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RESEARCH

POLITICAL PATHWAY OF HOME HEALTH CARE IN MINAS GERAIS

TRAJETÓRIA POLÍTICA DA ATENÇÃO DOMICILIAR EM MINAS GERAIS

TRAYECTORIA POLÍTICA DE LA ATENCIÓN DOMICILIARIA EN MINAS GERAIS

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ABSTRACT

Home care has been reinterpreted in the context of Brazilian public health policies, anchored in a new way of conceiving and offering care. The political, juridical and ideological trajectory of the home care offer in the country has instigated studies. It was analyzed the political trajectory of the implementation of Home Care in the state of *Minas Gerais*, Brazil, discussing the movements evoked by the regulation of the National Policy of Home Care published in the country in 2011. Descriptive-exploratory research, with a qualitative approach, carried out in 19 Home Care Services offered in *Minas Gerais*, which respected the ethical aspects of research with human beings. The data were obtained from an interview with 22 coordinators/service managers and 03 key informants, and were submitted to the Thematic Content Analysis. The results are organized into two categories: the political configuration of Home Care; the path of implementation of the provision of Home Care in *Minas Gerais* and effects of the Policy. The findings point to the political configuration of HC in the country, based on federal regulations; and the expansion of services in the state driven by the financial induction of the National Policy. It is concluded that home care is an alternative care that welcomes the demands of the "old" services, but at the same time, it has contributed to advances in the comprehensive care provision and productive restructuring of the health work.

Keywords: Home Health Care; Home Care Services; Public Health Policy.

RESUMO

A atenção domiciliar vem sendo ressignificada no contexto das políticas públicas de saúde brasileiras, ancorando-se em um novo modo de conceber e ofertar o cuidado. A trajetória política, jurídica e ideológica da oferta da atenção domiciliar no país tem instigado a realização de estudos. Analisou-se a trajetória política de implantação e implementação da atenção domiciliar no estado de Minas Gerais, Brasil, discutindo os movimentos provocados pela regulamentação da Política Nacional de Atenção Domiciliar publicada no país em 2011. Pesquisa descritivo-exploratória, com abordagem qualitativa, realizada em 19 serviços de atenção domiciliar ofertados em Minas Gerais, que respeitou os aspectos éticos da pesquisa com seres humanos. Os dados foram obtidos de entrevista com 22 coordenadores/gestores de serviços e três informantes-chave, e foram submetidos à análise de conteúdo temática. Os resultados estão organizados em duas categorias: a configuração política da atenção domiciliar; a trajetória de implantação da oferta da atenção domiciliar em Minas Gerais e efeitos da política. Os achados mostram a conformação política da AD no país a partir das normativas federais; e a expansão dos serviços no estado impulsionada pela indução financeira da política nacional. Concluiu-se que a atenção domiciliar é alternativa assistencial que acolhe as demandas dos "velhos" serviços, mas, ao mesmo tempo, ela tem contribuído com avanços na integralidade do cuidado e reestruturação produtiva do trabalho em saúde.

Palavras-chave: *Assistência Domiciliar; Serviços de Assistência Domiciliar; Políticas de Saúde Pública.*

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RESUMEN

La atención domiciliaria asume nuevos significados dentro del contexto de las políticas públicas de salud brasileñas, basada en una manera nueva de pensar y ofrecer cuidados. La trayectoria política, jurídica e ideológica de la oferta de la atención domiciliaria en el país ha fomentado la realización de estudios. Se analizó la trayectoria política de implantación e implementación de la atención domiciliaria en el estado de Minas Gerais, Brasil, y se discuten los movimientos provocados por la reglamentación de la Política Nacional de Atención Domiciliaria publicada en 2011. Investigación exploratoria, descriptiva, de enfoque cualitativo, llevada a cabo en 19 servicios de atención domiciliaria de Minas Gerais, que respetó los aspectos éticos de la investigación con seres humanos. Los datos se recogieron en entrevistas a 22 coordinadores / gestores de servicios y 3 informantes clave y se analizaron según el contenido temático. Los resultados se organizaron en dos categorías: configuración política de la atención domiciliaria, trayectoria de implantación de la oferta de la atención domiciliaria en Minas Gerais y efectos de la política. Los hallazgos muestran la configuración política de la AD en el país a partir de las regulaciones federales y la expansión de los servicios en el estado impulsada por la inducción financiera de la política nacional. Se concluye que la atención domiciliaria es una alternativa asistencial que incluye las demandas de los "antiguos" servicios y que contribuye a los avances en la integralidad de la atención y en la reestructuración productiva del trabajo en salud.

***Palabras clave**: Asistencia Domiciliaria, Servicios de Asistencia Domiciliaria; Políticas de Salud Pública.*

INTRODUCTION

Health care in Brazil has become a right of the population and a duty of the State through the implantation, at the beginning of 1990, of the Unified Health System (SUS – *Sistema Único de Saúde*, in Portuguese), one of the largest public policies in the field of social security. Universal and equal access to actions and services for the promotion, protection, recovery and rehabilitation of health were guaranteed.[1]

The health policies that support the SUS converge towards the construction of care and management models that provide answers to health problems and needs, considering the country's heterogeneity and political, economic and cultural diversity. They reinforce the need to reconfigure sanitary practices to overcome the disease-centered care model and care provided in the hospital environment, betting on new knowledge and practices that focus on the identification and analysis of contemporary health problems and needs, focusing on the user and on the key characteristics of health care.[2]

As a consequence, the emergence and expansion of non-traditional care spaces; and home care (HC), already expanding in the country since the 1990s, in its various modalities, stood out, requiring the proposal of public policies that incorporated the possibility of offering home care to those who demand it and regulation for its operation. HC is progressively taking place within the scope of SUS, among the shocks suffered by an economic and political crisis, reacting against the proposals and attempts to privatize or outsource its management; and in the midst of the relationship with people and organized collectives, from new forms of production of care and counter-hegemonic and liberating knowledge.[2-4]

With the current organizational model of health services provision in SUS, the HC strengthens as a device with potential for interlocution between health care points, instigating health workers, managers and policy makers to invest in this perspective. It is also considered the premise that health care, when performed in people's homes, has the power to advance in the search for comprehensiveness, by enabling the in-depth knowledge of the user, their needs, routines, culture and their family.[5]

HC in Brazil, therefore, has been redefined, especially over the last two decades by a set of normative devices, anchoring itself in a new way of conceiving and providing care in the context of health care offered by SUS.[3] However, despite the expansion of HC in Brazil, there are gaps in scientific production that demonstrate the effective repercussions of this type of attention in the conformation of new management and care arrangements focused on users' needs.

The *Política Nacional de Atenção Domiciliar* (PNAD) in Brazil was instituted by the Administrative Rule No. 2029, of August 24, 2011[6], and modified by Administrative Rules No. 2,527 of October 27, 2011[7] and No. 1.533, of July 16, 2012[8] and, next, the Administrative Rule No. 963 of May 27, 2013[9]. Currently, PNAD is governed by the Administrative Rule No. 825, dated from 2016.[10]

Updates and policy changes have implications that need to be investigated. Thus, the political, legal and ideological pathway on HC in the country has instigated studies and research on the movements and effects that this policy has generated on the demand and supply of HC services in SUS.

In this sense, it is assumed that the political definition and financial induction of regulatory devices have greatly contributed to broaden the supply of HC services in the country. However, it is asked: how does one establish the political pathway of the "new" services implemented after the publication of PNAD? In the political pathway, on what bases are the "new" HC services organized? Have they been aimed at the de-hospitalization and cost rationalization, traditionally accepted demands in home care, or have they been able to incorporate, even in an incipient way, population groups with poorly served needs in the traditional health care model?

Faced with this problem, the study aimed to analyze the political pathway of implementation of HC in *Minas Gerais*, discussing the movements provoked by PNAD.

The relevance of this study is based on the need to broaden the understanding about home care services, considering that this modality is in full expansion in Brazil. It is justified, above all, by the potential of this public policy to respond,

through HC services, to the demands of a progressive aging of the population; from the triple burden of diseases that persists in the country, with emphasis on increasing disease morbidity and chronic conditions; and the high hospital costs that they have represented for SUS and for the families. It should be emphasized that HC is an important scenario for the performance of nursing,[11] as an area of knowledge and practice, that assumes the centrality, whether through actions that go through clinical and administrative supervision, or through mediated care provision through relational, educational and technical procedures.[12]

METHOD

A descriptive and exploratory study was carried out, with a qualitative approach in the scope of the multicentric research "Home Care in Health: effects and movements in supply and demand in SUS in the state of *Minas Gerais*", carried out by research groups from six universities in the state.

The study had as a scenario the home care services (HCS) of *Minas Gerais*, in municipalities that were in compliance with the Ordinance MS No. 963 of 2013, in force at the time of the beginning of the project. A total of 19 municipalities with HCS in MG were contacted by telephone, which accepted to participate in the study, between February 2014 and July 2015. Interviews were conducted with the 19 HCS coordinators. In three municipalities, also the municipal managers of the areas that housed the HCSs participated. In addition, data from interviews with three key informants linked to the federal management of PNAD were included.

Of the 19 coordinators, 12 have been in the position of coordinator since the creation of the "*Programa Melhor em Casa*" (PMC) program; four coordinators were male and 15 female; and they had the following grouping: 10 nurses, three social workers, two physiotherapists, one doctor and three with other professionals out of the health area. As for the managers, two are male and one female and they had the following training: Medicine, Dentistry and Accounting Sciences.

The interviews were guided by a semi-structured script containing questions about the institutional linkage of the home care services (HCS) in the network; the number, composition and profile of qualified teams; referral flows; and articulation with other services. They totaled 15 hours, 48 minutes and 15 seconds of recordings, with an average duration of 43 minutes/each interview.

The material obtained in the interviews was transcribed in its entirety and submitted to thematic content analysis, according to Bardin's guidelines.[13] Content analysis is a technique for analyzing communications through systematic and objective description of message content.[13]

Three phases were analyzed: floating reading as the first approximation with the material (in this phase, the material was subjected to reading and revision, exclusion of repeated expressions, identification of the participants and the scenarios); depth reading for the exploitation of the material (in this phase the units of registration and the units of signification were identified by the frequency repetition of the central ideas in the text, originating the themes that, grouped, conformed the thematic categories: political configuration of home care and pathway of home care in *Minas Gerais* and the effects of the policy); and treatment of the results through the interpretations and inference of the authors, confronting the empirical material and the literature produced on the subject.

For ethical reasons, the participants were assigned numerical alpha codes in their speeches, where M stands for municipality and G for manager, followed by numbers that represented the order of the interviews. The municipal institutions were designated by YY. The participants were informed about the objectives and purposes of the study and they signed the Free and Informed Consent Term, obeying the ethical precepts of Resolution 466/12 of the *Conselho Nacional de Saúde*. The research was approved by the *Comitê de Ética em Pesquisa* under the opinion Nº CAAE 07698212.7.0000.5149.

RESULTS AND DISCUSSION

The analysis of the data allowed the construction of two empirical categories: the political configuration of home care in Brazil, through which the findings regarding the political composition of HC in the country are described and analyzed based on federal regulations; and the pathway of home care in *Minas Gerais* and the effects of the policy, whose findings allowed the analysis of the political pathway of implementation of HC in *Minas Gerais* and how the movements are provoked by PNAD with the expansion of services in the state, driven by the financial induction of the national policy and by the need to organize the care provision for the de-hospitalization and cost reduction. The discussion of these two categories is presented below.

Political configuration of home care in Brazil

The offer of HC in SUS began to be guided by the PNAD as of October 2011, through the Ordinance GM Nº 2,527, which created the PMC.[6,7] With the political and juridical framework of this program, the goal of providing comprehensive care to the person, from an ethical point of view, committed to respect for individuality, was taken on the offer of HC in the country, thinking about the care offered at home with the family consent, user participation, caregiver existence, and interdisciplinary teamwork.[5]

The HC offer began to be organized through three modalities: home care type 1 (HC1), home care type 2 (HC2) and

home care type 3 (HC3), according to the complexity and technological density demanded by the needs of the care of the user, the characteristics of their health, as well as the frequency of care demanded for them.[7]

The initial evaluation on the creation of the PNAD identified the need for revision, in order to broaden the access of users who have demands for these services, safeguarding the SUS principles. As a result, the group of eligible municipalities, which previously encompassed those with a population of up to 100,000 inhabitants, started in 2011, to cover all those over 40 thousand, with the final revision of this ordinance in 2013. The first version, dated from 2011, was restrictive and, with the subsequent versions, the possibility of adhesion of the municipalities was expanded, highlighting that the changes occurred due to pressure from both the municipalities and from the existing services in the country.

> *And it was [...] restrictive! [...] We had the restriction of being a municipality above 100 thousand inhabitants, right? [...] The second ordinance, which was already one, this movement of listening, [...] we had a "screaming", I remember: a crazy "screaming" [...] Everybody saying: "But, my city has 40,000 and I can't?"* (Key informer 1).

Thus, by the GM/MS Ordinance No. 963, of May 27, 2013,[9] the possibility of adherence of municipalities with more than 20 thousand inhabitants was extended, with the possibility of qualifying a multiprofessional home care team (MHCT) independently or by group of municipalities, regionally.

The concept of HC is strengthened as a modality of health care, with a substitutive and complementary character that maintains the premises of health promotion, prevention, treatment of diseases and illnesses and rehabilitation of health through home care, offered in an integrated way with services of different technological densities, strengthening and making *Redes de Atenção à Saúde* (RAS) effective. Therefore, one of the HC's objectives is to reorganize the "work process of the teams that provide home care in basic, outpatient, emergency and hospital contexts". The immediate expectation of this investment is the "reduction of the demand for hospital care and/or reduction of the period of stay of hospitalized users, the humanization of care, deinstitutionalization and the expansion of the users' autonomy".[4]

The new versions extended the policy's inductive capacity, especially Ordinance No. 963, from 2013, which extended the possibility of municipalities joining the program by reducing the population size, building a consortium and conformation of different team models. In addition, a review of the funding was made, with an increase in resources, in order to take into account local realities, from R$ 34,560.00 to R 50,000.00 for type 1 team, according to a key informer of the research:

> *Due to one of the problems they brought* **[the municipal managers]** *it was clear that it was a financial resources problem. [...] The financial resources of the team costing were calculated by this WG* **[work group]** *as the ideal cost for a team of this size, to make such attributes that are in the ordinance. [...] It was around 42 thousand reais a month. Then the Health Department, in the agreement, said: "we're going to pay 80% of that, which was R$ 34,560.00. [...] We did the average salary table for professionals, by category, gasoline, car rental and input based on the calculations that the WG had produced with the municipalities, which are in the WG". Then that was it. But it was enough... many places paid the same bill, easy, and other places did not pay the bill, because it depended on the salary practiced, mainly of the doctor, depended on how much he was able to lower the price in licitation, depended on the market, depended on several things. And it depended on the clientele that the HCS had at that moment. So some HCS had more complex patients, and it was even more expensive and others had many HC1 patients and they were very cheap, so that varies, right? But it became clear that R$ 34,560.00 [...] it was not by itself a stimulating factor for managers, because he had to do the math, put it on the tip of the pencil. And then that appeared a lot, we took it to Padilha* [Health Minister at the time]. *Padilha said: "Increase the fund for "Better at Home". Then, it went from R$ 34,560.00 to R$ 50,000.00. Then, the adjustments were in the field of the adherence criterion and also in the field of financing* (Key informer 2).

In April 2016, the PNAD underwent a new revision, with the promulgation of Ordinance No. 825 by the *Ministério da Saúde* (BR),[10] which reaffirms the conceptual aspects of HC, but changed the profile of users to be considered by PNAD, in the different HC modalities, and expanded the user's access by expanding the list of eligibility conditions for the HCS admission, enabling definition, sharing, and co-responsibility for care within the network. The requirement of the family caregiver has since been flexibilized considering the functional and clinical condition of the user.[10]

It is important to highlight that, in addition to the expansion of the possibility of eligibility and inclusion of users, from Ordinance No. 825/2016, it is possible to identify a redirection in the defining focus of the service responsibilities, moving from a procedural perspective to a care-focused orientation. Thus, the condition of illness (acute, chronic or exacerbated) is considered in the evaluation of users, and technologies are incorporated, such as the *Projeto Terapêutico Singular* (PTS), which contributes to a HC focused on the user's needs and for the transformation of health practices.[10]

The pathway of home care in *Minas Gerais* and the effects of the policy

The analysis of the pathway of HC in MG identifies a chronology that demarcates relevant historical moments in the field of public policies. It is acknowledged the HC modalities that existed prior to the implementation of SUS, developed in an unsystematic way, in the interface between families and health services, in a timely manner, outside the scope of technical-administrative and public policy care provision guidelines. However, the research data enabled the construction of a historical line of the HCS implementation in *Minas Gerais*, showing an increment with the implementation of SUS, following the course of health policies.

The interviewees reported on the timing and context of the services in their municipalities, some of them occurring in the 1990s and others since the beginning of the 2000s.

> *1994 is [...] the hospital was still an emergency room, but it already had an overcrowding because the lack of beds in the region always existed [...] In this context, the proposal of home hospitalization came out* (M7G1).

> *When it started, it started with the Programa de Internação Domiciliar (PID), that was in 2000 and there was already this discussion, right, that to attend patients only for dressings, oh [...] in 2001 to 2002 emerged the discussion of long-term patients* (M17G1).

> *Well, this came about around 1996 as a Programa de Atenção Domiciliar, the PAD, with the intention of taking some chronic patients with ventilatory support from inside the hospital, where a lot of infections are recurring, right? So they went home and it was well accepted, the family accepted. So it started at this time. Now, when the ordinance came out in 2011 we sent the project [...]* (M14G1).

In the scope of the SUS implementation process, throughout the 1990s a set of policies for system consolidation was launched by the *Ministério da Saúde* (BR) and, among them, the first regulations for the creation and regulation of home care in Brazil are identified. The Ordinance Nº 1,892,[14] published in the Official Gazette on December 22, 1997, and the Ordinance Nº 2,416,[15] of March 23, 1998, and the Law Nº 10,424[16], of 15 April 2002 stood out.

These legal provisions created and provided criteria for home care, especially home hospitalization, which represented the normative basis for the first services created in this period in MG. At that time, the policy emerged as a device to support the primary care, providing guidelines and criteria for hospitalization and home care; and the home care services created focused on the de-hospitalization of users considered as "long-stay" or with demands for ventilatory support. In the regulations, the guidelines for multiprofessional care, medical indication based on clinical criteria, were highlighted. Other conditions were also included regarding the health status of the user and the family context.[3]

However, most of the services were implemented based on the induction made by the publication of federal regulations with the "*Programa Melhor em Casa*" (PMC):

> *At the end of 2011 and beginning of 2012 [...] the service was already working, so that our, our launch was May 3, but we were already working* (M4G1).

> *In fact, the better at home was created in mid-September 2013. So we took all the regulations, all the laws and with the help of the key informant, who was the coordinator of the "Melhor em Casa" at the national level at the time, and she helped us immensely* (M1G1).

The systematization of these findings is shown in Figure 1. For the analysis, this line was compared with the normative and regulatory milestones of the BHP; with the Law Nº 10,424 and Ordinance Nº 2,416, 2,029, 2,527, 963 and 825 and with the publications that preceded it in the HC field as public policy.[6-10,14,16.]

The services analyzed have an implementation pathway of about 20 years, the first one having started in 1994. In this trajectory, the services were being reconfigured, being modeled according to the normative devices and the needs of the services and the population.

> *And then, at the time, this group that was composed of me and a doctor, who, incidentally, is the service doctor until today, we were building the project. We have visited YY, [...] which began with a work more targeted for Oncology, then for AIDS and then it opened for everything, we went there, visited the services and came back and did the project for YY. And then, it was approved by the City Hall and then it was somehow, also, approved in other instances: CIB* [Comissão Intergestora Bipartite] – deliberative instance between the municipalities and the State] *and Ministério [...]. And the work began. But it all started, [...] two people working at first! We visited using our vehicles, we did not even have a car for it. So, I was already working here at the YY hospital and [...] we had a really good traffic in here. Then, we started to pick up things from the hospital and separate [...] what was from the PID and now this is from PID! This is PID! This is from PID! "Puf", I would put there and such [...]* (M7G1).

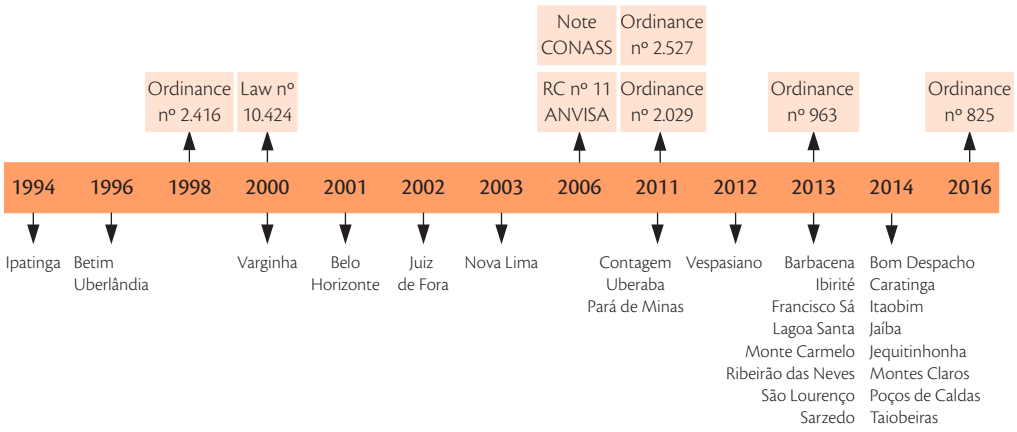

Figure 1 - Historical line of implementation of the HC services in *Minas Gerais*, Brazil.
Source: research data.

The HCS managers and coordinators participating in this study reported that the main reasons for the HCS implantation were the lack of beds and the need for the de-hospitalization of patients, especially those with a long stay. In this sense, the municipalities implemented different service models.

> *At the YY hospital, it emerged as an emergency room and was forcibly transformed into a hospital because it served, provided the first care, had nowhere to refer, then it was channeling and it was creating structures almost improvised to give answers to the hospitalizations. In this context, the proposal of home hospitalization emerged* (M7G1).

> *Then it starts there* [in the M4 municipality] *this discussion and, when I went to implant in* M4, *It was because it was a dream of ours. [...] of the hospital to implant it, because we saw the need to de-hospitalize the patient* (M11G2).

> *It started inside YY because he* [the patient] *I would come and go, I would come and go, I would stay home one day and come back to do some dressing... with a terrible condition in my house! We saw that these long-term patients needed to leave the hospital, [...] then, what we [...] [did]: it raised the need to take these long-term patients home so that they would truly feel like citizens* (M17G10).

> *Then the intention is to de-hospitalize, right? Those patients who are able to stay at home and we can provide home care. So, it was in this sense that we went to look for this alternative, to seek new funding, it is also important, and to pay attention to the patient. The recovery of the patient at home is much better than in the hospital environment* (M14G1).

The shortage of beds was indicated, above all, as the condition that stimulated the discussion in order to create other possibilities of service provision, even before PNAD. To this, the need for de-hospitalization as a demand is added, in order to revisit the health care model with its care offerings. From this perspective, HC is a great opportunity for managers.

> *In this context, the proposal of the home hospitalization arose [...], and, then a group began [...] That began to study this, to think of this possibility, from the first moment, with the intention of giving some kind of assistance to the patient, who did not have the absolute need to be in the hospital and was there occupying a bed, because the lack of beds was great* (M7G1).

> *The need, too, for the de-hospitalization. Oh! The bed issue [...]* [the condition that the] *the hospital beds are today, [...] this was one of our [...] great challenges (M12G1).*

> *From the implementation: then, we started to work together, right, the municipality began to work together with the hospital staff, who used to be of interest to the hospital to de-hospitalize patients who stayed here reserving a bed, right? Preventing* [the care provision to] *new patients. Right? Now [...] it already has the interest of the municipality, right? To provide care, to do home care and such, because we understand that it is better, right? Both for the patient and for the health team itself* (M14G1).

Long-term hospitalizations and the need to ensure the continuity of care also appear as reasons for the implementation of HCSs, especially for the care management of elderly populations.

> *The need to do the project was [...] to really lower the hospitalization rate, improve the care of patients out of therapeutic possibilities that the family health team really did not account for. [...] Patients who demanded a greater continuity of home visits* (M6P1).

> *Nowadays, basically, there are two main reasons to implant it: first that the patient will be taken care of with his/her family and secondly that the patient treated at home greatly reduces our cost. So I think these two reasons alone justify the investment we make* (M8G1).

The promulgation of the PNAD and the institution of the PMC produced needs for adjustments in the existing services, making them able to qualify in the MS.

> *And in 2013, the "Programa Melhor em Casa" ordinance, the municipality* **M16** *met with the direction of the YY Hospital to be able to organize what would be the division of home care programs.* **M16** *it was contemplated by seven teams. [...] Every 100 thousand people we could register a team. So, the council in this organization took over five teams, they hired [...] And [...]* **[names of two professionals]** *and I subsidize these teams, right?! And YY Hospital has got two teams. So we divided that way* (M16G1).

> *At the time, this team was created to support the UBSs, where we did not have a medical and nursing follow up at the residence. So this team worked for a long time, five years on that model, right? And attending those places where we did not have the doctor at home. Then, with the arrival of the possibility [...] of our accreditation, we took advantage of it. We had a doctor, a nurse and a technician and we started [...]. Our accreditation took place in October 2014, right? And, what happened? We had to start HCS, right? Respecting the ordinance and maintaining, also, the care provision of this patient who does not have [...] any place, so... to whom to appeal. So, so we are in a moment of [...]* **[change]** *and "changing the wheel and the car moving"* (M12G1).

Some municipalities initially chose to focus efforts on a larger scale to prevent hospitalizations by allocating type 2 (HC2) and HC3 *Equipes Multiprofissionais de Atenção Domiciliar* (EMADs) in the emergency care units (UPAs). Others allocated them in hospitals to fasten the process of de-hospitalization and there were still those who preferred the allocation in the primary health care, aiming to attend areas that were not covered and prevent the re-hospitalization.

The financial support was mentioned as being an important inductor for the implantation and advances of the HC in the municipalities. Along with the financial support was discussed and implemented the expansion of the teams and the space and actions offered so far.

> *The municipal domiciliary care, it has always been kind of [...] It was not considered as an important policy in the municipality. So much so that from the beginning it had no MS funding, for example, although there was already the possibility of having it. So, it was funded by the resources of the municipal treasure itself, which was very onerous to the management. [...] And, as of last year, 2013, we organized the team, as recommended by the Ministério da Saúde (BR), and now our teams are accredited, complete, with all the professionals required and with HD funding* (M8G1).

The implementation of the PMC brought another identity to the services that, in the majority, changed their "names" and changed the profile, being adapted to the norm. It is observed that, by implanting the "new" service, with PMC guidelines, that the names of the previous services, such as, for example, Home Hospitalization Program (HHP), *Departamento de Internação Domiciliar* (DID) or PAD, are giving place to the PMC, identity in construction in the HC.

> *Well, [...] the hospitalization program already existed, right? 14 years ago. Today, completing 15 years, and we are in this phase of implantation, to be the HCS, the "Better at Home". With the Ordinance approved since October 2013 [...] we are waiting for the implantation of two teams [...]* (M7G2).

> *[...] Before this process, this change, even though we had this certain difficulty, but with consistency, because, you get a service that has been there for 12 years, that the family has already a care provision, which already has a follow up, we had an issue. But nothing that was a hindrance for the Programa de Saúde da Família (PSF). Just so you have an idea, before starting the evolution of "Melhor em Casa"* (M11G1).

The PMC implementation changed the profile of the services: it complicated the patient care profile, except for the inclusion of patients in mechanical ventilation; it expanded the teams in number and in professional specialties. This was a political induction considered fundamental to restructure the services.

> *It built a structure out there, and we did so [...] Then, over time, things were added, right? New professionals, it*

> *is [...] the vehicle, the material, itself, the structure itself, and was, at times, with a low support, at other times, with more effective support from the city hall, this has already 20 years, right? Right [...] Last year, with the teams in line with the new ordinance, we got approval for a new project with two teams from EMAD and one from Equipe Multiprofissional de Apoio (EMAP), and we are working towards this* (M7G1).

The main change reported in the implementation of the PCM was the restriction of services to patients classified as HC1, who should be taken care of in the primary care. Thus, the data allows to recognize that the HCS sometimes include in the service the users who need care of lower technological density, that can be performed, mainly because they reside in areas considered by the managers as "discoveries", that is, they are not included as a territory attached to a *Atenção Primária à Saúde* (APS).

> *HC2 stays with us, HC1 is a health clinic and then we enter Núcleo de Apoio a Saúde da Família (NASF) and Centro de Reabilitação (CREAB) there or together with HC1, HC2 is ours and the patient stays around for 30 and 60 days. Then we [...] have this meeting, also, once a month, between HCS, NASF and CREAB to "pass" these patients. Precisely for the patient not to lose this continuity of care. Then he leaves me and goes to another service [...]* (M9P1).

> *[...] The profile [...] The program determines that HCS, in the case of the "Melhor em Casa", serves HC2 and HC3 patients. HC1 at any given time if it becomes more acute. What we see, even for the issue of primary care, is that we have many AD1 patients, from areas that are not covered by FHP and that could be taken care of either by the neighborhood polyclinic or the PSF team* (M18P1).

The participants also reported the repercussions that the HCS caused in the expansion of supply, reorganization of demand and attention to the needs of the population. They found that they create tactics and strategies to escape the rules imposed by the regulations, adapting the services to the local reality and the health needs of the population.

> *We follow the guidelines of the Ministério da Saúde (BR) and of the State Secretary [...] but it makes available, for example, an ambulance to transport the person when we needs it, because none of this is foreseen in official policies* (M8G1).

Therefore, the HC implementation initiative was based on four fronts of care demands, with different technological densities, however, borderlines: the de-hospitalization of users retained in long-stay hospitalizations; assistance to others "out of therapeutic possibilities", in palliative care; the resolution of acute problems or exacerbations of users who live with chronic conditions that seek emergency room care; and those who require continuity of home care, whose care needs go beyond the competence of family health teams. Thus, the path of implantation and expansion of HC in *Minas Gerais* has been responding to the health needs of the population, at the same time as it is proposed as a solution to the SUS challenges.

The need for de-hospitalization, the lack of beds and the recognition that, in the eligible cases, home care offers less risk of infection compared to that offered in hospital institutions are the main reasons for the expansion of the provision of HC services in the state. These are in line with the proposals published in the literature, which records that the reasons for the implementation of HC services are of a technical and political nature, establishing the offer both to meet the needs of care of the user in the family and to reduce costs with hospitalizations.[2,5,11]

The hospital stay has been reoriented by different health systems of the world with emphasis on the rationalization of the supply and modernization of the management, according to the premise that patients should stay in hospital for short periods, returning as early as possible to their usual rhythm of life. Among the pillars supporting this change are the insecurity related to the hospital environment and the need to de-concentrate the provision of the health service according to other available care modalities, such as HC, day hospital, outpatient surgery or even the nursing centers.[2,3]

Among these, home care is progressively becoming a health care provision modality that allows for better quality of care, de-concentration of the procedures with greater technological density for the home environment, in addition to alleviate the shortage of hospital beds. In view of the mutual benefits for service providers and also for users with dynamic and attentive service of the HCS teams, permeated by dialogue and guidance to caregivers and patients,[17] the de-hospitalization, as a worldwide trend, contributes to the organization of the provision of health services.[2,3]

For the de-hospitalization, among other aspects, it is necessary to consider the scheduling of hospital beds necessary for a given population. This is a complex task for managers, since, in addition to being based on the usage rates, the resources and technology available for the supply, they have to take into account the demand, represented by the care needs. In Brazil, the parameters for hospital beds distribution and hospital admissions consider the organization model of RAS, its structure and the yield of the installed capacity and the production of the hospitals and the available beds. One of the variables is the

average time of permanence of the user, which oscillates according to the age group and the specialty.[18]

In the current hospital beds management scenario, there is a reduction in the number of beds, length of stay that exceeds 30 days and hospitalizations of users with potential for treatment through other types of care.[18] In addition to the local realities, studies have subsidized the search for new strategies by the managers, among them the health treatment through HC, aiming, in addition to qualifying the care provision after hospital discharge, to reduce the hospitalization time and re-hospitalizations.[19]

In the organization of health care in SUS, regulations have assumed a prominent role, due to the strong power of induction in the definition of a sectoral policy [20]. The growth of HC services evidenced as of 2011, with more force from 2013, reveals the driving power of the PNAD.

The policy formulation in Brazil traditionally follows a top-down model, that is, decisions are made by authorities that have some control of the process and decide which policies will be implemented and how this will be done. This model does not always produce the desired effect on the expected induction of regulations.[20]

In the case of the PNAD, it is possible to analyze that the regulation and the financial component had limited induction capacity. In part, the limits for the growth of the number of services and teams are due to the lack of professionals and the difficulty of the management to adhere to the proposals defined by it.

The HC requires a professional profile with clinical and managerial skills specific to a health service, but with the capacity to work at home.[11,12] These professionals are not yet available in the labor market, in the quantity and quality required for a large-scale expansion of HC. Added to this is the management challenge, especially in small municipalities, to develop projects to enable new services.

It is important to analyze that the adoption of inclusion, exclusion and eligibility criteria organized by levels of complexity and the caregiver's requirement for inclusion in the services ended up making the HC services restrictive, especially for those users who, before the "*Melhor em Casa*", were attended in the multiple arrangements in the municipalities.[21] This limit mentioned in the regulations of the HC seems to have been partially overcome with the GM/HD Ordinance Nº 825 of 2016. It stands out the effort expressed by this regulation to overcome the procedure-centered model and to build a logic of user-centered care.

In HC, actions must be permeated by sociodemographic, psychosocial, clinical variables and degree of user dependence, which favor the identification of the type of HC to be performed.[22] These may support the team's decision-making about health priorities and needs based on the territorialization and micro-tools of organization of health services, such as care lines, clinical coordination, cases, health conditions and waiting lists, allowing a contextualized look and the valorization of loco-regional specificities.

However, it is important to highlight the relevance of meeting the needs of the user, not only in the training of the team, but also in the review of the work process, linked to the development needs of more complex actions, as in the case of care for people who require palliative care, which goes beyond light-hard and hard technologies, requiring a reorganization and articulation of actions.[3,4]

FINAL CONSIDERATIONS

The accomplishment of this study allowed concluding that there is a pathway of implantation of the home care in *Minas Gerais* in a period of approximately 20 years. The services were being reconfigured, modeled according to the legal provisions and the needs of these and of the population.

Even acknowledging the limits, it can be affirmed that the PNAD played an important role in the reordering of the services with changes in the profile, expansion and qualification of teams and the complexity of care. The expansion of the provision of home health procedures, which represents the context of the user's private life, has exposed the complexity of the care process, signaling the need for transformation both in the way the professionals work and in the models of service organization and health work, based on the demands of actions of greater complexity and technological density.

Thus, taking up the questions that open this study, it was concluded that HC is a care alternative that accommodates the demands of the "old" services, but, at the same time, it has contributed to a better understanding of productive restructuring in health. Through it, population groups with poorly met needs in the traditional mode of health care gain visibility, given the potential of this care modality to form new arrangements focused on the needs of these users.

The limitations of the study are recognized, which did not include, at this stage of the research, the perspective of the professionals of the teams and the users, evidencing as relevant an investigation from their point of view. Thus, it is indicated the continuity of studies on this theme. The results carry restrictions on the scope in which the study was developed, limited to the state of *Minas Gerais*. Nevertheless, the findings indicate the need for new research to deepen the understanding of the HC political pathway in different scenarios for a possible comparison with other national and international contexts.

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