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An Innovative Healthcare Model for the Elderly in Brazil: Care Coordination Extends Care Quality and Reduces Costs

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ABSTRACT

The present article discusses the creation of an elderly care model. Population aging caused by demographic and epidemiological changes in Brazil, a relatively recent phenomenon, requires an efficient response. Based on a critical analysis of healthcare models for the elderly, the text presents a proposal for the healthcare of this age group, with emphasis on low intensity levels of care, focusing on health promotion and prevention, in order to avoid overload in the system. Integrated care models aim to solve the problem of fragmented and poorly coordinated care in current health systems. The more health professionals know about the history of their patients, the better the results. This is how the contemporary and resolutive models of care recommended by most major national and international health agencies should function. A higher quality, more resolutive and cost-effective care model is the focus of the present study.

Keywords: National Health Policy for the Aged, Aging, Elderly, Disease prevention, Health care

INTRODUCTION

The recent phenomenon of population aging in Brazil, caused by demographic and epidemiological changes, requires an effective response. Based on a critical analysis of healthcare models for the elderly, we propose the creation of a model entitled Caring Senior, emphasizing low-intensity levels of care, focusing on health promotion and prevention, in order to avoid burdening the system. Integrated care models aim to solve the problem of the fragmented and poorly coordinated care that currently prevails in health systems. We advocate an approach that prioritizes low-intensity interventions and constant monitoring, through different care settings, as recommended by most major national and international health agencies, which include: integrated medical treatment, with a flowing process of educational actions, health promotion, prevention of preventable diseases, delayed onset of illness, early care intervention and rehabilitation from sickness.

POPULATION AGING IN BRAZIL AND IN THE WORLD

One of humankind's greatest achievements has been the increase in life expectancy, accompanied by a substantial improvement in the health parameters of populations, although these achievements are unequally distributed across countries and socioeconomic contexts. Reaching old age, which was once the privilege of the few, has today become the norm, even in the poorest countries. The accomplishment, however, has resulted in a major challenge: how to add quality to the additional years of life.

While this growth in longevity initially occurred in developed countries, it has manifested itself in a more pronounced manner in developing countries. According to the World Health Organization (WHO) the number of people over the age of 60 in the world will reach 2 billion by 2050; this will represent one-fifth of the world's population. Brazil, in 2030, will have the fifth oldest population in the world. In face of these numbers, the theme of human aging gains great relevance.

This population aging stems both from an increase in life expectancy, an improvement in health conditions, and a reduction in the fertility rate, since the average number of children per woman has been falling [1]. By 2060, the percentage of people over 65 will increase from the current 9.2% to 25.5%. That is, one in four Brazilians will be elderly, according to studies conducted by the Brazilian

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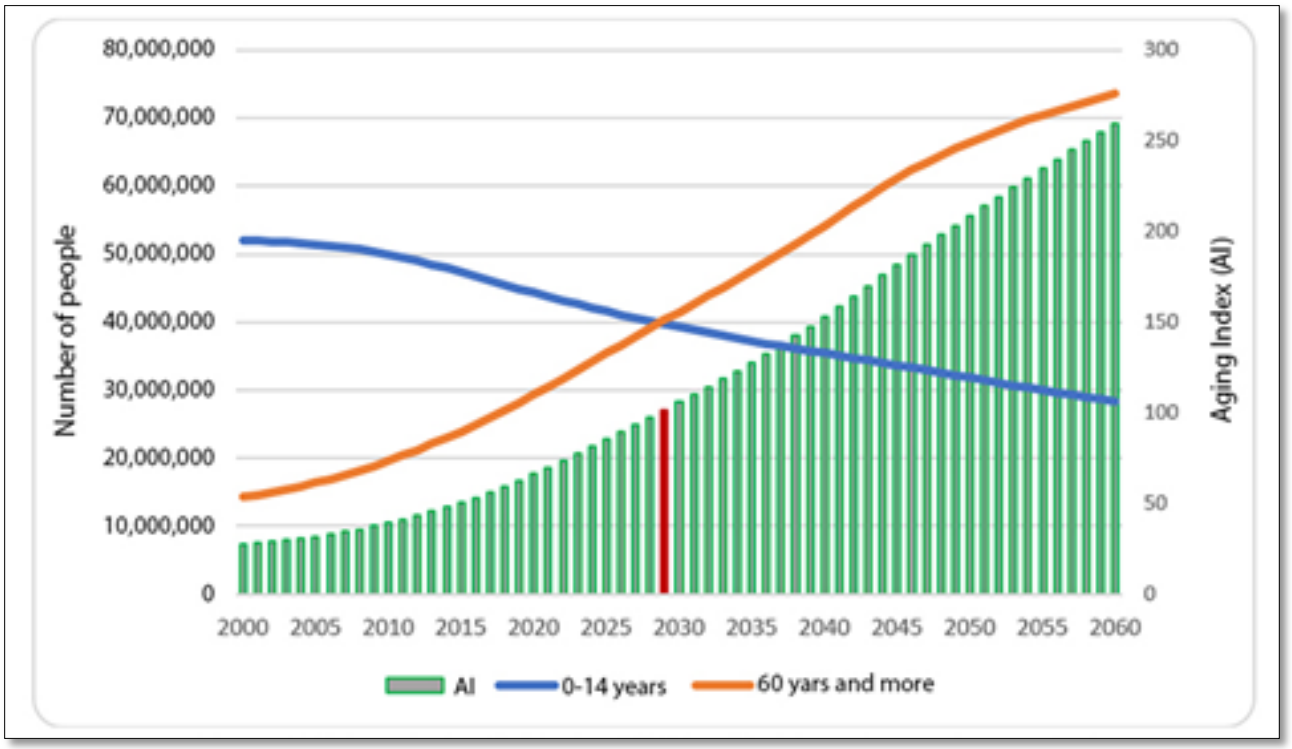
Institute of Geography and Statistics (IBGE, 2013). Women make up a significant majority in this group, with 16.9 million (56% of the elderly), while the elderly men are 13.3 million (44% of the group). Still according to IBGE, the proportion of people over 65 will reach 15% of the population by 2034, surpassing the 20% barrier by 2046. And by 2039 the number of older people over 65 will exceed that of up to 14 years, which will accelerate the aging process of the population. Currently, the population up to 14 years of age represents 21.3% of Brazilians and will fall to 14.7% by 2060. And the population aged between 15 and 64 years, which now accounts for 69.4% of the population, will fall to 59.8% in 2060 [2]. In 2010, this age group accounted for only 7.3% of the Brazilian population **(Graphs 1-3 and Table 1)**.

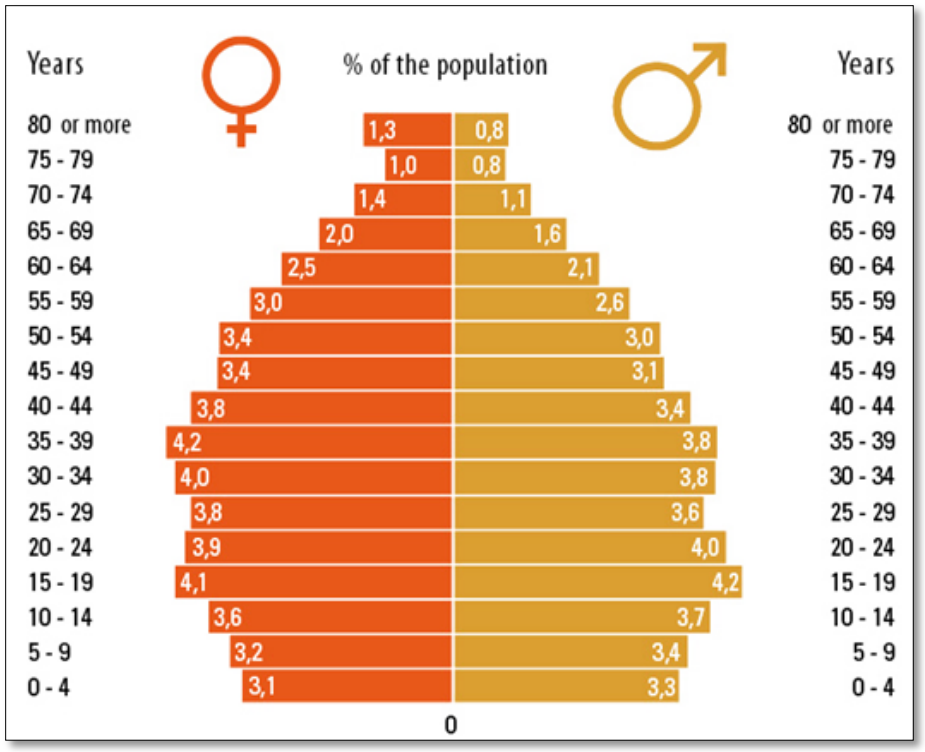
Table 1. Elderly population in Brazil 2000-2020.

		2000		2010		2020	
		Male	**Female**	**Male**	**Female**	**Male**	**Female**
Proportion of elderly population (60 and over)		7.8%	9.3%	8.4%	10.5%	11.1%	14.0%
Proportion of population groups of ages	60-64	46.8%	53.2%	46.4%	53.6%	45.6%	54.4%
	65-69	45.8%	54.2%	45.2%	54.8%	44.5%	55.5%
	70-74	44.8%	55.2%	43.2%	56.8%	42.8%	57.2%
	75-79	43.9%	56.1%	40.2%	59.8%	39.9%	60.1%
	80 or more	39.9%	60.1%	34.7%	65.3%	33.8%	66.2%
Elderly population		**6,533,784**	**8,002,245**	**7,952,773**	**10,271,773**	**11,328,144**	**15,005,250**

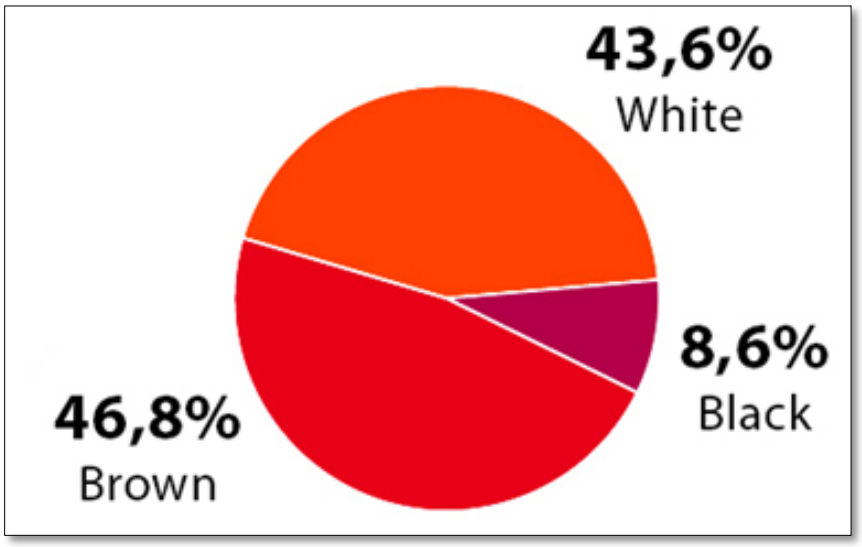
Source: IBGE (2013)



Graph 1. Number of young people (0-14 years old) and the elderly (60 years and over) and aging index AI, Brazil 2000-2060.
Source: IBGE, Population Projections (2013 revision)
https://www.ibge.gov.br



Graph 2. Population distribution by sex and age group - 2017.
Source: IBGE, PNAD Continous – Characterstics of households and residents



Graph 3. Population distribution according to color and race.
Source: IBGE, PNAD Continous – Characterstics of households and residents

The elderly have a number of well-established health characteristics – more chronic diseases and frailties, greater health costs and lower social and financial resources. Even without chronic diseases, aging involves functional loss. Due to the many adverse situations they face, care for the elderly must be structured differently from that of adults, in order to provide special assistance. Current health services are based around fragmentary care, with multiple specialist consultations, little sharing of information, and numerous drugs, tests and other procedures. This burdens the system, with a major financial impact at all levels, and does not generate significant benefits in quality of life [3,4].

The demographic projection for the next few years predicts further population aging. The current scenario, therefore, is

likely to worsen if the model remains unchanged. Increased longevity leads to greater use of health services, generating higher costs and demands on resources and threatening the sustainability of the system. The chronic and multiple diseases that this group suffers require constant monitoring, permanent care, continuous medication and periodic examinations [5,6]. Our care models date from a time when Brazil was a country of young people and acute diseases. Today, however, we are a young country with grey hair. Actions based on health promotion and education, the prevention and delay of the onset of diseases and frailties, and the maintenance of independence and autonomy must be expanded [7,8].

HEALTHCARE SYSTEMS AND THE ELDERLY

In health systems outside Brazil, general practitioners or family doctors are entirely responsible for the treatment of 85% to 90% of their patients, without the need for referral to specialists. Health professionals with specific training (in Nutrition, Physical Therapy or Psychology) are also involved in care. In this way, the elderly will have a much wider range of qualified professionals, recommended to them by their own doctor [9].

In Brazil, however, there is an excess of specialist consultations, with the current model prioritizing the fragmentation of care. This can be clearly seen in comparisons with the UK model, the National Health Service (NHS). Here, the central figure is the general practitioner (GP), who has a high resolutive capacity and can establish a strong bond with patients. The NHS is available to every citizen, regardless of income or social status, in a similar manner to the SUS in Brazil. To be eligible for free public health care, a citizen must register with a General Practitioner (GP). The main health service units are local clinics made up of general practitioners and nurses. Any medical care required, provided it is not an emergency or caused by an accident, will be performed by the health center doctor.

In contrast, the American model is based around referral to numerous medical specialists, resulting in a model of care that is the opposite to that of the UK. These two rich countries, with great medical traditions, therefore employ different models and achieve quite different results [10].

A contemporary elderly healthcare model should employ a flow of actions based on education, health promotion, the prevention of disease where possible, delayed onset of illness, early care and rehabilitation from diseases. A care pathway for the elderly based on efficacy and efficiency must presuppose an articulated, referenced network with an information system based on this approach [11].

Health systems currently operate with a small number of non-integrated points of care. Patients generally enter this disjointed network at an advanced stage, with the hospital emergency room often the entry point. Such a model, as well as being inadequate and anachronistic, offers a very poor cost-benefit ratio, being hospital-centered and involving intensive use of expensive technologies. Its failure, however, should not be attributed to users, but to the care model itself, with an overburdening at more complex levels of care due to a lack of resolutive treatment at earlier levels.

One of the problems faced by most current care models is an exclusive focus on disease. Even when a program based on anticipating illness is offered, the proposals are primarily geared towards the reduction of a certain disease. This overlooks the fact that when a chronic disease is established the objective should not be a cure, but stabilizing the clinical picture and constant monitoring to prevent or ameliorate functional decline [12].

Studies have shown that care must be organized in an integrated manner and should be coordinated throughout its duration in a logic-based network, from entry into the system to end of life care. New models of healthcare for the elderly should therefore present a proposal for a care pathway that focuses on actions of education, health promotion, the prevention of diseases where possible, delaying the onset of disease, early care and rehabilitation.

Financial pressure

Demographic transitions and the improvement in Brazil's social and economic indicators, when compared with previous decades, have led not only to the growth of the elderly population, but also to greater financial pressure on public and private health systems. As the number of elderly people increases, so, naturally, does the prevalence of chronic diseases and spending [8].

In recent decades it has been seen that most of the public health problems that affect the population – both communicable and non-communicable diseases – can be prevented. This is demonstrated by a significant decrease in mortality from coronary and cerebrovascular diseases and a reduction in the incidence of and mortality from cervical cancer, as well as a decline in the prevalence of smoking and the occurrence of lung cancer in men. A major social and economic burden can therefore be avoided through the reduction of disease [13].

Many still see preventative action as a burden of additional procedures and costs. In fact it is the inverse of such thinking and, in the medium and long term, can reduce hospitalizations and other, much more expensive procedures. All the evidence indicates that biomedical health systems are likely to suffer problems of sustainability in the future.

We live in the information age. In the Collective Health field, epidemiological information can be translated into a capacity to predict events, enabling early diagnosis, especially in relation to chronic diseases. It can delay the onset of such illnesses, improving quality of life and the effectiveness of the therapeutic approach [10].

The model we propose is based on the early identification of the risks of frailty among users. Once risk is identified, the priority is early rehabilitation in order to reduce the impact of chronic conditions on functionality, seeking to intervene before harmful effects can occur. The idea is to monitor health, not disease, with the intention of delaying the onset of illness so that the elderly can enjoy the time they have left. Thus, the best strategy for the proper care of the elderly is based on the permanent monitoring of health and keeping such individuals under continuous observation, varying only the level, intensity and context of the intervention [14].

The role of the health professional in these cases is not to avoid the disease (as it is already settled) or seek a cure, but to stabilize and reduce harm, aimed at maintaining quality of life and preventing or mitigating functional decline [15]. In general terms, these are the foundations of the healthcare proposed by the *Caring Senior* program.

AN INNOVATIVE HEALTHCARE MODEL

Elderly care should be structured in a unique manner. The current provision of health services fragments care for this age group, with multiple specialist consultations, a failure to share information, the widespread use of drugs, clinical and imaging exams, and other procedures that overwhelm the system, have a major financial impact at all levels and do not generate significant benefits for health or quality of life [5]. As stated above, one of the problems stems from the exclusive focus on disease.

The hierarchy of the network provides at least two fundamental benefits for the care of the elderly: reduced iatrogeny and more organized flow of care. Clinical guidelines and protocols are also essential for the construction of the treatment plan. They should direct good practices, be based on the best evidence available and be appropriate for each clinical situation. The treatment plan guides the care pathway according to the needs of the patient [14].

Programs aimed at this group should be based on integrated care, with the key health professional and his or her team managing not the disease, but the health profile of the patient. Often, a health problem can only be treated with the reduction or suspension of other actions [16]. Prevention is essential. The earlier an intervention is carried out, the better the chances of a more positive prognosis [9]. A health unit with a wider range of characteristics allows the anticipation of problems through the early identification of possible symptoms, changes in mood or possible functional loss. In this way, the elderly individual can be referred promptly to their attending doctor [15].

A phrase which has been repeated for decades in medicine is that the more a healthcare professional knows about the history of their patient, the more positive the results will be. This belief is supported by the World Health Organization and all managers and professionals in the field of health. As logical as it is old, it continues to represent a modern idea of a health care model [13]. It is surprising, then, that we do not see it practiced on a daily basis. There should be an emphasis on the integrated care of the elderly, adding conventional medical care to the development of supervised educational and leisure activities. The purpose is to maintain a good quality of life for as long as possible.

The hospital is often seen as the ideal location for healing. This, however, is a conceptual error. Instead, the model should include several care settings prior to the hospital, and hospitalization should occur only at the acute moment of chronic illness or in cases of emergency, and should be as brief as possible. The entry point to the system should be somewhere that allows the client and their family to feel protected and supported. It is in this setting of first contact that the user is informed of all the care possibilities and pathways available to them. The reception phase is fundamental for those entering the system, and is a stimulus for developing trust and fidelity.

The proposal of care for the elderly should be understood as a strategy for establishing care pathways, organizing the movement of individuals through the system according to their degree of frailty. The identification of risk and the integrality of care at the different points of the network are key to this model. Hierarchization does not presuppose an evolutionary path between the care levels of the model, although expected patterns can be anticipated. The stages cannot be absolutely fixed, however, as there is always the possibility of reverting disability and returning to less complex levels of care, depending on each individual situation.

Better care results and economic-financial outcomes are needed. To achieve this, everyone involved in the model should understand the need for change and allow themselves to innovate – in the care they provide, in the remuneration of the model, and in the evaluation of the quality of the sector. Innovation often means recovering the simplest forms of care and values that have been lost within our health system.

The main risk factor of most of the chronic diseases that affect the elderly individual is age itself. Aging without chronic illnesses is the exception rather than the rule. Thus, the focus of any contemporary policy should be to promote healthy aging, by maintaining and improving – where possible – the functional capacity of the elderly, the prevention of diseases, the recovery of the health of those who have become sick (or the stabilization of illnesses) and the rehabilitation of those who have had their functional capacity restricted. Actions such as these, however, are still rare. The greatest investment continues to be in traditional care, with emphasis on the hospital structure [4].

To say that monitoring health and anticipating predictable illnesses is a "different and innovative" way of caring questions the efficiency of healthcare managers. Ideally,

health care services should focus on providing qualified care and well-being for the elderly, ensuring their clients have a referral doctor, and that all doctors have a portfolio of clients for whom they provide care. The care unit space should have the characteristics of a social center, with a variety of activities including medical consultations and actions aimed at integration and participation, encouraging the establishing of trust and client loyalty within the model. This "innovation" is at least 70 years old, as it has operated in the UK since 1948. It is nonsensical to consider it new. The model proposed here, which we will call *Caring Senior*, embraces the successful British experience and offers permanent monitoring of health.

Our proposal: The caring senior model

To put these theories into practice, the model of care for the elderly in Brazil must be urgently redesigned [17]. The Caring Senior model was designed with these basic assumptions in mind, and is characterized by a focus on low-intensity instances of care, through the constant monitoring of the elderly and the provision of light, but intensive care, as it is known that when properly monitored, more than 85% of such clients do not require more complex care.

Other healthcare actions will be the responsibility of a separate structure, which is responsible for dealing with segments such as the emergency unit, the hospital, clinical and imaging exams and medical specialists. Caring Senior will involve specialist doctors and will also accompany its clients in high-intensity instances of care – but as a support mechanism, not as a central element of care, as we will see below.

Four aspects underlie the entry point (or level 1) of Caring Senior: reception, fidelity, integrality and assessment of the risk of frailty/ disability. Within this model, levels 1 to 3 are low-intensity settings, or in other words involve lower costs and are largely composed of care provided by well-trained health professionals. Efforts should be made to maintain patients at such low-intensity levels of care to preserve their quality of life and social engagement [18]. The other settings, which involve more serious cases, are expensive and include hospitals and other long stay facilities. Within these settings, the preference is to rehabilitate the patient and transfer them to low intensity settings, although this will not always be possible. Efforts should be made to maintain the elderly within the first three levels of care, to preserve quality of life and reduce costs. The goal is to concentrate more than 90% of the elderly in these settings [19].

Care models for this age group should be people-centered, based on the specific needs of individuals. Care should be managed from the moment of entering the system to the end of life, with constant monitoring. We know that the elderly face specific challenges due to chronic diseases and the bodily and social frailties they suffer [8]. Entering the model through Level 1 (reception) guarantees conscious access to the system, a start based on transparency of the rules of the healthcare plan, grace periods, rights and obligations, the care offered, and bonuses and rewards. It is, therefore, the entry point, a crucial moment for establishing empathy and trust, fundamental elements of user fidelity.

Another important differential is the proposal to register the care pathways of patients through a comprehensive information system, which will record not only the clinical evolution of the elderly persons, but also their participation in individual or collective preventative actions, as well as interaction with the care support manager and phone calls made to or by the "GerontoLine" (the name we have given to a qualified and resolutive call-center) or use of computer or smart phone apps. This allows the sharing of information, enabling a more complete evaluation of the individual and including the medical records of the hospital unit, governed by specific norms.

Caring Senior is based on certain principles. The first is the role of the doctor, who is responsible for a portfolio of clients. A nurse will also be available, and will perform an effective role in providing care to the clientele and ensuring better quality of care. The clinical unit will have several such pairs of general practitioners and nurses, and a 40-hour work week will allow for portfolios that can provide care to between 800 and 1,000 clients. This will guarantee that healthcare professionals have the time to attend each client properly, ensuring appointments at least four times a year, and accompanying them in other instances of care, if necessary.

A full Caring Senior unit, for example, will have five pairs of doctors and nurses who are responsible for around 4,000 to 5,000 patients. Health professionals must be trained to provide care within the philosophy of the program, prioritizing health promotion and disease prevention. These will include psychologists, nutritionists, physiotherapists and physical educators, who will attend cases as selected by doctors. These professionals will lead group activities and lectures and provide guidance on relevant topics. In addition, each region (depending of course on demand) will have two or three minimum capacity units, featuring only a doctor/nurse pair, with support services provided in the full unit.

To allay fears about the possible high costs of maintaining such a structure, it is worth noting that health professionals cost much less than a day's stay in an Intensive Care Unit or hospital. To provide good care and avoid the exaggerated use of specialist doctors and unnecessary hospitalizations, it is essential to maintain a high quality reception structure.

This relationship between the healthcare system and the user must change. It should be transparent, establishing a pact based on truth. The actions performed must be recorded in the information system, which must begin at reception and continue until the end of the patient's life [20].

The hierarchy of the care model provides knowledge of its users, their profile and their needs, in order to better organize the delivery of services. One thing is certain: without better organization of the care of the elderly and the elaboration of a care plan, population aging and the greater prevalence of diseases will cease to be opportunities, and will instead become obstacles for the sustainability of the Brazilian supplementary health system.

It is important to emphasize that the proposal presented herein is not only intended to discuss mechanisms for the reduction of health costs, which, while important, is not the only concern. Like the other issues, it drives us towards a greater goal, namely the integral care of the elderly. The model presented has a commitment and goal of improving the quality and coordination of the care provided from the entry point to the system and throughout the continuum of care, avoiding redundant examinations and prescriptions, interruptions in the health trajectory of the user and iatrogeny generated by the disarticulation of health interventions.

The hospital and the emergency room will always be important settings for the provision of health care, but it is necessary to redefine and recreate the roles they play in today's health care network. These units of care should be reserved primarily for moments of acute chronic illness [21].

An adult client aged over 49, with one or more chronic diseases will not be cured. The duty of the physician is to stabilize, monitor, and ease the pain caused by the disease, which is likely to remain with the patient for the rest of their lives. The role of the Caring Senior general practitioner will be to maintain the functional capacity of clients so that they can enjoy a full and healthy life. The benefit of Caring Senior will be the reduction of the numbers of specialist doctors and subsequently fewer exams and drugs, as loyalty will prevent the client from resorting to emergency units and so greatly reduce hospitalization periods.

It should be remembered that Caring Senior involves low-intensity instances of care, and is largely composed of care provided by well-trained health professionals concerned with preserving the quality of life and social participation of their elderly clients. Instances considered high-intensity are expensive and involve the hospital and other long stay units. All effort must be taken to rehabilitate the elderly and return them to low-intensity instances of care.

Central points of the model

Three aspects must be considered, namely:

1. The doctor and nurse are responsible for a portfolio of clients.
2. The user will receive a financial stimulus (reward) for adherence to the care model, which is based on monitoring and fidelity to the health team.
3. The remuneration of the physician and the health team will be established through the success of the care. Better performance results in better rewards. It is acknowledged that health professionals are poorly paid.

The quality of care offered by the attending physician, his or her client portfolio and his or her variable remuneration are of similar importance. Emphasis is also placed on the client portfolio, functional assessments, the tracking of risks, the work of the care support manager, and an efficient information system that records all client events. The importance of the various care settings, such as the outpatient clinic, the hospital, home care, rehabilitation, the multidisciplinary team, the cohabitation center and palliative care, should also be highlighted. All are part of the network of care and are integrated through the information system and the attending physician, who remains the clinical reference throughout the course of the model. It is clear that the hospital is only one setting. It is equal to the others, but less important than preventive actions, which are the center of the model. The logic is based on low-intensity settings and integral care, the multidisciplinary team and the doctor responsible for the patient.

For the model to succeed, therefore, it is essential that clients are encouraged to participate in the proposed programs and actions, instead of the current logic of using a health plan only when undergoing tests or going to hospital with a disease already in an advanced stage. The model includes all possible care settings, excludes nothing in relation to the care required – in fact, it includes new units not usually offered to the clients of many healthcare providers – and prioritizes the provision of care in "lower intensity" settings. These offer the best possible care, with trained and qualified professionals, based on modern scientific conceptions of treatment. In short, our proposal is to invest in health to reduce spending on disease.

A high quality, easy to use technology information system will provide fundamental support for the doctor/nurse pairing and facilitate client loyalty. Technology is an essential part of the Caring Senior project, and so participants must be able to use the system to its maximum potential.

For example, the faces of clients could be recognized when they come through the door of the clinic, allowing their medical records to be open on the receptionist's desk by the time they get there. The receptionists can then address the clients by name, ask about their families, and check the list of medications they are taking. These simple actions add enormous trust to the relationship, making the client feel protected and welcomed from the first instance.

Registering the care pathways of the patient is a unique feature of this model. A high-quality information system of broad scope can document not only the clinical evolution of the elderly person, but also their participation in individual

or collective prevention actions, as well as the support provided by the nurse and telephone calls made, all of which must be resolutive and performed by trained and qualified personnel.

Information from telephone, computer or cell phone contact between patients and professionals should be shared among the team, to enable a comprehensive assessment of the individual. The information system, which begins with the registration of the client, is one of the pillars of the program. It allows the entire care pathway to be monitored at each level, verifying the effectiveness of the actions and contributing to decision-making and follow-up care. It is a unique electronic record, which is both longitudinal and involves a range of professionals, and accompanies clients from reception onwards. This medical record differs from existing registries as it includes a record of their life history and health events.

The creation of a mobile app with individualized information and reminders of consultations and prescribed actions is also planned. This can, among other actions, ask the client to take a photo of their breakfast and send it to the nutritionist, who will observe if the meal is balanced and if there are adequate amounts of fiber, for example.

Caring Senior will focus on keeping its clients within its units, avoiding the use of specialists. However, five areas of medical specialties related to our model will be required to assist the general practitioner – cardiology, gynecology, urology-proctology, dermatology and ophthalmology. These are chosen based on demand and high prevalence, and include areas where annual preventive control examinations can be carried out and registered.

Consultation with the specialties listed will only be possible at the request of the general practitioner of the client. If they require the care of one specialist, Caring Senior will not necessarily include the other specialties. The same reasoning applies to hospitalization. Doctors and nurses will be responsible for contacting the hospital doctor, armed with knowledge of the case and, preferably acting to ensure the best care and the briefest period of hospitalization, as well as being able, if necessary, to suggest a medical specialist.

Another key element of Caring Senior is the form of payment of physicians, the Accountable Care Organization (ACO) system, which encourages healthcare professionals to organize themselves as a group, managing the quality of services provided, being responsible for cost management and the distribution of bonuses [22].

There are two key points: the provision of services of excellence at a lower cost and a model of remuneration based on added value. The segmented and non-integrated healthcare that is offered to patients today is largely due to the service remuneration model, in which the incentive is production, rather than quality [23]. In other words, there is no benefit in seeking new forms of care or new payment models if transferring part of the responsibilities, risks and benefits of providers is not associated with the results achieved through the care provided. The challenge is to make this new care model acceptable to the client, since trust (which will lead to loyalty) is an indispensable factor if the process is to function as planned. One cannot, after all, ask a person to trust something they do not understand.

Simply stating that Caring Senior is the best model is irrelevant, however, if it is not applied by Brazilian supplementary health services. Society needs to be made fully aware of the proposal if it is to become convinced of its benefits [6]. Otherwise, healthcare will continue to opt for the "siren song" of excess and consumption, which burden the system, generate higher costs, and render long-term care unfeasible.

FINAL REMARKS

The desire for a higher quality and more effective elderly care model is not solely a Brazilian concern. The entire world is debating this issue, recognizing the need for change and proposing improvements in their health systems [33].

There is no single model, but instead a multi-faceted approach that favors low-intensity care, constant monitoring, an efficient telephone service and the use of mobile apps, a doctor responsible for a portfolio of clients who then accompanies them through all the care settings, a nurse who works in partnership with the doctor, teamwork, the use of epidemiological tools to monitor functionality, and a quality electronic medical record. All these elements contrast with the model based around specialist doctors, the disarticulation of professionals, the prioritization of use of the hospital, the excessive consumption of drugs and an overuse of laboratory and image exams [25].

There are a number of suggestions for care pathway models. The important thing is for each health institution to be aware of its users, their profile and their needs, to construct the best way of organizing the delivery of its service. One thing is certain – without the organization of elderly care and the elaboration of a care plan, population aging and the increased prevalence of chronic diseases in the public or supplementary health sector in Brazil may no longer be seen as opportunities, but instead become obstacles to the sustainability of the system.

The socioeconomic transformations of recent decades and the consequent alterations in the lifestyles of individuals in contemporary societies – with changes in eating habits, increased sedentarism and stress, plus the greater life expectancy of the population – have contributed to a higher incidence of chronic diseases, something that today represents a serious public health problem.

The current provision of health services fragments care for the elderly. It overburdens the system, causes a serious financial impact at all levels and does not generate

significant benefits for quality of life. It is therefore imperative that a new model is adopted. If we know the population is older, that diseases are chronic and multiple, that the costs of care are increasing, that the models of care are from an era of acute diseases and that a knowledge of epidemiology can inform us of risk factors, why do we continue to offer an outdated and ineffective product? Especially if we have all the information required to implement an assistance-based care model in which everyone benefits?

It is necessary to rethink and redesign care for the elderly, turning the focus towards the individual and their particularities. This will bring benefits not only to this part of the population, but also quality and sustainability to the entire Brazilian health system.

We believe that it is possible to grow old with health and a good quality of life, provided that all the actors in the sector see themselves as responsible for the necessary changes and allow themselves to innovate through improvements in care, in forms of remuneration and in evaluating the quality of the sector [26].

Elderly persons, because of their greater vulnerability and greater use of the health system, are among the most affected by the current care model.

As Don Berwick [27] wrote in the Institute for Healthcare Improvement (IHI) – "Every health system is perfectly designed to achieve the results it achieves". Our health system has achieved a demographic transition (aging), an epidemiological transition (we now have a triple burden of diseases), a nutritional transition (we have moved from malnutrition to obesity), but we have not been able to make the much-needed transition in our health institutions, which remain organized to treat acute, infectious diseases [28]. Some elements are necessary if a system is to change health outcomes, such as evaluation and remuneration based on quality and an information system that can facilitate the care pathway of the patient.

It is possible to reorient the healthcare of the elderly population and to construct an organization within this sector that provides greater well-being and better economic-financial results. To achieve this, everyone involved must realize they are responsible for the changes required and allow themselves to innovate – which, in many situations, means recovering the simpler care and values that have been lost within our health system.

The entire model proposes a reorganization of care that has already been shown to be much more effective and cheaper for the health system. It simply means doing what is necessary, in the right way, focusing on the most important element of every process, which is the patient.

Another key point is the participation of the elderly person in the model, using strategies that can help to convince these individuals of the importance of preventive care, such as the rewards offered by health plans.

Finally, the time has come to include the debate over healing and caring in our discussions about professional training and the organization of the service. We need to structure ourselves to take care of people in a health system that has so far focused on curing patients. This will make a great difference in this era of population aging.

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