Original Article

Home care assistance and the right to health: an experience in the Brazilian net*

Atenção domiciliária e direito à saúde: uma experiência na rede pública brasileira

La atención domiciliaria y el derecho a la salud: una experiencia en la red pública brasileña

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ABSTRACT

Objective: To consider, careful, how the home care has contributed to the population health. **Methods:** the study was processed through observation of interviews (with: 7 users, 22 workers, 2 managers and 3 representatives of the Local Board of Health) and documentary research, between March and July 2006, in a primary care health unit, in Porto Alegre, RS. **Results:** The results were systematized using developed indicators, they showed that workers and managers understands the home care as being relevant to community health, however, they do not apply that understanding in their work practice. **Conclusion:** The home care assistance has been conducted focusing on disease; its aim is to work on individual subjects; emphasizes the development of curative care and does not developed inter-sector actions. From another point of view, tries to resolve the situation in the first contact, offers continuous and longitudinal attention, has a defined territory, promotes inter-personal relations (workers and users), and acts trying to provide a humanized care.

Keywords: Domiciliary attention; Health system; Primary health attention

RESUMO

Objetivo: Refletir de que forma a atenção domiciliária tem contribuído para a saúde da população. **Métodos:** Processou-se por meio de observação, de entrevistas individuais com 7 usuários, 22 trabalhadores e 2 gestores 3 representantes do Conselho Local de Saúde e de pesquisa documental, entre março e julho de 2006, em uma unidade de atenção primária à saúde de Porto Alegre - RS. **Resultados :** Os resultados foram sistematizados a partir de indicadores formulados e mostraram que os trabalhadores e gestores têm compreensão da atenção domiciliária como relevante para a saúde da comunidade, porém, não objetivam essa compreensão na sua prática de trabalho. **Conclusão:** A atenção domiciliária tem sido realizada com foco na doença, tem como objeto de trabalho um sujeito individual, enfatiza o cuidado curativo e não desenvolve ações intersetoriais. Porém, busca resolutividade no primeiro contato, presta atenção contínua e longitudinal, tem território definido, promove as relações interpessoais (trabalhadores e usuários) e atua visando um cuidado humanizado.

Descritores: Assistência domiciliar; Sistema de saúde; Atenção primária à saúde

RESUMEN

Objetivo: Reflexionar de qué forma la atención domiciliaria ha contribuido para la salud de la población. **Métodos:** Se procesó por medio de observación de entrevistas (con: 7 usuarios, 22 trabajadores, 2 administradores y 3 representantes del Consejo Local de Salud) y de investigación documental, entre marzo y julio de 2006, en una unidad de atención primaria de salud de Porto Alegre, RS. **Resultados:** Los resultados fueron sistematizados a partir de indicadores formulados y mostraron que los trabajadores y administradores entienden la atención domiciliaria como relevante para la salud de la comunidad, sin embargo, no aplican esa comprensión en su práctica de trabajo. **Conclusión:** La atención domiciliaria se ha realizado enfocando en la enfermedad, tiene como objeto de trabajo un sujeto individual, enfatiza el cuidado curativo y no desarrolla acciones intersectoriales. Por otro lado, busca ser resolutiva en el primer contacto, presta atención continua y longitudinal, tiene territorio definido, promueve relaciones inter-personales (trabajadores y usuarios) y actúa tratando de ofrecer un cuidado humanizado.

Descriptores: Asistencia domiciliaria; Sistema de salud; Atención primaria a la salud

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INTRODUCTION

Primary health care (PHC) is a level of care that offers an entry in the health care system to solve needs and problems; provides care to individuals (rather than to a disease); provides care to all diseases except for those very uncommon and rare; and coordinates or integrates care provided by other places or by other people[1].

All the problems faced by health services show the need to invest in primary care[2]*; the Ministry of Health has, to some extent, included it in the public health policies with new regulations. Discussions that led to the *Plano Nacional de Atenção Básica* (National Plan for Primary Health Care) in 2006, were based on the transversal axis of universality, integrality and equity, in a context of decentralization and social control of the management, care and organizational principles of the National Health System (SUS), recorded in the legislation.

In this process to structure primary health care, there is the possibility to insert programs of homecare as another component for the guiding principles to consolidate SUS effectively. Home Care (HC) is a strategy to articulate the system in its different levels, it can be performed with the clientele in the hospital, continuing with home care and then, referring patients to individuals working in primary health care. Home Care is regulated by Ordinance # 2,529,/2006, which established home care in SUS[3].

The need for health care and the advantages provided by this type of care makes this service very attractive both to patients, family members, workers, and managers of the health system. The advantages reported are: minimal change in patients' life; more individual care; more integral care; decrease in patients' anxiety; cost reduction both for the family and the government; decrease in the risk of hospital infection; greater patient control; possibility of performing relational diagnosis, possibility of using family therapy as an instrument; more rational use of beds and hospital resources; promotion of family, community and society participation in care and recovery of patients; encouragement of doctor-patients relationship in a horizontal manner; contribution to demand medical professionalism; encouragement of professional development and more independence to nurses; irreplaceable experience for teaching and post graduation[4].

HC is a promising perspective in the health area. However, it is important to highlight that despite the advantages reported, "there can be a family overburden and even costs, which requires special attention for its implementation"[5].

Workers should fully understand the different and unique space where they develop their work. To that end, together with the concepts necessary to care, the specificity of home care should be understood, encompassing economic, social, and affective aspects; the material and human resources available; the social network of support; the relationship established within and outside the home; the physical space; the conditions of hygiene and safety of homes; everything involving patients and their families[6].

To understand a little better this work process, the study objective proposed was to assess a successful initiative in home care developed by the Brazilian public health care system, and to reflect how it has contributed to the health of the population.

METHODS

Case study developed at the Conceição Family Medicine Unit, Community Health Service (SSC), Grupo Hospitalar Conceição (GHC), in Porto Alegre/RS/ Brazil.

Individuals studied were workers, managers, and users of the unit divided into three groups: the first group was formed by 22 health workers from the unit. The second group was formed by managers: the coordinator from SSC, the chief of the health unit and the three representatives of the community in the Local Health Council. The third group was formed by users, including both patients and their families, using the saturation criteria to finish the sample with the participation of seven users.

Data collection occurred from March to July 2006, and the following three techniques have been used: documentary survey of the records used by workers, documents referring to creation and development of the unit proposal, direct observation of the work process identifying its elements and a meeting of the Local Health Council. Initially, all participants gave their written consent and after one month of observations, individual interviews with workers, managers and users of the home care program were carried out; the interviews were recorded after patients' approvals. The project was sent to the Research Ethics Committee from GHC and authorization to develop the research was obtained through Act #. 105/05.

The study question was answered through categories/ indicators built and described to demonstrate the reach of answers. An assessment question can only be answered if we take a part of what must be assessed and this part is defined by indicators[7].

Possible answers were assessed from the study question – How the HC developed by the public health sector has contributed to the health of the population?

The concept of basic health care is more commonly found in the international literature as primary health care

Indicators were built based on the assumptions of a health institution belonging to SUS and considered as PHC. They are organized next, in the presentation of results.

RESULTS

Results are arranged in the indicators taken as reference for the present study and highlighted below:

Workers in home care develop their work process according to the guidelines for PHC

To discuss the work process developed in the unit studied, we have focused on some guiding principles of PHC such as first contact, "longitudinality", coordination, and focus on the family[1].

Workers considered that HC was a way to provide accessibility to people who cannot obtain health care in health units. However, by the observation of the work process and the statements of users, so far, there is no routine for home visits.

Work observation and the problems found during this time showed a deficit in internal planning as there was a long and varied interval from one visit to the next, which shows lack of regularity.

There is no difference between the care provided at home and in health units. The actions are the same: a clinical appointment to assess the disease. Most times, there were no actions for health promotion or education. Families are usually not considered as the focus of work.

In this practice, efforts are concentrated on the performance of care to sick individuals that are in bed or impaired for some reason. In this type of individualized care, workers spend time with families; however, the other family members do not receive care, even if they are as old as the patient.

Regarding the principle of coordination, the use and organization of patients' chart and family chart is the parameter. This is a very important instrument for this organization principle since it presents information and impressions of several members of the work team. It is the most logical and organized way to keep an effective communication between the several workers, even among different institutions.

The chart is seen by many workers as a work instrument; however, it is not that important in the practice. An example is the filling out of both the unit and home chart, usually, professionals choose one of them.

Another aspect which is part of the same principle is the intersectoral approach which is little explored. There is no connection between the sectors and institutions that can meet patients' needs. There is no formal path that works as a guide for workers' actions.

HC becomes a continuity of the care provided before it, developed in the appointment in the health unit, or in the participation in therapy groups, vaccine rooms or even the care provided by a home visit by community health agents performed for data survey. Continuity is the arrangement where care is offered in an uninterrupted succession of events.

As for "longitudinality", the health unit studied uses this principle in the work process to guide its actions since when the unit was first established there was a concern to limit an area of work to drive the work. Limiting the area is a restriction of the focus of care for a feasible action.

Workers and managers follow the principles of SUS supporting primary health care

This reflection is based on the principles of integrality, universality and equity of care, resoluteness and community participation.

The connotation of integrality presented is of a work developed multi-professionally by most individuals of the study. Statements demonstrate a meaning of integration of the team and of group work.

When workers talk about universal care, they all consider the access to services as an essential aspect to ensure this principle.

There is the understanding that people should have access to health services and this is done through understanding the principle of equity. Equity in the routine of work is understood as closely connected with the concept of equal care, and there is the concern of treating patients in the same way.

Physicians have a thinking of providing care to those people most in need, who need care the most and, therefore, require a different treatment.

As for resoluteness, almost all participants have a positive opinion; they see HC as resolving within its objectives. It is stated that is has worked to avoid hospital admissions. This has not been measured, so the evidences are not scientific but rather reflective.

Some workers mentioned the need for other workers in HC. This difficulty, found in many institutions, hinders resoluteness of care because it prevents continuity of care.

One of the workers presented a different view regarding resoluteness of the work. He thought that the work process is not developed as expected for the type of service.

As for the principle of community participation, workers were not satisfied with the current situation. Even representatives of the Local Health Council presented behaviors that are not expected for a community council. They should think about the health actions performed and give opinions, they should think not only on the care aspects, but also on the priorities the management should think about.

Perception of health as a citizen right

The assumption that health is a right means that users should have universal and equal access to it. To that end, constant assessment is essential to make adjustments in care or in the institutions if necessary and to meet users' needs.

Users do not know the services. They have a passive behavior during the work process in home care, waiting for the actions of workers. When they were asked if community members are entitled to health which is ensured by the constitution, the answers are vague, something like 'I believe so'.

Data both from interviews and from the observation of the work developed in home care have demonstrated that workers are concerned with the access of users affected in their physical mobility, which implicitly means they understand that everyone should be entitled to health services.

Another element investigated was the assessment, both of work and workers. All users mentioned they never took part in an assessment process. One of the families thought this was a positive thing, they understood this was not done because there was no need for it, since it was clear to them the importance and relevance of this type of work practice.

There is mobilization because of the complaints and problems mentioned however, no actions are taken to organize work, to see how it is developed, and to assess if it meets the needs of patients. This occurs with work assessment and also with workers who do not feel evaluated.

Bond and satisfaction of the population with home care

The assessment is to understand if a worker-user bond is created through their relationship, reflecting on their idea of care humanization in the work developed. An important aspect, approached in this theme, is the satisfaction of the clientele with the service which is considered as characteristic of a work that values users in the health system.

The interaction between workers and users in the household environment strengthen their relationship, creating a greater bond and giving safety to patients. The bond is a characteristic of the institution that patients connect with humanization of care.

The bond is one of the advantages reported by patients and family members when they were asked to comment on the easy parts of performing this activity. In this care process, listening is important and it has been highlighted by workers.

During follow-up of the work process in the units and at the homes, the characteristic of a team that is trying to develop humanizing work was that of *grupo das arteiras* (group of artisans), with the purpose of providing leisure and well being to the population with several handicraft activities.

One of the aspects of the valuation of users of the health care system is to take their opinions on the health service into account, assessing their level of satisfaction.

In the unit studied, the population is satisfied with care, expressed by tender gesture, care, smiles and a cordial and happy welcome in the family space and at home. Interpersonal relationship is so strong that when there are doubts, problems and dissatisfaction with a certain situation, users spontaneously look for one of the workers to explain the problem and request a solution.

DISCUSSION

The principle of the first contact implies accessibility and the use of services for each new problem or episode of a problem to which health care is searched for[1] and, because of that, home care is already a step towards this. However, it is not systematical, partly because of the excessive demand that makes this activity less important than the other actions. This is an inverted logic within the model that workers say they follow. Activities such as home care can contribute to invert a bit this demand.

Focus on the family is another guiding principle of primary care that should be known and used. "Focus on the family is essential because family is the subject of care, demanding an interaction of the health team with this social unit and the total knowledge of their health problems"(1:14).

Regarding the principle of coordination, this can be made easier through more formal connections between the levels of care and through communication, and it can be enhanced through electronic mechanisms for information flow"(1:195).

The intersectoral approach can be understood as: "the development of integrated actions between health institutions and public agencies to articulate policies and programs of interest to health whose performance involve areas that are not part of the National Health System, thus potentiating financial, technological, material and human resources available and avoiding the use of two means for the same end"(8:196).

To make the principle of coordination concrete, workers need to ensure patients' needs are met, by offering several health institution and information.

The work developed depends on the individuality of each worker who tries to solve issues that are not part of their immediate action. The system must be organized as a whole, and each institution according to their uniqueness. So, workers cannot be blamed if the intersectoral approach is not carried out in the routine of health care.

Another guiding principle of primary care is "longitudinality". In the context of primary health care, it

is a long, personal relationship between health professionals and patients in their health units. Continuity is not necessary for this relationship; interruptions in care continuity for any reason do not necessarily stop this relationship (1:247).

As for integrality, Law # 8,080/90 understands it as an "articulated and continuous set of preventive and healing actions and services, that are individual and collective required for each case in all levels of complexity of the health system"(8:195). It is understood that there are several views of the same work objective and a tendency to increase the comprehensiveness of care since each worker has a different background.

At this point, the principles of integrality and the intersectoral approach blend. There is the need for an effective intersectoral approach to make the recommended integral care possible. Therefore, it is understood that having different types of professionals do not necessarily guarantee integrality in actions. The possible integration between workers may be considered as an instrument to make integrality effective through the exchange of knowledge and complementation of care, however, we must consider that there can be many professionals just coexisting in an institution with no contribution to integral care.

As for equity[9], institutions should adjust their actions to the features of the population they care for, thus providing health care according not only to patients needs, but also to the conditions of access to these institutions. Therefore, the idea of this concept is not to care to all in the same way in the sense of not having any prejudice or discriminating feelings, but rather to care differently to those most in need precisely because they are the ones that need care the most and have less conditions to obtain it.

Resoluteness is associated with solving clinical problems presented by patients, once again confirming the theoretical and conceptual framework behind this care. A study carried out to assess professional appointment in home care also found that the judgment and the actions were restricted to the technical side[10]. Regarding workers who present a different understanding, we see that they are aware of the care model that has been developed, focused on the clinical aspect and they believe resolvability is positive in this model. However, it is clear that is does not go beyond. So, this assessment depends on the point of view, if the analysis is on the work process being developed according to the model that is driving it, we get one answer; if the analysis is on the model that should be used then the answer is different.

To materialize projects of general interest, an essential aspect involving the work process is to assess it. How can we know if the health needs are being met? How can we ensure that the right type of work is being developed to the population? Through continuous assessment of the care provided, so that there can be parameters to keep or change the work. Assessing the institutions is an important component to validate the rights of the clientele because it is a way to ensure that health levels of this clientele are reached.

The term assessment involves meanings that can be connected with the work process, with the clinical evolvement of the users, and the product reached through work and quality of care, among others. The sense presented in the statements included only direct questions of each patient cared for at home and their relationship with clinical evolvement. Assessment is not performed to identify problems and redesign actions developed, or to assess practices and measure the impact of actions performed by the institutions in the services and programs on the health of the population.

The context of home care favors the performance of assessment and insertion processes of users. Without these processes, users are not included as citizens.

When workers get into the homes they have to deal with a subjective dimension that is present in the relationship established between human beings "in their spaces of power, privacy, with greater autonomy to live their lives, that is, when they leave the health institutions which is the place they know, the relations between users and health care workers can become more horizontal"(11:78).

HC to the clientele establishes a deep bond between users and workers, with workers being acknowledged for their work and being considered as a reference by users to solve their health issues.

Listening is a very important aspect in the care to these human beings; it goes beyond listening to what the other says. One should try to understand what is being said and share the feeling that is being mentioned at that important moment of the relationship. Knowing how to listen with the ears and also with the eyes, the feelings, with reason, to what is said and unsaid. Listening not only to sentences, but also to the intonation, speed, and irony (12:147).

Among the propositions found in health institutions that translate the humanizing intention is the organization of pleasant and playful interaction activities such as toy & leisure libraries and other connected with arts, music and drama[13].

Reflecting on the institution communication, it seems that it is not carried out – which is mandatory – if it is done, maybe it will not be possible to meet all the demands that will occur. This is because the demand in the health care unit is extremely high and the amount of workers is not enough to meet the needs of the population.

Contradictorily to the need for communicating the services to guarantee citizenship, there is the need for not communicating it so that the most necessary work can be

carried out. Even though they understand the importance of home care to give access to those most dependent on care, currently, workers cannot develop this work with all individuals. For that reason, they stress the importance of establishing criteria to include new patients in the program. So that, at least, they can follow the equity principle, offering more care to those most in need.

One of the greatest objectives of home care is to ensure that very dependent individuals have access to the health system as any other citizens. Thus, individuals who cannot go to the health units, because they are very dependent, can get the necessary care, decreasing "the inequity of exclusion"(12:147).

It is also very important to increasingly encourage the participation of the community in health issues, making them feel involved and committed to it. It is said that when there is knowledge production on health services, the problems seen in the routine will be understood and this may help the community, together with health workers, fight for better conditions to develop the work.

Health is everyone's right but, at the same time this is easily said and heard by all, how many citizens are using this right? Having rights implies having duties as well. And, in the case of health, this means to know the institutions, to take part in planning and assessment of actions as a way to ensure that the right to health is being met. If the community does not share their questions and wishes with their representatives, managers will fight for or demand what they see as necessary according to their experiences which may not meet the needs of the population.

The goal of developing the process of work in health can only be democratically stated with the incorporation of citizens in the definition of projects, stating the type of society desired, and in the political action to materialize the possibilities of managing projects of general interest (13:1350).

FINAL CONSIDERATIONS

Home care facilitated the access to health care to some users somehow affected in their mobility. Better access makes care more humane and the relations are more effective because the time available for care outside health units is greater, the hurry that is characteristic of outpatient appointments because there are other patients waiting does not exist. Also, when patients are treated in their environment, in their space, they feel more at ease.

The greatest restraint is the work force. If there were more workers, they would have more time to carry out this type of work practice. Other restrictions are: non-systematization of the routine of home visits; inefficiency of the intersectoral approach and the increased demand in the health unit.

The idea that drives the work in home care is health care to users affected in their lives and health, suffering from diseases, and that need to be "cured" or, at least kept in their current health state. They forget that HC involves other forms of care which are not necessarily oriented to an organic body let alone a sick body.

We conclude that even though the work process of home care still focus on the disease, and that the object of work is an individual subject with emphasis on healing, and a lack of actions with an intersectoral approach, it is a work of primary health care that aims at solving the problem right from the beginning, providing continuous and longitudinal care in a defined territory, promoting interpersonal relationship (workers and users) and with actions to humanize care.

The assessment carried out demonstrated that workers, managers and users understand home care as extremely relevant to the health of the community seen by the health unit, however, this understanding is not used in their work practice.

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