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Care and protection for institutionalized elderly persons in the perspective of sanitary surveillance

Cuidado e proteção aos idosos institucionalizados na perspectiva da vigilância sanitária

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ABSTRACT

Health care in the western world has undergone major changes, influenced by cultural, economic and institutional events and transformations. The institutions that deal with this care have undergone transformations – from secularization to the phenomenon of commodification/marketing process. This article aims to develop, based on a bibliographical review on care, health care, situation and care for the elderly in institutions that perform human care, a notion of care in sanitary surveillance and care carried out by Sanitary Surveillance in Long-Term Institutions. It is observed that the care of the State to the institutionalized elderly occurs in a limited and fragmented way and without the proper connection between the sectors. The action of Sanitary Surveillance occurs predominantly by regulation.

KEYWORDS: Long-Term Care Institution for the Elderly; Caution; Sanitary Surveillance

RESUMO

O cuidado à saúde no mundo ocidental tem passado por importantes mudanças, influenciado por acontecimentos e transformações culturais, econômicas e institucionais. As instituições que se ocupam desse cuidado têm vivenciado processos de transformação em relação ao mesmo – da secularização ao fenômeno da mercantilização/marketização. Este artigo tem por objetivo elaborar, a partir de revisão bibliográfica sobre o cuidar, o cuidado em saúde, situação e atenção ao idoso em instituições que realizam o cuidado humano, uma noção de cuidado em vigilância sanitária e de cuidado realizado pela Vigilância Sanitária nas Instituições de Longa Permanência (ILPI). Constata-se que o cuidado do Estado ao idoso institucionalizado ocorre de forma limitada e fragmentada e sem o exercício da intersetorialidade. A ação da vigilâncias sanitária se dá, predominantemente, pela regulação.

PALAVRAS-CHAVE: Instituição de Longa Permanência para Idosos; Cuidado; Vigilância Sanitária

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INTRODUCTION

In most cultures, care is part of the female social role. Some historians and anthropologists consider that instinctual maternal protection was the first expression of human care[1]. This practice also has a defense and protection meaning for individuals and groups. In the Middle Ages, care was institutionalized in the church and done by organized charity under the name of mercy. Individuals who for some reason had no family, like orphans, indigents and the elderly, were supported by the charitable services of those days – gift houses, monasteries, hospitals, parishes and schools[2]. With the beginning of secularization – the process of abandoning the cultural principles based on religion that began in the 15th century – it is the State that incipiently begins to play the role of caregiver. With the development of the modern State, it starts to have even more responsibilities in terms of health care. In this context, better-defined health policies are built (French Hygienism, German Medical Police, English Labor Force Medicine) and the State takes on its caring role more clearly. From then on, hospitals, which used to house the socially outcast, the elderly, and were the places where people were taken to die, became education and medical practice institutions based on modern scientific grounds[3], whereas nursing homes became the main place of care for the elderly.

Institutionalized care has made substantial progress supported by cultural, economic and institutional events and changes. Important changes have taken place in the institutions responsible for care – from secularization to specialization and finally to the phenomenon of commodification/marketization[2].

Changes in the role and function of the State after the nineteenth century, and especially in the mid-twentieth century, in societies that experienced the "welfare state," favored the expansion of care to social areas. In the case of health care, this led to the expansion of institutions that directly and indirectly take care of people's health; including the so called Long-Term Institutions (LTI). These changes were also influenced by changes in families, especially women's increasing participation in the labor market. Today, the care provided to the elderly varies according to how societies are organized. In Brazil, family care still predominates, but there is an important growth in LTI. Although LTI are not health care institutions, they provide services to a portion of the population that is exposed to risk factors related to this stage of their life cycle. Therefore, health surveillance services should act to regulate the control of these risks.

DISCUSSION

In Brazil, policies aimed at the elderly only began to take clearer shape after 1980, with the struggle to regain democracy and social rights. Two important achievements were made by the Federal Constitution of 1988 (FC/88)[4]. The first is the incorporation of the concept of social security as an expression of social rights and the State's responsibility to guarantee the right to health for every citizen; the second is the recognition of the right to health of the elderly as a fundamental right, inherent in every human being in the Brazilian territory, and the inclusion of this care in FC/88. The constitution assigns this duty to the family, the society and the State, to ensure the elderly's participation in the community, their dignity, well-being and right to life. This new constitutional order for the elderly population gained momentum in 1989, with the issuance of Federal Ordinance n. 810, of September 22, 1989[5], which regulated the standardized functioning of institutions or establishments that care for the elderly. But it was not until 1994 that Federal Law n. 8.842, of January 4, 1994[6] was approved and enacted. It established the National Policy for the Elderly and created the conditions for their integration and effective participation in society and promotion of their autonomy, prohibiting any form of discrimination against the elderly. Corroborating what is determined by FC/88[4], this Policy encourages the implementation of social centers, day centers, day hospitals, nursing homes, sheltered workshops and home care. It also prioritizes the care of the elderly within their own families, to the detriment of care in nursing homes. Later, the enactment of the Statute of the Elderly (Law n. 10.741, of October 1, 2003)[7] reaffirmed the obligation of the public authorities to ensure – with absolute priority – the elderly's right to life, health, food, education, culture, sports, leisure, work, citizenship, freedom, dignity, respect and family and community life. It is the first law that refers to institutions of the long-term type. With the progress of the Unified Health System (SUS) institutionalization, the Pact for Health was designed in 2006 (Ordinance MS/GM n. 399, of February 22, 2006)[8]. One of its components, the Pact for Life, prioritizes the implementation of the National Health Policy for the Elderly. It is in this context that the role health surveillance in LTI becomes clearer. This paper aims to address the notion of care from the perspective of health surveillance and the work done by health surveillance in LTI.

Population aging has become a significant and global problem in recent decades. However, developed countries face it by expanding social protection systems and implementing appropriate policies for this demographic transition. In Brazil, this process was fast, intense, but with unfinished epidemiological transition, i.e. the coexistence of chronic diseases and their complications with communicable diseases also persists at this stage of life.

The definition of "elderly" differs from society to society[9]. In developed countries, people aged 65 or more are considered elderly. In developing countries, as is the case of Brazil, they are considered elderly as from the age of 60. This definition was established by the United Nations (UN) in 1982, through Resolution n. 39/125, prepared at the 1st United Nations World Assembly on Ageing. Data from the Brazilian Institute of Geography and Statistics (IBGE)[10] revealed that in 2010 Brazil had 190,755,799 inhabitants, of which approximately 21 million – roughly 11% of the population – were elderly. The most recent National Household Sample Survey (PNAD-IBGE-2017)[11] revealed that 14.6% of the population belonged to this age group, which corresponds to 30.2 million elderly people. This number has already exceeded the estimate for 2020. According to Carvalho

and Garcia[12], Brazil will be one of the countries with the largest number of elderly people in the world.

A study by Pasinato and Kornis[13] comparing care for the elderly in countries like Denmark, Germany and the United States found that the Danish social-democratic model is based on a broad social security system and a universal health care system. Faced with rising costs, from 1987 onwards, the process of deinstitutionalization began, prioritizing the construction of a home care structure and programs aimed at supporting informal caregivers. In Denmark, families are not legally responsible for care, which is more focused on the autonomy and independence of the elderly[14]. From 1994 onwards, the German model was structured as long-term care insurance (LTCI), co-funded by employees and employers at a 1.7% rate on wages. It is decentralized, with focus on dependence, and families are legally responsible for caring for their elderly[14]. In the United States, the insurance system is liberal, and care for the elderly is provided with significant participation of the private market. There is also Medicare for the elderly, which covers only some services directly related to the health area, like nursing and physical therapy.

In Brazil, despite changes in the national landscape regarding social protection policies for the elderly, these policies are still very limited in the provision of Public Health services and programs, as well as in the scope of their intervention. Traditionally, there is a predominance of home care for the elderly under family responsibility. In some cases the State supplements the provision of social and health services, like in the case of the Family Health Strategy. This way, the State appears as a partner with limited responsibilities. There is still no policy that clearly defines the attributions of families and a care network for the elderly. Institutional care, although not recent, has traditionally been provided by religious institutions. As noted above, only recently has the state taken part in this care. According to the Constitution, care provided by nursing homes is aimed at the elderly who are not able to guarantee their own survival, like those in situations of abandonment, lack of family group or home or lack of financial resources of their own or their family's.

However, although in Brazil families take priority in the care of their elderly, the modernization experienced by society has led to scarcity of care, possibly due to smaller families, new family arrangements, the new social role of women and their increasing participation in the labor market and lower fertility rates. According to Camarano and Kanso[15], these changes have affected families' ability to provide care for the elderly, which seems to decrease as their demand increases. This scenario, coupled with the lack of more effective state support for home support, results in increased families' demand for private LTI. It is important to draw a parallel between how long-term care is provided in institutional settings in advanced countries and in emerging countries, like Brazil. Born and Boechat[16] revealed that advanced countries have undergone changes in their institutionalization profile as they have options to keep older people in the community through a service network. The LTI of these countries predominantly care for older individuals with serious functional losses and dementia. This study is supported by the findings of Camargos et al.[17], who state that in developed countries, institutionalization is a choice for older people who have difficulty staying independent or for those in need of medical care. In Brazil, there is already some growth in the LTI market. These institutions usually house seniors over 60 years old, with varying degrees of dependence. Camarano and Kanso[15] reported that the number of older people who will need long-term care between 2010 and 2020 may grow from 30% to 50%, regardless of whether or not there are improvements in autonomy. The increase in demand for LTI care may be due to the boom in the elderly population since the 1980s. In addition to that, old age is increasingly perceived as a phase of life and no longer as a disease. Küchemann's study[18] also provides subsidies that support a strong tendency for the elderly care market to expand in the institutional model. The author says that, although the State offers some services to the elderly, this coverage is not sufficient, especially for long-term care accommodation. The type of care instituted by the State depends on its nature and role. In countries where the Welfare State is strong, this type of care is more comprehensive. In Brazil, the State is divesting itself of the responsibility to ensure social rights to the population. In the case of LTI, the direct provision of care by the State is almost nonexistent, and the State is left with a regulatory role only. On the one hand, the market has a significant participation in the care of individuals and groups, on the other hand, there is increasing deregulation of the practices and objects of this care.

The term "Long-Term Care Institution for the Elderly", as suggested by the Brazilian Society of Geriatrics and Gerontology (SBGG)[19], was meant to express the new hybrid function of these institutions. SBGG understands that LTCIE are full and institutional care facilities and must meet the needs of their residents. This expression, according to Delboni et al.[20] is an adaptation of the English term "Long-Term Care Institution" used by the World Health Organization (WHO). It is up to the LTI to comprehensively meet the needs of the elderly in view of this new reality, in which there is an increase in the survival of people with reduced physical, cognitive and mental capacity. That said, these institutions must be part of the social and health care network. Goffman[21] described the shelters for the elderly, as well as asylums and prisons, as segregators of social life, at the same time they dominate the entire life of the subjects (hygiene, food, clothing) submitted to them. The author emphasizes the closed nature of these institutions and also calls them total institutions. The vast scientific production about LTI has divergent opinions among several authors. Some agree with Goffman[21] as to the total nature of these institutions and their harmful consequences to the elderly, like social isolation/segregation, loss of individuality and even the "mortification" of the individual. Others admit a different position by considering them as alternatives for better care and protection for the elderly, arguing that families cannot always meet these needs. Silva and Figueiredo[22] agreed with Goffman[21] regarding the institutional domain over individuals and point to the limited or nonexistent freedom of choice of the institutionalized elderly, that is, institutions without freedoms. Casadei et al.[23] reinforced the negative perception of the LTI by considering the Brazilian nursing home model similar to the so-called total

institutions, functioning as spaces of segregation and integral administration of the lives of the dependent, disadvantaged, retired, poor and rejected, or of those who are unable to live by themselves or with relatives. Born and Boechat[16] sought to explain that the negative connotation related to LTI is largely due to how they were created and how they are structured.

In this debate we understand that institutions are at the same time providers of care and limiters of freedoms. These intrinsic characteristics may change, depending on the management model that is adopted. Based on the definition of Born and Boechat[24], we understand LTI as:

> a medical-social, social-health care service that should provide care and be a place where one can live with dignity. This care should cover social and emotional life, daily living needs and health care, thus being characterized as a hybrid service that addresses social life and health.

The constitution ensures health as a fundamental right, an indispensable condition for life with dignity, and establishes the obligation of the State to promote actions and services aimed at promoting, protecting and restoring health. The rapid aging of the population has forced the State to take a new look at the elderly. This also required adjustments and changes in public policies, recognition of the rights of the elderly and the consequent emergence of specific legislation aimed at this stage of life, such as the Statute of the Elderly, in which we can see – for the first time – some requirements, guiding principles, enforcement rules and penalties. The Statute recognizes, in its art. 37 § 3, that:

> Institutions that house elderly people are required to maintain housing standards that are compatible with their needs, as well as to provide the elderly with regular food and hygiene that are consistent with sanitary standards, subject to the penalties of the law.

In a more up-to-date context, Clos and Grossi[25] made harsh criticism of the space occupied by the private market in this kind of care. According to the authors, these establishments come to the twentieth century as a profitable business, filling the gap of gerontological services of reception and residence that form a promising market. The authors attribute this fact to the incompatibility of family structures with specific care for the elderly in the process of illness. Although the state has been playing a limited role as care provider, its participation seems to be increasing in the design and enforcement of protective legislation and regulatory norms.

Reinforcing this legal and regulatory obligation, Law n. 8.080, of September 19, 1990[26], in its Article 6, conceptualizes health surveillance and provides for its control of the provision of services directly or indirectly related to health. Although not classified as health units, LTIs perform some assistance activities, like nursing care, physical therapy, nutrition, administration of medicines. They are, therefore, subject to regulation, control and supervision of the Government. Health surveillance bodies have the role of regulating, from the sanitary perspective, the activities related to the production/consumption of goods and services of health interest, their processes and environments, whether in the private or public scope[27].

The term "care" (*cuidado*, in Portuguese) has several meanings in the Portuguese language, including assistance, caution, responsibility, protection. According to Teixeira[28], health care (*cuidados de saúde*) involves actions aimed at health promotion, prevention of risks and injuries, as well as the diagnosis and treatment of diseases and actions for the rehabilitation of reduced capabilities due to disease or accidents. It corresponds to the English *health care*. From this point of view, it is important to establish a comparison between care in health and care in health surveillance. There are countless studies addressing health care, but the emphasis on assistance is more prevalent. Care assistance to the elderly is, in most cases, a social relationship that is established between the caregiver and the individual (object of care), whose intention is to heal or provide comfort (palliative care). For this care to be effectively provided, it is necessary to evaluate the health status through diagnostic analysis and the application of technical knowledge, thus ensuring that patients will receive the treatment they need. The studies by Ayres[29] pointed to the importance of humanization in health care as a relevant factor to be applied by health professionals. To meet this requirement one must consider the exercise of otherness in the care process. Otherness can be understood as one's ability to apprehend the other in the fullness of their dignity, their rights and, above all, in their differences.

Unlike the field of care, where care is direct and humanized[29], care from the perspective of health surveillance is indirect, exercised over its objects of care and not over people, through protective and prevention actions to control risks in health protection and defense. In the case of LTIs, this translates into the adoption of sanitary measures with the objective of promoting safe conditions regarding food, clothing, physical structure and healthiness of the facilities, water quality, medicines and work processes, regulating any and all health activities and promoting the protection of the community. In relation to its extension, while in the vast majority of situations health care is focused on individual attention, from the perspective of health surveillance care comes about at the collective level, and its final objectives are the promotion and protection of health. This care, therefore, relies on actions targeted at health risks and risk factors. Thus, it corresponds to the set of technically-oriented procedures/interventions aimed at the prevention and control of risks and injuries, related to its objects in order to promote health and protect the population.

Considering that the objects on which health surveillance acts are consumer goods as well as social goods (food, medicines, health services, among others), it is recognized that many of them bear intrinsic risks, making its control fundamental for the protection of the community. Thus, it can be considered that care in health surveillance, albeit indirect in relation to the subject, is directly reflected in the protection of the health of individuals and the population and is based on health regulation.

The notion of care in health surveillance outlined above needs to be adapted to enable better understanding of health surveillance care in LTI. The current role of the State in these private institutions has been mainly regulatory. Thus, we understand that the regulatory role of health surveillance eventually becomes the main form of organization of this care. The notion of regulation in health surveillance is also polysemic and presents at least three perspectives. The first is about establishing rules, enforcing them according to the law, adjusting, containing, repressing[27]. The second is more focused on risk control: "all studies of risk analysis, as well as the resulting regulations and risk management policies undertaken by the State, which shape its intervention in the area of health risk"[30]. The third has to do with the regulatory role of health surveillance in relation to the market: "every sustained and specialized control exerted by the State or on its behalf, which intervenes in market activities that are ambivalent because, although useful, they present risks for the health of the population"[31].

In this study, it is understood that the care that should be provided by the health surveillance in LTIs must include these three perspectives. The first can be evidenced by Resolution of the Collegiate Board (RDC) n. 283, of February 1, 2005[32], which deals with the technical regulation defining operating rules for LTIs. This ruling includes aspects related to physical structure, food, medicines, clothing and work processes as relevant categories in health care in view of the risk they pose. It is noteworthy that this RDC resulted from the enactment of the Statute of the Elderly. The second regulatory perspective is intrinsically related to the final function of health surveillance, which is the control of health risks with the purpose of health protection. The third concerns the role of regulating health and market interests. Since most LTIs are part of this market, it is necessary that health surveillance bodies act in this regulatory process. In LTIs the risks may be due to the intrinsic nature of the object (e.g. medicines), failures in the work process (nursing/physical therapy care services, food and laundry services), absence and/or failure to manage/monitor the physical conditions of the environment. In these institutions, the magnitude of the risk is relevant given the greater susceptibility of the individuals residing there (elderly). Risks tend to increase because of the increase in consumption in contemporary society. This increase is an important challenge for health surveillance in LTIs in terms of avoiding the "objectification" of care, that is, care as a commodity[25]. For Clos and Grossi, once human care becomes a necessity, it also becomes a product to be economically exploited. This overlapping of things to the detriment of people can result in the invisibility of those being cared for, that is, the elderly. In the context of the market, this "objectification" is dealt with by the health surveillance through sanitary regulation. In this sense, we consider that the regulatory perspective of Souza[31] becomes even broader in this study. That is because we are talking about direct action of the health surveillance on private, market-oriented institutions. We reiterate that this perspective includes caring for another instance of health surveillance, although in a complementary fashion: consumer protection, given its power to intervene in market activities. The consumer is legally defined in the caput of art. 2 of the Consumer Protection and Defense Code – CDC (Law n. 8.078, of September 11, 1990)[33] as "any natural or legal person who purchases or uses a product or service as a final recipient." Private LTIs, therefore, abide by this Code by establishing the provision of services through formalization of a contract, whether with the elderly, their families or direct guardians. In legal terms, in consumer relations the consumer is always considered vulnerable *par excellence*. However, elderly consumers are considered extremely vulnerable, which puts them in a special condition when entering into legal consumer relations. The special condition of elderly consumers makes them more susceptible to abusive practices in the consumer market, given the typical weaknesses (emotional, physical, social, economic, etc.) that come with old age. It is therefore mandatory to recognize their extreme vulnerability. Their condition is so peculiar that the legal system entitles them to two specific legal microsystems, both of a tutelary nature, namely, Law n. 8.078/1990[33] and Law n. 10.741/2003[7]. Within the scope of Health Regulations, RDC n. 283/2005[32] appears in response to said Statute, ensuring the elderly the right to live in a space that meets their needs and is in good conditions of habitability, health and safety.

CONCLUSIONS

The increasing work of health surveillance in countless activities related to its objects of activity (medicines, food, health services and health interests, among others) requires deep reflection on its role, performance and practices. In the case of the topic of this essay, the care provided by health surveillance in long-term institutions is an important challenge for analysis. First, because there is no elaboration of what this care is, second, because the role to be played by health surveillance in LTIs has not been the subject of further discussion. In this sense, the reflections produced here are only intended to encourage the debate so that we continue to improve our reflections and practices on the subject.

It is also noted that although in the last three decades Brazil has made relevant achievements (Constitution of 1988 and the design and setup of SUS) that enabled the expansion of care for the elderly, the market has expanded greatly in this same period in the health sector, either directly or indirectly, which can be evidenced in the case of LTIs.

LTIs seem to have characteristics of total institutions that limit the freedom of individuals, but at the same time they seek to reproduce family care. In private LTIs, the State operates only by regulating the practices of objects of interest of health/epidemiological surveillance and, in some cases, by doing vaccination efforts. This action also needs further study. State health care for the elderly at the family level is also poorly provided in Brazil, except for actions carried out by the Family Health Strategy, especially in the control of hypertension and diabetes, and experiences like the Better at Home Program of some municipalities.

Although demographic growth has been accompanied by better living conditions, expressed in social and health indicators, there is still little State-provided care for the elderly population, whose vulnerability and risks are high.

In the current context, because of the small participation of the State in direct care for the elderly, LTIs appear as a promising market with a tendency for strong growth as a result of the fast aging of the Brazilian population and insufficient elderly care networks of family support.

Elderly care has become a lucrative business for the LTI market in Brazil. From this situation arises the need for changes in the internal organization of these institutions to make them comply with the new rules established by the State, enforced by the health surveillance, under penalty of being shut down (closing of the establishment). We understand that there are other organizational systems around the LTIs to perform different functions that form a health, social and legal assistance network aiming at the care and protection of the elderly. Finally, the poor care provided by the State for the elderly in Brazil, if any, is still fragmented and requires more effective partnerships between various bodies for the protection of the elderly, in addition to cross-sector initiatives.

However, it is noteworthy that Brazil, through Ordinance n. 2.528, of October 19, 200634, has been performing actions under the National Health Policy for the Elderly, whose purpose is to maintain, recover and promote the autonomy and independence of senior citizens. Some of its guidelines are the promotion of Active and Healthy Aging, following the guidelines of the WHO document called "Active Aging: a Health Policy", which is based on four pillars: health, lifelong learning, participation and safety. This policy already has some developments, such as the recently launched Brazil Friend of the Elderly Strategy. This initiative seeks to enable active, healthy and sustainable aging for all Brazilians. In the assistance area, Brazil has been investing in the Elderly Health Reference Units (URI). They are specialized units to serve the elderly in their area, with care provided by an interprofessional team, individually and collectively, within an integral view of the person.

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Conflict of Interest

Authors have no potential conflict of interest to declare, related to this study's political or financial peers and institutions.