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Integration of health policies and social assistance on the care of the elderly

A Integração das políticas de saúde e assistência social no atendimento ao idoso

La integración de las políticas salud y asistencia social en la atención a los ancianos

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The objective of this article is to present the intersectoral relationship between health and social assistance policies in elderly health care in the city of Franca. The text discusses aging and the guarantee of rights according to the Federal Constitution, the Statute of the Elder and the rights that come from laws regarding health, social assistance, education and others. It shows how Health and Social Assistance policies are structured to offer attention to the elders, as well as the intersectoral relations between these two different policies in the scope of the municipality. This research was guided by the Municipal Health and Social Assistance Plans for the 2014-2017 period, from the city of Franca/SP. Data also shows that, although it is one of the directives of these policies, the intersectoral relationships are still being constructed, and there are challenges to be overcome, such as the fragmentation of the actions of public policies and the action of workers, which comes from a biopsychosocial model, and demands constant professional training and a management which is committed to this proposal.
Descriptors: Aged; Health; Social assistance; Public policy.

Este artigo tem como objetivo apresentar a intersetorialidade presente nas políticas de saúde e assistência social na atenção ao idoso na cidade de Franca. O texto reflete sobre o envelhecimento e a garantia de direitos, tendo em vista a Constituição Federal, o Estatuto do Idoso e os direitos na saúde, assistência social, educação e outros. Ele indica como estão estruturadas as Políticas de Saúde e de Assistência Social para o atendimento ao idoso, bem como o processo de intersetorialidade entre estas duas políticas no âmbito municipal. O texto utiliza como balizas os Planos Municipais de Saúde e de Assistência Social 2014-2017 do município de Franca/SP. Os dados demonstram que, apesar de ser uma das diretrizes destas políticas, a intersetorialidade ainda está em processo de construção, com desafios a serem superados, como a fragmentação das ações das políticas públicas e a ação dos trabalhadores, com vistas ao modelo biopsicossocial, exigindo capacitação profissional constante e gestão comprometida com esta proposta.
Descritores: Idoso; Saúde; Assistência social; Política social.

Este artículo tiene como objetivo presentar la intersectorialidad presente en las políticas de salud y asistencia social en la atención al anciano en la ciudad de Franca. El texto reflexiona sobre el envejecimiento y la garantía de derechos teniendo en cuenta la Constitución Federal, el Estatuto del Anciano y los derechos advenidos de la salud, asistencia social, educación y otros. Expone cómo están estructuradas las Políticas de Salud y de Asistencia Social para atendimiento al anciano así como el proceso de intersectorialidad entre estas dos políticas en el ámbito municipal. Usa como indicador a los Planes Municipales de Salud y de Asistencia Social 2014-2017 del municipio de Franca/SP. Los datos demuestran que, a pesar de ser una de las directrices de estas políticas, la intersectorialidad aún está en proceso de construcción, con desafíos a ser superados como la fragmentación de las acciones de las políticas públicas y la acción de los trabajadores, con el fin de un modelo biopsicosocial, exigiendo capacitación profesional constante y gestión comprometida con esta propuesta.
Descriptores: Anciano; Salud; Asistencia social; Política social.

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INTRODUCTION

Brazil has been presenting a new demographic pattern that is characterized by the reduction of the populational growth rates and by profound changes in the composition of its age structure, with a meaningful increase in the amount of elders, due to a fast fall in the natality rates and, at the same time, of mortality – a reflex of the improvement of the quality of life of population.

Understanding aging in its different aspects is a challenge for society and for Public Policies, especially those that are part of the Brazilian Social Security: health policies, social assistance and social security.

The Social Assistance Policy has, as users, elderly people in situations of vulnerability or social risk and many lacking in orientation about their social rights. Strengthening the aging process considering the proposals of the National Social Assistance Policy (NSAP) and the Basic Operational Standard / Single Social Assistance System (BOS / SSAS) is a constant challenge for professionals working in the area.

Health Policies universally serve the entire Brazilian population through the Unified Health System (SUS) as defined by the Federal Constitution of 1988 and the Organic Law of Health (LOS) 8080/1990, but needs to direct services to the elderly population, which requires Considerable investments in medicines, physical space, skilled workers, adequate equipment and technologies.

The Federal Constitution (FC) of 1988 designed a legal structure for the country to universalize rights, the participation of civil society in the management of social policies and political-administrative decentralization. However. From the 1990s on, however, the country has opened its doors to a neoliberal conjuncture that brings several contradictions, especially in directing the implementation of social security policies. On one hand, the construction process of a legal standard of social protection, and on the other, the changes taking place at the global level and the hegemony of neoliberalism, which has imposed several limits on the conduction of this model, which, although universal in the legislation, is focused on extreme poverty.

The trend of the neoliberal standard is based on the logic of monetary stabilization, trade liberalization and privatization[1]. It is totally contrary to the democratic standards of social policy. In this context, the management of the social protection system characterizes the privatization of social policies, focalization and precariousness. It also directs the management of the social protection system based on benevolence, philanthropy, charity and assistance.

One can perceive, due to these issues, a regression in relation to the concept of social law, encouraging the growth and valorization of non-profit Non-Governmental Organizations (NGOs), the spirit of solidarity and turn the social assistance to philanthropic.

Therefore, this article aims to present the intersectoral relations present in the policies of health and social assistance in the care of the elderly in the city Franca. For such, this analysis is done through the Municipal Plans of Health and Social Assistance 2014 – 2017, from Franca.

METHOD

This article is a reflection on Health Policies and Social Assistance Policies in a city in the countryside of São Paulo.

For that, a bibliographical review and a documentary research were performed, regarding the services offered to people over 60 years old in Franca / SP / Brazil.

This work was developed in 2016 and did not involve human beings, since it only analyzed open access documents.

RESULTS

For the purposes of this study, the documents related to the Municipal Health Policy and the Municipal Social Assistance Policy of Franca were evaluated, based on 19 references that substantiate the problematization and discussion of the context in which these policies are inserted in the city, in line with state and federal perspectives.

DISCUSSION

Aging and the guarantee of rights

The aging process is quite unique as it can vary from person to person and such variations are related to a high number of factors such as lifestyle, socioeconomic conditions and presence of chronic diseases. It is, therefore, a biopsychosocial phenomenon[2].

On the other hand, during the aging process, the adaptive capabilities of the individual tend to decrease. Their self-esteem and their well-being are closely associated with their satisfaction with their family and social environment. The permanence of the affective bond between the members of the family and the elderly makes them feel valued and able to live with dignity and tranquility this new phase of life[3].

As a continuous process, aging brings benefits to those whose lives surround it: wisdom, feelings of understanding, patience and tolerance, knowledge, comprehension, maturity. However, many seniors face intolerance, prejudice and disrespect for their condition. Elders have more vulnerable physical and emotional condition than other members of society do, and when they leave the job market, whether for health reasons or due to retirement, they are no longer part of the productive system and are often disregarded by society or their own family members.

Aging with quality depends on factors ranging from family life to adequate survival conditions, such as health, housing, education, urbanization and others, which are strictly related to public policies and to the condition of all the elderly: legal people.

The Federal Constitution (CF) of 1988[4], article 230, states that it is the duty of the family, society and the State to support the elderly, assuring their participation in the community, defending their dignity and well-being and guaranteeing them the right to life[4]. In addition, the Statute of the Elderly - Law 10.741/2003[5] establishes the rights of people aged 60 or over. In article 3, it establishes that it is the obligation of family, community, society and of the public power to ensure to the elderly, with absolute priority, the effect of their right to life, health, food, education, culture, sports, leisure, work, citizenship, freedom, dignity, respect, and family and community coexistence[5].

In art. 15, the Elderly Statute states that comprehensive health care for the elderly is assured through the Unified Health System - SUS, guaranteeing universal and equal access, jointly and continuously to actions and services for prevention, promotion, protection and recovery of health[5].

The CF of 1988[4] assures the entire population access to health as a public and universal system, through the Unified Health System (SUS). Specific for the elderly is the creation of geriatric units of reference; Home care and home hospitalizations, if necessary.

The Statute of the Elderly, in paragraph 2 of article 15, establishes that it is incumbent upon the Government to provide the elderly, free of charge, with medicines, especially those of continuous use, as well as prostheses, orthotics and other resources related to the treatment, habilitation or rehabilitation of their health[5].

Despite the principles of universality and integrality of its health policies, the SUS user population faces numerous problems, such as long delays in appointments and elective surgeries; lack of medicines (even those of continuous use), need for legal processes to demand the supply of medicines or care.

Linked to this issue there is a tendency of the media and of the State itself to stimulate people in good financial situations to pay for private health insurances. It is important to note that the legislation forbids insurance companies to charge the patients differently based on the advance of their age and the consequent need for constant specialized care. This was a common practice before the legislation in force.

The article 19 of the Elderly Statute[5] establishes the obligation of health professionals to report cases of suspected or confirmed ill-treatment of the elderly to the following public bodies: police authority, Public Prosecutor's Office, Municipal Council of the Elderly, the State Council for the

Elderly and the National Council for the Elderly.

The elderly who contributed to the National Institute of Social Security (NISS) during their working life are entitled to retirement. In the case of death, their spouses are entitled to a pension[4]. However, the value of the benefit falls short of their daily expenditures due to issues regarding labor relations during the working period and the limits and ceilings of benefits (im) placed by the social security office throughout the reforms carried out in 1998 and 2003.

Two issues call attention to these reforms: one of them is the Constitutional Amendment 20/1998, which determines the elimination of the ceiling of ten minimum wages for the payment of retirement by length of service and its rule of calculation (the arithmetic average of the last 36 months of Contribution). The second refers to the introduction of the social security Factor, which consists on the average of the highest salaries contributed during 80% of the insured's contribution period. The reduction factor is added according to the age of the insured, taking into account their life expectancy, age and length of contribution, thus harming especially those who started working very young.

It stands out that the main arguments for the reforms of Social Security were: the growing deficit of Social Security advertised by the media and economic interests, the decrease in the rate of population growth, the increase of life expectancy and finally the search of the State for macroeconomic stability, with the creation of the primary surplus.

On the other hand, it is necessary to add that with the restructuring of production that occurred primarily from the decade of 1990, the work situation suffered profound inflections, such as the deregulation of labor relationships, outsourcing processes, and informal work, all of which impacted the life of the workers. As a result, many workers have had difficulties to pay for Social Security, and consequently, difficulties in enjoying retirement.

For those who have not been able to contribute during their working life and are unable to enjoy retirement, there is the Continuous Benefit (CB) which is of one minimum wage, guaranteed by the Federal Constitution of 1988[4], article 203, item V - for people with disabilities and elders over 65 years of age, who prove that they do not have the economic conditions to maintain themselves and that their subsistence cannot be by their family, and may thus require it. However, it faces conditions imposed by the policies that regulate the benefit.

The National Social Assistance Policy (NSAP) of 2004 manages the CB, based on the Organic Law of Social Assistance (OLSA), Law No. 8,742 / 1993[6], through the Single Social Welfare System (SSAS).

Law 8,742 / 1993, amended by Law 12,435 / 2011[7], defines social welfare as the right of the citizen and the duty of the State to ensure that minimum basic needs are met.

The management of this policy is carried out by the Unified Social Assistance System (USAS). It is decentralized, participative, and conducted through social assistance services, having as one of its structuring axes social and family matrices.

USAS encompasses social protection in the levels: basic - understood as a form of prevention; and special – a level which is subdivided into medium complexity (violated rights, but still with family and community ties) and high complexity (full protection, when all ties were broken).

The target population to be covered by basic social protection is the one under situations of social vulnerability, due to poverty, income deprivation, difficulties in accessing public services and the weakening of affective bonds. This protection is effected through the Reference Center for Social Assistance (CRAS), inside its area of coverage[8].

The social protection offered by social assistance consists in a set of actions, care, attention, benefits and aid offered by USAS to reduce and prevent the impact of social and natural changes of life, human dignity, and the family as the basic nucleus of affective, relational, and biological sustenance[9].

Health and social assistance policies in Franca and their integrality

Franca has 318,640 thousand inhabitants according to the last 2010[10] census. Data from the Franca Municipal Health Plan of 2014-2017 indicates that the Municipal Human Development Index (MHDI) is 0.780 (2010 data), i.e., the municipality is considered to have a High Human Development level (between 0.700 and 0.799). Between 2000 and 2010, the highest growth rate in absolute terms was Education (growth of 0.193), followed by Longevity and Income. In this respect, out of 5,565 Brazilian municipalities, in 2010, Franca occupied the 128th position, and in relation to the 645 other São Paulo municipalities, it occupies the 66th position[11].

Extreme poverty (measured by the proportion of people whose per capita household income was less than R$ 70,00 - seventy reais) increased from 0.95% in 2000 to 0.65% in 2010, and inequality remained. The Gini Index, used to measure the income concentration degree (0 represents a situation of total equality and the closer to 1, the greater the income inequality) went from 0.51 in 2000 to 0.46 in 2010[12].

Another significant finding is that, between 2000 and 2010, the city's aging rate increased from 5.57% to 7.60%, and in 2010, according to data from the Brazilian Institute of Geography and Statistics (IBGE), there were 20,705 60 to 69 years old elders and 15,516 between 70 and 80 or older[12].

Based on these issues, this work presents how Health and Social Assistance Policies for elderly care are structured in this municipality, and from that, the intersectoral process between these two policies is understood.

Intersectoral relations guarantee more effectiveness and a greater degree of effect to actions and programs, and therefore, require research, planning and evaluation for joint actions[13]. An intersectoral work points to the need to build a network of services aimed at social protection from a perspective of totality, because reality is an indivisible whole[14].

In Franca, the service offered to the population in Primary Health Care is made up of 14 Basic Health Units (UBS) and 05 Family Health Teams (FHT).

The specialized outpatient attention offers a Core of assistance Management - NGA (a specialty service), STD/AIDS Prevention Center, STD/AIDS and hepatitis Outpatient Clinic, a Network Specialized in Mental Health (Adult and Child Mental Health Clinic, CAPSad - Psychosocial Support Center), Endocrinology, Geriatrics, Hansen's disease, Tuberculosis, Chronic Kidney Disease Outpatient Clinics, ACAR - High Risk Outpatient Clinic, AGAR - Outpatient Street Clinic for Pregnant Women,(CR) and Damage Reduction(DR). The AMC-16 (Assistance Management Center) is a specialized attention center consisting of 23 medical specialties for diagnosis, treatment and indication of conduct. In addition, it conducts diagnostic exams such as endoscopies, colonoscopies and laryngoscopies, provides minor surgeries, monitors ostomized patients, offers care and treatment in buco-maxillary surgery and endodontics, as well as medium complexity dressings, a Program of Orthoses and Prostheses, a Home Healing Program, and a Hearing Health Service.

The municipality has 01 Adult Emergency Room, 01 Children's Emergency Room, 01 SAMU and a 24-hour Basic Health Unit (UBS).

In order to care for the elderly, the city has a Geriatric Outpatient Clinic, which attends users referred by the Basic Health Units, who are fragile due to the decline in functionality provoked by the aging process. They are usually carriers of some geriatric syndrome (Alzheimer and Vascular dementia), cognitive incapacity (aphasia / apraxia / agnosia / executive dysfunction), depressive framework, chronic degenerative diseases (neurodegenerative, cardio-degenerative and osteo-degenerative). The clinic can also attend people younger than 60 years old with an early diagnostic of diseases such as Alzheimer's provoked dementia.

This clinic offers a group work that conducts the following activities:

- Guidance group for caretakers of people with Alzheimer's (for family members and professionals);
- Educational groups with guidance about diabetes and arterial hypertension.

In Hospital Care, the municipal network has an agreement with the Foundation Casa de Misericórdia de Franca/Santa Casa, for the conduction of elective surgeries, births, general and pediatric hospitalizations, and urgent treatments. There are also: a Cancer Hospital, a Heart Hospital and the Psychiatric Hospital Allan Kardec.

Another type of attention offered by the municipality is the Domestic Care (DC), that offers attention to patients and their families, aiming at self-care, early hospital discharges with continued domestic care, and even the possibility of minimizing the risk of hospital infections, sometimes provoked by lengthy stays in the environment of a hospital, especially among the elderly. It also provides emotional support for patients in severe or terminal states and their families or caretakers, and offer guidance to the caretaker, who can be a relative, a neighbor, or any person with an emotional connection who is responsible for the care, together with the health professionals.

The Municipal Health Plan of the municipality[15] brings actions targeted at the health of the elderly, which aim to develop educational measures focusing on the self-care and on preventive attitudes that seek active forms of health promotion, as well as autonomy conservation, independence (functionality) and quality of life with age. It also includes specific recovery and rehabilitation actions. Actions are guided by the directives contemplated by the National Health Policy for the Senior Citizen (PNSPI)[16], that include: integral attention to the health of the elder; incentives to intersectoral actions aiming to offer integral care; implementation of services of domestic home care; priority in health units; healthy aging promotion; social participation strengthening; training and permanent education of health professionals regarding the health of elders.

The Social Assistance policy is another of extreme importance to the population. After the approval of the National Policy for Social Assistance (PNAS), that directs the organizational guidelines, the structuring directives, the management and the co-financing models organized at the SUAS and for the Basic Operational Norm (NOB/SUAS), the city of Franca, SP, organized its attention structure through 05 units of the CRAS (Social Assistance Reference Center) and 02 CREAS (Specialized Social Assistance Reference Center).

In 2009, the categorization of social assistance services was approved, and a standardized matrix of basic and special social protection was established, aiming to organize them according to their level of complexity. From 2011 on, with changes in the Law 12,4357, actions in the social assistance field started to be organized according to the Unified Social Assistance System.

Therefore, and thanks to the Municipal Social Assistance Plan[17], the reorganization of social assistance services in Franca, which is classified as a large city (from 100,001 to 900,000 people), counts on a social assistance network that offers all necessary services, and is organized according to the complexity level of the attention offered: basic and special.

In Franca, basic protection services are operated directly by five Social Assistance Reference Centers, and indirectly by public interest civil organizations. To care for the elders, the network of social assistance is structured according to the National Policy of Social Assistance[18]. The basic social protection is responsible for:

- Socialization and Bond Strengthening Services (SCFV), aimed at elders who live in isolation due to the lack of services and opportunities of family and community coexistence, whose needs, interests and availability suggests that should be included in the service. There are currently five social entities registered in the social assistance network of the municipality, and these offer a total of 730 vacancies;

• Domestic Basic Social Protection Services for People with Disabilities and Elders, a service for people with disabilities and elders who are in a situation of social vulnerability due to the weakening of family and social links, and/or to the lack of any access to social and community insertion and habilitation. Only one program offers this service and there are 50 vacancies, which are managed by a municipal entity.

To medium complexity attention, apart from the attention offered at the CREAS, the social assistance network is made up of:

• Special Protection Service, for people with disabilities, elders and their families. This program offers attention to people with disabilities, elders, and their caretakers and family members, through a social assistance network Institution that offers 70 vacancies.

• Special Protection Services for people with disabilities, elders, and their families, in the Modality Day Center. This service is for people with disabilities and elders above 60 years of age who require permanent or temporary care. Two institutions in the city offer this service, to a total of 45 vacancies.

Also, for the high complexity attention, the network is made up of:

• Institutional Sheltering Services for Elders in the Modality Institutional Shelter. This service is for elders with different degrees of dependency or who are completely independent, and offers 258 vacancies, through six assistance institutions.

Starting from the analysis of the Municipal Plans for Health and Social Assistance, it can be noted that none of the plans discusses how the link between the sectors is being or will be managed by both public policies. This makes it clear that, in spite of the approval of a possible intersectoral management system in the Organic Laws of both public policies, this practice is still, in many aspects, rudimentary, which is true not only for the city of Franca.

On this issue, Monnerat and Souza[19] stated that the health field incorporated some directives towards intersectoral work in its Organic Law from 1990. This decision aims at an articulated action, including other areas of social policies, to produce better health results, highlighting researches which show that "the notion of integrality has very diffuse characteristics, both for managers and health professionals". The authors also observe that this directive from SUS is not a priority for the management, and that it developed on the opposite direction of the decentralization and social control which are considered central to the trajectory of health. Two programs have been organized from intersectoral strategies: the Family Health Strategy and the Community Agents.

In social assistance, the National Policy of Social Assistance (PNA) presents intersectoral strategies as a fundamental necessity to guarantee the rights of the citizens. Also, the operationalization of the Unified System of Social Assistance (SUAS), social assistance actions are expected to happen in articulation with other public policies. One example in that direction is the Bolsa Família Program (PBF), whose organizational design includes intersectoral strategies, since it imposes conditions to the users that relate both to health and to education.

Regarding the intersectoral characteristics of these two policies from the municipality of Franca, a research was conducted by Martins[14], showing their embryonic state from many aspects: the fragmentation of public policies; the equation of actions divided in sectors by the professionals and the program "Cidade amiga do Idoso" (Elder Friendly City), which is also in an embryonic state.

Starting from the analysis of the Municipal Health and Social Assistance Plans, and from the literature on the field, two statements are necessary to discuss the subject, without the pretension of exhausting the subject: the fragmentation of the actions of public policies and the action of the health and social assistance workers.

On the fragmentation issue, it can be noted that public policis wort in a perspective of sectors, that is, if the specific demand of the family is for a health procedure, the health system will deal with it. Any specificity of that user or their families

regarding other policies can be referred to those responsible, but it will hardly ever be simultaneously accompanied by the two public policies.

The Family Health Strategy (ESF) and the Community Health Agents (ACS) - strategies that structure basic health care and are the gateway to SUS - can be examples of pacts between health policies and those of social assistance.

According to the Ministry of Health itself, one of the responsibilities of the family health team is acting between the different sectors, through agreements established with different social and institutional segments, to intervene in situations that transcend the specificities of the health sector, with effects that are determinant regarding the conditions of life and health of the individuals, their families and community[19].

The family strategy team acts since the 1990 decade, and still faces difficulties, especially those related to establishing permanent physicians for the multiprofessional health team all over the country. This issue is not only related to the work market, but also to the "persistence of the biological paradigm, still hegemonic in the health field, which makes even the perception of the insufficiency of health actions more difficult, when faced with the current harms and their corollary, which would be the search for intersectoral partnerships"[19].

In this aspect, the professionals find themselves following the tendency previously described, that is, the workers from the health and social policies end up specializing in their own areas. That means that the workers from both public policies often may not know the options of attention, the activities, programs and projects developed by the other policy, or all the public equipment's from both policies - the focus of this debate - as well as the social assistance network that is in place. That demands constant training, not only in their specific field of work, but also in that which involves the work territory experienced by them.

A study[14] reveals that working between sectors demands recognition and willingness to face the fact that one policy will depend on the other. That means that the health policy can offer attention using the material and human resources, but needs to be aware that success in work/attention also depends on the salubrity conditions of the residence, the availability of materials, of medicines, from the family or from the policy; the permanence of the person among their families with informed caretakers who are trained in regarding the necessary care, or the referral for Long Permanence Institutions (ILPI) when it is not necessary according to the evaluation of the weakened family links, negligence, and others.

This leads to the understanding that intersectoral relations are only possible if they are thought through, planed with the efforts of managers from the many areas of policies that are interested in discussing the issue.

With different trajectories and techniques, the challenge of this management is the creation of new and innovative mechanisms that favor the integration and cross-sectional practices present in the idea of systems and social protection networks.

The articulation among health and other sectors of social policies is not a perspective predominantly adopted by the managers of the three levels of government responsible for the execution of the health policy[19], and thus, one of the issues that need to be confronted by the health field involves, necessarily, a change in the biological paradigm, which persists in the area for the biopsychosocial model.

CONCLUSION

The relevance of both public policies for the elders cannot be denied. The elder, naturally, loses the vigor of his physical strength, and in many situations, the family cannot or has no financial conditions to continuously coexist with them, due to hectic contemporary lifestyles.

Brazil, currently, has enough legal measures to protect the elder, but apart from them, it is paramount to change the

perspective of society and of the State in the performance of the public policies that relate to the elder.

Many actions needed for health promotion involve instances that are outside of the health field, for example, social assistance, which also considers issues related to a healthy aging process. In this aspect, health promotion is the establishment of public agendas with the participation of many actors, to reach a state where there is more health, and a higher quality of life.

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CONTRIBUTIONS
Andreia Aparecida Reis de Carvalho Liporoni conducted the bibliographical survey and wrote the article.

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