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HOME HEALTH CARE IN BRAZIL: A GLANCE AT THIS POLICY THROUGH AN INTEGRATIVE REVIEW

Atenção domiciliar em saúde no Brasil: visão dessa política por uma revisão integrativa

Atención domiciliaria en salud de Brasil: opinión sobre esa política a través de una revisión integrativa

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ABSTRACT

Objective: To review the scientific production about home care in Brazil. **Methods**: An integrative review of the literature was conducted from August to October 2018 on the following databases: Medical Literature Analysis and Retrieval System Online (MEDLINE), accessed via PubMed; Latin American and Caribbean Health Sciences Literature (LILACS), accessed via the Virtual Health Library (VHL), and SciELO (Scientific Electronic Library Online). The following descriptors and their combinations in Portuguese, English and Spanish were used to search for articles: “Home Care”, “Home Nursing”, and “Hospital-based Home Care Services”. A total of 20 articles were selected for the final analysis. **Results**: The findings were categorized as Home Care as an aid to the public health system and Home care in complement health care, given the importance of home care integrated into the health care network. **Conclusion**: Scientific evidence points to home care as a tool to be used in the reorganization of the health system, in disease prevention, and in health promotion.

Descriptors: Home Care; Hospital-based Home Care Services; Public Health Policies.

RESUMO

***Objetivo**: Revisar a produção científica acerca da política da atenção domiciliar em saúde no Brasil. **Métodos**: Revisão integrativa de literatura realizada no período de agosto a outubro de 2018, nas seguintes bases de dados: Medical Literature Analysis and Retrieval System Online (MEDLINE), consultada por meio do PubMed; Literatura Latino-Americana e do Caribe em Ciências da Saúde (LILACS), consultados pela Biblioteca Virtual em Saúde (BVS) e SciELO (Scientific Eletronic Library Online). Foram utilizados, para busca dos artigos, os seguintes descritores e suas combinações nas línguas portuguesa, inglesa e espanhola: “atenção domiciliar”, “assistência domiciliar”, “serviços hospitalares de assistência domiciliar”. Selecionaram-se 20 artigos na análise final. **Resultados**: Os achados foram categorizados na seguinte forma: atenção domiciliar como subsídio do sistema público de saúde e atenção domiciliar na suplementação à saúde, dada a importância da atenção domiciliar integrada à rede de atenção à saúde. **Conclusão**: As evidências científicas apontam a atenção domiciliar como uma ferramenta a ser utilizada na reorganização do sistema de saúde, prevenção de agravos e promoção da saúde.*

***Descritores:** Assistência Domiciliar; Serviços Hospitalares de Assistência Domiciliar; Políticas Públicas de Saúde.*

RESUMEN

***Objetivo**: Revisar la producción científica sobre la política de la atención domiciliaria de salud en Brasil. **Métodos**: Revisión integrativa de la literatura realizada en el período entre agosto y octubre de 2018 en las bases de datos Medical Literature Analysis and Retrieval System Online (MEDLINE), consultada a través de PubMed; Literatura Latino- Americana y del Caribe en las Ciencias de la Salud (LILACS) consultada a través de la Biblioteca Virtual en Salud (BVS) y SciELO (Scientific Eletronic Library Online). Se ha utilizado los descriptores y sus combinaciones en los idiomas portugués, inglés y español a continuación:*

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"atención domiciliaria", "asistencia domiciliaria", "servicios hospitalarios de asistencia domiciliaria". Fueron elegidos 20 artículos para el análisis final. ***Resultados****: Se han categorizado los hallazgos en: atención domiciliaria como subsidio del sistema público de salud y atención domiciliaria para la suplementación de salud debido la importancia de la atención domiciliaria integrada a la red de atención de salud.* ***Conclusión****: Las evidencias científicas señalan la atención domiciliaria como una herramienta para utilizarse en la reorganización del sistema de salud, la prevención de agravios y la promoción de la salud.*

Descriptores: *Atención Domiciliaria de Salud; Servicios de Atención a Domicilio Provisto por Hospital; Políticas Públicas de Salud.*

INTRODUCTION

The Brazilian population has been experiencing times of economic, political and social crises, which has highlighted the importance of public health services in providing alternatives for improving care for chronic patients[1].

Population aging and improved survival in chronic conditions in different age groups require the Unified Health System (*Sistema Único de Saúde – SUS*) to offer and provide the resources needed for quality care[2].

Within that context, home care has been gaining prominence as an alternative for the continuity of care of the user by guaranteeing the basic principles of SUS, such as comprehensiveness and equity, but with the need for management, monitoring and financing to achieve the goal of granting the population's with quality of life[3,4].

Home care is a generic term that involves health promotion and disease prevention, treatment and rehabilitation actions developed at home with the main objective of ensuring patients' comprehensiveness at home[5].

In 2016, Ordinance No. 825 was approved to redefine the Best at Home Program. It considers home care a modality of health care integrated into the Health Care Network (*Rede de Atenção à Saúde – RAS*) and characterized by a set of services aimed at disease prevention, treatment and rehabilitation, palliation and health promotion provided at home to ensure continuity of care[6,7].

There is a need to build healthy policies to improve population's health through the development of individual and collective skills to promote quality of life and reduce fragility and health risks[8]. In this regard, home care has been establishing itself as a tool for continuity of care through health promotion and disease prevention actions[9,10].

Considering the importance of health promotion in the context of home care, this study sought to review the scientific production about the home care policy in Brazil.

METHODS

An integrative review of the literature was conducted based on the following steps: construction of the research question; definition of databases and definition of criteria for inclusion and exclusion of studies/sampling or search in the literature; definition of the information to be extracted from the selected studies; evaluation of the studies included in the integrative review; interpretation of results and presentation of the review/synthesis of knowledge[11,12].

The articles were selected through a bibliographic search carried out from August to October 2018 to answer the research question: How is the health care policy being evaluated by the scientific community? The following databases were used: Medical Literature Analysis and Retrieval System Online (MEDLINE), accessed via PubMed; Latin American and Caribbean Health Sciences Literature (LILACS), accessed via the Virtual Health Library (VHL), and SciELO (Scientific Electronic Library Online).

Combinations of the following descriptors in Portuguese, English and Spanish were used: "home care" AND "home nursing" AND "hospital-based home care services". All the descriptors were defined on the Health Sciences Descriptors (*Descritores em Ciências da Saúde – DeCS*) platform.

Articles that addressed home visits made by the Family Health Strategies (*Estratégias de Saúde da Família – ESF*), opinion articles, bibliographic and editorial reviews, letters to the editor, comments and articles that portrayed the reality of home care abroad were excluded.

The initial search for associations of descriptors yielded 620 publications. After reading the titles and abstracts, we excluded duplicates and studies that did not meet the inclusion criteria and/or addressed the proposed theme. Thus, 42 articles were selected for reading of full texts. Of these, 17 were not fully available and five were rejected because they did not provide information on issue, year or volume. Thus, of the 42 fully read articles, 20 answered the research question and were hence included in the final sample of this review.

RESULTS

A total of 20 articles met the inclusion criteria to achieve the proposed objective and were hence included in the study. All the articles were published between 2008 and 2018. The largest number of publications were found on the SciELO database (85%), followed by MEDLINE (8%) and LILACS (7 %). There was a predominance of articles published in Portuguese (19 publications) and publications in journals specializing in the Nursing field.

The main findings of the studies show that home care features a complex and diverse set of actions, which allowed the construction of two thematic axes: 1. Home care as a public health policy; 2. Home care in complementary health care.

Home care as a public health policy

The analysis of the articles revealed that home care is a political strategy that is still under implementation; however, it is important for the effectiveness of the SUS principles, such as comprehensiveness, equity, preservation of people's autonomy and health care equality.

The selected articles highlighted comprehensiveness as one of the main characteristics of home care. A qualitative study that aimed to analyze home care practices in outpatient and hospital services and their constitution as a substitute health care network concluded that the essence of home care needs to consider elements such as care comprehensive, economic and financial rationality, the subjects of care[4] and the articulation with other health services[13].

Comprehensive care is essential for the effective implementation of home care as it will guarantee the continuity of care. Therefore, it should be expanded within the scope of the public health system to allow greater humanization of the patient and individualization of the care provided[13,14]. If the integrality of the individual is not prioritized in home care, the effectiveness of this type of care can be jeopardized. This idea is exposed in the study that analyzed the process of dehospitalization in a general public hospital in Minas Gerais from the perspective of directors, professionals and users. The study showed that if there are weaknesses in the process of safe dehospitalization, the comprehensiveness and continuity of care can be compromised during home care[15].

Home care is an important strategy to carry out practices based on comprehensiveness in three directions: vertical direction, which presupposes the search to identify users' needs through a comprehensive and expanded perspective; the horizontal direction, which shows that the answers to the users' needs are generally not obtained through the first or only one contact with the health system; and the transversal direction, which draws attention to conditions that are sometimes not valued in the hospital environment[16].

Health care equity was highlighted in a study carried out in 23 Brazilian states that aimed to identify the prevalence of home care among Brazilian older people and its association with demographic and socioeconomic factors, health conditions and the use of health services. The prevalence was higher among women, the old-old, people with lower levels of education and purchasing power and those diagnosed with chronic morbidity, history of falls, previous hospitalization and medical consultation in the last three months. The results highlighted a greater use of home care by the most vulnerable older adults, which indicates a contribution of home care to the promotion of equity in health care in the country, mainly due to the expansion of the ESF[17].

The association between home care and the autonomy and humanization of care has been addressed in some studies[1,18,19]. Home care has the following characteristics: dehospitalization, which favors the rotation of beds; the continuity of care, which reduces hospital admissions among patients being monitored and the costs of prolonged hospitalizations; and the humanization of care through the therapeutic plan and classification of care with family autonomy. It occurs in association with multidisciplinary and interdisciplinary work and seeks to solve problems in the first contact, provide continuous and longitudinal care in a defined territory, and promote interpersonal relationships (workers and users) for humanized care[14].

Home care expands user/family autonomy by recognizing the family as a unit of social organization and a provider of immediate care that uses the household as a therapeutic setting, thereby constituting a substitute for the organization of care[19,20].

This type of care – home care – has been shown to be a form of care that offers patients and their families the possibility of getting individualized care, which brings some security to family members. Thus, care management should be aimed at improving the quality of care and providing better health conditions to individuals[16].

However, the analysis of the concept of home care autonomy from the perspective of caregivers reveals a lack of support from the health sector, which overburdens the family in relation to care. Many lawsuits occur due to family despair at the lack of effective support for caregivers as there are no home-based social support services. Thus, home care is a possibility of organizing the health service that collaborates to preserve the autonomy of the person dependent on long-term care who experiences human vulnerability up close, which indicates the need to associate health services with social support services[17,19,20].

Finally, there is a need to institutionalize a health care network for users in order to implement home care as a public health policy, an issue that was addressed in some articles. The health care network has a determining role in the management of care extended by its services for the team's decision-making about priorities and the best way to meet the health needs of those who need home care in the health territory. However, there are some difficulties for the articulation of the Home Care Program (*Programa de Atenção Domiciliar – PAD*) with the other services in the network, which highlights the importance of this articulation as it is considered significant to implement the doctrinal principles of SUS[18,21,22].

Complementing the discussion raised by the studies mentioned above, it is necessary to clarify the importance of having home care integrated into the health care network and enhance the cross-cutting nature of care by focusing on users and their needs. In order to do so, the Home Care Service (*Serviço de Atenção Domiciliar – SAD*) must feature flows and protocols well established and agreed with all the points of care of this network[18,22].

Home care in complementary health care

Still with regard to the emphasis on the importance of home care as a public health policy, the articles included in this review discussed concepts of this modality of care within complementary health care justified by the idea that home care has always been associated with private health services since its origin in the United States.

Home care is a process of productive restructuring, that is, there are important changes in the mode of production of care. Additionally, home care in complementary health care is not regulated by the National Health Agency (*Agência Nacional de Saúde – ANS*) as it only obeys National Health Surveillance Agency (*Agência Nacional de Vigilância Sanitária – Anvisa*) regulations. It does not appear in the operators' contracts with their customers and it is considered an additional product offered to beneficiaries. Therefore, the definition of the modeling and operation of the programs is left to the operator and, when applicable, this is done jointly with the provider of this type of service. All that is done through networking and multidisciplinary care through an integrated therapeutic project[23].

To demonstrate the performance of home care within the structure of complementary health services, a study sought to describe and analyze the production of care in the PAD of a medical cooperative and found that home care was being provided together with home-based hospitalization, in which the beneficiary receives care according to their clinical condition with the aim of reducing the operator's expenses related to hospital admissions. In these cases of home-based hospitalization, the health care operator provided all materials, equipment, supplies and professionals to the customer, which turned out to be costly for the cooperative as a result of frequent judicialization of health and the transfer of family responsibility to the health care insurer[24].

Home-based hospitalization is understood as the set of activities provided at home to clinically stable people who can be assisted at home in a comprehensive and continuous manner but who require more intense care with the use of technologies, human resources, equipment, materials and medicines[3].

A study showed that home care was pointed out as the main activity included by operators in the list of health promotion activities and its execution was transferred to third party providers. Another important issue is the rationalization of costs, which is decisive in the offer of health promotion and home care programs; however, they do so with a critical discourse that recognizes the need to reduce expenses and do not deny that there are other interests of the family, operator, hospital and beneficiary that make up this relationship[23-25].

The analysis of the PAD in complementary health care from the point of view of the right to health showed that the lack of regulations on this type of care in complementary health care was a challenge for guaranteeing the right to health and that it was predominantly provided according to the interests of the operators who adopt strategies to avoid judicialization, such as not disclosing the benefit.

The suspension of care by unilateral decision of the operator and the transfer of responsibilities to the public health system and to families go against the users' right to receive services in the modality that best respond to certain health situations. It is concluded that home care in complementary health care is permeated by tensions that show the urgency of greater regulation in the field[26,27].

DISCUSSION

To start the discussion of the relevant data in this study, we decided to describe Law No. 8080, of September 19, 1990, which refers to the Organic Health Law, which provides for the conditions for the promotion, protection and recovery of health and the organization and functioning of the corresponding services[2].

Based on these determinations, it is emphasized that the principles that govern the Brazilian health system, that is, universality, comprehensiveness and equity, as well as the guidelines that operationalize the referred system, such as decentralization, hierarchization and community participation, have not been sufficient to guarantee the universalization of health due to its dual character, in which the majority of public resources are directed to private services.

A reproduction of two unequal worlds persists: that of the poor, who resort only to SUS, and that of those who have health insurance or directly pay for services, but who are also users of the public system. There are hospitals and clinics for all levels: for the poor who only count on SUS; for the poor who pay low-cost health insurances; for middle-income people who hire higher-cost health insurances; and for the wealthy, who attend the largest state-of-the-art medical centers or who will be treated in first world countries[18,26,27].

Taking into account home care and the principles that govern the SUS, studies show us that this modality of care constitutes an alternative for this purpose to ensure the comprehensiveness and continuity of care[25] and to objectify the humanization of care[17] by improving the user's and the family's autonomy for care when self-care is not possible[18].

The effectiveness of home care was described in Ordinance No. 825 of 2016, which redefines home care by considering it a technological incorporation of a substitute or complementary character into low and medium complexity hospital intervention, care initiated in the Urgency and Emergency Care Services, and services complementary to Primary Health Care[10-28]. It is structured in the perspective of Health Care Networks as lines of care through clinical care practices based on user needs, thus reducing the fragmentation of care[24,26].

Beneficiaries of complementary health care are afraid of the care offered by health insurers and point out that some of the cost reduction strategies have affected the quality and compromised the comprehensiveness of care. The economic sustainability of the private sector depends on the use of biomedical logics and fragmentation of care, thus ultimately producing an increasing demand for increasingly specialized procedures and services with high technological density and high cost, which, in the face of increased spending for increase of profits, must always be reduced and hence redirected to the costs originating from the government in most cases[27,28].

Still in 2013, the Ministry of Health issued Ordinance No. 1208, which provides for the integration of the Best at Home Program (home care within the scope of SUS) into the SOS Emergencies Program, both inserted in the Urgency Care Network. The integration of home care into the SOS Emergencies Program aims to: avoid unnecessary hospitalizations of patients treated at the entrance doors of Urgency Hospitals that make up the SOS Emergencies Program; provide for the shortening of hospital admissions when clinically indicated, thus making it possible to allocate beds to the entrance doors of Emergency Hospitals that make up the SOS Emergencies Program; humanize care for patients in hospital and treated at the entrance doors of Emergency Hospitals that make up the SOS Emergencies Program, thereby allowing them to be monitored in the home environment by the Multiprofessional Home Care Team (*Equipe Multiprofissional de Atenção Domiciliar – EMAD*)[10,25,28].

According to data from the Ministry of Health, the Best at Home Program covers 135 municipalities, counts on 433 teams and released approximately 3,500 hospital beds per day to other SUS patients. Of the patients currently cared for at home by program staff, almost 70% are aged 60 or over – almost half of them (31%) are aged 80 or over. These patients include: people who have chronic diseases and face difficulties in getting to health services, people who use tubes, tracheostomies or who are dependent on mechanical ventilation or oxygen therapy, people undergoing motor or respiratory rehabilitation, those who need complex dressings pre- or postoperatively, low birth weight infants, among others. The relief that the program represented for patients and their families was demonstrated in a user satisfaction survey carried out by the SUS ombudsman with more than 2,000 patients or caregivers. According to the survey, 93.9% of the respondents rated the service provided by the teams between 7 and 10 and 70% of these rated it 10. In addition, 95.9% of the respondent said they would recommend the service to friends and family[29].

The effectiveness of the Best at Home Program was reported in three scientific articles found on the databases analyzed. The modes of organization of home care in the context of the health care offered in the municipalities that adhered to the Program detected the emergence of a way of organizing supply that is consistent with management demands. Moreover, the modes of organization are mediated by user needs and the profile of local health[28-30].

A genealogical-inspired study aimed to problematize home care as a safety tool proposed by the Better at Home Program and concluded that the home is a safer and better place for the patient who is close to the family. In addition, the patient does not run the risk of getting hospital infection and receives care from a team that will provide the technology needed[31].

Home care is presented as the best option due to the comfort of the home, the bond with the family and the team, and the overcoming of barriers to accessing other facilities in the health care network. From the users' perspective, home care builds new relationships which expand the user's access, autonomy and quality of life[29,31,32].

Technical Opinion No. 05/GEAS/GGRAS/DIPRO/2018[33] issued by the National Health Agency regulates home care coverage and lists the non-inclusion of health care in the home environment (home care) in the set of services of mandatory coverage, which can be offered by operators as an alternative to hospitalization. It is important to emphasize that only the beneficiary's physician will be able to determine whether or not there is an indication for home care instead of hospitalization. The operator cannot suspend a hospital stay due to a simple request for home care. If the operator does not agree to offer the home care service, it must keep the beneficiary hospitalized until hospital discharge[33].

This study shows the need to carry out a larger number of studies on the cost-benefit ratio, customer and family satisfaction, efficiency and effectiveness of this type of care, and the advantages and disadvantages of having health care incorporate home care as part of its services with the aim of providing comprehensive care and promoting the health of those dependent on care.

CONCLUSION

Scientific evidence points to home care as a tool to be used in the reorganization of the health system, in the prevention of diseases and in the promotion of health.

CONFLICTS OF INTEREST

The authors state that there were no conflicts of interest in the development of this study.

CONTRIBUTIONS

Carmem Rita Sampaio de Sousa and **Maria Socorro de Sousa** contributed to the study design and conception; the acquisition, analysis and interpretation of data; and the writing of the manuscript.

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