

Supplementary health system and home care of the elderly in the perspective of critical bioethics

Cláudio Andraos¹, Cláudio Lorenzo²

Abstract

Home Care (HC) is currently the main option in elderly dehospitalization, especially in the supplementary system. Varied ethical conflicts arise in the context of assistance along with varied familiar contexts. We performed an explanatory study of two HC cases in health insurance providers, in which the ethical conflicts were delimited in two main Bioethics playing fields: the clinical bioethics, regarding to interpersonal relationships and decision-making on assistance; and the Bioethics applied to public health, regarding to challenges to the organization and provision of services. The conflicts were discussed based on the critical bioethics model. The study generated propositions for reducing some ethical conflicts on HC, and demonstrated the need of more extended studies in order to know in greater length and depth this problem in Brazil.

Key words: Bioethics. Home care. Elderly. Public health. Private sector.

Resumo

Sistema suplementar de saúde e internação domiciliar de idosos na perspectiva da bioética crítica

No Brasil, atualmente, a internação domiciliar (HC) é a principal opção para a desospitalização de idosos, sobretudo no sistema suplementar. Variados conflitos éticos surgem no contexto da assistência em meio a contextos familiares diversos. Neste trabalho, realizamos um estudo exploratório de dois casos de HC em operadora de planos de saúde, na qual os conflitos éticos identificados foram delimitados a dois campos principais de atuação da bioética: o da bioética clínica, no tocante às relações interpessoais e tomadas de decisão em torno da assistência, e o da bioética aplicada à saúde pública, no pertinente aos desafios para a organização e oferta de serviços. Os conflitos foram discutidos com base no modelo de bioética crítica. O estudo gerou proposições para a redução de alguns conflitos éticos envolvidos na HC e demonstrou a necessidade de pesquisas mais amplas para conhecer em maior extensão e profundidade este problema.

Palavras-chave: Bioética. Assistência domiciliar. Idoso. Saúde pública. Setor privado.

Resumen

Sistema de salud complementario y la atención a domicilio a los ancianos en la perspectiva de la bioética críticos

En Brasil, actualmente, la hospitalización domiciliar (HC) es la principal opción para disminuir la ocupación de los ancianos en el sistema adicional de salud. Surgen varios conflictos éticos para la asistencia en medio a diversos contextos familiares. En este trabajo, realizamos un estudio exploratorio de dos casos de HC en las operadoras de seguros de salud, en la cual los conflictos éticos identificados fueron delimitados a dos campos principales de actividad de la bioética: el de la bioética clínica referente a las relaciones interpersonales y en las decisiones en torno a la asistencia, y el de la bioética aplicada a la salud pública, respecto a los desafíos para la organización y prestación de los servicios. Los conflictos fueron discutidos en base en el modelo de bioética crítica. El estudio generó proposiciones para la reducción de algunos conflictos éticos involucrados en la HC, y fue demostrado la necesidad de investigaciones más amplias para conocer en mayor extensión y profundidad este problema.

Palabras-clave: Bioética. Asistencia domiciliar. Anciano. Salud pública. Sector privado.

Approval CEP/FS-UnB nº 055/12

1. **Master** claudioandraos@gmail.com 2. **Doctor** claudiolorenzo.unb@gmail.com – University of Brasilia (UnB), Brasilia/DF, Brazil.

Correspondence

Cláudio Andraos – SHCES, Quadra 501, bloco E, apt 203, Cruzeiro Novo ZIP 70650-515. Brasilia/DF, Brazil.

The authors declare no conflict of interest.

The phenomenon of population aging in Brazil has accelerated in the last 20 years, following the country's development, poverty reduction and some improvement in access to health goods and services. *The very old* (aged over 80 years) have been considered as the fastest growing population segment, representing, at present, 12.9% of the elderly population and 1.1% of the total population¹. The projections of the Brazilian Institute of Geography and Statistics (IBGE in Brazil) for 2050 are that the population over 65 years represents 22.71% of the total².

There is a consensus in public health that this age group is more susceptible to chronic degenerative diseases³, fall accidents and to important factors leading to increased morbidity and mortality, being responsible for 56.1% of hospitalizations due to external causes⁴. The particular vulnerability of this group leads to greater utilization of hospital services in long-term treatments; meaning, as a consequence, health care higher costs⁵. Thus, population aging represents, in addition to a demographic transition, an epidemiological transition, with clear implications for the health care organization⁶.

In Brazil, home care (HC) has been one of the most used programs for the dehospitalization of the elderly and the most widely searched by the supplementary health system. Veras *et al*⁷ showed that the largest proportional insurance coverage of the supplementary health system is directly exactly to the age group of the elderly, and the self-health insurers are the ones that own the highest proportion of elderly in the portfolio, representing 28.2% of total insured.

The State recognizes that it still does not exist in the country a satisfactory practice of health care for the elderly⁸. This actually ends up making the family the almost exclusive *locus* of social care for the elderly, going the opposite way of the reality of everyday life and the socioeconomic context of Brazilian families in contemporary, in which most adults work out of home and there are no financial conditions for hiring professional caregivers. As shown by Lima-Costa *et al*⁹, most of the elderly in Brazil have monthly income below the minimum wage – which they spend a quarter with purchase of medicines.

Given this context, the criteria for eligibility of HC should consider three aspects: 1) the individual circumstances of the patient, 2) environmental conditions, and 3) characteristics of the family group¹⁰. The first aspect relates to the clinical status of the elderly, his/her functional dependence and socioeconomic status. The second refers to the residence

conditions for the installation of equipment and to host the team. The third relates to the type of family care the elderly receive and the possibilities and willingness of the family to participate in health care.

Despite the obvious need to consider these aspects related to decision by HC, health insurance companies use clinical criteria to produce both the score of eligibility for home care as to classify the degree of complexity required in the health care planning¹¹. Then there is, in many cases, a deep disagreement on how the family and the health insurance provider define and understand the needs of the elderly and consequently on the HC indication; mismatch that has contributed to the already advanced process of judicialization of health¹². In addition, the new relationships established within the residence concerning the elderly health care are, by their specific characteristics, potentially to generate conflicts.

The objective of this study was to investigate, from a case study, ethical conflicts involved in two cases of HC installation by self-health insurers; analyze them from the perspective of critical bioethics and, from these results, point out possible actions contributing to reduce or avoid those conflicts, also providing data for the development of more extensive research on the issue.

HC at the supplementary health care system in a bioethical perspective

The supplementary health care system is a reality in the country and is set in the very organization of the Unified Health System (UHS, SUS in Brazil). According to the National Health Agency (NHA, ANS in Brazil), Brazil has 48.6 million people insured by a health insurance plan¹³, which represents 25.1% of the current population, which insurance is provided predominantly by people's formal jobs¹⁴.

The NHA defines how *health insurance companies* shall sell health plans. This classification can be condensed into five types: private health insurers and benefits management organization, medical and dental group, dental and medical cooperatives, nonprofit health insurer and self-health insurers¹⁵. The mode self-health insurance (self-insurance) is defined as an entity or part of a company that operates supporting services or is responsible for the health insurance plan of their own employees, having no profit. Today, this modality is responsible for 5.2 million insured people.

The fact that there is no profit should theoretically offer to this modality managers more leeway in providing services, since the final financial statement would need only to maintain a self-sustaining industry, without burdening other sectors. However, the administrative challenges posed by limited expansion of customers and the continuous accumulation of older age groups have led self-health insurers to apply a rationality based mainly on the analysis of the cost-effectiveness of their programs; driven almost exclusively by prioritizing collective over individual issues, in line with the hegemonic utilitarianism in public health, for situations where there is a shortage of resources. Therefore, in order to define HC indication they often use the same criteria from other for-profit health insurance providers.

Poorer residences generally have more restricted space, predisposing to respiratory diseases and presenting less possibility of adaptation to the elderly's limited mobility, as well as providing a greater risk of falls. Additionally, the unfavorable socioeconomic conditions also interfere in interpersonal relations, reducing the time available for the elderly's health care. Studies have shown that even minor differences in the monthly *per capita* income between families are sufficient to determine the elderly's poor health, greater dependency and reduced physical mobility¹⁶. Moreover, empirical data has not methodologically well-documented recorded the existence of families in which, regardless of socioeconomic status and the possibility of its members to provide care, there is a progressive affective emptying regarding the elderly, which is why these families simply want to transfer to the professional level and institutional dimension all responsibility with the required care. In such cases, the possibilities for closer cooperation between informal caregivers (family) and formal (professional) are also greatly reduced¹⁷. The meanings that emerge from family experiences are particular and specific, hence the need to know and consider these singularities when providing home care¹⁸.

The diversity of contexts has two direct implications for bioethics: interferes with interpersonal relationships around individual health care for the elderly, causing conflicts in the field of clinical bioethics, and impacts the planning and execution of HC supply referring the problem also to the field of bioethics applied to public health¹⁹. To account for the complexity of ethical conflicts generated by this problem a theoretical model of bioethics need to consider the interests and power games around

the provision of health care, to interpret the forms of rationality that elect criteria and organize service offerings, and to analyze influences of social structures and data contexts in the generation of interpersonal and inter-institutional disputes. Then produce reflections and proposals for actions aimed at the two involved bioethical fields.

Latin America has excelled in producing theoretical models that emphasize the analysis of ethical conflicts in health arising from social practices of domination; market-State relations; conflicts of interest in institutions; etc., directing its propositions to health systems reforms designed to solve these injustices and establishing close relations with the fulfillment of human rights²⁰⁻²³. In Brazil, among those models, the best known are the bioethics of protection, originally elaborated by Schramm and Kottow²² and later perfected by the latter, as well as the intervention bioethics, by Garrafa and Porto²⁴. The confluence of bioethical theories and thoughts working in this perspective has received the title of social bioethics²⁵.

The present study examines the research problem from a model that fits this social perspective, the critical bioethics. Two currents of thought have fought for space regarding this model: one is based on the social sciences' criticism to bioethics, formulated by authors such as Renée Fox, Barry Hoffmaster and Charles Bosk, whose opinion is that bioethics has relegated to a second place social and cultural factors and privileged idealized philosophical theories, proposing, from there, that it passes to produce empirical investigations to confront theory with evidence²⁶. And the second one, best developed in Latin America, is based on the critical theory of the Frankfurt School, especially in the theory of communicative action by Habermas^{27,28}. It is that constitutes our theoretical framework for analysis. A more detailed description of this model extrapolates the purposes of this article, so we will address only the definitions and concepts that contribute to the discussion of results.

The critical theory is born from a critique of the alleged scientific neutrality, especially when it reaches the humanities and defends as its main purpose the emancipation of those who become vulnerable by a social structure based on a fusion between State and capital, market and science. Thus, it denies a neutral approach to social phenomena and proposes an investigation of the possibilities for change in conditions that favor the breach and exploitation of individuals and groups. Thereby, a

bioethics grounded in the critical theory takes the ethical conflicts, both in interpersonal relationships and in terms of collective impact decision-makings, as sociocultural facts historically produced and under unavoidable political influence. Bioethics should seek ways of resolving or preventing conflict from a perspective that considers the limitations imposed by the specific circumstances of the individuals involved, without moving away from the broader socio-political dimensions that influence the generation and maintenance of conflicts.

Accordingly, in the Brazilian context, socioeconomic differences, which are so expressive with the various families which have conditioned their availability of time to take care for their elderly, are taken as historically determined social facts, as a product of the very injustices upon which the social structures in the country were consolidated. Likewise, the absence of the State in regard to senility, driving families to accept home care a solution so that they can have a daily caregiver, is also a historic reflection of a function that the State accepts and that ends up reproducing social injustices. To study these social facts three fundamental concepts for critical bioethics are especially important: *instrumental rationality*, *colonization of the lifeworld* and *communicative rationality*.

Instrumental rationality is defined as a form of rationality directed to find the best ways to reach a certain goal, without regards to any moral reflection on the nature and use of these means. The actions that flow from it are always strategic. According to the critical theory, modern capitalism in this form of rationality merged with scientific rationality and became the preferred form of rationality of economic, political and administrative powers. In a way, the use of eminently clinical criteria by health insurers for the development and delivery of home care services to the elderly is supported by an eminently instrumental rationality.

Colonization of the lifeworld is the individual dimension emerging from the meeting of three formative elements of subjectivity: personality, society and culture. *Colonization* would be the invasion of that world by emerging values from the dominant powers. The main one would be the *colonization by instrumental rationality*, producing hegemonic forms of social interaction mediated by financial interests and administrative bureaucracy, causing interpersonal relationships to start to be dominated by selfish strategies for personal fulfillment. Affective emptying of the elderly by family members from wealthy classes, for example, may be a result of

this *colonization*, since the elderly, limited to their residences, do not seem capable of contributing to these objectives, and more than that, imposes obstacles to fulfillment.

Communicative rationality is intended to be the main form of opposition to instrumental rationality and the route by which it is reached the planning of actions that contribute to the emancipation of those who have become vulnerable and resolution or prevention of moral or political conflicts. It starts from the premise that the only legitimate way to recognize the validity of a proposition, whatever it is, having this proposition either an evaluative or prescriptive intent in relation to social practices, is through free discussion among the various social actors involved and the rational acceptance of the strength of arguments. Communication is its foundation and the democratic discussion spaces created in the political or institutional context, such as ethics and bioethics committees, are the necessary structure to its practice.

Method

We used in this research the case study. This is a qualitative research method defined as an investigative exploration of unique or multiple cases that form a well-defined system in time and space²⁹. We have worked with the model described by Yin³⁰, whereby selected cases form a system consisting of multiple sources of information and data, such as interviews, observation and document analysis, embedded in a specific socio-economic and cultural context that defines the whole a *unit of analysis*.

In order to perform our research we selected two cases: case A in which HC was indicated because it met the clinical criteria for eligibility, and case B, where HC did not meet the criteria and it was granted only upon compliance with the injunction. The *analysis unit* consisted of: 1. Analysis of elderly's medical records; 2. Direct observation of the residence and family relationships; 3. Semi-structured interviews with four actors involved in each case: elderly, family caregivers, professional caregivers and health insurance companies' managers.

Other criteria for selection of cases were: elderly people shall have sufficient degree of autonomy to respond to the interview and understand the goals and discomforts of the research; the professional caregiver must have been watching the elder for a period of two weeks or more; the family

caregiver shall be at the same time the family member who assumes major responsibility and decision making in elderly care and the member who had requested HC; health insurance companies' managers were those directly responsible to release or not the HC request.

The data analysis allowed us to separate the ethical conflicts identification into two main categories:

- Conflicts around HC request and installation;
- Conflicts around direct assistance to the elderly.

The research was conducted in full compliance with the guidelines and Brazilian standards on ethics in research involving human beings. All participants signed terms of informed consent and the research protocol approved by the Ethics Committee of the Faculty of Health Sciences at UnB.

Results and discussion

Case A – HC met the clinical criteria

The data file shows it is a 73 years old man suffering from pulmonary emphysema, *diabetes mellitus*, prostate cancer and larynx cancer in remission that after diabetes complications had long hospitalization and showed enough clinical score to HC indication. He has lived for 27 years with his wife (family caregiver), aged 53 years, and a young adult son, just out of adolescence, surrounding the Federal District, approximately 40 km from Brasilia.

The family inhabits a large and airy house, with good conditions for the home care service installation without impairing circulation through the room. There was a table next to the bed, with a blood pressure and glucometer, plus an oxygen concentrator in continuous use. The relationship between the old man and his wife showed signs of mutual affection and attention, with a tendency to predominance of authority on her part. The son, at no time, has had any participation during the contacts made with the family, looking like he assumes a tendency to distance himself from the problem.

Conflicts around the id of the request and installation

According to his wife, the elderly spent more than a hundred days in the hospital without anyone commented on the possibility of HC until, finally, she learned of the existence of the service and their possible right to request it by a physical therapist. And thus she describes her first contact with the health

insurance provider to request the HC: *"I went to the health insurer and the girl [employee]: 'No! This is not like this! We have to see if the patient is able to enter the home care', and I don't know what..."* After obtaining the HC request from the attending physician, the family caregiver seems to have been elevated to a higher level regarding the quality of care: *"They heard me. Wow! So..., I think they looked more for me because initially I was so so, huh? Very worn..."*.

The first moral problem identified here is related to the deficiency of communication by the hospital and the health insurance company, which interferes with the patient and his family's autonomy and the right to health. First, there was lack of information to the family about the possibility of HC, which can be a result of the some games of interest around earnings and expenses related to hospitalization, or simply lack of information to clients by the health insurance company.

Second, the approach of the health insurance company's employee at the first touch seemed to be, above all, more concerned with the present requirements of the health insurance for the provision of the service than to understand the customer's demands, which we can understand as a *colonization* of social interactions by bureaucratic-administrative elements. These communicative disabilities, besides being a poor welcome procedure, brings direct negative results on the well-being of the patient and his family, increasing physical and psychological distress, and also meaning submission to a higher risk of hospital infections to the elderly.

In the view of the health insurance company manager, increasing HC requests is a result of the process of denial of illness by the family, their fear and the difficulties to take or share the responsibility of care:

"Most families do not face the patient's illness, denies the patient's illness. As they spend much time hospitalized, seeing the patient full of devices, probe, catheter and ventilator, they think it is a... monster in front of them... There are two sides, one side is the fear, one side is the denial of the patient's illness and there is that social issue that 'we're paying', we have the right, then it is the health insurance provider who has to take care of my family, not me... Don't want to share that responsibility..."

In the discourse of the family caregiver it was possible to perceive insecurity in dealing with the

equipment, *“How am I going to be seeing this glycaemia thing, these things? I do not know!”*. This is fully understandable, since handling the equipment introduces a new reality in the daily lives of families, for which there were not prepared³¹. But at no time it was possible to perceive denial of illness or unavailability of dividing responsibilities. On the contrary, the importance of HC was clearly reaffirmed: *“If it was not this [HC] he could have already gone to the hospital. Because he fell twice of hypoglycemia, he fainted. If not for this [HC] he would have died...”*.

The tendency to generalize in understanding family behaviors before the HC by health insurance company's managers may be an especially promoter of conflicts as it influences how the insurance company itself handles the requests and establishes their relationships with customers around them. This seems to point to the absence of opportunities for discussion between health insurance company's managers, health professionals and patients.

Conflicts around the direct care of the elderly

In the case in point, the wife was the only family member responsible for the elderly's health care, evidencing her degree of wear: *“Actually I have no more life, right? This is what reality is. (...), I can no longer travel, I cannot be away from home. Even if there is a technic (...), my concern today, twenty-four hours, is him.”* The elderly also demonstrates to recognize this wear: *“More burden for the wife, right? The time I was in the hospital she had to turn me around, cuddle, put me in the chair to the bath. (...) Poor woman, she took heavy, I weighed over 80 kilos...”*.

It is worth noting, however, that the family caregiver alleviates the non-involvement of her son. *“He is young, teen, and is studying, doing college and looking for an internship, he doesn't have time to be caring for his father”*. Factors such as overloading of family caregivers, tendency to isolation and abdication of their own needs have already been described in the literature in relation to prolonged hospitalizations^{17,18,32,33} and may be even more severe in HC, because it is a condition with no deadline set to end.

In relation to professional caregivers there is recognition for the value of the technical work performed, but the family caregiver makes clear his place of command, *“As I have a personality so... strong, I come in and I say what I want to say: ‘Oh, I did not like it, it's not okay’. Because you create a rela-*

tionship of friendship, but first of all, here is like boss and employee”. The elderly demonstrates to recognize the importance of both types of care, family and professional: *“If one is taken from me, the other is missing. Taking the other, I'm gonna miss. Here I depend on both”*.

Three aspects related to interpersonal relationships concerning the health care are worth mentioning: First, it should be considered a moral duty of the health insurance company's employees to take into account the degree of wear of family caregivers at the time to establish relationships with them, including whether psychological support when needed; second, the fact that the family caregiver using typically instrumental rationality arguments, when it puts the need of study and professional education of the son, something natural at that moment in the life of every young, as sufficient to justify a selfish attitude of moving away from the health care that needs to be provided to his father, demonstrates that the *colonization of the lifeworld by instrumental rationality* is not unique to health professionals and institutional managers; and thirdly, by considering the technical nursing as a kind of domestic worker, the family caregiver can be considered a result of historical relations of domination of classes, which may influence the relationships and deserve clarification at the moment of HC installation.

Regarding respect for the autonomy of the perfectly lucid elderly, as in this case, the patient states to participate in important decisions, *“Oh, I go into the participation too. Mostly in therapy, right?”*. However, it was revealed that it was in fact a subordinate autonomy. The professional caregiver reports his conduct when the elderly try to modify the form or time of medication administration: *“Sometimes he thinks that the medication has to be a certain way, that it is not that. I make the medication as prescribed. As it is in the prescription”*. In the family caregiver it was noticed an even stronger authoritarian paternalism: *“Usually I'm the one who gives the final hammer blow, you know”; “I see that he is like a child, he totally depends on me. So sometimes I argue with him, I call his attention, but always for his well-being”*.

Even though there may be some rigorous therapeutic requirements in terms of schedules and forms of administration, it is often possible to flexible them with safety. Here, the use of *communicative rationality* could help, where possible, to ensure that small changes were agreed, as they value the elder's independence and contribute thus to their

well-being and self-esteem. Likewise, although paternalistic attitudes are very common and represent an expression of extreme caution in relationships of affection, it is important that the family is informed about the importance of valuing the choices of the elderly, since the crystallization of authoritarian relationships has been described as capable of raising the emotional dependence of the elderly, reducing their ability to self-care and creating the risk of taking infant behaviors in relation to health³⁵.

Creating forums for group discussions, where family and health professionals may practice communicative rationality to exchange information and experiences, could be an excellent way for planning together actions and support for all involved.

Case B – HC was obtained by court injunction

The data file shows it is an elderly woman, aged 84 years, with heart failure (mild), Parkinson's disease (early stage) and controlled hypertension. She has a healthy looking, good mobility without the aid of a walking stick, and shows some dynamism and participation in the management of the house. Her home, located 45 kilometers far from Brasília, is small, with narrow rooms, a typical lower middle class home. We observe an excess of furniture considering the size of the rooms, narrow doorways and uneven floors, turning to be an environment with high risk for accidents.

There was, in this case, no requiring for installation of furniture and hospital equipment. Elderly has three children and lives with two of them; all are now elderly, one is retired and the other carries schizophrenia stabilized by medication. The relationship between the elderly and those children has some degree of formality and coldness, and it is clear that none of them actually participates in the care of their mother. The third, aged close to 50 years, does not live in the same house, but is who has demonstrated the greater involvement in taking care and better relationship with the mother, being identified as the family caregiver.

Conflicts around the HC request and installation

In this case, the HC was requested by a family and not by a doctor, since the elder was not hospitalized. For this reason, the health insurance provider did not even open the process to analyze the elderly eligibility and repeatedly denied the request. The insurance company's manager confirms there is no formal means to meet a request that comes directly from the family: *"If that request comes from the fa-*

mily we discard it because we have the internal procedures of authorization here, so I cannot even go on with the opening of the process". This demonstrates a bureaucratic rigor for opening request processes based on a purely instrumental rationality aiming at administrative efficiency. Another moral problem is that the "disposal" of the request is not even matched by any other procedure to support the family.

In parallel, the interview of the family caregiver makes it apparent the deadlock they lived due to the profound difficulties to balancing work, family and the mother's health care. He acknowledged that there was no indication for HC itself, but reaffirmed the need to have a professional caregiver daily, watching the elderly, which was out of their financial conditions:

"I never was called attention by my boss, I had to be asking all the time, asking, asking, asking, I was embarrassed, I got the impression that this has greatly diminished my possibilities to... to grow at work";

"It disturbed me a lot here in the family, right? Because I have two kids, I have my wife... sometimes I had to choose who I would take care of at that moment, my wife, my two children";

"I went after researching prices and see if I was capable of maintaining caregivers, even without that professional qualification, and even that I couldn't afford."

One of the health insurance company's managers interviewed acknowledges the lack of low-complexity home care programs, demonstrating sensitivity to the distinction of socially induced demands:

"The clinical reason is the minority of cases, the large majority, around seventy-five percent and eighty percent, searches in the effort to have caregiver and not an integral home care";

"The social issue, it is the classes issue, so to speak... financially disadvantaged, the middle and wealthy classes seeks to transfer the health care responsibility to the insurance company. That's the truth. "

Despite this recognition by senior employees of the health insurance company, it is worth noting that this has not been enough to mobilize the management, in order to study the feasibility of new kin-

ds of daily home care, not a proper HC, that might result, including, in reducing the number of hospital admissions caused by instabilities and complications of existing morbidities or in accidents such as falls which are common in elderly patients who receive inadequate care. In the public health system, the identification of a significant demand implies a moral duty to making all efforts to program actions in response to it.

By reports of family caregivers it is seen that the way insurance providers' employees have notified the family about the impossibility of meeting the request has contributed to cause a high level of interpersonal conflict, which led to the juridicalization of the demand:

"The medical auditor said: no! It is your obligation (...), she was rude to me, I reacted, I was rude to her";

"A manager was quick and dirty with me: no, we don't do, that's your problem! She used terms like that, then I said that: because it is not your mother! Wow, this girl was mad at me! She said: of course not! Glad it is not my mother who has to go through this. I said: oh, your mother you don't want to go through that, now the insured people you don't care, right? Then the conversation ended, I had to leave her room... "

It may be noted the clear moral problem in the way that this procedure was performed because there is disrespect for the customer, which originates in the non-recognition of the other and unwillingness to be sensitive to their needs, demonstrating unpreparedness to deal with conflicting situations and to establish a communication process that can lead to understanding even facing limits to meet demands. Rationality is typically instrumental: if the case does not fall in my scientifically developed clinical criteria, then: "the obligation is yours", "it's your problem", which actually is not mistaken way to welcome, but it is not to welcome, an unjustifiable attitude for any company that intends to be responsible for the welfare of the insured.

The impact of obtaining HC by court injunction (even if limited only to the presence of a professional caregiver) on the well-being of the elderly and the family was always evident in the reports of the family caregiver: *"That day care, which is typical of a caregiver, (...) [gives] conditions so that I can continue working and supporting, because today, even with home care, I spend around almost a third of my*

salary to keep my mother alive." This fact underlines the importance to study and implement the provision of new forms of low complexity home care, and the development of new criteria that take into account the actual social conditions of the family and the degree of risk to which the elderly are submitted by social factors involved in their care.

Conflicts around the elderly's direct care

From the point of view of the reports, this case was much less marked by conflicts regarding the elderly health care. Perhaps the fact that the service has been implemented, by injunction, has inhibited them to report interpersonal problems related to the health care, in order to protect the service obtained. No conflicting relationships between the professional caregivers and the elderly were described.

The professional caregiver describes as "good" the relationship established with the elderly. But you can see that the high degree of autonomy of the elderly and her insistence on trying to lead details of her own treatment or her own behavior are understood as stubbornness: *"She is a great patient, sometimes ... a little stubborn"* – which may show a tendency to infantilization of the elderly, also found in Case A.

As for the HC benefits, the elderly seem to understand those as they were directed to her condition of loneliness rather than her health: *"...I'm liking it. I have a company, right?"*, and leaves between the lines the lack of her children. The professional caregiver shows also to realize the distance between the elderly and the children who live in the same house: *"Because her children usually go out a lot (...) it has to have someone who... knows her well"*.

Several authors have demonstrated that, in addition to reducing the risk of complications and accidents, to accompany the elderly is both therapeutic and preventive for depression and cognitive loss that can cause loneliness in old age³³. Thus, a service, even low complexity, cannot be considered a minor benefit to the health of an elderly person. This finding reinforces, once again, the need to rethink the criteria to provide HC so that they can meet the care needs of the elderly broadly consistent with human rights, to promote health and quality of life.

It was also possible to see, in relation to the possibilities of family care, that there was an embarrassment, almost an obstacle, in monitoring the elderly to bathing, using the toilet or helping in war-

drobe changes. Even to the son, defined as a family caregiver, it seemed clear: *"This daily care really has to be with the girls"*. The literature shows that, regardless of the elderly under health care's gender, there is a predominance of females in tasks related to their care, represented especially by daughters, daughters-in-law and wives, as family caregivers^{34,35}.

The designation of such assignment, of course, is influenced by cultural determination of social gender roles, but also reflects gender relations of domination that contribute to higher overhead over females. Those are issues that could be addressed with a view to transforming them into democratic forums for discussion promoted by health insurance companies.

Final Considerations

The two cases presented and discussed here show conflicts that can arise around the home care of the elderly, both in the individual aspect of the assistance, which is related to clinical bioethics, as to the size of the organization and health services supply, which are related to bioethics applied to the public health system.

Although the provision of HC in almost all categories of health insurance providers in the supplementary health system in Brazil has very similar characteristics and follow the same clinical criteria for indication, this study, being an exploratory case study, has limited power of generalization, requiring more extensive and in-depth approaches to identify wider range of moral conflicts in HC and consequently propose broader ways to prevent them, reduce them or solve them.

However, the combination of case study methodology, with a reflection based on critical bioethics on the communication deficits in interpersonal

relationships and the influence of the variety of socioeconomic contexts and forms of everyday life of the families on household health practices allowed pointing some ways of resolving identified conflicts, such as: the need to develop information and communication to customers about HC programs from the time of the hospitalization; supply of an intermediate home care modality, based on the part-time presence of the professional caregiver; development professional training and continuing education programs for preparing the welcome, especially in situations of disagreement; provision of psychological support services to family, creation of discussion forums to exchange experiences and information among professionals, elderly patients and families involved in home care.

It can be argued that the generation of a demand for low complexity home care arrangements, when they do not meet the clinical criteria for HC used by the supplementary health care system, is caused by the fact that the Brazilian State, even with a national policy of elderly healthcare⁸, does not efficiently develops programmatic actions toward special care with the aging population. However, it can also be counter-argued that as a supplementary system the different types of health insurance carriers assume the responsibility of caring for the health of those insured. This means ethical commitment to the welfare of their insured and using a broad concept of health in designing their programs⁷.

For a country that within 37 years expects to have a population of around 215 million inhabitants, of which about 49.4 million will be aged over 65 years², the planning and provision of health care services to assist the elderly, as well as prevention and reductions of ethical conflicts that may arise from those, become urgent and fundamental. We hope this work has succeeded in stimulating the necessary discussion on the subject.

Work produced under the Bioethics Postgraduate Program, UNESCO Chair of Bioethics/Faculty of Health Sciences, University of Brasilia (UnB).

References

1. Brasil. Ministério da Saúde. Envelhecimento e saúde da pessoa idosa. Brasília: Secretaria de Atenção à Saúde; 2007.
2. Instituto Brasileiro de Geografia e Estatística. Projeção da população no Brasil por sexo e idade 1980-2050: revisão 2008. [Internet]. Rio de Janeiro: IBGE; 2008 (acesso 27 jan. 2013). (Estudos e pesquisas. Informação Demográfica e Socioeconômica; n° 24). Disponível: http://www.ibge.gov.br/home/estatistica/populacao/projecao_da_populacao/2008/projecao.pdf
3. Alvarenga MRM, Mendes MMR. O perfil das readmissões de idosos num hospital geral de Marília/SP. Rev Latinoam Enferm. 2003;11(3):305-11.

4. Gawryszwski VP, Jorge MHPM, Koizumi MS. Mortes e internações por causas externas entre os idosos no Brasil: o desafio de integrar a saúde coletiva e atenção individual. *Rev. Assoc. Méd. Bras.* 2004; 50(1): 97-103.
5. Coelho Filho JM. Modelos de serviços hospitalares para casos agudos em idosos. *Rev. Saúde Pública.* 2000;34(6): 666-71.
6. Chaimowicz F. A saúde dos idosos brasileiros às vésperas do século XXI: problemas, projeções e alternativas. *Rev Saúde Pública.* 1997;31(2):184-200.
7. Veras RP, Caldas CP, Araújo DV, Kushnir R, Mendes W. Características demográficas dos idosos vinculados ao sistema suplementar de saúde no Brasil. *Rev Saúde Pública.* 2008;42(3):497-502.
8. Brasil. Ministério da Saúde. Portaria nº 2.528, de 19 de outubro de 2006. Aprova a Política Nacional de Saúde da Pessoa Idosa. [Internet]. 2006 (acesso 25 jul. 2012). Disponível: <http://portal.saude.gov.br/portal/arquivos/pdf/2528%20aprova%20a%20politica%20nacional%20de%20saude%20da%20pessoa%20idosa.pdf>
9. Lima-Costa MF, Barreto S, Giatti L, Uchoa E. Desigualdade social e saúde entre idosos brasileiros: um estudo baseado na Pesquisa Nacional por Amostra de Domicílios. *Cad Saúde Pública.* 2003;19(3):745-57.
10. Barros SRTP, Braz MG, Cruz ICF. Pós-graduação em home care: uma exigência pela qualidade parte I. *Revista Brasileira de Home Care.* 1999;3(1):34-6.
11. Dal Ben LWD, Gaidizinski RR. Sistema de classificação de pacientes em assistência domiciliária. *Acta Paul Enferm.* [Internet]. 2006 (acesso 9 out. 2010);19(1):100-8. Disponível: <http://www.scielo.br/pdf/ape/v19n1/a16v19n1.pdf>
12. Ventura M, Simas L, Pepe VLE, Schramm FR. Judicialização da saúde, acesso à justiça e a efetividade do direito à saúde. *Physis.* 2010;20(1):77-100.
13. Agência Nacional de Saúde Suplementar. ANS Tabnet: informações em saúde suplementar. [Internet]. 2004 (acesso 20 fev. 2013). Disponível: http://www.ans.gov.br/anstabnet/tabcgi.exe?anstabnet/dados/TABNET_BR.DEF
14. Agência Nacional de Saúde Suplementar. Foco saúde suplementar. Jun. 2012 (acesso 5 dez. 2012). Disponível: http://www.ans.gov.br/images/stories/Materiais_para_pesquisa/Perfil_setor/Foco/20120816_web_foco_junho_2012.pdf
15. Agência Nacional de Saúde Suplementar. Resolução RDC nº 39, de 27 de outubro de 2000. Dispõe sobre a definição, a segmentação e a classificação das operadoras de planos de assistência à saúde. (acesso 3 nov. 2010). Disponível: http://www.ans.gov.br/texto_lei.php?id=380
16. Lima-Costa MF, Loyola Filho AI, Matos D. Tendências nas condições de saúde e uso de serviços de saúde entre idosos brasileiros: um estudo baseado na Pesquisa Nacional por Amostra de Domicílios (1998 - 2003). *Cad Saúde Pública.* 2007;23(10):2.467-78.
17. Schwanke CHA, Feijó AGS. Cuidando de cuidadores de idosos. *Bioética.* 2006;14(1):83-92.
18. Sena RR, Leite JCA, Costa FM, Santos FCO, Gonzaga RL. O cuidado no domicílio: um desafio em construção. *Cogitare Enferm.* 1999;4(2):58-62.
19. Fortes PAC, Zoboli ELCP. *Bioética e saúde pública.* São Paulo: Loyola; 2009.
20. Correa FJL. Fundamentos y principios de bioética clínica, institucional y social. *Acta Bioéth.* 2009;15(1):70-8.
21. Porto D, Garrafa V. Bioética de intervenção: considerações sobre a economia de mercado. *Bioética.* 2005;13(1):111-23.
22. Schramm FR. Bioética da proteção: ferramenta válida para enfrentar problemas morais na era da globalização. *Rev. bioét. (Impr.).* 2008;16(1):11-23.
23. Albuquerque AAS. *Bioética e direitos humanos.* Rio de Janeiro: Loyola; 2011.
24. Garrafa V, Porto D. Intervention bioethics: a proposal for peripheral countries in a context of power and injustice. *Bioethics.* 2003; 17(5-6):399-416.
25. Correa FJL. Principios para una bioética social. *Revista Bioéticos.* 2009;3(1):18-25.
26. Hedgecoe AM. Critical bioethics: beyond the social science critique of applied ethics. *Bioethics.* 2004;18(2):120-43.
27. Hoyos G. Estructuración del discurso bioético: comunicación y lenguaje. In: Garrafa V, Kottow M, Saada A, organizadores. *Estatuto epistemológico de la bioética.* México: Universidad Nacional Autónoma de México/Unesco; 2005. p. 193-219.
28. Lorenzo C. Teoria crítica e bioética: um exercício de fundamentação. In: Porto D, Garrafa V, Martins GZ, Barbosa SN, organizadores. *Bioética, poderes e injustiças.* Brasília: CFM; 2012. p. 171-88.
29. Creswell JW. *Qualitative inquiry and research design: choosing among five traditions.* Thousand Oaks: Sage; 1998.
30. Yin RK. *Estudo de caso: planejamento e métodos.* 4ª ed. Porto Alegre: Bookman; 2010.
31. Ciosak SI, Braz E, Costa MFBN, Gonçalves N, Nakano R, Rodrigues J et al. Senescência e senilidade: novo paradigma na atenção básica de saúde. *Rev Esc Enferm USP.* [Internet]. 2011(acesso 22 jan. 2013);45(spe2):1.763-8. Disponível: http://www.scielo.br/scielo.php?pid=S0080-62342011000800022&script=sci_arttext
32. Garbin CAS, Sumida DH, Moimaz SAS, Prado RL, Silva MM. O envelhecimento na perspectiva do cuidador de idosos. *Ciênc Saúde Coletiva.* 2010;15(6):2.941-8.

33. Saad A. Prólogo. In: Tealdi JC. Dicionario latino-americano de bioética. [Internet]. Bogotá: Unesco/Universidad Nacional de Colombia; 2008 (acesso 10 jan. 2013). Disponível: <http://www.unesco.org.uy/shs/fileadmin/templates/shs/archivos/DicoPartel.pdf>
34. Almeida L, Azevedo RCS, Reiners AAO, Sudre MRS. Cuidado realizado pelo cuidador familiar ao idoso dependente, em domicílio, no contexto da estratégia de saúde da família. *Texto & Contexto Enferm.* [Internet]. 2012 (acesso jan. 2013);21(3):543-8.
35. Fernandes MGM, Garcia TR. Determinantes da tensão do cuidador familiar de idosos dependentes. *Rev Bras Enferm.* [Internet]. 2009 (acesso 25 jan. 2013);62(1):57-63. Disponível: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0034-71672009000100009&lng=en

Participation of the authors

Cláudio Andraos has conceived the article, conducted the research procedures and data analysis, performed the literature review and participated in the writing. Claudio Lorenzo has participated in defining the methodology and data analysis, contributed to the literature review and gave the final shape to the writing.

