SPECIAL CALL "RESEARCH IN LONG-TERM CARE FOR OLDER PEOPLE"
ORIGINAL ARTICLE

Health care strategies in long-term care facilities in Bahia State, Brazil

Estratégias de atenção à saúde em instituições de longa permanência para idosos na Bahia, Brasil

Meirelayne Borges Duarte[a], João Victor Nunes Freitas[a], Rafaela Andrade Correia[a], Mônica Hupsel Frank[b], Helena Patáro de Oliveira Novaes[b], Janine Cardoso Soub[b], Diana Oliveira Noronha[b], Peter Lloyd-Sherlock[c]

ABSTRACT

OBJECTIVE: To describe health care strategies for older people living in long-term care facilities (LTCFs) in Bahia state, Brazil. **METHODS:** This is an ecological study involving LTCFs identified in Bahia state, which were invited to participate in a survey conducted between April and June 2021. The variables of interest were LTCF characteristics, health care strategies, visits received from national public health system (SUS, in Portuguese) teams, and health care actions taken by SUS. A comparative analysis was performed between LTCFs located in the East macro-region and other parts of the state, in general and also stratified by funding type (private and non-private). **RESULTS:** The sample consisted of 177 LTCFs, more than half of them were located in the East macro-region, seat of the state capital. Most facilities declared themselves as non-private (68%). Less than one-third of the LTCFs had their own health teams. Although 67% of LTCFs reported some health care provided by SUS, only 49% reported clinical consultations, with even lower percentages for other SUS actions, except for vaccination (91%). The East macro-region had a lower percentage of LTCFs accompanied by a SUS team, and the highest percentage of LTCFs with supplementary health insurance. **CONCLUSIONS:** This study shows the limited access of LTCF residents to essential health services, due to a general neglect of this population by public health care providers. The inadequacy of public policies to support LTCFs has important consequences for the quality of care offered to residents.
KEYWORDS: long term care; delivery of health care; public policy.

RESUMO

OBJETIVO: Descrever as estratégias de atenção à saúde dos idosos residentes em instituições de longa permanência para idosos (ILPI) na Bahia. **METODOLOGIA:** Trata-se de um estudo ecológico que envolveu as ILPI identificadas na Bahia, as quais foram convidadas a participar de uma pesquisa realizada entre abril e junho de 2021. As variáveis de interesse foram: características das ILPI, estratégias de atenção à saúde, visitas recebidas das equipes do Sistema Único de Saúde (SUS) e ações assistenciais fornecidas pelo SUS. Foi realizada análise comparativa geral entre as ILPI localizadas na macrorregião Leste e as demais partes do estado, bem como análise estratificada por tipo de financiamento (privado e não privado). **RESULTADOS:** A amostra foi composta de 177 ILPI, mais da metade localizada na macrorregião Leste, sede da capital do estado. A maioria das instalações declarou-se não privada (68%). Menos de 1/3 das ILPI possui equipe de saúde própria. Embora 67% das ILPI tenham referido algum atendimento de saúde prestado pelo SUS, apenas 49% referiram consultas clínicas, com percentuais ainda menores para outras ações do SUS, exceto vacinação (91%). A macrorregião Leste apresentou menor percentual de ILPI acompanhadas por equipe do SUS e maior percentual de ILPI com plano de saúde suplementar. **CONCLUSÕES:** Este estudo mostra a limitação de acesso dos residentes de ILPI aos serviços essenciais de saúde, em razão de negligência por parte dos prestadores de serviços públicos de saúde. A inadequação das políticas públicas de apoio às ILPI tem consequências importantes para a qualidade da assistência oferecida aos residentes.
PALAVRAS-CHAVE: assistência de longa duração; atenção à saúde; política pública.

[a]Universidade Salvador – Salvador (BA), Brazil.
[b]Centro de Referência Estadual de Atenção à Saúde do Idoso – Salvador (BA), Brazil.
[c]School of International Development, University of East Anglia – Norwich, United Kingdom.

Correspondence data:
Meirelayne Borges Duarte – Universidade Salvador – Campus Professor Barros – Avenida Luiz Viana Filho, 3.146 – Paralela – Salvador (BA), Brazil.
E-mail: meirelayne.duarte@unifacs.br @DMeirelayne
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INTRODUCTION

By 2050 there will be about 2 billion people aged 60 years and over in the world, mostly in low and middle-income countries.[1] In Brazil, as in many countries, there is a growing demand for residential care for older people.[2]

Long-term care facilities (LTCFs) date back to colonial Brazil, with a model resembling an "older person warehouse" associated with the idea of charity. This persisted until the 20th century.[3] Only in recent decades have such places had their objectives specified, with the establishment of rights and guarantees for older residents.[3]

The Collegiate Directive Resolution 502/2021 defines LTCFs as collective residences for people aged 60 years or over. Because they are not considered to be health facilities, the presence of health professionals is not mandatory in LTCFs, but they should provide residents with transport to health facilities when needed. Also, LTCFs should develop and implement comprehensive health care plans for each resident.[4]

In high-income countries and globally, it is increasingly recognized that LTCFs should form part of a seamlessly integrated set of health and social care services.[5,6] LTCFs are part of Brazil's Unified Social Care System (SUAS, in Portuguese), anchored in a wider context of social care. However, linking these facilities exclusively to the social dimension of care fails to recognize residents' rights to health, as stated in the National Health Policy for Older People.[7]

The high prevalence of health problems and the high percentage of frail older people in LTCFs call for comprehensive personalized care plans.[7] Since LTCFs are collective residences, local health teams should consider them as part of an integrated set of health and care services for older people. Although LTCFs have the right to access services provided by Health Care Networks, often they have no link to primary care teams of the Unified Health System (SUS, in Portuguese). Also, it is not always possible to maintain dedicated multiprofessional teams in LTCFs, given the scarcity of financial resources in both philanthropic and private facilities.[8,9]

From this perspective, this article aims to describe the health care strategies for older people living in LTCFs in Bahia state, Brazil.

METHODS

This is an ecological study involving LTCFs in the state of Bahia, previously approved by the National Research Ethics Commission (Opinion 4,506,012, on January 21, 2021).

All active 210 LTCFs identified by the Intersectoral Monitoring Commission of Long-Term Care Facilities in the State of Bahia, from April/2020 to March/2021, were included. The inclusion criterion was to have at least one resident aged 60 years or over during the COVID-19 pandemic period. Institutions that did not respond to the survey conducted from April to June/2021 were excluded (n = 33) from the aggregated database provided by the commission.

The variables of interest were:

1. LTCF characteristics: health macro-region, financing type;
2. Health care strategies: existence of a reference health team, SUS team accompaniment before and after the pandemic, presence of an LTCF health team, contracting supplementary health insurance;
3. Visits received from SUS health professionals: community health agents, nursing technicians, vaccination teams during campaigns, general practitioners, nurses, dentists, physical therapists, nutritionists, psychologists, occupational therapists, physical educators, psychiatrists, endemic disease control agents, social workers;
4. Care actions taken by the municipal health team: immunization, whether it met scheduled or spontaneous demand, clinical consultations, dental consultations, examinations, collective activities, medicines from SUS basic pharmacy.

The data were tabulated according to the 9 health macro-regions of the state of Bahia: East Center (EC), North Center (NC), Extreme South (ES), East (E), Northeast (NE), North (N), West (W), Southwest (SW), and South (S). A comparative analysis was performed between LTCFs located in the East macro-region (where Bahia's capital is located) and other parts of the state. This comparison was done in general, and also stratified by funding type (private and non-private). Simple and relative frequencies were calculated. To evaluate associations between the variables, the corrected chi-square was calculated using EpiInfo, with a significance level of 5%.

RESULTS

The sample consisted of 177 LTCFs (82% of the LTCFs identified in the state of Bahia). More than half of these LTCFs (57%) are in the East macro-region, the most populous one in Bahia, whose municipalities belong to the metropolitan area of Salvador. The number of

institutions identified in each macro-region ranged from 5 to 124. All health macro-regions are represented in the sample (Table 1).

There was a predominance of non-private LTCFs (68% of the sample), corresponding to 55% of LTCFs in the East macro-region and 86% of LTCFs in the rest of the state ($p < 0.001$).

The existence of a reference health team was reported by 82% of LTCFs in the state of Bahia, with a lower percentage in the East macro-region ($p = 0.01$). Monitoring by a SUS team fell during the pandemic (from 76% of LTCFs before the pandemic to 67% during the pandemic), but there was no statistical significance. The East macro-region had a lower percentage of LTCFs accompanied by a SUS team, both before and during the pandemic, but had the highest percentage of LTCFs with supplementary health insurance. All these differences found between the East macro-region and the rest of the state reached statistical significance. Less than one-third of the LTCFs reported to have their own health teams, both in the East macro-region and in the rest of the state (Table 2).

Although the East macro-region had a higher percentage of private LTCFs than the rest of the state, the stratified analysis of these 2 regions by funding type did not reveal significant differences between private and non-private LTCFs regarding health care strategies, except in SUS team accompaniment before and during the pandemic, with a higher percentage among non-private LTCFs than among private ones in the East macro-region ($p = 0.04$).

Concerning visits received from SUS teams, before or during the pandemic, the highest percentages corresponded to general practitioners, community health agents, and nurses, who make up the minimum teams in primary health care. Despite this, about half of LTCFs in the state of Bahia reported receiving no home visits from these health professionals, before or during the pandemic. It is noteworthy that, in the East macro-region, such visits were even rarer than in the rest of the state, with a statistically significant difference ($p < 0.05$). The visits of other health professionals with higher qualifications were less common throughout Bahia. Significant differences between the regions were found regarding the visits of nutritionists, physical therapists, and dentists, with higher percentages outside the East macro-region. There was no significant difference in the visits of other health professionals. It is noteworthy that only one LTCF in the entire state of Bahia reported

Table 1. Distribution of long-term care facilities across health macro-regions in the state of Bahia.

	EC	NC	ES	E	NE	N	W	SW	S
Total population*	1 048 060	239 676	549 401	3 910 687	224 031	477 158	399 426	807 179	858 683
Older population estimated*	128 455	31 561	58 018	493 300	28 260	55 693	32 790	109 328	119 829
LTCFs identified	20	5	11	124	12	5	5	18	16
LTCFs included in the sample	11	5	8	101	8	5	5	18	16
% LTCFs included	55.00	100	72.72	81.45	66.67	100	100	100	100
Number of older residents	310	126	203	2474	168	113	98	477	596

EC: East Center; NC: North Center; ES: Extreme South; E: East; NE: Northeast; N: North; W: West: SW: Southwest; S: South; LTCFs: long-term care facilities. *Preliminary estimates provided by the National Department of Health (2019).

Table 2. Comparative analysis of long-term care facilities in the East macro-region and the rest of Bahia, according to health care strategies.

	Bahia (n = 177)		East macro-region (n = 101)		Rest of the state (n = 76)		p-value
	n	%	n	%	n	%	
Existence of a reference health team	145	81.92	76	75.25	69	90.79	0.01
SUS team accompaniment	119	67.23	53	52.48	66	86.84	< 0.001
SUS team accompaniment before pandemic	134	75.71	64	63.37	70	92.11	< 0.001
Presence of own health team	55	31.07	32	31.68	23	30.26	0.97
Supplementary health insurance	58	32.77	43	42.57	15	19.74	0.002

SUS: acronym in Portuguese for Brazilian Unified Health System.

that they had been visited by an endemic disease control agent (Table 3).

SUS immunization actions were reported by the vast majority of LTCFs throughout the state (91%), but clinical consultations were restricted to half of LTCFs and dental consultations to only a quarter of them. All these activities were less frequent in the East macro-region, with a significant difference ($p < 0.05$). SUS appointments, either by scheduled or spontaneous demand, were reported by approximately half of LTCFs. Appointments from spontaneous demand did not differ between the regions studied, but those from scheduled demand differed significantly between the East macro-region (27% of LTCFs) and the rest of the state (70% of LTCFs). In the entire state of Bahia, only one LTCF reported performing basic laboratory tests through SUS and another one reported receiving medicines from SUS basic pharmacy: both of these facilities were outside the East macro-region (Table 4).

Table 3. Comparative analysis of long-term care facilities in the East macro-region and the rest of Bahia, according to visits received from SUS health professionals.

	Bahia (n = 177)		East macro-region (n = 101)		Rest of the state (n = 76)		p-value
	n	%	n	%	n	%	
General practitioner	83	46.89	28	27.72	55	72.37	< 0.001
Nurse	81	45.76	35	34.65	46	60.53	0.001
Community health agent	90	50.85	38	37.62	52	68.42	< 0.001
Nurse technician	68	38.42	36	35.64	32	42.11	0.47
Physical therapist	23	12.99	7	6.93	16	21.05	0.01
Nutritionist	21	11.86	6	5.94	15	19.74	0.01
Psychologist	15	8.48	5	4.95	10	13.16	0.09
Dentist	20	11.30	6	5.94	14	18.42	0.02
Psychiatrist	3	1.69	0	0	3	3.95	0.15
Occupational therapist	10	5.65	4	3.96	6	7.89	0.43
Physical educator	7	3.95	2	1.98	5	6.58	0.24
Social worker	2	1.12	0	0	2	2.63	0.36
Endemic disease control agent	1	0.56	0	0	1	1.32	0.89

SUS: acronym in Portuguese for Brazilian Unified Health System.

Table 4. Comparative analysis of long-term care facilities in the East macro-region and the rest of Bahia, according to health care actions taken by SUS.

	Bahia (n = 177)		East macro-region (n = 101)		Rest of the state (n = 76)		p-value
	n	%	n	%	n	%	
Immunization actions	161	90.96	86	85.15	75	98.68	0.004
Scheduled demand	80	45.20	27	26.73	53	69.73	< 0.001
Spontaneous demand	92	51.98	48	47.52	44	57.89	0.22
Clinical consultations	87	49.15	31	30.69	56	73.68	< 0.001
Dental consultations	41	23.16	11	10.89	30	39.47	< 0.001
Examinations	1	0.56	0	0	1	1.32	0.89
Collective activities	10	5.65	3	2.97	7	9.21	0.15
Medicines from SUS basic pharmacy	1	0.56	0	0	1	1.32	0.89

SUS: acronym in Portuguese for Brazilian Unified Health System.

DISCUSSION

This survey shows some differences between the East macro-region and the rest of the state of Bahia regarding health care strategies in LTCFs. These differences may be due to the higher concentration of these facilities and the higher percentage of private institutions in the East macro-region, but they may also reflect inequalities among the cities regarding the implementation of national public policies.[10]

In Brazil, about 78 000 older people currently live in LTCFs, and most of them are partially or totally dependent.[8] Throughout the country, most LTCFs function only as a residence for older people, characterized as a social care intervention, without specific health care provision.[11]

Although without statistical significance, the reduced support of LTCFs by SUS teams during the pandemic deserves some consideration. Primary health care in the context of the pandemic is organized along 4 axes: health surveillance in specific territories, care to users with COVID-19, social support for vulnerable groups, and continuity of previous actions.[12] Support for LTCFs may have been reduced by increased demand, reducing the available supply, compounded by the removal of infected health care workers due to the increased risk of infection.[13] In this context, it has become relevant to create new mechanisms to relieve the burden on health units and focus them on the most urgent issues. This has included more remote strategies, such as telephone services for monitoring milder cases.[14,15]

As revealed in this study, most of the facilities in Bahia do not have their own health care teams. This included the East macro-region that proportionally contains more private LTCFs than the rest of the state. Thus, more than two-thirds of the sample would depend completely on health care actions received from SUS as outpatient care. This indicates an important gap in health provision for a population with complex health demands living in conditions of extreme clinical and social vulnerability. Most LTCFs do not receive visits from other health professionals besides physicians and nurses.[9] In a sample of 36 private and philanthropic LTCFs, distributed in 11 municipalities of 5 regions in Brazil, the main attendance of health professionals with higher qualifications also corresponded to physicians and nurses.[16] Similar data were found in another study of 11 philanthropic LTCFs in Rio Grande do Sul state, where, in general, the nurses were hired and the physicians were volunteers.[17] Unlike the present study, both of these surveys did not specifically evaluate health care actions taken by SUS.

The low coverage of LTCFs working with mental health professionals (psychologists and psychiatrists) is noteworthy, considering the high prevalence of depressive symptoms among older people in LTCFs. Depression among older people has been shown to be associated with living in an LTCF, lack of contact with family members, and ageist practices by some LTCF caregivers.[18] The low percentage of LTCFs offering services from physical therapists, occupational therapists, and nutritionists is also noteworthy, considering the high prevalence of frailty and undernutrition among older LTCF residents.[19]

Likewise, this survey found a low percentage LTCFs in Bahia offering dental consultations. Brazil's National Oral Health Policy aims to ensure integrated oral health actions, both individually and collectively, through promotion and prevention, as well as treatment and recovery.[20] This is clearly failing to reach most LTCFs. Older people are at higher risk during dental procedures, have a higher incidence of oral cancer, and more commonly use prostheses that need proper oral hygiene and adjustment.[20] Neglecting these needs substantially affects the quality of life of older people, since oral health is important not only for proper chewing but also for social interaction.

The right to public health is a constitutional right,[21] but the low coverage of SUS health services, other than COVID-19 immunization, in Bahia's LTCFs is reflected in the small number of visits by health professionals. This leads better-resourced LTCFs to contract supplementary health insurance. Supplementary health insurance, regulated by the National Supplementary Health Agency (ANS, in Portuguese), provides private health care access without making members lose their right of access to care through SUS.[22] Even though the ANS considers LTCFs as part of a wider system of care for older people, access to supplementary health care is not universal.[23]

The present study showed that the East macro-region had a lower percentage of LTCFs monitored by a SUS team and a higher percentage with supplementary health insurance. LTCF interest in supplementary health insurance reflects the neglect of institutionalized older people by primary care teams as well as LTCF managers' limited knowledge of how to effectively engage with SUS.[24] A 2020 survey of municipal primary health care services in São Paulo state reported that 68% had their performance rated as "intermediate." Of those, only 15% offered support to LTCFs. Only 50% of services were rated as "good" (13% of the sample) and offered LTCF support.[25]

In contrast to the overall low health care coverage, immunization actions were received by almost all LTCFs in Bahia. The National Immunization Program is responsible for coordinating vaccination campaigns and defining specific schedules for each age group.[26] Vaccination in older people is justified by immunosenescence, whereby, as a person ages, the immune system is weakened, making one more susceptible to infections

and serious conditions.[27] Historically, Brazil's vaccination campaigns have paid specific attention to institutionalized older people, because they often have reduced functionality and live in crowded environments. This led to the decision to make this group a priority for COVID-19 vaccination. Vaccines were given in the LTCFs themselves in order to reduce the exposure of their residents to queueing in crowded vaccination centers and to promote vaccination uptake.[28]

By contrast, LTCFs lacked access to basic medicines, diagnostic tests, and group activities from SUS primary care teams, which should offer multidimensional care.[10] The lack of continuous monitoring impeded linking this population to SUS teams and the organization of responses to their health needs. This contravenes a key purported role of primary care as the preferred gateway to the Health Care Network, entailing integrality, longitudinality, and coordination of care.[29]

Although many LTCFs had scarce resources and high prevalence of polypharmacy, medicines from SUS basic pharmacy were not always made available to them. Inappropriate use of medications, due to shortage of more suitable drugs or inadequate monitoring, overloads the health system, since problems related to reduced access of LTCFs to primary health care can lead to increased use of expensive hospital care.[30]

Because this is an ecological study, there are no individual data for older LTCF residents to allow specific inferences about the quality of life of this population. In addition, the data were provided by LTCFs' managers through electronic questionnaires, which does not fully guarantee the reliability of the results.

CONCLUSION

Despite the inherent limitations of analysis based on secondary and aggregate data, this study shows the limited access of LTCF residents to essential health services, due to a general neglect of this population by public health care providers. The inadequacy of public policies to support LTCFs has important consequences for the quality of care offered to residents. In the context of an aging population and changes to family configurations, there is a growing number of older people living in LTCFs in Brazil. Rather than a piecemeal approach (as with vaccination), this requires the development of comprehensive personalized health care. A key step to achieve this goal will be policies that promote stronger engagement between primary care teams and LTCFs, as part of a more coordinated strategy across SUS and SUAS.

CONFLICT OF INTERESTS

The authors declare no conflicts of interest.

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AUTHORS' CONTRIBUTIONS

MBD: conceptualization, supervision, validation, writing – review & editing. JVNF: formal analysis, writing — original draft. RAC: formal analysis, writing — original draft. MHF: conceptualization, validation. HPON: conceptualization, validation, writing — original draft. JCS: conceptualization, validation, writing — original draft. DON: conceptualization, validation, writing — original draft. PLS: validation, visualization, writing – review & editing.

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