care and guide services to the context of the growth of non-communicable diseases. In the Portuguese system, people with diseases that cause limitations are the focus of the RNCCI, for whom differentiated services have been created. In Brazil, the conformation of the public health system considers the triple burden of diseases that still afflicts the country, requiring the expansion of care to non-communicable diseases without neglecting acute conditions. Hence, thematic networks were structured in priority areas.

Evidence indicates that networking improves the efficiency of public systems, reduces costs (by avoiding duplicity of visits and examinations), and responds more effectively to people's needs by providing timely attention, at the right times and places. By maximizing the quality of services while minimizing costs, such a model is powerful in facing financial crises in the health area. (Mendes, 2011).

In this context, intersectoral integration can increase the efficiency, effectiveness, and efficacy of public management, especially when it provides budgetary integration in priority areas. Despite all the progress in the SUS legislation, especially with the implementation of RAS and the National Health Promotion Policy, intersectoral activism still does not translate into sufficient influence on the governance of Brazilian

public policies (Akerman *et al.*, 2014). Unlike Portugal, where the implementation of the RNCCI was forged in a context in which the integration between the health and social sectors was already established, requiring the advance in the integration with the other sectors. The healthy aging-related documents established the means for this integration's advancement.

The policies related to the healthy aging of both countries addressed the formulation of actions aimed at self-care, home care, and family and community engagement to keep elderly people integrated into society. The prominence of this set of interventions shows them aligned with the precepts of aging in place. In other words, aging safely and independently at home and in the community (Fonseca *et al.*, 2018).

Information and Communication Technologies applied to telehealth have been important tools to support home care, especially for elderly people. Telemedicine has been encouraged by WHO since 2001 due to its potential to integrate services, facilitate access to health care for the population, and promote distance education for professionals (Grone; Garcia-Barbero, 2001).

The COVID-19 pandemic has made telehealth grow in relevance, given the context of the overload of health systems and the need to reformulate care strategies. This practice was consolidated in Portugal before the pandemic, possibly due to the discussions promoted within the European Union (European Commission, 2016). Brazil, which had already regulated teleconsultation and teletraining before the pandemic, was forced to move forward in the regulation of teleconsultations in this context.

It is important to highlight that the overload of health systems caused by the COVID-19 pandemic acted as a setback in the integration of care from 2020 onwards (Chudasama *et al.*, 2020). Social distancing, necessary to contain the transmission of the virus, caused adverse psychosocial impacts, especially considering the crucial role of the social integration of the elderly (Brooks *et al.*, 2020).

The benefits provided by the implementation of integrated care models in terms of efficiency are easily identified in the literature (Oliver; Foot; Humphries, 2014). An example of this is the findings of a systematic literature review that analyzed integrated care models evaluated in different countries, either at the community level or in large-scale systems. In seven of the nine studies analyzed, not only was there a reduction in costs but also hospitalizations and/or long-term care for frail

elderly people were reduced (Béland; Hollander, 2011). It should be noted that, by reducing inappropriate care and shortening acute hospitalization periods for the elderly, resources can be freed up to meet other needs, which benefits society as a whole (Oliver; Foot; Humphries, 2014).

The aspects discussed above are in line with the Kings Fund recommendations for making systems suitable for an aging population (Oliver; Foot; Humphries, 2014), as well as the lessons learned from an analysis of seven integrated care programs for elderly people with complex needs in Australia, Canada, the Netherlands, New Zealand, Sweden, the UK, and the USA made by Wodchis *et al.* (2015).

As a final suggestion, we advocate for enhanced involvement of the elderly in the decision-making processes regarding their care. It is widely observed that most patients desire a more active role and seek recognition for their ideas. Professionals and providers can help share information with patients about their prognosis, their care plan, the reality of services, and coping strategies (Gusmão *et al.*, 2022; Greenfield *et al.*, 2014).

The analysis conducted in this study allowed the identification of convergent and divergent aspects of the normative documents of both countries that made it possible to consolidate integrated care in their health systems. However, the documentary analysis establishes limits to understanding the obstacles and challenges to implementing the policies analyzed, especially considering the different contexts of the analyzed countries.

Conclusion

The present study showed that legislative changes in recent decades led to the advancement of comprehensive and integrated care in both countries. Practices such as coordination of care by Primary Health Care, organization of the networked health system, adoption of telehealth, and inclusion of the family and community in care for the elderly contribute to overcoming the fragmentation of care, to facilitate access to the necessary care, including health promotion and disease prevention actions, to avoid duplication of consultations and tests, as well as polypharmacy and unnecessary hospitalizations.

This transformation, which is accompanied by scientific evidence published by organizations such as the WHO and research centers focused on healthy aging,

contributes to greater effectiveness and efficiency of the two health systems analyzed. Therefore, the advances of both countries can be celebrated. On the other hand, it is expected that the aspects discussed will contribute to the development of successful paths to overcome the challenges related to the integrality of the moment, such as those imposed by the COVID-19 pandemic.¹

References

- AKERMAN, M. *et al.* Intersetorialidade? Intersetorialidades. *Cien Saude Colet.*, Rio de Janeiro, v. 19, n. 11, p. 4291-300, 2014. DOI: <http://dx.doi.org/10.1590/1413-812320141911.10692014>.
- AKINTAYO-USMAN, N. O. Fragmentation of care: a major challenge for older people living with multimorbidity. *Geriatr Gerontol Aging*, Rio de Janeiro, v. 15, e0210030, 2021. DOI: <https://doi.org/10.53886/gga.0210030>
- ARAÚJO, J. D. Polarização epidemiológica no Brasil. *Epidemiologia e Serviços de Saúde*, Brasília, v. 21, n. 4, p. 533-8, 2012. DOI: <https://doi.org/10.5123/S1679-49742012000400002>.
- BARDIN, L. *Análise de conteúdo*. Lisbon: Edições 70, 2009.
- BÉLAND, F.; HOLLANDER, M. J. Integrated models of care delivery for the frail elderly: international perspectives. *Gaceta Sanitaria*, Barcelona, v. 25, p. 138-146, 2011. DOI: <https://doi.org/10.1016/j.gaceta.2011.09.003>.
- BRAZIL. Lei nº 13.989, de 15 de abril de 2020. Dispõe sobre o uso da telemedicina durante a crise causada pelo coronavírus (SARS-CoV-2). Brasília: *Diário Oficial da União*, 2020. Available at: http://www.planalto.gov.br/ccivil_03/_ato2019-2022/2020/lei/L13989.htm. Access on: Apr 15, 2021.
- BRAZIL. Lei nº 8.080, de 19 de setembro de 1990. Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências. Brasília: *Diário Oficial da União*, 1990. Available at: http://www.planalto.gov.br/ccivil_03/leis/l8080.htm. Access on: Apr 15, 2021.
- BRASIL. Ministério da Saúde. *Decreto nº 7.508*, de 28 de junho de 2011. Regulamenta a Lei nº 8.080, de 19 de setembro de 1990, para dispor sobre a organização do Sistema Único de Saúde, o planejamento da saúde, a assistência à saúde e a articulação interfederativa, e dá outras providências. Brasília: Ministério da Saúde, 2011a. Available at: http://www.planalto.gov.br/ccivil_03/_Ato2011-2014/2011/Decreto/D7508.htm. Access on: Apr 15, 2021.
- BRASIL. Ministério da Saúde. *Diretrizes operacionais dos Pactos pela Vida, em Defesa do SUS e de Gestão*. Brasília: Ministério da Saúde, 2006a. Available at: http://bvsms.saude.gov.br/bvs/publicacoes/PactosPelaVida_Vol1DiretOperDefesaSUSeGestao.pdf. Access on: Apr 15, 2021.

BRASIL. Ministério da Saúde. *Plano de ações estratégicas para o enfrentamento das doenças crônicas não transmissíveis no Brasil 2011-2022*. Brasília: Ministério da Saúde, 2011b. Available at: https://bvsmis.saude.gov.br/bvs/publicacoes/plano_acoes_enfrent_dcnt_2011.pdf. Access on: Apr 15, 2021.

BRASIL. Ministério da Saúde. *Política Nacional de Promoção da Saúde*. Brasília: Ministério da Saúde, 2006b. Available at: http://bvsmis.saude.gov.br/bvs/publicacoes/politica_nacional_promocao_saude_3ed.pdf. Access on: Apr 15, 2021.

BRASIL. Ministério da Saúde. *Portaria GM nº 2546/GM*, de 27 de outubro de 2011. Redefine e amplia o Programa Telessaúde Brasil, que passa a ser denominado Programa Nacional Telessaúde Brasil Redes. Brasília: Ministério da Saúde, 2011c. Available at: http://bvsmis.saude.gov.br/bvs/saudelegis/gm/2011/prt2546_27_10_2011.html. Access on: Apr 15, 2021.

BRASIL. Ministério da Saúde. *Portaria de consolidação nº 2*, de 28 de setembro de 2017. Consolidação das normas sobre as políticas nacionais de saúde do Sistema Único de Saúde. Brasília: Ministério da Saúde, 2006c. Available at: https://bvsmis.saude.gov.br/bvs/saudelegis/gm/2017/prc0002_03_10_2017.html Access on: Jul 24, 2023.

BRASIL. Ministério da Saúde. *Portaria de consolidação nº 3*, de 28 de setembro de 2017. Consolidação das normas sobre as redes do Sistema Único de Saúde. Brasília: Ministério da Saúde, 2010. Available at: https://bvsmis.saude.gov.br/bvs/saudelegis/gm/2017/prc0003_03_10_2017_comp.html. Access on: Jul 24, 2023.

BRASIL. Ministério da Saúde. *Portaria nº 2.436*, de 21 de setembro de 2017. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes para a organização da atenção básica, no âmbito do Sistema Único de Saúde. Brasília: Ministério da Saúde, 2017. Available at: https://bvsmis.saude.gov.br/bvs/saudelegis/gm/2017/prt2436_22_09_2017.html. Access on: Apr 15, 2021.

BRASIL. Ministério da Saúde. *Portaria nº 1.395*, de 10 de dezembro de 1999. Aprova a Política Nacional de Saúde do Idoso. Brasília: Ministério da Saúde, 1999. Available at: http://dtr2004.saude.gov.br/susdeaz/legislacao/arquivo/Portaria_1395_de_10_12_1999.pdf. Accessed Apr 15, 2021.

BRIGGS, A. M. *et al.* Elements of integrated care approaches for older people: a review of reviews. *BMJ Open*, London, v. 8, n. 4, e021194, 2018. DOI: <https://doi.org/10.1136/bmjopen-2017-021194>

BROOKS, S. K. *et al.* The psychological impact of quarantine and how to reduce it: Rapid review of the evidence. *Lancet*, London, v. 395, p. 912-20, 2020. DOI: [https://doi.org/10.1016/S0140-6736\(20\)30460-8](https://doi.org/10.1016/S0140-6736(20)30460-8)

CHUDASAMA, Y. V. *et al.* Impact of COVID-19 on routine care for chronic diseases: A global survey of views from healthcare professionals. *Diabetes Metab Syndr.*, v. 14, n.5, p. 965-967, 2020. DOI: <https://doi.org/10.1016/j.dsx.2020.06.042>

ELLINS, J. *et al.* *Understanding and improving transitions of older people: a user and carer centered approach*. Final report. Southampton: National Institute for Health Research Service Delivery and Organization Programme, 2012.

EUROPEAN COMMISSION. *The 2021 Ageing Report: Underlying Assumptions and Projection Methodologies*. Brussels: Institutional Paper 142, 2020. Available at: <http://dx.doi.org/10.2765/733565>. Access on: Apr 15, 2021.

EUROPEAN COMMISSION. *eHealth: connecting health systems in Europe*. Brussels, 2016. Available at: https://ec.europa.eu/health/sites/health/files/ehealth/docs/2016_ehealthleaflet_horiz_en.pdf. Access on: Apr 15, 2021

FONSECA, A.M. *Boas Práticas de Ageing in Place. Divulgar para valorizar: Guia de Boas Práticas em Portugal* Lisboa: Fundação Calouste Gulbenkian, 2018.

GREENFIELD, G. *et al.* Wake up, wake up! It's me! It's my life! Patient narratives on person-centeredness in the integrated care context: a qualitative study. *BMC Health Services Research*, London, v. 14, n. 619, 2014. DOI: <https://doi.org/10.1186/s12913-014-0619-9>

GRONE, O.; GARCIA-BARBERO, M. Integrated care A position paper of the WHO European office for integrated health care services. *Int J Integr Care*, London, v.1, e21, 2001. <https://pubmed.ncbi.nlm.nih.gov/16896400/>. Access on: Apr 15, 2021.

GUSMÃO, M. S. F. *et al.* Multimorbidade em idosos comunitários: prevalência e fatores associados. *Rev. Bras. Geriatr. Gerontol.*, Rio de Janeiro, v. 25, n. 1, e220115, 2022. DOI: <http://dx.doi.org/10.1590/1981-22562022025.220115.pt>

HAGGERTY, J. *et al.* Operational definitions of attributes of primary health care: consensus among Canadian experts. *Ann Fam Med.*, Ann Arbor, v. 5, n. 4, p. 336-44, 2007. DOI: <http://dx.doi.org/10.1370/afm.682>.

INSTITUTO BRASILEIRO DE GEOGRAFIA E ESTATÍSTICA (IBGE). *População com mais de 65 anos sobe para 10,5% em 2022*. Available from: <https://agenciabrasil.ebc.com.br/economia/noticia/2023-06/populacao-com-mais-de-65-anos-sobe-para-105-em-2022>. Access on: Jul 24, 2023.

MATTOS, R. A. *Os sentidos da integralidade*. In: PINHEIRO, R.; MATTOS, R. A. (Orgs). *Os Sentidos da integralidade na atenção e no cuidado à saúde*. Rio de Janeiro: IMS ABRASCO, p. 43-68, 2006.

MENDES, E. V. *As redes de atenção à saúde*. Brasília: OPAS, 2011, 549 p. Available from: https://www.paho.org/bra/index.php?option=com_docman&view=download&category_slug=servicos-saude-095&alias=1402-as-redes-atencao-a-saude-2a-edicao-2&Itemid=965. Access on: Apr 15, 2021.

OLIVER, D.; FOOT, C.; HUMPHRIES, R. *Making our health and care systems fit for an aging population*. London: Kings Fund, 2014.

PORTUGAL. Directorate-General for Health. *Plano Nacional de Saúde – Revisão e Extensão a 2020*. Lisbon: DGS, 2015. Available at: <http://pns.dgs.pt/files/2015/06/Plano-Nacional-de-Saude-Revisao-e-Extensao-a-2020.pdf.pdf>. Access on: Apr 15, 2021.

PORTUGAL. Directorate-General for Health. *Estratégia Nacional para o Envelhecimento Ativo e Saudável 2017-2025*. Lisbon: DGS, 2017. Available at: <https://www.sns.gov.pt/wp-content/uploads/2017/07/ENEAS.pdf>. Access on: Apr 15, 2021.

PORTUGAL. Directorate-General for Health. *Programa nacional para a saúde das pessoas idosas*. Lisbon: DGS, 2006. Available at: <https://www.dgs.pt/documentos-e-publicacoes/programa-nacional-para-a-saude-das-pessoas-idosas-pdf.aspx>. Access on: Apr 15, 2021.

PORTUGAL. General Directorate of Health. *Plano Nacional de Saúde 2004-2010*. Lisbon: DGS, 2004. Available at: <https://pns.dgs.pt/pns-2004-2010/> Access on: Apr 15, 2021.

PORTUGAL. Decreto Lei nº 74-C/84. Cria, no âmbito do Ministério da Saúde, a Direcção-Geral dos Cuidados de Saúde Primários. Lisbon: Presidency of the Council of Ministers and Ministries of Finance and Planning and Health, 1984, Available at: <https://dre.pt/web/guest/pesquisa/-/search/405702/details/maximized?perPage=100&sort=whenSearchable&sortOrder=ASC&q=educa%C3%A7%C3%A3o+f%C3%ADsica>. Access on: Apr 15, 2021.

PORTUGAL. *Lei nº 95/19*. Aprova a Lei de Bases da Saúde e revoga a Lei nº 48/90, de 24 de agosto, e o Decreto-Lei nº 185/2002, de 20 de agosto. Lisbon: Republic Diary. 2019. Available at: <https://dre.pt/home/-/dre/124417108/details/maximized>. Access on: Apr 15, 2021.

PORTUGAL. *Lei nº 48/90*. Lei de Bases da Saúde. Lisbon: Diário da República. 1990. Available at: <https://dre.pt/application/conteudo/574127>. Access on: Apr 15, 2021

PORTUGAL. *Lei nº 56/79*. Serviço Nacional de Saúde. Lisbon: Diário da República. 1979. Available at: <https://dre.pt/home/-/dre/369864/details/maximized>. Access on: Apr 15, 2021.

PORTUGAL. Ministério da Saúde. *Retrato da Saúde*. Lisbon: MH, 2018. Available at: https://www.sns.gov.pt/wp-content/uploads/2018/04/RETRATO-DA-SAUDE_2018_compressed.pdf. Access on: Apr 15, 2021.

PORTUGAL. Ministério da Saúde. *Decreto Lei nº 28/2008*. Estabelece o regime da criação, estruturação e funcionamento dos agrupamentos de centros de saúde do Serviço Nacional de Saúde. Lisbon: MH, 2008. Available at: <https://dre.pt/pesquisa/-/search/247675/details/maximized>. Access on: Apr 15, 2021.

PORTUGAL. Ministério da Saúde. *Decreto Lei nº101*, de 6 de junho de 2006. Cria a Rede Nacional de Cuidados Continuados Integrados. Lisbon: MH, 2006. Available at: <https://dre.pt/pesquisa/-/search/353934/details/maximized>. Access on: Apr 15, 2021.

PORTUGAL. Ministério da Saúde. *Decreto Lei nº 281*, de 8 de novembro de 2003. Cria a rede de cuidados continuados de saúde. Lisbon: MH, 2003. Available at: <https://dre.pt/pesquisa/-/search/468981/details/maximized>. Access on: Apr 15, 2021.

PORTUGAL. National Health Service. *Plano Estratégico Nacional para a Telessaúde (PENTS) 2019-2022*. [National Strategic Plan for Telehealth 2019-2022]. Lisbon: SNS, 2019. Available at: <https://www.sns.gov.pt/noticias/2019/11/12/telessaude-plano-estrategico/>. Access on: Apr 15, 2021.

SEVERINO, A. J. *Metodologia do Trabalho Científico*. São Paulo: Cortez, 2007, 304 p.

STARFIELD, B. *Primary care: balancing health needs, services, and technology*. New York: Oxford University Press, 1998, 448 p.

WODCHIS, W. P. *et al.* Integrating care for older people with complex needs: key insights and lessons from a seven-country cross-case analysis. *Int J Integr Care*, London, v. 15, n.6, e021, 2015. DOI: <http://doi.org/10.5334/ijic.2249>

WORLD HEALTH ORGANIZATION. *Decade of Healthy Ageing 2020–2030*, Geneva, 2020. Available at: <https://dre.pt/home/-/dre/369864/details/maximized> Access on: Apr 15, 2021.

WORLD HEALTH ORGANIZATION. *Continuity and coordination of care: a practice brief to support the implementation of the WHO Framework on integrated people-centered health services*. Geneva, 2018. Available at: <https://apps.who.int/iris/handle/10665/274628> Access on: Apr 15, 2021.

Note

¹ L. Weber: conception and design, data acquisition, analysis and interpretation of data, drafting of the manuscript and obtaining funding. I. Craveiro and C. F. Colussi: conception and design and critical revision of the manuscript for important intellectual content.

Resumo

Atenção integral e integrada nas políticas de envelhecimento saudável: comparação entre os sistemas de saúde português e brasileiro

Este estudo investigou como o cuidado integral e integrado expressa-se na legislação do Sistema Nacional de Saúde português e do Sistema Único de Saúde brasileiro, especialmente nas políticas de envelhecimento saudável. A análise de conteúdo foi realizada através de pesquisa documental envolvendo 24 documentos, 12 de cada país, publicados até 2020. Os achados indicaram que a atenção primária é o nível de atenção responsável pela integração do cuidado nos dois países. Ambos apostaram na formação de redes de atenção, articulação intersetorial e adoção de tecnologias de informação e comunicação para facilitar a integração. As políticas de envelhecimento saudável enfatizaram a importância do cuidado comunitário, integrando usuários, seus familiares, equipamentos de saúde e outros setores, promovendo a autonomia e prevenindo doenças crônicas e situações de violência. As transformações nos dois países acompanham as evidências científicas divulgadas pela Organização Mundial da Saúde e por centros de pesquisa voltados para o envelhecimento saudável e contribuem para tornar seus sistemas mais eficientes e resolutivos. Apesar dos avanços, o risco de descaso e os impactos do isolamento social provocados pela Doença do Coronavírus 2019 desafiam a efetividade da integralidade. Espera-se que os aspectos discutidos contribuam para a construção de formas exitosas de superação deste desafio.

► **Palavras-chave:** Integralidade em saúde. Assistência integral à saúde. Envelhecimento. Sistemas de saúde.

