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REFLECTION ON THE SOCIO-HISTORICAL HUMANIZATION OF BRAZILIAN ELDERLY PEOPLE IN VIEW OF THE UNIFIED HEALTH SYSTEM AND NATIONAL POLICIES RELATED TO OLD AGE

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Abstract: In recent decades, Brazil has shown a decrease in birth and death rates, and, consequently, an increase in the elderly population. In this sense, life expectancy has increased more and more, demanding an adaptation and formulation of public policies to this new demographic profile. Regarding the health needs of the elderly, which require specific attention, the National Health Policy for the Elderly (PNSI) was implemented in Brazil, which guarantees social rights to the elderly, by creating conditions to promote their autonomy, their integration and their effective participation in society and reaffirm their right to health in the different levels of care of the Unified Health System (SUS (UNIFIED HEALTH SYSTEM)). Among so many other important movements that are part of the SUS (UNIFIED HEALTH SYSTEM) and intertwine with it, the national humanization policy (PNH), which is related to the elderly, indicates that welcoming remains embedded in care and management actions, and that it brings together those who share the same health evolution. The importance and care for the elderly is one of the premises of humanization in health. According to the relevance, seriousness and esteem for the subject addressed, the present study intends to reflect on population aging, seeking to highlight the importance of humanization and embracement of the elderly in the context of public health, basing this research through current and previous readings, including laws related to the Statute of the elderly.
Keywords: embracement, humanization, elderly, health, SUS (UNIFIED HEALTH SYSTEM),

INTRODUCTION

> True philosophy is to relearn how to see the world, and in this sense a narrated story can signify the world with as much "depth" as a philosophy treatise (MERLEAU-PONTY, 2011, p. 19).

The discussion around aging gains emphasis from the 20th century onwards, when the elderly person enters the scene, as a new political and social actor capable of promoting changes and transforming the scenario of public policies in Brazil. The National Humanization Policy, National Policy for the Elderly, the National Health Policy for the Elderly and the Statute for the Elderly are legal provisions that guide social and health actions, guarantee the rights of the elderly and oblige the State to protect them. (RODRIGUES, 2001; MENDONÇA, 2015). However, it is known that the implementation of a public policy requires the conscious, ethical and citizen attitude of those involved and interested in living aging in the healthiest possible way. The State, health professionals, the elderly and society in general are all co-responsible for this process (BRASIL, 2006a). The elderly became a subject of law within the Brazilian legal obligations with the Federal Constitution of 1988, period of reorganization of the democratic state of law. Articles 229 and 230 established a new citizenship for the elderly population in Brazil. The Elderly as a subject of law comes from an alignment of public policy in Brazil with international organizations, and their rights were guaranteed in the area of social action (BRAZIL,2002; BRAZIL,2004). Agustini (2003), emphasizes the growing concern related to Brazilian legislation with regard to the elderly citizen, placing them in relation to their rights in old age. The Brazilian Constitution of 1988 was the first to treat the elderly and old age as a social problem, moving beyond social security assistance and ensuring protection in the form of social assistance (BRAZIL, 1988). For Goldman (2006), society needs to adapt to the growing number of elderly people, working on the capacity and potential of this population group and creating structures that

meet their unique needs. Among so many other important movements that are part of the SUS (UNIFIED HEALTH SYSTEM) and intertwine with it, the Humanization Policy (PNH) has asserted itself in defense of the right to health, in defense of life and in defense of democracy in organizations, responding to a social demand for humanization in care and management. Social mobilization and transversality call on the PNH to make an effort towards a broader approach in terms of understanding and taking action in the face of the problems and challenges of the SUS (UNIFIED HEALTH SYSTEM). It is for this very reason that the PNH does not present itself as a specific policy for any type of health service, professional specialty or managerial scope in the SUS (UNIFIED HEALTH SYSTEM), so that the focus on other health policies, without opposing specialized approaches, seeks to compose with them (BENEVIDES, 2005; FERNANDES, 2006). In this movement of multiple connections, both in the spaces of health services, governments and academics, the Humanization Policy has also, and one would not imagine it otherwise, modifying and expanding its experimentations, ratifying its function and task in the SUS (UNIFIED HEALTH SYSTEM): humanization as a strategy for the democratization of health management and practices. The Humanization Policy has understood, in line with current discussions in management and academic spaces, that primary care is a significant space for the qualification of SUS (UNIFIED HEALTH SYSTEM) as a public policy (HUMANIZAR, 2018; MINISTRY OF HEALTH, 2000). Reception in the Unified Health System (SUS (UNIFIED HEALTH SYSTEM)) is an element that plays a fundamental role in the process aimed at autonomy and better quality of life for the elderly (MORICI; BARBOSA, 2013; MORI; OLIVEIRA, 2009).

> "Welcoming as an act or effect expresses, in its various definitions, an action of approximation, being with and being close to, that is, an attitude of inclusion" (MINISTRY OF HEALTH, 2006, p. 2).

Through welcoming, it is possible for health professionals to learn to deal with the social reality that the elderly and their families constantly experience, thus allowing the professional teams to have the clarification to guide the elderly population to seek access to their rights, providing intervention in reality, when necessary. The elderly have some particularities, such as chronic diseases, frailties, higher costs and lower financial resources. Faced with so many peculiarities, care for the elderly must be structured differently (LEHR, 1999; DA SILVEIRA, 2016). The problems that affect the elderly can result in an increase in the number of hospitalizations, which are more frequent and continuous and, therefore, aging implies a greater burden of diseases in the population, more disabilities and, consequently, an increase in the use of health care services. health (VERAS, 2009). From this perspective, with the greater presence of the elderly population in health services, it is necessary that they are prepared to receive them, based on SUS (UNIFIED HEALTH SYSTEM) principles and guidelines, such as integrality, equity and decentralization, in addition to health policies capable of contributing with active and healthy aging, as well as a more favorable social and cultural environment for the elderly. And, in order to qualify the assistance aimed at this public, the National Health Policy for the Elderly (PNSI) emerges. The Policy highlights healthy aging, in addition to other guidelines such as: maintaining functional capacity; comprehensive care, integrated to the health of the elderly; stimulus to intersectoral actions, aiming at comprehensive care; provision of resources capable of ensuring the quality of health care for the elderly; encouraging

participation and strengthening social control; training and continuing education of SUS (UNIFIED HEALTH SYSTEM) health professionals in the area of elderly health; support for studies and research; among other guidelines (BRAZIL, 2003; STATUTO DO ELDERLY, 2017). Data from the Ministry of Health reinforce the importance of functional capacity, which emerges as a new health paradigm, proposed by the National Health Policy for the Elderly (PNSPI), with emphasis on care for the elderly, which must be a joint effort between the team health, elderly and family. In addition, this policy is based on the promotion of active and healthy aging (MINISTRY OF HEALTH, 2010). This work aims to reflect based on the results of bibliographical research on the demographic rate of the elderly, their reception in the SUS (UNIFIED HEALTH SYSTEM) and the Policies aimed at humanization. This research is relevant to the health care of the elderly, this care, in addition to enabling the understanding of the humanization work processes, allows a knowledge of how essential the existing challenges are for elderly people, family members and health professionals to carry out the practice of user embracement in public health.

METHODOLOGY

To enable the development of this research, we opted for a quantitative and qualitative systematic review study. The data collection period took place from 08/10/19 to 03/18/21 in the following databases of the Virtual Health Library: SciELO (Scientific Electronic Library Online) Bdenf (Nursing Database), including Ministry of health and their respective ordinances related to the National Health Policy. The systematic review is the design of a secondary study through other studies, called primary, which are carefully analyzed and evaluated regarding their scientific quality to be included, or not, in a statistical analysis. The following descriptors were used: National Policy for the elderly, Public Health Policies; Elderly; Nursing. The Inclusion Criteria of the references were as follows: Having adherence to the proposed objective; contain articulation with the aforementioned Health Programs. The analysis of references was based on publications over the last thirty-one years (from 1989 to 2020), including Law No. 8842, of January 4, 1994, Ordinance No. 1395, of December 9, 1999 and the caveat from the research by Franco, Bueno and Merhy, (1999) due to the great majority of the programs being contained in this period. To meet the proposed objective, it was decided to follow the methodology of exploratory, qualitative research, of the bibliographic type, which according to Leopardi (2002, p.131), is used to know its frequency, regularity, types, subjects examined, methods employed in texts. It requires access to the bibliography provided for the analysis of the topic, time and precautions regarding the uniformity of records. According to Marconi and Lakatos (2010, p.26), bibliographic research obeys eight distinct phases: choice of theme, elaboration of the work plan, identification, location, compilation, filing, analysis and interpretation, writing. The selected studies were treated as follows: initially, the titles and abstracts were read to identify the approach to the theme. Subsequently, the selected studies were read in full, reaffirming the approach to the theme, obeying the inclusion criteria and the steps of the bibliographical research. By using the descriptors: “humanization”, “reception”, humanization policy”, “Unified Health System” and “elderly”, a total of 50 studies were found related to the theme of the proposed work. Obeying the inclusion criteria, 43 articles were available in full. Of the 43 articles that were read for the research, 38 were preliminarily analyzed, 6 did not fit

the inclusion criteria, as they were repeated in both databases and 10 did not address the investigated topic.

THEORETICAL REFERENCE

For the investigation of the proposed theme, it is important to highlight some aspects, such as humanization and welcoming, especially in the hospital context, the Unified Health System, the National Health Policy for the Elderly (PNSPI). The humanization of health care, although formally contextualized along the lines of a policy "National Humanization Policy - PNH" in 2003 by the Ministry of Health, still requires reflection and discussion, as it permeates subjective and objective aspects of all those inserted in the care process in health, be it the user, the professional and the manager.

> The mission of humanization in a broad sense, in addition to improving intersubjective treatment, it would be said that it is about encouraging, by all possible means, the union and interdisciplinary collaboration of all those involved, managers, technicians and employees, as well as the organization for the active and militant participation of users in prevention, cure and rehabilitation processes. Humanizing is not just "softening" hospital coexistence, but a great opportunity to organize oneself in the fight against inhumanity, whatever forms it adopts (OLIVEIRA, COLLET and VIEIRA, 2006).

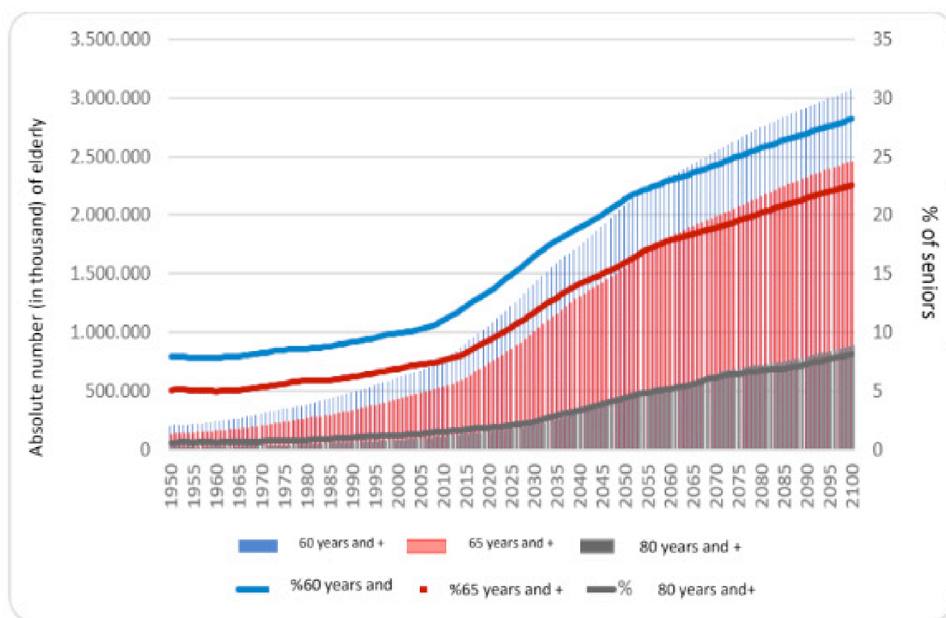
OLD AGE (SENILITY)

As it is a biological process, we can mention senility, which must be understood as this process with psychological effects. Like every human condition, aging changes the inclusion of the person with the moment, which can cause changes in their relationship with the world and with their life (MORAES, 2012). According to the World Health Organization (WHO) the time to reach old age is from 60 years for developing regions and 5 years more in developed countries. At the end of the 1990s, the WHO designated as active aging elderly people who are afraid of old age due to the likelihood of becoming dependent due to illness or being unable to perform their usual activities (ONU, 2003; SANTOS et al.2014; VERAS, 2012). The aging of the Brazilian population has impacted and brought about changes in the demographic and epidemiological profile across the country, producing demands that require responses from social policies involving the State and society, implying new forms of care, especially prolonged care and home care. The Brazilian demographic transition presents particularities such as: 55.7% of women among the elderly (IBGE, 2014). If we consider the older population, aged over 80 years, the percentage of women rises to 61% of the elderly contingent. Distribution according to color or race shows that 55% of the elderly population are white, 8.6% are black and 35.2% are brown. Another important feature is the growth of the elderly population, with 10,473 million (44.5%) aged 70 or over, 5,623 million (23.9%) between 65 and 69 years and 7,440 million (31.6%) %) between 60 and 64 years old. Also noteworthy is the increase in the number of centenarians. (WONG; CARVALHO, 2006; IBGE, 2018).

THE HUMANIZATION OF HEALTH IN OLD AGE

When caring for the elderly, the health team must be attentive to a series of physical, psychological and social alterations that normally occur in these patients, and that justify a differentiated care (CARVALHO; GARCIA, 2003). These professionals play an important role with the elderly, as it is believed that, through an empathetic relationship, there is a humanized assistance and a commitment to personalized care, ensuring their physical

Absolute and relative population of elderly aged 60 and over, 65 and over and 80 and over
World: 1950-2100



UN/Pop Division: World Population Prospects 2019 https://population.un.org/wpp2019/

Figure 1: Graph of the elderly population

Source: < https://population.un.org/wpp2019/

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and emotional balance (Franco et al., 1999). There was evidence of a new care model for care and management strategies in the SUS (UNIFIED HEALTH SYSTEM) and for the training of health professionals. Thus, much has been discussed about humanization in health care, probably due to its fundamental relevance, since it is based on principles such as equity, comprehensiveness of care, among others, thus rescuing the appreciation of the dignity of the user and also of the worker (WESTHEPAL, 2009, VERAS, 2015). Thus, it is suggested that, under the influence of the humanization movement, care comprehensiveness can be developed, not only by overcoming technical dichotomies between preventive and curative, between individual and collective actions, but also as valuing and prioritizing responsibility for the person, of zeal and professional dedication by someone, as another way of overcoming the sides of these dichotomies. That is, humanization leads one to think that it is not possible to equate the issue of comprehensiveness without valuing an encounter that goes far beyond solutions with technical models for programming programmed service actions (PASHE, 2010; PUCCINI; CECÍLIO, 2004). Deslandes (2004) emphasizes the Ministry of Health about the humanization of care and believes that, despite the polysemy of the concept of humanization of care and the possible range of practices that call themselves humanizing, this process can provide a contribution to the improvement of quality of care provided. It could mean a new model of communication between professionals and patients and probably new care practices.

NATIONAL HUMANIZATION POLICY (PNH)

Seeking to improve the existing relationships between users and health professionals in the care process, as well as health practices in general, the National Humanization Policy (PNH) emerges, listing changes in the relationships established in health services in principles such as protagonism, co-responsibility and autonomy of the subjects, in addition to its main guideline, which is welcoming (BRAZIL, 2010a). Welcoming includes interpersonal relationships and aims at comfort, in addition to recognizing the user inserted in their context and with subjective and objective dimensions (COSTA; GARCIA; TOLEDO, 2016). Caring constitutes giving special attention, restlessness, dedicating oneself to someone or something, having responsibility for someone. Such meanings are attributed to a social dimension that implies interaction between subjects. However, over the years the term has become more focused on health care, this phenomenon occurs mainly due to the fact that the act of caring in a more specialized way is linked to diagnosing, treating and preventing based on technical knowledge and scientific. This technical ideal is related to the biomedical model, which has been widely criticized since it does not consider the subjectivity of the individual, 20 and therefore, current medicine emphasizes respect for subjectivity and individuality (CONTATORE; MALFITANO; BARROS, 2017). Therefore, welcoming constitutes a fundamental instrument for improving care. Humanization has been constantly addressed, in current debates about the health context and in recent research in the health area, as a relevant topic and as a subsidy for improving care and for consolidating the principles and values of the SUS (UNIFIED HEALTH SYSTEM), being focused on in the texts analyzed from a discourse that values emotional and subjective aspects to aspects that involve changes in health management and practices (MEDEIROS, 2017). It is a process that is in constant transformation and that is influenced by the context in which it occurs,

only having advanced and submitted to what could be the great policy of humanization of health care in the country, guaranteed by the man himself (CASATE; CORRÊA, 2012, RIZZOTO, 2002). It is believed that through a humanized and personalized assistance by health professionals, the physical and emotional balance of the elderly patient is guaranteed. As a result, and considering the "humanization of assistance", the Ministry of Health created, in the late 1990s, the National Program for the Humanization of Hospital Assistance (PNHAH), its objective is to enhance the educational training of health professionals to in order to enable the incorporation of values and attitudes of respect for human life, according to the understanding that quality in health must be composed of technical competence and interaction, not limited to technical or organizational aspects, which result in a progressive distance from the users' health professionals, reducing the bond in relationships, making them more distant, impersonal and depersonalized (MINISTRY OF HEALTH, 2009, FORTES, 2004). The National Policy for the Humanization of the Elderly (PNH) indicates that welcoming remains embedded in care and management actions and that it brings together those who share the evolution of health (BRAZIL, 2007). The way of acting of the (PNH) is due to the ease of interaction, using technique, instruments and ways of operating. Among these strategies, welcoming is promoted, which is characterized as a way of operating health work methods in a way that pays attention to those who seek health, meeting their needs and establishing commitments at work, assuming a welcoming behavior that listen to the user and provide them with the most appropriate answers (SILVA; CARVALHO, 2010; BRAZIL, 2010).

MANAGEMENT MODE IN THE NATIONAL HUMANIZATION POLICY (PNH)

Humanization, as a set of strategies to achieve the qualification of health care and management in the SUS (UNIFIED HEALTH SYSTEM), is established, therefore, as the construction and activation of ethical-aesthetic-political attitudes in line with a project of co-responsibility and qualification of interprofessional bonds and between them and users in health production. Humanizing health care and management in the SUS (UNIFIED HEALTH SYSTEM) is thus a coherent strategy for such purposes, effectively contributing to the qualification of care and management, that is, comprehensive care, weighted with accountability and bonding, for the appreciation of the workers and to advance the democratization of management and participatory social control (SANTOS-FILHO, 2007; RIOS, 2009). The implementation of the PNH presupposes action on several axes that aim at institutionalizing, disseminating this strategy and, above all, the appropriation of its results by society. In the axis of work management, it is proposed to promote actions that ensure the participation of workers in the discussion and decision processes, recognizing, strengthening and valuing their commitment to the health production process and their professional growth (FLEURY, 2014; BRAZIL, 2011). For the implementation of a PNH that is effectively transversal to other health actions and policies, it is necessary to combine the decentralized action of the various factors that constitute the SUS (UNIFIED HEALTH SYSTEM), with the necessary articulation and coordination to build synergy and accumulation of experiences. Thus, at the same time that new proposals for action are tested and successful experiences are multiplied with due mediation, the processes of debate

and agreement between the Federal, State and Municipal levels of the SUS (UNIFIED HEALTH SYSTEM) must consolidate humanization as a common and disseminated strategy across entire attention network. Thus, it is up to the Technical Coordination Nucleus of the PNH to articulate the actions of the areas of the Ministry of Health, at the same time that it contributes to strengthening the action of the State and Municipal Health Secretariats (DESLANDES, 2005).

FIELD OF HUMANIZATION

The PNH understands that, in its articulating role, it must focus, on the one hand, on facilitating and integrating the processes and actions of the other areas, creating the field where the Humanization Policy will take place; on the other hand, it must also assume itself as a nucleus of knowledge and competences with offers specially aimed at the implementation of the Humanization Policy (SOUSA; HAMMANN, 2009). The creation of the field of humanization will be done through intercession in different health policies. In this case, the PNH will work on actions decided upon with the areas in order to integrate them, in addition to facilitating contacts and interacting with the instances of the SUS (UNIFIED HEALTH SYSTEM) where such policies are carried out. Its humanization core functions are defined by strategically guaranteeing the specificity of the Humanization Policy and, in this sense, it will offer content and methodologies to be worked on processes and priorities considered essential for each area of care. In addition, it will establish lines of implementation, integration and dissemination of the PNH (DAMASCENO; SOUSA, 2016; PEDROSO; VIEIRA, 2009). The PNH assumes the commitment of: proposing and integrating action strategies that constitute the "field of humanization", operating as matrix support for the areas, coordinations and health programs in whatever is established with them; propose and integrate action strategies for the implementation of the PNH within the scope of the Ministry of Health in interface with other areas and coordinations and other instances of the SUS (UNIFIED HEALTH SYSTEM); create a group of regional supporters of the PNH, who will work with the State Health Secretaries (SES), the Municipal Health Secretaries (SMS), the Permanent Education Centers, hospitals and other health equipment that develop humanization actions. This group will function as an articulating device and promoter of humanizing actions, stimulating multiplier processes at the different levels of the SUS (UNIFIED HEALTH SYSTEM) network; create and encourage mechanisms for disseminating and evaluating the PNH in interface with other areas, coordinations and programs of the Ministry of Health (MOH) (MINISTRY OF HEALTH, 2008).

HUMANIZATION POLICY AND DEMOCRATIC MANAGEMENT AS A REINVENTION OF ORGANIZATIONS FOR THE EMERGENCE OF DIFFERENCE

In the field of health, alienation at work causes destructive effects, as the production of health depends on the quality of the encounter with the other, an encounter that results from the forms of relationship and intercession processes between subjects. This issue has pointed to the need to reorganize health work from the perspective of producing meaning for those who carry it out. Without this sense, alienation cannot be reduced, that is, it is not possible to reposition the subjects in the relationship for the production of color accountability contracts in care (GOMES, 2017). Reinventing management and the ways in which the care network and care offers are organized implies, on the one hand, the

triggering of a cultural process, which in turn requires the production of new relationships between subjects and new institutional processes (RIBEIRO ; FUREGATO, 2006). On the other hand, this reinvention requires the restructuring of organizations, of health establishments, which need a new architecture capable of providing and fostering new modes of power circulation and subjectivity production, capable of fostering the construction of innovations in practices of health (PNHAH, 2002). Reinventing the ways of governing institutions, therefore, recreating them for a new expression of the correlation of forces - is an exercise in improving institutional democracy. This requires, among others, the formulation of arrangements and processes that allow the sharing of interests and the production of new contractualities in the differences between subjects. For that, it is necessary to make use of expanded concepts of management, subject, subjectivity and groups, which allow the understanding and concrete operation of new contracts (CASATE; CORREA, 2005; PAIM, 2015).

THE IMPORTANCE OF THE NATIONAL HEALTH POLICY FOR THE ELDERLY (PNSI)

The year of publication of the National Immunization Policy (PNI) 1994 coincided with the implementation of the Family Health Program (PSF) as a health care model for the entire Brazilian population (BRAZIL, 1994). The progressive implementation of the PSF and its transformation into a Family Health Strategy led the National Elderly Health Policy (PNSI) to adapt to the change in the care model in primary care for the person National Elderly Policy: old and new elderly issues (BRAZIL, 1999). The PNSI was revoked in 2006, and a new policy was published – the National Health Policy for the Elderly (PNSPI), which consists of two major complementary and non-excluding axes: facing the weaknesses of the SUS (UNIFIED HEALTH SYSTEM), families and the elderly; and the promotion of active aging, as proposed by the WHO in 2002, which also poses the need to implement care policies for the frail elderly population, which requires support for families with elderly people and training for professionals (CAMACHO ; COELHO, 2010). The 2012-2015 National Health Plan established as one of its guidelines the guarantee of comprehensive health care for the elderly and those with chronic diseases, encouraging active aging and strengthening actions to promote and prevent the health of the elderly, in order to increase their degree of autonomy and independence for self-care, involving family members and the community (SILVESTRE; COSTA,2003). It is consistent with what is proposed in the PNI, but funding was not guaranteed by the 2012-2015 Multi-Year Plan. According to some authors, in the budget document, the Health of the Elderly was rarely contemplated. Thus, the non-effectiveness of the PNI in Health reflects structural issues or political choice of priorities in the general public health system (VERAS, 2015). The National Health Policy for the Elderly (PNSPI) was recently updated, considering the Pact for Health and its Operational Guidelines for the consolidation of the SUS (UNIFIED HEALTH SYSTEM) and reaffirming the need to face the challenges posed by an aging process that is now characterized by diseases and/or conditions chronic non-transmissible, but preventable and controllable, and by disabilities that can be avoided or minimized (PAIM, 2019). Among these challenges, the scarcity of multidisciplinary and interdisciplinary teams with knowledge on aging and the health of the elderly stands out. Undoubtedly, old age IS a phase of the life cycle whose specificity demands specialized health care and, therefore,

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requires qualified personnel to care for these people. In this perspective, issues related to health education, qualification and training of human resources and the development of studies and research in the area permeate the guidelines that guide this Policy. Such guidelines are intersectorally articulated with co-responsibility actions between managers of the SUS (UNIFIED HEALTH SYSTEM), education, science and technology and other sectors (RODRIGUES; RAUTH, 2002). The PNSPI bases the action of the health sector on comprehensive care for the elderly and aging population, as determined by Organic Health Law no. 8080/90* (Preservation of people's autonomy in defense of their physical and moral integrity) and Law no. 8842/94, regulated by Decree no. 1948/96. It ensures the rights of the elderly and seeks to create conditions for the promotion of autonomy, integration and participation of the elderly in society, with the health sector providing access for the elderly to services and actions aimed at promoting, protecting and recovering health. For the feasibility and implementation of the PNSPI, it is therefore necessary to know and understand how the Brazilian population is aging, as well as to act in partnership with the elderly, in order to go beyond the legal provision, to take critical and constructive action (RODRIGUES et., al, 2007). Despite the magnitude of this world event that is population aging, we feel a lack of investment in research and public and private incentives to streamline and optimize policies for this segment of society. Like other countries, Brazil has been faced with the issue of an aging population. It becomes a challenge for the country to care for the elderly and the responsibility of families and society (PICCINNI et al., 2006). Law nº 8.842/94 (PNI) proposes that knowledge of Geriatrics and Gerontology be included in the curricula of higher education courses in the area of Health, aiming at training academics with competence to meet the demands of elderly clients and their families, with the greater objective of investment in promoting healthy aging that effectively affects the general population. According to this law, it is up to the health sectors to provide the elderly with access to services and actions aimed at promoting, recovering and protecting health. It is necessary to develop cooperation between the spheres of government and between the various social and health sectors that serve the aging being (MINISTRY OF HEALTH, 2003, STATUTO DO IDOSO, 2003). To this end, this policy defines the guidelines that must guide all actions in the health sector, and indicates the institutional responsibilities for achieving the purpose already explained. In addition, it guides the continuous evaluation process that must accompany the development of the PNSPI, through which the eventual resizing that may be dictated by practice must be possible. To implement such a policy, it is necessary to define and/ or readjust plans, programs, projects and activities in the health sector, which are directly or indirectly related to its primary object, the articulation between the Ministry of Health and the State and Municipal Health Secretariats., for its operation. Finally, for it to reach its objectives, its essential guidelines need to be fulfilled (COSTA, 2009, VERAS, 2016). The Pact for Life is one of the priorities, articulated and integrated, assumed by SUS (UNIFIED HEALTH SYSTEM) managers as a public commitment to the construction of the Pact for Health (BRAZIL,2006b). The health of the elderly is part of this priority, as it seeks comprehensive care and the implementation of the PNSPI, in which again the concern with the preparation of health professionals is translated into strategic action of a permanent distance education program, with content aimed at the process of aging, individual

health and management of health services (COTTA et al., 2013).

HEALTH CARE FOR THE ELDERLY POPULATION IN THE SUS (UNIFIED HEALTH SYSTEM)- NATIONAL HEALTH POLICIES FOR THE ELDERLY (PNSPI)

There must be an identification of the specificities of the elderly population that must be considered throughout the care production process by teams, services and health actions. Strategies for organizing health care for the elderly population in the SUS (UNIFIED HEALTH SYSTEM), based on the Comprehensive Care Model: Highlights the importance and potential of networking; It defines as a strategy the integration with the different points of attention of the SUS (UNIFIED HEALTH SYSTEM), aiming at the production of comprehensive care for the elderly, adapted to their needs; Identifies the strategic points of care in Primary Care, Specialized Ambulatory Care, Specialized Hospital Care, Urgency and Emergency (ARCANJHO; BARROS, 2014). for the years 2013/2014, the elaboration and dissemination of the Proposed Model of Comprehensive Health Care for the Elderly, integrated into the Health Care Networks, organized by Primary Care, and articulated with strategic areas and programs of the Ministry of Health that present an interface with the field of action (SCHENKER; COSTA, 2019). To guide sectoral and intersectoral actions in the field of aging and elderly health, legal and normative frameworks were prepared and published. An important example is the National Policy for the Elderly, enacted in 1994 and regulated in 1996, which provides for the guarantee of social rights for the elderly, defined as a person aged 60 or over. In 2003, with the publication of the Statute of the Elderly, the rights of the elderly were reaffirmed, and Health was responsible for ensuring comprehensive care for this population, through the Unified Health System. Such proposals were relative to the needs that arose in that context. Thus, the composition of specific networks for the elderly population was centered on General Hospitals and Reference Centers for Health Care for the Elderly, suitable for offering different care modalities, such as: hospitalization, specialized outpatient care, day hospital and home care (FERREIRA ; BANSI; PASCHOAL, 2014).

RESULTS AND DISCUSSION

According to the Socio-Historical context of the Development of Public Policies for the Care of the Elderly in Brazil, the implementation of a public policy for the elderly in Brazil is recent, since it dates from January 1994. In this project, it was possible to analyze according to the readings based on life of the elderly that in relation to the socio-political context of the public policy of care for the elderly in Brazil there are many policies focused on the elderly, however, the difficulties in implementation range from the precarious fundraising to the fragile information system for the analysis of the living and health conditions, as well as inadequate training of human resources. The aging process concerns society in general and the elderly must not suffer discrimination, they must be the main agent and recipient of the transformations indicated by the policies related to the elderly. One of the main regulations that focus on the socio-political context and provide for the conditions for the promotion, protection and recovery of health, the organization and functioning of the corresponding services and other provisions is the Organic law on health. In its principles, the preservation of autonomy, the physical and moral integrity of the person, the integrality of assistance, and the setting of priorities based on epidemiology stand out.

In Brazil, the universal and integral right to health was conquered by society in the 1988 Constitution and reaffirmed with the creation of the Unified Health System (SUS (UNIFIED HEALTH SYSTEM)), through the Organic Law of Health nº 8.080/90. The understanding of this right involves universal and equal access to services and actions for the promotion, protection and recovery of health, with a guarantee of comprehensive care, considering the different realities and health needs of the population. These constitutional precepts are reaffirmed in Law No. 8,142, of December 28, 1990, which provided for community participation in the management of the Unified Health System and for intergovernmental transfers of financial resources in the area of health and the Basic Operational Norms (NOB), edited in 1991, 1993 and 1996, which, in turn, regulate and define the strategies and tactical movements that guide the operation of the System. Concomitant with the regulation of the SUS (UNIFIED HEALTH SYSTEM), Brazil organizes itself to respond to the growing demands of its aging population and ensure the social rights of the elderly, by creating conditions to promote their autonomy, integration and effective participation in society, reaffirming the right to health at the various levels of SUS (UNIFIED HEALTH SYSTEM) care. Following the development of the PNI, the Integrated Government Action Plan appears. This action plan was composed of nine bodies: Ministry of Social Security and Assistance; Education and Sports; Justice; Culture; Work and Employment; Health; Sport and Tourism; planning, budget and management; and the Urban Development Secretariat, whose purpose is to guide integrated actions in order to make the implementation of the PNI feasible. In this sense, it defines the actions and strategies for each sectorial body, negotiates financial resources between the three spheres of government - federal, state and municipal - and monitors, controls and evaluates the actions to ensure all the rights of citizenship to the elderly, with the family, society and the State responsible for guaranteeing their participation in the community, defending their dignity, their well-being and their right to life. Thus, this plan deals with preventive, curative and promotional actions, with a view to a better quality of life for the elderly. In 2003, the Statute for the Elderly was approved and together with the PNI, these important documents expanded knowledge in the area of aging and elderly health and were fundamental for the affirmation of dynamic and consistent actions. The Statute corroborates the principles that guided the discussions on the human rights of the elderly. It is an achievement for the realization of such rights, especially for trying to protect and form a basis for the claim of action by all (family, society and State) to protect and respect the elderly. The Statute for the Elderly has prioritized service in general, as well as that clientele that already has some degree of dependency. It is with these fundamental actions of secondary prevention, rehabilitation, health promotion, in addition to care and treatment, that it is possible to guarantee a better quality of life for the elderly in family life and in society. The study on humanization in the health of the elderly is of fundamental importance and relevance, since the constitution of a service molded in principles such as comprehensive care, equity, social participation of the user, among others, requires the review of daily practices, in order to value dignified treatment for patients and professionals. The statute emphasizes the interface between the sectors and the right to health. The PNSPI seeks to ensure adequate and dignified care for the Brazilian elderly population, aiming at their integration. In addition, it guides the continuous evaluation process that must accompany its development,

considering possible adjustments determined by practice. Its implementation comprises the definition and/or readjustment of plans, programs, projects and activities in the health sector.

CONCLUSION

The SUS (UNIFIED HEALTH SYSTEM) instituted a public health policy that, despite the accumulated advances, today still faces fragmentation of the work process and relationships between different professionals, bureaucratization and verticalization of the system, in addition to the training of health professionals far from the debate and formulation of public health policy, among other aspects as important or even more important than those mentioned above. What resulted from actions considered little applied in relation to humanization in the elderly age group in the public health service The transversal dimension of the Policy for Humanization of Health Care and Management in the SUS (UNIFIED HEALTH SYSTEM) implies, necessarily, for its execution, a collective construction. This means agreement processes within the scope of the Ministry of Health, as well as in the various instances of the SUS (UNIFIED HEALTH SYSTEM). Mapping existing humanization programs, projects and initiatives, articulating them and, from there, proposing guidelines, outlining objectives and defining action strategies in the composition of the PNH, in a constant dialogue with the specificities of the health areas, are tasks of which one cannot give up if, in fact, the objective is to operate transversally. For the implementation of a PNH that is effectively transversal to the other health actions and policies, it is necessary to combine the decentralized action of the various sectors that make up the SUS (UNIFIED HEALTH SYSTEM), with the articulation and coordination necessary for building synergy and accumulating experiences. Thus, at the same time that new proposals for action are tried out and multiplied with due mediation, successful experiences, debate and agreement processes between the federal, state and municipal levels of the SUS (UNIFIED HEALTH SYSTEM) must consolidate humanization as a common strategy and disseminated throughout the care network. Thus, it is up to the Coordination of the PNH to articulate the performance of the areas of the Ministry of Health, at the same time that it contributes to the strengthening of the actions of the state and municipal health secretariats. It is necessary to affirm that humanization as the guiding axis of health practices is inherent in the very method of its construction. For the policy to be transversal, its mode of operation must also be. Therefore, to integrate the contributions of the health areas, as well as of programs and projects, in the construction of the Humanization Policy. The engagement of society as a whole is fundamental, so that the reality of the elderly can be transformed and humanize the relationships between living and aging. The elderly population, society and managers in the various spheres of government need to continuously discuss the health needs of the elderly in different regions of Brazil in relation to service offerings, with organization and integration of care networks into systems for health maintenance, but above all in its functionality. The various proposals of the National Policy for Elderly Care are well outlined and outlined, however, it is up to government service managers and the health team to discuss care priorities and promote a policy aimed at the network in question.

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