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Original Article

Changes in the care context: challenges for nursing

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This research aimed to identify global changes in the way of practicing and understanding care, as well as the demands population change has generated and the implications for family and professional caregivers. An integrative literature review was performed, identifying 284 papers with the following descriptors: care and caregivers, associated with the descriptor "Nursing", published between 2005 and 2010. Forty-one papers were selected that correspond to the intended goal. The results point towards a care transition model, reconfigured by new care demands, which are mainly associated with the increase in chronic conditions and population aging. In addition, the change in social and individual roles takes care beyond the family sphere and closer to shared social responsibility. Care is the axis around which nurses rotate. Hence, it is fundamental to analyze this context, which demands evolution in professional care development.

Descriptors: Care; Caregivers; Nursing.

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Mudanças no contexto do cuidado: desafios para a enfermagem

Este trabalho teve por objetivo identificar mudanças globais, relacionadas à forma de fazer e entender o cuidado, assim como as demandas geradas pela mudança populacional e as implicações para cuidadores familiares e profissionais. Realizou-se revisão integrativa da literatura, identificando-se 284 artigos com os descritores: cuidado e cuidadores, associados ao descritor "Enfermagem", entre os anos 2005 e 2010, selecionando-se 41 artigos que correspondem ao objetivo proposto. Os resultados apontam para um modelo de transição no cuidado, reconfigurado pelas novas demandas de atenção associadas, principalmente, ao incremento das doenças crônicas e ao envelhecimento populacional. Além disso, a mudança nos papéis sociais e individuais situam o cuidado além do âmbito familiar e o aproximam da responsabilidade social compartida. O cuidado é o eixo onde gravitam as enfermeiras, daí resulta indispensável analisar esse contexto que demanda evolução no desenvolvimento do cuidado profissional.

Descritores: Cuidado; Cuidadores; Enfermagem.

Cambios en el contexto del cuidado: desafíos para la enfermería

Este trabajo tuvo por objetivo identificar cambios globales relacionados con la forma de hacer y entender el cuidado, así como las demandas generadas por el cambio poblacional y las implicaciones para cuidadores familiares y profesionales. Se realizó una revisión integradora de la literatura, identificando 284 artículos con los descriptores: cuidado y cuidadores, asociados al descriptor Enfermería, entre los años 2005 y 2010, seleccionando 41 artículos que corresponden al objetivo planteado. Los resultados apuntan a un modelo de transición en el cuidado, reconfigurado por las nuevas demandas de atención asociadas principalmente al incremento de las enfermedades crónicas y el envejecimiento poblacional. Además, el cambio en los roles sociales e individuales sitúan al cuidado mas allá del ámbito familiar y lo aproximan a la responsabilidad social compartida. El cuidado es el eje gravitatorio de las enfermeras, por ello resulta indispensable analizar este contexto que demanda evolución en el desarrollo del cuidado profesional.

Descriptores: Cuidado; Cuidadores; Enfermería.

Introduction

In current times, changes have emerged in the people offering care as well as in the people taken care of. This pair interacts in an environment that reflects and conditions those changes. Through a systems perspective, it could be appointed that, in the macro-system, demographic structure changes, mainly brought about by the drop in mortality and birth rates, and increased life expectancy have led to the so-called population aging which, in turn, entails a notable rise in family care needs[1].

The fact that, historically, the family has been the central institution in terms of care for people would explain why the changes families are going through exert a decisive influence on the way care is delivered to the people who need it. Like the family itself, a new care concept is emerging, which has driven changes that condition transformations in the way care is understood and practiced[2]. Concrete issues like the collapse of social-sanitary systems and changes in family composition and functioning have enhanced this even further, and this involves women, who are the main care providers and produce modifications in the way they traditionally distinguish care, whether in the institutional or home context[3].

Method

The goal of this integrative review was to answer the following question: from a systemic perspective, what are the most relevant changes that have been generated in care and how do they affect professional and family caregivers?

Thus, a review was carried out in SciELO and LILACs, between 2005 and 2010, using the descriptors caregivers and care, associated with the descriptor Nursing, resulting in 284 papers. After identifying the papers, abstracts were read and 41 were selected, related to the study goal.

Articles were grouped in three thematic categories, which the team identified and defined as follows.

- Structural population changes, related to the demographic and epidemiological transition.
- Changes in family and social-sanitary systems.
- Changes in the ways of understanding and practicing care.

Results

The number of publications identified in this review increased by 75% in 2010 when compared with 2005 (58 and 33 publications, respectively), underlining the growing interest in the care theme.

The *age groups* are mainly those focusing research on children and elderly people (19.4%), the complexity of the theme is more oriented to the analysis of *conditions* that surpass age groups, such as impairment (14.6%), dependence (24.2%) and chronicity (17%). On the other hand, the analysis of the care experience from the (family or professional) caregiver's perspective is the *most* recurrent topic in this group of papers (48.7%), while other *themes* like the empowerment of people who receive the necessary care or social support appear less (Table 1).

Table 1 – Themes identified in the selected papers

	2005	2006	2007	2008	2009	2010
Universe 284 articles	33	38	38	48	69	58
Sample 41 articles	7	6	8	4	10	6

Identified theme					
Family and professional caregivers	Social changes	New proposals to perform care	Empowerment	Social support	Quality of life
48.7%	17%	14.6%	4.8%	2.4%	2.4%

Next, the obtained information is presented in an integrated way, like in the papers under analysis, as the discussion of the care theme clearly goes beyond the standardization approach, focused on one-dimensional factors like age, situation (chronic, acute) or condition (disease, impairment).

Structural population changes related to the demographic and epidemiological transition

Changes in the population structure are happening all over the world, but the aging trend is clearer in developed countries[4]. Demographic[5] and epidemiological[6] transition theories have described this trend, alluding to changes in the population's age structure, such as the decrease in infectious diseases at the expense of chronic degenerative ones. Despite these theories limited ability to explain variants present in distinct social realities, and their failure to analyze the social component in structural changes[5,7-8], they are useful to show how care needs and, consequently, care burdens have been modified.

A more specific analysis of implicit figures in the new population pyramid evidences that this is not only about the aging phenomenon, related to the rise in life expectancy and the drop in mortality rates. Instead, the increasingly large silhouette of these population graphs reflects the decrease in birth rates and, thus, in population and family size[9]. Hence, this is about the growth phenomenon of the population with care needs and the reduced availability of home caregivers[10].

According to the global aging report the UN presented in 2008, the elderly represented 10% of people around the world, i.e. almost 700 million[4]. On the other hand, in a research on aging, the UN Department of Social and Economic Affairs estimates that, in 2050, the percentage of elderly over 60 years of age will increase all over the

world, surpassing 30% in Europe and 20% in developing countries[11].

These population phenomena multiply and enhance the complexity of current care activities. In other words, today, the family core can comprise, to a greater or lesser extent, children, elderly, ill people, disabled people, or the combination, in the same person, of several of these conditions[10]. That evidences not only the increased complexity of home care, but also the constant need for innovation and adaptations that improve care.

Changes in family and social-sanitary systems

When the demographic and epidemiological transition are combined with social evolution and consequent modifications in social and gender roles, care moves from the private to the public sphere, turning into a social function, through State participation, through social policies that attempt to satisfy these people's basic needs, thus moving beyond the limit of the family context as an exclusive care space[9,12].

In countries that have incorporated social services as the welfare state's fourth pillar, the State had taken responsibility for tasks families can no longer address, either due to the knowledge they demand or to lesser availability. That includes a large part of activities related to care for people, increasingly considered a social right not only the State, but all welfare societies grant[13], offering public care services to those who need them and thus directly responding to the needs of those who cannot claim them by themselves, and granting time off from work to take care of relatives who need them. That supposes inverting the priority productive activity generally receives to reproductive activity, and implicitly suggests that the job world should make room for workers' family responsibilities[9,14].

Many countries that have assumed this welfare model, privileging productive over reproductive activity, display a consolidated phenomenon called the second demographic transition. Lesthaeghe coined the term to describe the changes related to the dissolution of families and unions, and in the patterns for their reconstitution present in Western countries since the Second World War[15]. In addition to this second demographic transition, there is the effect of the first transition, which is aging, characterized by: (a) increased number of single people, (b) postponed matrimony, (c) delay to have one's first child, (d) expansion of consensual unions, (e) expansion of extra-marital births, (f) increased number of broken marriages and (g) diversification of family structure modes.

These changes undoubtedly condition the transformation of the traditional family model, which presupposed a stable matrimony, a woman at home busy with family maintenance and children's education, and a man who got out to work to obtain the resources needed for family survival[16]. Thus, this transformation includes a functional change through a much more individualistic orientation of its members, and also a change in composition, broadening the family concept far beyond the inclusion of father, mother and children and presenting new family forms[2,15].

Changes in the ways of understanding and practicing care

At the end of the 1980's, in most Western countries, a crisis emerged in social protection systems, which encouraged the reinterpretation of family care in view of the flaws and limits of public or group solidarity. It is the addition and enhancement of all of these factors that has granted visibility and new relevance to care as a concept and activity[9, 17-18].

Care aims to guarantee subjects' life and enhance their autonomy[19], but has often been understood from a clinical focus only, fundamentally directed at disease control. In its most basic sense, the goal of care centers on guaranteeing survival through attendance to basic needs. When extending the life expectancy of ill or disabled people, however, and claiming their right to an integrated life, like other people, a movement is generated that is centered on independent and self-determined life, which implies that the goal of care has had to agree with and diversify in response to as many spheres and forms of support as people's needs[18,20- 21].

In that sense, the subjects framed under medicine, predominantly characterized by the search for cure, have varied this trend, among other things through the increase in diseases and chronic conditions. As a result, quality of life-related issues have been enhanced when cure is impossible and the goal of treatment has been converted into maximum functionality and good existence, with quality of life. Consequently, a new preponderant role for the family and care is due[22].

From this perspective, in the health context, the evolution from the cure to the care concept and from healing to recovering gain relevance[22]. This refers not only to "recovery" from the disorder, but mainly to the recovery of the vital project, as the disease has emerged and has moved the care focus from the disease to another focus, centered on the enhancement of people's abilities[23].

A care-related core issue precisely refers to the postural change, which implies the central and active role of people in what has been called self-care[18]. That is how programs and interventions focused on the promotion of self-determination have been structured, through the provision of general support. Also, initiatives have been developed related to specific training for medication handling, sign and symptom control, coping with diseases and, in general, support for independent life in a broad sense[23-27]. These support forms, necessary in the distinct spheres of individual development, demand the participation of distinct actors who comprise the social network and, in different contexts, offer natural and formal support. In other words, care is needed which is offered and developed at the heart of the family and social group, as well as care designed with due competence, with a specific goal and offered by entities external to the family[28].

It has been observed that the origin of care clearly rests in the family, which in the simplest sense aims to guarantee the survival of its members. That does not mean that its nature is innate. Even if great social changes have been produced, modifying women's position inside the family, it is not less certain that the naturalization and biologization socially imprinted on care still label women as the best or most adequate for care. Despite the persistence of this naturalization, an evolution of the care concept is already perceptible[29-30].

In the above approach to the care evolution, the intrinsic characteristics of home care providers seem to have changed less, as they are linked with continuing gender differences, and whose best reflection is the existence of most women as caregivers. This situation occurs despite women's increasing labor role, in addition to men's scarce contribution to the domestic/family sphere, to women's daily tasks[9,16] and to the changes that can be observed in three characters' new dynamics: immigrant women, elderly people and men[10,31].

The migration phenomenon could be understood as a contribution to the second demographic transition. The United Nations Population Fund informed that 3% of the world population had migrated[31-32]. One of the main stimuli for this phenomenon is the possibility to find employment, and care delivery has generated a particularly attractive market for women from less developed countries, who in turn exchange care for their own families with other women, giving rise to a phenomenon called global care flows, defined as cross-country links constituted to sustain life on a daily base, in which home care activities have been transferred from one to the other, based on power axes, among which gender, ethnic origin, social class and place of origin can be highlighted[32-35]. In this case, they refer to female caregivers, which have basically focused on care for sick elderly[36], in which one women replaces another.

In case of elderly people, in countries with aged demographic structures, basically, grandchildren or partners deliver care, corresponding to women's incorporation in the job market and population aging, which demands social policies according to these realities[9,37].

In case of male participation, changes seem to be oriented at care delivery by children. Studies on care show this challenge for the 21st century. A study developed in Spain appoints that men are more involved in tasks that are gratifying or related to the public sphere (strolls, baths, games, help to crawl…), while mothers still perform heavier and more monotonous tasks in the domestic sphere[9]. A similar trend is observed in Mexico, where the study Men and Women in Mexico observes that men enhance their participation in care for the temporarily ill, but are hardly involved in care for children and the physically or mentally disabled[38].

This evolution proceeds at the same speed as the multiple technical knowledge transfer to home care providers. Thus, alternatives like early discharge, outpatient management and medical technology management at home, as well as the increase in chronic degenerative conditions in the general population, make care today different from what it was some decades ago[1,39-40] (Picture 1). The above, in combination with the growing acceptance of the benefits of keeping people linked with their family environment, has enhanced knowledge acquisition to accomplish specialized care tasks. These go beyond traditional help, accelerating the need to transfer knowledge to caregivers and also to care receivers[30,41].

This understanding of care and the evolution of its complexity lead to a distinct configuration of the informal caregiver and care receiver's profiles. The borders between care as a profession and family work are distorted when delivering care to a relative implies cost for the State and represents a trajectory of changes in the conditions in which care is accomplished and in the nature of the State's and the family's participation[42].

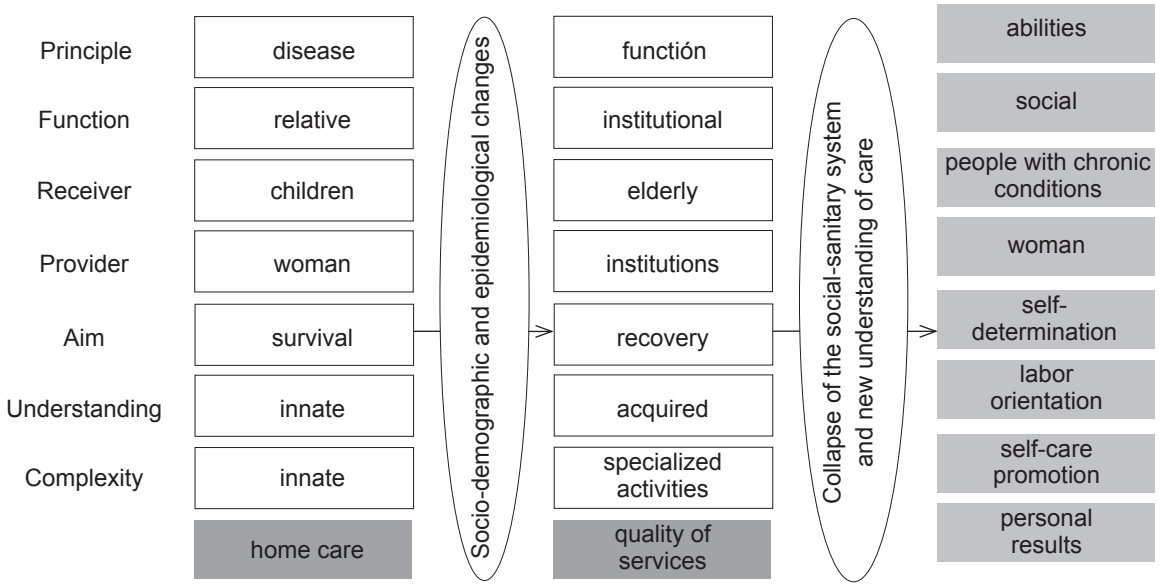

Figure 1 – Systemic changes that have modified care

In some European countries, care delivery to dependents represents a strategy to increase female work[43]. This possibility raises the discussion on the implications of care in the sociopolitical sphere, like in the Spanish case, where the Law for the Promotion of Personal Autonomy and Care to people in situations of dependency proposes economic compensation for people who serve as care providers for a relative and, therefore, cannot perform a remunerated job (Law No 39/2006, November 14th).

In this respect, since the Law was published, the issue emerged about the possible professionalization of caregivers in view of the traditional consideration of their caregiving role and, in 2009, this discussion was revived when the possibility was announced that people who had lacked the opportunity to get a degree in the care area could get professional education, accrediting family experience in care delivery to minors or dependent relatives, with a view to integrating them into the job market. To recognize professional competencies gained through job experience, Royal Decree No 1224/2009, intends to facilitate citizens' employability, mobility, enhance learning across the lifetime and social cohesion, especially for those groups lacking acknowledged qualification (R.D. No 1224/2009, July 17tt).

This recognition raises a new issues, deriving from the perspective of finding a mixed form between formal and informal caregivers, given their job insertion and, thus, the possibility of new job markets[44]. This possibility reflects that the care context is experiencing a new feminization and that, in a way, the establishment of this new job option again places women in the domestic sphere[41]. Hence, family pressures are maintained for women, who have taken care free of charge, to continue doing this, but now with economic help and social security, reinforcing all aspects of the female naturalization of care[43].

On the other hand, the emergence of this economic activity sector entails the genesis of new job characters, like family worker, geriatric assistant or personal assistant for autonomy for example. All of these emerge at a precarious time in the job market. Given their incipient professionalization process, this puts them in a vulnerable situation and results in discrimination for the people performing these jobs. That is, as these jobs are frequently mixed up with an expression of femininity, they tend towards invisible jobs[33,41]. On the other hand, as these jobs are executed in the family context, they entail the implicit understanding about the permanent availability of women's time at the service of the family, as opposed to what happens in the economic sphere, where goods are exchanged for other goods and a specific time exists for this exchange[45]. This phenomenon has been called the domestication of work, a term that implies that remunerated work is increasingly similar to domestic/family work: elasticity, fragmentation and dispersion in terms of job conditions, such as time availability, flexibility, dedication and polyvalence. Besides, and to an increasing extent, they suppose an underlying quality – affect – which was considered exclusive to the private sphere of individuals' lives until now, and totally detached from any work concept[33].

In that respect, a study[43] appoints that distinct care regimes make room for specific types of markets

in this sector. To give an example, in Sweden, qualified occupations have been created with qualified jobs, in the framework of universal policies and public services parallel to and integrated with gender equality policies. In Southern European countries, on the other hand, with scarce social services and a greater trend towards monetary transfers, a precarious job market sector and employment conditions similar to the British case are being generated[33,43].

Despite the care formal caregivers deliver, it is predictable that the characteristics of the social-sanitary support network indirectly determine the level of informal support patients receive from their close environment[46]. The degree of access to technical help, as well as the price and availability of informal care substitutes, can affect its intensity and nature. In view of these changes and growing care demands, the perspective is increasingly complex, as individualized foci are needed to address this diversity[18].

Conclusions

In structural population changes related to the demographic and epidemiological transition, it can be identified that aging, which occurred to different extents around the world, has enhanced the dependence phenomenon, a situation in which two conditions are intertwined: chronicity and impairment, which entail enhanced care complexity. This situation increasingly demands family caregivers' participation and the emergence of new professional caregiver characters. On the other hand, it also reinforces the new for care receivers to assume a new position, moving towards knowledge appropriation with a view to self-care.

Implications for professional caregivers not only appoint a change in the way they perform their individual practice, but also modifications in social-sanitary service organization and position, which demand, besides new modes like home care, a new concept aimed at understanding care as a social function, more than an individual issue. Increased social support needs for care delivery in more diversified areas and populations raises the opportunity and need for professional nurses to participate not only in direct care delivery to people, but also in care planning and management, given that that is the discipline's rotational axis.

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