Home care in the Brazilian National Health System (SUS)

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Abstract

Objectives
To assess home care programs implemented in three cities and to identify components indicating the integration of these programs into the reform of health care.
Methods
An exploratory descriptive study with a qualitative approach was carried out in the cities of Marília and Santos, state of São Paulo, and Londrina, state of Paraná, Brazil. Empirical data was obtained from interviews with five nurses and one social worker who worked in home care services, and through analysis of reports on these programs. The data was analyzed using the discourse analysis technique.
Results
The findings show the importance of home care services as a strategy for dehospitalization and humanization of care. Components were identified showing that home care focused on building up a health care model based on light technology, and multiprofessional and intersectorial work. It was found that, despite advances in the implementation of home care services, there are obstacles for an effective health care model change, such as ineffective referral and counter-referral mechanisms and complex relationship of health care providers with service users, their families and caregivers.
Conclusions
Care provided by home care programs is a strategy to decentralized care based on hospitals and to build up a new approach focused on health promotion and prevention, reducing risks and humanizing care. Strategies must be drawn up to allow its implementation in the public health network.

INTRODUCTION

The present study is supported by the notion that home care program (HCP) constitute a reversal approach to hospital centered-care, enabling to conceive a new way of thinking care, focused on health promotion and prevention and humanization of care. The evaluation of current home care programs could be helpful to define public health policies that effectively integrate the Brazilian Health Care System (SUS) standards.

Assuming that the experience of Brazilian cities where HCP were implemented provides input for further developing home care public health policies and a model for similar programs to be adopted by other cities, the purpose of this study was to better examine and evaluate the HCP reality.

A movement has been increasing worldwide in the last decades toward new solutions for the phenomenon of high social costs of hospital care and inadequate response to population's needs evidenced by health care quality indicators.

The analysis of public expenditures on health care

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reveals an existing gap between hospital and primary and secondary care expenditures. The burden of increased hospital care costs are due to high hospitalization rates, supported by a prevailing hospital-centered care model and increasing use of high technology.

Mendes[9] says "there is a need to develop, in the social experience, new hospital roles, which are often restricted to acute and intensive care and high technology outpatient care". In order to improve the quality of services, new ways of delivering care, settings and work processes, including day hospitals, home care services, home nursing, and training for self-care, all of which incorporating family and community knowledge, need to be implemented.

By the end of the 18th century, before the advent of large hospitals and outpatient care, home nursing has been widespread in Europe. Nowadays, delivering care at home aims at rationalizing the use of hospital beds and reducing care costs as well as developing a new way of thinking care focused on health monitoring and its humanization.

The model of care consists of the way health actions are developed and how services are organized to generate and provide these actions.[5] An in-depth careful evaluation of all settings and technologies involved, work relations and action structuring and management is required as well as reviewing the concept of health and historical and cultural determinants which affect technical interventions and people's health conditions and needs.

The model of health care still prevailing in Brazil prioritizes medical care delivered to the population through as many care services as possible but restricted to individual services focused on treating health conditions or rehabilitating disabled users through clinical practice and increasing technologies.[9]

The re-evaluation of the model of care requires health providers to go beyond the prevailing disease-centered model to build up a line of thought and action based on the social generation of the health-illness process. The development of new policies and approaches for care model change should be built on identifying and examining current health concerns and needs and focused on users and care provided.[15]

The aim of conceiving a new model of care is reducing hospital stay and promoting new care settings and new arrangement of technologies. Within this context, the Family Health Program, HCP and hospice settings constitute different approaches for reducing hospital costs, humanizing care, reducing risks and extending the outreach of health providers, especially nursing staff.[7]

In April 2002, the Brazilian Ministry of Health passed the Law 10,424, which created HCP within SUS. It has mostly established the delivery of medical and nursing treatment, physical therapy, mental care and social welfare work to SUS users needing comprehensive home care.[3]

The Brazilian Ministry of Health advocates home care services as part of the guidelines to primary care staff aiming at humanizing care and providing more comfort to people while emphasizing it should not take the place of hospitalization. Therefore it should be provided when user's medical condition and their family's situation allow for that.[4]

The purpose of the present study was to examine the HCP implementation process and functioning as well as to identify aspects indicative of the integration of these programs into the change of health care model and provide input to the development of specific public health policies.

METHODS

A qualitative descriptive exploratory study was carried out to evaluate home care service models. It was examined whether home care service programs constitute a landmark in the change of the health care model so as to strengthening SUS guidelines and standards.

To define the study scenarios, local health departments of 20 Brazilian cities with a population of more than 200,000 inhabitants were contacted in the period from December 2001 to March 2002 to identify those cities which had implemented home care services as part of their public policy. The following cities were identified and studied as study scenarios: Marília (state of São Paulo), Londrina (state of Paraná) and Santos (state of São Paulo). For data collection, these cities were randomly numbered one to three to preserve interviewees' confidentiality.

The methodological approach conceived sought to apprehend and recognize the actual dynamics and contradictions of home care services in the study scenarios.

Primary data were collected using a semi-structured interview guide. The questionnaire was applied individually to the home care service manager and nurse in each scenario, to a total of six interviewees —five nurses and a social worker. Before visiting each sce-

nario, data were collected from reports and literature available on home care service.

Data analysis was performed using Bourdieu's method.[2] The main ideas, which were more well-defined and precisely and concisely described the meaning of discourses, were identified and reported. The ideas were grouped into empirical categories.

This process included arranging empirical data and its classification. Provider's discourses provided input for data interpretation from the association with the theory references. Empirical and theoretical data were merged in the analysis as a means for understanding the experience and revealing what lies beyond the ideas, as proposed by Minayo,[11] which could contribute to dealing with problems and transformation of home care experience.

This study was approved by the Research Ethics Committee of the Federal University of Minas Gerais, according to the regulations of Resolution 196/96 of the National Ethics Committee.

RESULTS

Scenario city 1

The local HCP was implemented in 1999 as a joint effort by the general city hospital and the Municipal Department of Hygiene and Health (SMHS). In this partnership, SMHS took charge of management, equipment procurement and staff pay while the city hospital managed staff capacity-building, input, drugs and equipment supply and sterilization of items.

In this scenario city, the HCP has aimed at improving its users' quality of life, humanization of home care delivered by an interdisciplinary team and early dehospitalization. It provides care to city users who had been discharged from a hospital and are referred by primary care or family health units with the purpose of involving family members and caregivers in the care provided.

Besides SUS health insurance included in hospital admission approval, this service is monthly supported by the Municipal Health Fund. These resources cover users' expenses with staff transportation, input, drugs and special diets.

Referrals to HCP come from the general hospital or the city's specialty outpatient clinic, though inadequate communication can still be seen between HCP and local hospitals.

In this scenario city, HCP users can be referred by either public or private services, regardless of their level of care. Identification of potential HCP cases, described as an "active search" by interviewees, is occasional.

Admission criteria include having a permanent residence address, a caregiver, a health condition covered in HCP and no need for complex testing and procedures. According to interviewees, the program has changed over time. Many HCP providers do not agree with users' eligibility criteria, such as having a definite diagnosis, being registered in a primary care unit and no supplementary testing needed.

Scenario city 2

The local HCP was implemented in March 1992 by the Municipal Department of Hygiene and Health. The local HCP has aimed at relieving hospital bed shortage, reducing care costs, and providing comprehensive humanized care, at the same time as strengthening the relationship between the health care team and family members and users. Dehospitalization is part of the program, backed on the worldwide trend of structuring health care systems focused on quality of care.

The city home care service was first limited to diabetic patients but now it has been covering patients with numerous conditions and diseases, as long as they meet the program's admission criteria.

Referrals to HCP have been made by the city's central emergence department. Shortage of beds in public central hospitals has compelled users and their family to resort to their private health insurance when hospitalization is needed, evidencing the flaws of the program's referral system, which weakens HCP impact as an agent for health care change.

In addition, the city has available another Home Care Program (PAD) for users whose care does not require any equipment. PAD and HCP referral and counterreferral systems operate systematically. Similarly to scenario 1, scenario 2 program is supported by the Municipal Health Fund.

The local HCP only accepts users referred by hospitals, multi-specialty clinics, emergence departments and PAD. There is no active search for patients and only doctors or nurses can refer patients to this service. At admission, users are evaluated by a doctor to assure they meet the admission criteria. Having a home caregiver, provided by the family, is obligatory for program admission and users have to be bed-bound or walking-impaired patients. Home condi-

tions are assessed, especially regarding to hygiene. When any changes are needed, the nurse talks to the family to have them provided.

Scenario city 3

HCP was implemented in the scenario city 3 by local health authorities in 1996. An interdisciplinary team is available to provide continuous comprehensive care during HCP length to users and their family. In this scenario, home care service is intended to be an alternative service, provided by doctors and nurses, aligned with SUS standards. Its major strategy is to promote better quality of life to its users and family while providing distinctive humanized care.

In regard to resources, five vehicles, equipped with cellular phone for internal use, are exclusively available to HCP staff and an ambulance is available for users' transportation to testing and specialty visits. Equipment and drugs are fully provided at no cost to users for a comprehensive care. Similarly to previous scenario cities, this program is supported by the Municipal Health Fund.

Referral for hospital admission of home care users is easy. However, counterreferral is a common flaw found in the three programs studied. Ineffective communication has been reported between home care teams and users and their family.

Refe

rral can be made by all levels of service, either public or private, by those located in other cities and even by intercity outpatient services. Having a home caregiver is also essential for program admission as well as having a medical diagnosis. After the user is admitted to the program, HCP staff develops a management plan and assigns care providers according to users' demands and needs, and establishes the frequency of team visits. Overall, medical visits are scheduled once a week and, in case of any adverse event, users are referred to central services.

Humanization of care was urged in all interviewees' discourses, making it the most important rationale for implementing home care services in the public care network.

DISCUSSION

Primary data analysis has shown that, in regard to HCP settings and technologies, but without disregarding institutional services and the needs of users and their family, the home is the locus of care.

Interviewees in the three scenarios acknowledged an existing link between HCP and the Family Health Program which does not generate conflicts in care delivery. They also saw the family and prevention as the main focus of the Family Health Program, while HCP focuses on individuals and their health conditions. This notion reveals a contradiction in the HCP work process, home is often only the physical and geographical setting where care is provided and the prevailing way of thinking of a hospital-centered, therapeutic individualized model remains unchanged.

The dichotomy of health-illness concept still prevails and it can be noted that HCP is actually focusing on disease, with no indicatives of the building up of a model based on social generation of health, prioritizing the shift of care from health recovering to risk and disease prevention and health promotion. It entails structuring health care systems to include not only interventions and services, as seen in the study HCP where the focus of care is on disease, disability and death, but, above all, developing actions aimed at health management, i.e., life styles and life conditions of different people and social groups.[12,14]

The relationship of HCP and primary care units is limited to care delivery and resource provision. No indications of a joint action to would ensure complementary actions and comprehensive care were identified.

It is pointed out the need for extending and improving communication and information systems between primary care units and HCP. A stronger link between primary care unit and Family Health Program teams is also needed, as well as streamlining referral and counterreferral systems between HCP and local progressive care network. Joint action will allow developing new technical and social relationships and structuring work processes based on the principle of health monitoring.

For an efficient and effective referral and counterreferral system, building up partnerships between public and private sectors is vital. These partnerships could be translated as an involving joint work where a horizontal relationship between services would be developed while respecting and preserving their own identities,[13] and the creation of a progressive care network, disrupting the concept of hierarchy and levels of care.

Interviewees' discourses point out to the existence of an effective helpful partnership between HCP and other spheres of health care network. However, no indications of this partnership were identified, which could

suggest an early stage of development. Similarly, where as interviewees mentioned intersectoriality as a fact, there were no aspects suggestive of an effective interaction which would allow providers to deal with the problems they face while providing home care.

According to Merhy's definition of technology[10] as light, light-heavy and heavy technologies, HCP structures its work process based on light technologies. Merhy describes light technologies as those involving the relationship between people and entailing bonding, comforting, and managing; light-heavy technologies refer to structured knowledge that operates the work process, such as knowledge of epidemiology, taylorism, social communication, among others; and heavy technologies comprise technological equipment such as machines, regulations, organizational framework, etc.

In home care services, the relationships between caregiver/user, team/user, family/user, caregiver/family are optimized by the daily bond created. These relationships are considered helpful for care delivery and user's recovery, emphasizing the relevance of light technologies to care quality.

It was identified a need for light-heavy technologies backed by home care protocols. Though interviewees mentioned the existence of protocols, the documents provided by services in the different scenarios cannot be considered protocols but rather rules and procedures for guidance to providers, caregivers and family.

Protocols streamline the available technologies, knowledge and operational processes to provide quality care. Developing and implementing protocols are crucial due to the complex structuring of the work process in health, which is based on the following major characteristics, described by Almeida:[1]

- It is used while delivered with little accruing of actions/procedures for future use;
- It is supported by subjective relationships between individuals under care and their caregivers, arbitrated by social and cultural values, and economic interests;
- There's no significant technological accrual; instead, there's a simultaneous use of available technologies and new technologies;
- The individual on whom care is centered is historically and socially determined;
- It is a social experience performed by providers with different cultural and professional backgrounds.

Bearing that in mind about work in health, protocols become a tool for guiding and setting the limits for different providers while performing their caring, managerial, and education tasks and assure quality of care. HCP is an organizational approach of technological resources for caring people in their environment who require continuous care monitoring and sometimes intensive care. Improvised setup and delivery of home care should be replaced with protocols that help to organize the work process, which have a different level of complexity compared to hospital or outpatient care.

Regardless of the controversies and contradictions of this approach, assurance of quality of care is paramount, and for that protocols constitute valuable support tools for caregivers, providers and family members.

Since HCPs "novelty" – though in fact as old as the Brazilian society – are provided by public and private care services and by the family itself, it can be noted that the prevailing care model has been replicated in these settings, i.e., models, techniques, procedures of traditional settings, especially hospitals, have been implemented.

Data analysis have shown that, in home care, nursing care follows strongly ingrained rules and routines, disregarding the particularities and habits of users and their family.

Providers have mentioned caregivers and users need to "change their values". Health providers reflect in their practices the biomedical training they have received and yet are not able to convert them into actions focused on individuals holistically. As a result, they perpetuate actions stressing the prevailing care model. Levcovitz & Garrido[8] warn that "if the training of providers, especially of doctors and nurses, won't be replacing where it is taught, the care model won't be replaced in their daily practice".

In this framework, HCPs lack recognition and active involvement by users for generating their own health, which Campos[6] recognizes as a key element of care models based on the paradigm of social generation of health.

To further develop HCP as part of SUS approach, studies on the program costs for health systems and families are crucial. Cost analyses carried out in the study scenarios have confirmed HCP positive cost-benefit when compared to hospitalization though these analyses did not contemplate the costs to the families.

Given that this care approach is built upon a concept where interpersonal relationships and environ-

ment aspects are key determinants, it is expected it would actually become a new care model as the way of thinking health needs will shape HCP technological and political structure.

Despite the existing gaps, HCP allows for building up a care approach stressing team work with the use of light technologies which enable the development of bonding, care comprehensiveness and action streamlining mostly aimed at providing quality care.

It is stressed the need for HCP restructuring and review of its knowledge and practices that will allow it to become a care approach which makes valuable use of the old practice to solve modern problems.

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