HEALTH PROMOTION AND AN INTERSECTORAL APPROACH IN SENIOR CARE NETWORKS

Promoção da saúde e intersetorialidade na rede de atenção ao idoso

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ABSTRACT

INTRODUCTION: Increase in longevity has caused new demands for health and social development, which in turn points to the need for changes in service structures, health programs, and professional education. **OBJECTIVE:** To analyze the relation between health promotion in care networks and the intersectorial perspective on senior care. **METHODS:** This descriptive-exploratory research project was carried out in the Metropolitan Region of Belo Horizonte (RMBH), Minas Gerais, Brazil. Among the 34 cities considered, 10 met the inclusion criteria and took part in the study, i.e. cities with two or more long-stay institutions for seniors (ILPI) in their region. **RESULTS:** An analysis of interviews enabled the establishment of two categories: "policies and healthcare network for seniors" and "the articulation of health promotion and intersectoriality in senior care." The analyses pointed out differences between the cities with regard to the implementation of national policies and the existence of a guiding document, the difficulty of including seniors in the healthcare network, the decrease in health promotion, and the difficulties and propensities for intersectoriality. **CONCLUSIONS:** Even though regulation laws for seniors have significantly advanced during the last few years, they were not properly implemented in most of the researched cities. In addition, there is no specific health network for senior care, which is done through Primary Healthcare. With regard to health promotion, actions focused on seniors are specific and isolated, which come from a conceptual reduction of this term.

KEYWORDS: aging; intersectoriality; health promotion.

RESUMO

INTRODUÇÃO: O aumento da longevidade acarreta novas demandas para os setores de saúde e desenvolvimento social, as quais apontam, por sua vez, para a necessidade de mudanças nas estruturas dos serviços, nos programas de saúde e na formação dos profissionais. **OBJETIVO:** Analisar a relação entre promoção da saúde na rede de cuidados e a perspectiva intersetorial na atenção ao idoso. **MÉTODOS:** Trata-se de uma pesquisa descritivo-exploratória, realizada na Região Metropolitana de Belo Horizonte (RMBH), Minas Gerais. Dos 34 municípios, participaram da pesquisa os 10 que atenderam ao critério de inclusão no estudo, de ter 2 ou mais instituições de longa permanência para idosos (ILPI) em seu território. **RESULTADOS:** A análise das entrevistas permitiu a construção de duas categorias: "políticas e rede de atenção ao idoso" e "articulação da promoção da saúde e intersetorialidade na atenção ao idoso". As análises apontaram para as diferenças entre os municípios quanto à implantação das políticas nacionais e à existência de documento norteador, às dificuldades para inserção do idoso na rede de atenção, à redução do conceito de promoção da saúde e às dificuldades e facilidades para a intersetorialidade. **CONCLUSÕES:** Este estudo verificou que, apesar da legislação pertinente ao idoso ter avançado significativamente nos últimos anos, isso não se concretizou na maioria dos municípios pesquisados. Constatou-se também que não existe uma rede de saúde específica para a atenção ao idoso, sendo este atendido na Atenção Primária à Saúde. No que tange à promoção da saúde, as ações destinadas ao idoso são pontuais e isoladas, advindas de uma redução conceitual desse termo.

PALAVRAS-CHAVE: envelhecimento; intersetorialidade; promoção da saúde.

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INTRODUCTION

Aging can be understood as a dynamic process in which morphological, functional, and biochemical alterations happen progressively in the human organism, which make it more susceptible to intrinsic and extrinsic aggressions.[1] Increase in longevity is a reality in Brazil not only with regard to the number of seniors, but also life expectancy — which has been changing the age range. This new demographic reality constitutes not only a very important public health issue but also an issue regarding the structure of policies directed toward the senior population.[2-4]

In Brazil, the 1988 Federal Constitution brought advancements to the social policies regarding the protection of senior citizens. This document legalized popular participation in public management, which in turn promoted the Council for Seniors, which was put in place in order to develop, follow, monitor, and evaluate policies in three governmental spheres, thus contributing to the implementation of the previously achieved rights. However, the rights only became effective after the implementation of regulation No. 8842/1994, which includes the National Policy for Seniors (PNI) as well as the creation of the National Council for Seniors. It was only after 2001 that the Brazilian Council for Senior Rights was established through regulation by means of Decree No. 4227/2002.[5,6]

The Brazilian Policy for Senior Health (PNSI) was instituted through Decree No. 1395/1999 with the aim of complementing the policies proposed in the PNI and by incorporating primary guidelines in its actions. This decree was updated in 2006 and became the National Policy for Senior Health (PNSPI), considering the Health Pact and the operational guidelines for the establishment of the Brazilian Unified Health System (SUS). It reasserted the need to better understand the promotion of senior health care.[7]

The Senior's Statute, which aims at strengthening the guidelines proposed in the PNI, served as a motivation and an instrument for the work of senior's councils throughout the country.[8] The approval of this statute was an advancement, since it gathers together all of the preexisting legal instruments in one place.[9]

Healthcare promotion is a challenging theme with regard to the increase in senior care practices, because it must emphasize the socioeconomic and cultural components and determiners that promote healthy and active aging. To do so, the development of intersectorial public policies is necessary.[10] Hence, intersectoriality can be defined as a political process of joint actions in a network, that goes beyond a management strategy focused on the construction of interfaces between sectors and institutions, regardless if they are governmental or not. Through intersectoriality, we seek to combat complex social problems that go beyond one area's competence, in order to confront social inequalities.[11]

Intersectoriality corresponds to a new way of governing, working and building public policies, which intends to overcome the fragmentation of knowledge and social structures and produce more significant effects in the health of the population.[12]

Considering the abovementioned, this study aimed to analyze the relationship between health promotion and an intersectorial perspective on senior care in the Metropolitan Region of Belo Horizonte (RMBH), Minas Gerais, Brazil.

METHODS

This is a descriptive-exploratory research that uses qualitative approach. It is part of a larger ongoing study about the quality of life of seniors in long-stay institutions for seniors(ILPI). Among the 34 cities from the RMBH, the 10 cities that met the inclusion criteria took part in the study. Cities with two or more ILPI in their territory were included, and they all adhered.

Determining who the interviewees would be was done through contact with city managers, who indicated the key informers regarding senior care in the social policies and health offices. After this contact was made, new participants were included and some of them were from other offices like sports and leisure, disability, reduced mobility, and senior care.

The interviews were recorded, typed and organized in order to describe the empirical investigation chart. The material was analyzed by means of a thematic content analysis proposed by Bardin.[13] Thus first, each typed report was read and re-read to identify the most relevant and confounding aspects regarding the initial hypotheses of the project. Then, data were classified into empirical categories that had the ability to apprehend determinations and specificities expressed in the empirical reality, which were built based on the elements given by the social actors.[14] To conclude, interpretations and articulations between the obtained data and the theoretical references were defined to answer the research questions based on their objectives.

The research met all ethical requirements. The Research Ethics Committee of the *Pontifícia Universidade Católica de Minas Gerais* (Protocol no. 817 032/2014) submitted and approved the research, and all participants signed the Free Informed Consent.

RESULTS AND DISCUSSION

Thirty-five interviews were done following a semistructured script from November 2014 to December 2015. It included 51 managers and/or technical references indicated as key informers of the researched cities, which were the study participants. Forty-three women and 8 men took part in the study – 24 health professionals, 22 from the social area, 3 from other departments, and 2 that did not report their occupation. The average working time of these professionals in the cities was nine years, and four years in the position specifically related to senior care. Discrepancies between the number of interviews and participants occurred because some interviews included more than one interviewee. The unit of analysis of the results was the participating secretaries, not the interviewed subjects.

The results found in the analysis of interviews were divided into two empirical categories: "policies and a healthcare network for seniors" and "the articulation of health promotion and intersectoriality in senior care."

Policies and a healthcare network for seniors

Although legal regulations were implemented in Brazil with the aim of ensuring senior rights based on the 1988 Constitution[6], we observed, from an analysis of interview reports on seniors' inclusion in the network, a lack of knowledge about the policies and possible violations of senior citizens' rights in many cities.

> [...] First, to think about this network and about this intersectorial work, we have to think first what are the senior's rights [...] What is best for him or her? (EA6).

> [...] The Health City Policy, right? For seniors. It was implemented in 2010, wasn't it? (ES4).

The research showed that despite developments in the establishment of policies for senior citizens, actions are still fragmented and limited in most of the studied cities. For Camarano,[9] fragmentation begins with legal regulations concerning seniors. Therefore, he mentions that the Federal Constitution, the PNI, the Statute for Seniors and other documents provide different chronological boundaries in their texts so that subjects can benefit from various social rights, such as access to public transportation without paying fees.

The interviews show, in general, that a senior healthcare network in the cities is not enough, demonstrated by the slowness in the effectuation of policies.

In the discussion about social policy organization, the Unified System of Social Support (SUAS) was mentioned as a recent or ongoing implantation in some of the participating cities.

> [...] we have organized SUAS, so now we only have the CRAS [Reference Center for Social Support] and the CREAS [Specialized Reference Center of Social Support] in the city, which are the two social care tools. [...] And we have just completed an administrative renovation in December, [...] so we have institutionalized the management issue of SUAS, which did not exist in this place (EA13).

The SUAS was approved in 2005 and is a non-contributory, decentralized, and collaborative public system that manages care policies in the Brazilian social protection area. This management model focuses on families and territory as the basis of organization and regulation of social-care services, and aims to materialize the Organic Regulation of Social Care (LOAS) and the 2004 National Policy of Social Care (PNAS).[15] With regard to the existence of documents that guide senior-focused actions, we have not observed the existence of documents that guide these actions in most of the cities. The interviewees mentioned documents from the Brazilian Department of Health, like the Senior Notebook [*Caderneta do Idoso*], the Caregiver Guide [*Manual do Cuidador*] from the Brazilian Department of Health, the Statute of Seniors, the Primary Care Notebook [*Caderno de Atenção Básica*] directed toward seniors, and the Collegiate Directive Resolution [*Resolução da Diretoria Colegiada*] No. 283, among other state documents for the direct care of seniors.

> [...] No, we use the Brazilian Department of Health protocol. The state protocols are going to be changed. [...] We do not have one ready yet, they are all adapted; sometimes, we have some characteristic actions of a certain protocol, but no actions of its own (ES10).

Some cities reported being in a process of developing documents and internal flows, using material prepared by the Secretary of Health to train technicians focused on daily care. Other cities, in turn, build and direct their documents as new demands arise. Finally, others know about guiding documents, but they do not use them.

> [...] We try to address, to build a little bit of this; but I think it is still done only in practice [...]. Some other texts are used for guidance as well; health professionals pass on some things, nurses end up providing this training for technicians on aging issues within daily care (EA10).

> [...] There is not a protocol yet, but we have to think of building one, because we really need one (EA13).

Working in networks increases the possibilities for action, because it facilitates the articulation between sectorial policies and organizations, with the aim of preventing social risk situations. Thus, the flow of information contributes to the process of change and facilitates intercommunication between the members that compose the service network, making actions more effective.[16]

Nevertheless, the interviews showed that the Healthcare Network expresses a setting with different service structures and actions where senior attention in primary care is the main entry into network care.

> [...] The Coordination of the Senior Reference Center is through the health organizational chart; however, direct management is done through the Office of Social Care (ES5).

> [...] Today, work here is done through the family health program. [...] We also have the NASF [Center of Family Health Care], so the gateway for seniors is through primary care (ES4).

As mentioned by Fernandes,[17] in Belo Horizonte and in other Brazilian cities, senior care in Health Primary Care (APS) has been the responsibility of family health teams since its implementation. Basic Health Units (UBS) are the main entryway into the system. For the last ten years, we have observed an increasing demand of seniors that seek care in the APS, which is one of the biggest health challenges for family health professionals.

Despite the increased demand of seniors in the UBS, there are still some challenges and problems regarding the lack of specificity of care provided to seniors, due to the lack of proper training for health professionals.

> [...] No, actually, we are scheduling the seniors' health issues for next month with the training of all professionals in senior health, which is a difficulty that we still have in senior citizen care and we still observe that the team has some difficulties regarding this service (ES1).

Fernandes[17] states that the Brazilian healthcare model is based on curative actions with centered medical care and demand-based services, but it is not enough to satisfy the demands of the elderly population. To do so, managers need to make an effort to innovate the organizational process of the health system by pointing out actions and services from the Healthcare Network in order to overcome the fragmentation of services.

Although the entire political context has been built on the structure of senior care, the discourses show that the difficulties regarding financial and human resources overpower the tendency to organize this structure, as pointed out in the following participants' reports.

> [...] we thought about trying to put into practice a specialized care service for seniors, but without proper financial support and without a legal budget, we could not find a solution (ES3).

> [...] The geriatrician XX got this guideline from the State, soaked it up and distributed to the units; this is one of my needs, when this geriatrician arrives, it is one of the duties that the girls were already starting to develop; they were developing a protocol regarding senior health (ES8).

In most of the studied cities, the interviewees did not have any specific training in aging, and senior care was dispersed among the programming for other patients. Motta[18] warns against the risk of iatrogenesis with regard to the network's lack of preparation in dealing with seniors. The network is not articulated well in the health system; therefore, the NASF was created in an attempt to increase the content of actions and its resolution, which is comprised of professionals from several areas and specialties. However, the center does not prioritize senior's health – a fact that is demonstrated by the small number or complete lack of geriatricians and gerontologists.

Articulation of health promotion and intersectoriality in senior care

The PNPS defends guidelines like integrality, equity and intersectoriality in the construction of citizenship and healthy cities.[19] In 2014, this policy was reviewed because "the sanitation sector was not able to answer on its own for the confrontation against the determiners and conditioners of health." This finding caused the health sector to become closer to other non-government sectors, including private and civil society sectors. It highlighted new priorities like the promotion of culture, peace and human rights.[20] Nevertheless, it is known that accomplishing public policy requires health professionals and managers to be conscious of these policies and be co-responsible for this process.[21]

Health promotion can be presented as a commitment that health managers and workers have to understand the social determination of health, sickness, death, and different damages in the subjects' lives, based on the voluntary and

active action of the community to diagnose the local social needs by promoting a reduction in inequality. The participation of all actors involved both in analysis and in performance is essential for the promotion of health with the aim of improving quality of life. It is worth noting that a healthier life with more opportunities can also have an impact with regard to decreasing health costs, both for the family and for society.[19,22]

The PNSPI strengthens and ensures the protection of seniors' life and health. Its main commitment is to the loss of functional capacity, which reaffirms the need to understand the aging process. Its guidelines support the promotion of healthy aging, the maintenance of functional capacity and support for seniors' health needs[7]. In addition, Resende[23] declares that the extension of the PNSPI primarily depends on the action guidelines developed in the health sector, which should go hand in hand with regular evaluations.

An analysis of the interviewees' responses showed a tendency to reduce the concept and the approach of health promotion actions; therefore, it is hard to develop these actions.

> [...] I believe promotion is still failing, it needs to be improved. [...] We are trying to have new views with regard to this management. [...] But we still face lots of difficulties in the city; the teams are not complete. [...] Some units do not know their region, some health units do not know their regions or their patients (ES8).

It is hard to define the term intersectoriality. Most of the attempts of providing a conceptual definition go beyond disintegrating different sectors that possess certain knowledge and area of action.[24] This conceptual difficulty is more noticeable with the investigated question: "How do you perceive intersectoriality with regard to senior care?." The responders provided diverging answers and mentioned isolated actions like celebrating Senior Day or meeting the demands of rights violations.

The interviewees from health and social development offices stated that intersectoriality is important. However, in practice, it is hard to make it a reality due to the fragmentation of actions with the offices involved in senior care and due to the difficulty of letting some knowledge go in each area.

> [...] So, it [intersectoriality] is hard, because it is not easy being responsible for other services (ES3).

> [...] We know intersectoriality is very nice, but it is hard in practice [...] we try to strengthen it, but it is still very fragmented, you know? (EA5).

The interviewees expressed difficulty regarding the development of intersectoriality, including the challenge of working in partnerships, the lack of resources and clarity, and the political situation of the cities.

> [...] It will be a challenge for the secretary to achieve this, you know? To make people let go of their pride, — what is mine, what is yours — and believe seniors belong to the city. [...] our challenges, the challenges that each city has, are the resources, because we cannot accomplish things without resources (EA5).

> [...] Because of resources, you do not get a lot of resources, partnerships. It is hard to get something done, to make partnerships with the government, the State, it is very hard (EA9).

Intersectoriality is essential to accomplish policies directed toward seniors. To make this happen, the proposed actions should be articulated. Intersectoriality is part of the public policy agenda of each city, however, the policies related to the elderly lose priority when competing with other policies. Thus, Resende[23] shows that programs for seniors are fragmented and isolated, contrary to the intersectoriality logic, which aims to overcome this fragmentation.

When the interviewees tried to report examples of intersectorial actions, we noticed that they were actually trying to show intrasectorial actions. What we really saw was the establishment of partnerships with the community's equipment. Intersectoriality, in its entirety, includes the permanent defragmentation of actions and services.

> [...] there is a path around the approached region of the Health Unit, they seek partnerships with the catholic church that is right beside it, or with the man that owns a garage on the other side of the street, or even with a bar that sells popcorn (ES8).

In most of the participating cities, no successful reports of intersectoriality were found. Emphasis should be given to one of the large-sized cities that had a sustained intersectorial project. One of the managers attempted intersectoriality through health promotion practices in his city, as follows:

> [...] We cannot make intersectoriality happen only with the office of health, you know? We need other

> offices that work with us in this area too; therefore, we built this senior care area slowly (ES2).

After analyzing the profile of the ten studied cities, we found that nine of them had a Seniors Council, which is recognized as the factor that facilitates the intersectoriality process, verified in some interviews.

> Look, we are beginning it thanks to the return of the Seniors Council, we came closer to our goal (EA10).

> [...] The council has a very active participation within this new reality of the city [...] A really, really close association with the council. Do not forget to register this (EA15).

The Seniors Councils represent an advancement in society's democracy, because they are comprised of government and civil society representatives. However, the implementation of these deliberative and joint collegiate boards in all Brazilian cities with an effective structure and proper working conditions is a great challenge. Nevertheless, although the councils are extremely important for articulating needs, they are not enough for the development of integrated projects that demand an interaction between sectors. Nevertheless, it is important to emphasize their role in increasing the visibility of promoting seniors' rights and their political protagonism[2].

The actions mentioned in the interviews seem to clarify some intrasectoriality advancements, i.e. the attempt to integrate actions within the same sector, because they do not have instruments that facilitate local intersectorial articulation. In agreement with these findings, a study carried out in cities in Minas Gerais shows that, despite the strategies used to answer complex problems that impact individual and collective welfare, intersectoriality remains restricted to the area of intentionality in the context of the analyzed practices.[25]

For Costa,[26] since Ottawa's Letter — which stated that health promotion and intersectoriality are inseparable —, a historical analysis of SUS demonstrates that health policies are still constructed and applied in individual sectors, thus making the follow through of the doctrinaire principle of comprehensive care difficult. According to this article, comprehensive care presupposes the articulation of intra and intersectorial actions with social participation.

Even though intersectoriality is a term with different meanings, difficulties and possibilities for use, it has been causing increased interest in the area of public policy in Brazil. This happens due to the recognition that the interaction between sectors leads to important changes in the management of services, and in public policies.[24]

CONCLUSIONS

This study shows that even though senior regulation laws have significantly advanced in the last years, they were not put into practice in most of the researched cities. It was also found that, in general, there is not a specific health services network for senior care, therefore the seniors are cared for in APS where they receive coverage from their family's health teams.

With regard to health promotion, actions focused on seniors are occasional and isolated from a conceptual understanding of this term. The greatest challenge that is faced in the development of this process is understanding the concept of health promotion and its articulation with theory and practice.

Reports point to the importance of recognizing the intersectorial perspective in senior care. However, there is a lack of communication between the actions of different sectors and their integration. Considering that the Statute for Seniors emphasizes the interface between intersectoriality and right to health, there are very few senior care actions in the studied cities other than those that were foreseen in the PNSPI.

Based on the assumption that intersectoriality is a health promotion principle and that these concepts are inseparable, these cities should have a better articulation and implementation of comprehensive and intersectorial policies, not only as fragmented actions, but as improvements that must be incorporated to the daily practice of senior care.

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CONFLICT OF INTERESTS

The authors declare no conflict of interest.

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