



PATIENT PROFILE AND COST ANALYSIS OF A PUBLIC HOME CARE SERVICE¹

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ABSTRACT

Introduction: Public Home Health Care in Brazil covers actions taken at home, for disease prevention and health promotion, in integration with the primary health care network. It mainly aims at de-hospitalization, resulting in the humanization of assistance to users, and cost reduction. **Objective:** To investigate, by means of a Home Care Service, the profile of assisted patients and the costs involved in home care and in the occurrence of hospital admissions. **Method:** Quantitative, descriptive and cross-sectional research conducted at a public Home Care Service, in a city in São Paulo. For data collection, three sources of information were used: patient records, electronic database belonging to the cost center and to the regulation and control body of the municipal health department referring to patients cared for by the Home Care Service in 2014. Descriptive statistical treatment was used for data analysis. **Results:** A total of 856 patients composed the sample, 791 of which were provided with Home Care only, while 95 (12.4%) were hospitalized; there was a predominance of men, elderly, married or widowed individuals and illiterate users coming from the primary health sector; the average patient/day cost of the home care was R\$ 28,26 – SD 4,10 (US\$ 12.03 – SD 1.74), while the average patient/day cost of hospitalization was R\$ 294,46 – SD 308,69 (US\$ 125.30 – SD 131.36). **Conclusion:** The elderly were the main users of the service; the component that most impacted the total cost was personnel expenses, and the much lower costs of the home care system compared to hospital care reiterates the feasibility and importance of the Home Care Service linked to the Brazilian Unified Health System, with a view to better using public resources.

Keywords: Home care. Costs and cost analysis. Health management. Evaluation of health programs and projects. Brazilian Unified Health System.

INTRODUCTION

Home health care (HC) is defined as a modality of care provided at the patient/client's home, and brings the opportunity of continuing the treatment outside the existing logistics of operation in a hospital unit. It aims to prevent, control and treat diseases, in addition to promoting palliative and rehabilitative measures in the health and disease process⁽¹⁻³⁾.

Brazil has two instituted forms of home care: private (supplementary – developed by health insurance plans) and public (organized on three levels, in accordance with the means for assisting users of the Brazilian Unified Health

System [*Sistema Único de Saúde*] (SUS). The Home Care Service (HCS) was implemented in our country in 2011, through the Better at Home Program, aiming to serve people with mobility difficulties to seek a health service, and encompasses three types of HC: HC1, which carries out actions for health promotion and disease prevention to be executed by a Primary Care Network (PCN) team; HC2, which offers outpatient procedures; and HC3, less common, which provides advanced health support^(2,3).

The Better at Home Program has as guideline the articulation with the other parts of the Health Care Network, with the Family Health Strategy (FHS) being the organizer of care, making the

¹This manuscript is part of the master's thesis entitled "Home Care: Patient Profile Analysis as to the Use of Resources and Costs in a City in Southeastern Brazil", year 2018, presented to the Postgraduate Nursing Program – Academic Master's – of the São José do Rio Preto Medical School [Faculdade de Medicina de São José do Rio Preto] (FAMERP).

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interface between the parts⁽⁴⁾. Its implementation depends on some requirements, such as a minimum of 20 thousand inhabitants per municipality, having a reference hospital, and having Mobile Emergency Care Service [*Serviço de Atendimento Móvel de Urgência*](SAMU) coverage⁽²⁾. Until the first quarter of 2020, the Better at Home Program was implemented in 26 states, 577 municipalities, covering 34% of the Brazilian population⁽⁵⁾.

The home care model that has been implemented in Brazil is based on a better health care management, quality and humanized care, lower costs and expenses, which are achievable through the creation of new forms of production of qualified care, by means of the work of an interdisciplinary and multiprofessional team⁽⁶⁾.

Whether about the focus of humanization of care, or about economic and financial issues, since the end of the 90s, in different Brazilian health care scenarios, the current biomedical, hospital-centered, technocratic and unequal model has been questioned. Debated points include the harms and limitations of the hospital for chronic patients or those in long-term rehabilitation, the possibility of technologies substituting those exclusive to hospital units and, most importantly, the high costs associated with hospitalization⁽⁷⁾.

Cost management is paramount for controlling resources, thus allowing managers to analyze not only the most profitable activities, but also controlling those that are less economically viable, which serves as a strategy to optimize expenses as to supplies and services used in production⁽⁸⁾. In this study, cost is understood as the financial expenditure for producing a good or a service⁽⁹⁾. The hospital sector is costly, a fact shown by the high rates of admission and readmission, use of expensive technologies, as well as unnecessary consultations, exams and hospitalizations⁽⁹⁻¹¹⁾.

Despite some progress in HC in Brazil, this health care modality is still poorly structured and studied, particularly with regard to costs, which justifies or reveals the need for further research in this context. It is necessary to bear in mind the potential of HC in reorganizing health care, especially for patients who demand higher hospital costs, such as those with chronic conditions or in a terminal-life situation.

In light of the foregoing, this study aims to

investigate, by means of a Home Care Service (HCS), the profile of assisted patients and the costs involved in home care and in the occurrence of hospital admissions.

METHOD

This is a quantitative, descriptive and cross-sectional study conducted with a type-2 public HCS, in a medium-sized municipality in southeastern Brazil (438,354 inhabitants)⁽¹³⁾.

The HCS was composed of five Multiprofessional Home Care Teams (MHCTs) made up of doctor, nurse, nursing assistant and/or technician, which has a Multiprofessional Support Team (MPST) composed of social worker, physiotherapist, speech therapist, psychologist, odontologist, and occupational therapist. In 2014, the studied Service engaged in an average of 2,505.58 home visits, and performed an average of 3,510.75 outpatient procedures.

The sample consisted of 856 patients assisted by the HCS throughout 2014, 761 of which were exclusively provided with home care, while 95 presented complications, which led them to being hospitalized.

Data collection was carried out by the main researcher, in July 2015, who used a sheet designed for recording, consisting of variables related to the profiling of the patients, HC costs, and hospital admission costs. To this end, data collection covered three stages:

The first one took place at the headquarters of the service, by means of searches through its own medical and electronic records; to describe the sociodemographic profile, the following variables were considered: sex, age group, education, marital status, income, origin, length of stay, and outcome.

The second stage unfolded at the cost center of the Municipal Health Department [*Secretaria Municipal de Saúde*] (SMS), to compose the statement of the HCS's costs; expenses on monthly costs related to human resources, permanent expenses, supplies, etc., were noted. The HCS's cost is structured on the absorption costing method, which considers all costs involved, from all of the health service's cost centers to compose the total cost of production⁽⁹⁾. The length of stay in HC was calculated from the date of admission until the end of assistance, or

until the last day of 2014.

In the third stage, at the Regulation and Control Department [*Departamento de Regulação e Controle*] (DERAC), belonging to the same SMS, to compose the costs of hospitalization of patients treated by the HCS, the following variables were searched in the electronic databases: materials, drugs, Orthoses, Prostheses and Special Materials (OPSM), Therapeutic Diagnostic Support Service (TDSS), daily rates, fees, total cost.

Initially, the data were inputted into an Excel spreadsheet, version 2007, with typing check. Also, they were organized in a Statistical Package for the Social Sciences (SPSS) file, version 2.13.0. For the quantitative variables, the summary measures used were: mean and standard deviation, median, and minimum and maximum, to indicate the variability.

In order to facilitate the understanding of the HC and hospitalization costs, the choice was to present, in Table 4, the values in Real, the Brazilian currency, and in US dollar, due to its wide use. The Brazilian Central Bank uses the Ptax dollar exchange rate to make conversions of the local currency into dollars official. Thus, for the conversion, US\$ 1 = R\$ 2,35 was used, which was the average exchange rate for 2014.

This study is part of the master's dissertation of the first author, which was approved by the Research Ethics Committee (opinion No. 1.268.061) of the academic institution São José do Rio Preto Medical School (FAMERP), in compliance with resolutions 466/12 and 510/16 of the National Health Council [*Conselho*

Nacional de Saúde] (CNS).

RESULTS

Table 1 shows data on the profiling of patients assisted in 2014 by the studied HCS, and it is possible to verify the following:

- 856 patients were assisted, 761 (88.90%) of which were provided with home care only, while 95 (11.1%) had hospitalization episodes;
- more than half were male, accounting for 54.8% among those provided with home care, and 51.6% of those hospitalized;
- most were aged 60 or over, accounting for 75.43% of those provided with home care, and 87.37% of those hospitalized;
- about education, among the patients cared for at home, 46.1% were illiterate, and such information was not available for 36.53%. Among the inpatients, 72.63% were illiterate, and 12.63% had no education record;
- among the patients provided with HC, there was no information on the marital status of 268 (35.22%), while 29.7% were married. Also, among the inpatients, most of them were married 40 (42.1%) or widowed 39 (41.05%);
- most of the patients in the study came from the primary health sector, accounting for 62.81% of those in-home care, and 77.9% of the hospitalized ones;
- the length of stay was on average 209.55 days for the patients in HC, and 5.65 days among the inpatients.

Table 1. Distribution of the profile of patients assisted in 2014 by Home Care (n = 761) and hospital care (n = 95). São José do Rio Preto, SP, Brazil, 2014.

Variables	Categories	HC n(%)	Hospital care n(%)
Sex	Male	417(54.80)	49(51.58)
	Female	344(45.20)	46(48.42)
Age group (years)*	≤18	17(2.30)	-
	19-59	168(22.10)	12(12.60)
	≥ 60	574(75.50)	83(87.40)
Education**	Illiterate	357(46.91)	69(72.63)
	Elementary School	81(10.64)	10(10.52)
	High School	45(5.91)	4(4.21)
	Does not apply	3(0.39)	-
Marital Status***	Single	81(10.64)	7(7.36)
	Married	226(29.70)	40(42.10)
	Widowed	186(24.45)	39(41.05)
Origin****	Primary	478(62.81)	74(77.89)
	Secondary	30(3.94)	2(2.10)
	Tertiary	117(15.37)	19(20)
LS(days)	Mean	209.55	5.65

Source: HCS – Home Care Service.

Legend: HC – Home Care; LS - Length of Stay; *NI – No information. *NI-2 (0.26%, n: 761); **NI-275 (36.13%, n: 761); NI-12 (12.63%, n: 95) ***NI-268 (35.21%, n: 761); NI-9 (9.47%, n: 95); ****NI-34 (4.46%, n: 761)

Table 2 shows the composition of the costs referring to the assistance provided by the studied HCS as to home care, and it is possible to observe the following:

- the monthly cost ranged from R\$ 154.385,66 to R\$ 288.383,43, totaling R\$ 2.587.134,34 throughout 2014;
- among human resources expenses, the total cost was R\$ 1.777.220,64, with a mean of R\$ 148.102,00 (SD: 42.314);
- Permanent expenses (water, sewage, electricity, telephony, property rental, security) had a cost of R\$ 100.88,92, with a mean of R\$ 8.357,40 (SD: 2.273);

- expenditure on supplies (office, medical and hospital supplies, and drugs, oxygen, laundry and sterilization, fuel and vehicle maintenance) had a total cost of R\$ 401.665,85, with a mean of R\$ 33.357,40 (SD: 14.708);

- expenses with third parties – service providers (contracts with drivers, and cleaning, IT, equipment maintenance, and printing services) – totaled R\$ 336.829,49, with a mean of R\$ 28.069,00 (SD: 7.263,30);

- the costs accounted for 67.65% of personnel expenses, 15.5% of permanent expenses, 13% of expenses with third parties, and 3.85% of permanent expenses.

Table 2. Cost composition statement (R\$) for patients assisted in 2014 by the HC (n = 761). São José do Rio Preto, SP, Brazil, 2014.

Variables	%	Mean	PE	Median	Minimum	Maximum
Monthly	100	215.595,00	44.133	215.030,00	154.385,66	288.383,43
HR	68.69	148.102,00	42.314	149.367,00	222.736,39	183.975,53
PE	3.87	8.357,40	2.273,1	6.920,60	6.721,17	12.098,75
Supplies	15.52	33.472,00	14.708	33.222,00	15.439,00	53.991,30
Third parties	13.01	28.069,00	7.263,30	28.977,00	21.044,80	46.843,20

Source: Cost center of the Municipal Health Department.

Legend: HR - Human Resources; PE - Permanent expenses; SD - Standard deviation; % - percentage.

Table 3 shows the costs of 95 inpatients. The average hospital cost was R\$ 1.648,00, mainly with regard to the consumption of

materials/drugs (79% - R\$ 2.018,57) and daily rates (11.28% -R\$ 532,30).

Table 3. Statement of cost composition (R\$) and length of stay (in days) of patients in hospital care in 2014 (N = 95). São José do Rio Preto, SP, Brazil, 2014.

Variables	%	Mean	PE	Median	Min	Max
Materials/drugs	76.56	1.261,80	4.034,30	561,22	33,34	3.8491,00
OPSM	2.44	756,77	727,61	525,02	118,80	1.989,50
TDSS	2.77	102,24	118,97	80,99	8,39	610,42
Daily rates	9.13	361,48	2.077,90	24,00	8,00	19.821,00
Other	2.15	170,82	126,57	154,03	16	574,40
Fees	6.94	114,47	164,37	75,36	10,88	881,40
Total cost	100	1.648,00	4.332,00	710,11	52,22	40.180,00
Length of stay (days)		5.65	6.98	3	1	46

Source: DERAC - *Departamento de regulação, avaliação e controle*.

Legend: OPSM - Orthoses, prostheses and special materials; TDSS - Therapeutic diagnostic support service; Other (medical gases, charges and rent)

As shown in Table 4, the average patient/day cost of home care was R\$ 28,26 (US\$ 12.03), while the average patient/day cost of hospital

care was R\$ 294,46 (US\$ 125.30). The difference between the HC and hospital care costs was -1,041%.

Table 4. Average-cost distribution (R\$ and US\$) for patients in HC and hospital care, in 2014. São José do Rio Preto, SP, Brazil, 2014.

Variables	Mean	PE	Median	Min	Max
HCS					
Total/month cost	215.595,00	44.133	215.030,00	154.386,66	288.383,43
US\$	91,742.55	18.780	91,502.12	65,696.45	13,732.54
Pat/month	375,25	46,98	383	276	442
Pat/month cost	573,42	80,14	591,27	384,04	675,33
US\$	244.01	34.10	251.60	163.42	287.37
Business days/month	20,41	2,06	21	12	23
Pat/day cost	28,26	4,10	29,07	17,45	32,25
US\$	12.03	1.74	12.37	7.43	13.72
HC					
Total cost	1.648,00	4.332,00	710,11	52,22	40.180,00
US\$	701.28	1,843.40	302.17	22.22	17,097.87
LS (day)	5.65	6.98	3	1	46
Pat/day cost	294,46	308,69	208,27	45,08	2.392,70
US\$	125.30	131.36	88.63	19.18	1,018.17
HCS/HC	10,41(1.041)	75,29(7.529)	7,16(716)	2,58(258)	74,19(7.419)

Legend: HCS – Home Care Service; Pat – Patient; HC – Hospital care

DISCUSSION

Public Home Health Care in Brazil covers actions for disease prevention, health promotion, treatment, control and rehabilitation, provided at home, in integration with the Health Care Network. It is organized from the primary health care network, having Better at Home as its main structuring program, created in 2011. It is set as a complementary care strategy, motivated by several concerns, including: de-hospitalization, rationalization of the use of hospital beds, humanization of assistance by organizing a patient-centered care, and cost reduction. In general, home care has as management focus being a strategy that minimizes costs and complications resulting from hospitalization and, within the scope of the patient, improving their emotional state, providing benefits such as decreased anxiety, thus leading to faster recovery or less stress in situations of chronic diseases^(12,13).

Due to the characteristics of the Brazilian health system, both public and private, concepts vary when it comes to the home context, such as: *home care*, a term used for any health action deemed adequate at home, from the simplest to the most complex ones; *home hospitalization*, related to multi-professional care of medium or high complexity at home, displacing part of the hospital structure; and *home service*, which covers health care actions, multi-professional or not, that are similar to a doctor's office⁽¹³⁾.

There is evidence in the scientific literature, in the Brazilian case, that transferring a patient

to be treated at home brings several benefits, both for the patients who need assistance and for the SUS. Such benefits include: release of hospital beds by opening vacancies for new admissions; reduction of risks of iatrogenesis, complications and infections; better quality of life for patients, due to the possibility of being with the family, all of which result in lower treatment costs and shorter recovery time^(14,15).

As a public health policy in Brazil, HC is configured as a government strategy still in the implementation phase, but a relevant one in consolidating the SUS's principles of integrality, equity, isonomy and autonomy – in short, fairness, humanization, economic-financial rationality, and higher resolution in health care. In the private sphere, HC is not regulated by the Brazilian Health Agency [Agência Nacional de Saúde] (ANS), only by the Brazilian Health Regulatory Agency [Agência Nacional de Vigilância Sanitária] (ANVISA), with tensions and judicialization being common, since the operation modeling is the responsibility of each Health Insurance Plan Operator (HIPO) with its clients/beneficiaries⁽¹⁶⁾.

It is worth mentioning that the lack of regulation in Brazilian private home care has resulted in conflicts and complex discussions in the legal universe of the HIPOs, which end up entering the SUS, regarding requests for home care coverage, particularly in situations of higher-cost diseases⁽¹⁷⁻¹⁹⁾.

As for the profile of patients assisted in the HCS, this research found a majority of men; elderly individuals (in Brazil, people aged 60 or

over are considered elderly); illiterates; married or widowed people, coming from the primary health sector, with an average of 209.55 days using the HCS, and an average hospital stay of 5.65 days. In a study at an HCS in Curitiba, in 2017, the profile showed a majority of women, with an average age above 71 years old, and an average of eight years of study; the patients' predominant origins were Basic Health Units or Family Health Strategy, and the average assistance time was more than 38 days⁽²⁰⁾.

The elderly represents the main group of patients cared for by the HCS, mainly women, with health problems related to hypertension, stroke and dementia⁽²¹⁾. It is worth comparing this research with national studies on the profile of patients in HC: a study in northeastern Brazil, involving 445 HCS users, found a prevalence of women and senior citizens, with 45% of deaths⁽¹⁰⁾.

Another study on the same theme, but in the Southeast of the country (n: 46)⁽²³⁾, reported the predominance of women (71.46%), average age of 82.76 years old, widowers (43.78%), incomplete elementary education (60.88%), and an income linked to the receipt of financial aid (91.3%)⁽²²⁾. In addition to these analyses, the latest 2019/2020 census (n:16,739) by the National Center for Home Care Services Companies [*Núcleo Nacional das Empresas de Serviços de Atenção Domiciliar*] (NEAD)⁽⁵⁾ are worth highlighting, which found the prevalence of elderly individuals (n:7,099) and women (n:9,730).

The cost analysis in this study pointed to variations in personnel expenses, justified by the expansion of the MHCT and MPST teams in 2014, and in permanent expenses (water & sewage, electricity, telephony, property rental, security), justified by a higher energy consumption on hot days, water leaks, rent readjustment, in addition to spending on supplies (office, medical and hospital supplies, oxygen, laundry and sterilization, fuel and vehicle maintenance) and outsourced services, which may have readjustments.

In a research on the evolution of spending on hospital admissions financed by the SUS, in the years 2000, 2005, 2010 and 2013, expenses on hospitalizations for conditions sensitive to primary care were analyzed. There was a reduction in costs among children, the elderly

and women, but high costs persisted among patients with cardiovascular diseases, with an increase in hospitalizations due to angina⁽²³⁾.

As for the origin of referrals to home care in this research, primary care was the main responsible, with 62.81% (n:761). It is known that primary health care (PHC) is the first level of home care, and that home visits allow assessing the care needs of patients and including them in one of the types of home care offered by the SUS⁽²⁴⁾.

Another challenge for the management of care is related to the length of stay in HC; this study found an average of 209.55 days, which is below the average found in another Brazilian study, whose length was 614.13 days. The length of stay can influence the management of HC services, as it suggests the presence of gaps such as network stagnation, low turnover, waiting lines for vacancies, low de-hospitalization, among other aspects^(2,3,14).

Knowing the length of stay in HC contributes to the management of the health system, for which home care represents an enormous support^(2,3,10,11,24).

Deepening the relationship between home care and unplanned hospitalizations, an investigation in Australia identified a predominance of women, average age of 77.6 years old, and average length of stay in hospital of 5 days⁽²⁵⁾. The same study also reports that they were 3.6 and 2.6 times less likely to go through hospital readmission if they received a phone call or a nursing visit at home, respectively⁽²⁵⁾.

The NEAD identified, in the last census, that of the 31 participating companies, 5% on average presented hospitalization rates among its patients⁽⁵⁾. On this theme, another study concluded that patients residing in areas with greater HC coverage had their average hospital stay reduced. The same study also indicated that an increase of 10% in HC coverage would reduce by 1.2% to 2.1% the length of stay in hospital among patients cared for at home⁽²⁶⁾.

Understanding the profile of patients in HC who are admitted to hospital helps identify the risk factors associated with this profile, and how HC can manage all that at home, with a view to avoiding unnecessary hospitalization, which not only raises costs for the health system, but brings serious harm to patients as well⁽²⁷⁾. There is a

logistics in the market that money saving in home care costs should be 30-60% lower compared to hospital care⁽²⁸⁾.

Still on cost management in HC and hospital care, the Union of Self-Management Health Institutions [*União das Instituições de Autogestão em Saúde*] (UNIDAS) described that, in 2016, the expenses with daily home hospitalization were higher than the expenses with daily hospital stay. However, in the same year, the expenses with materials and drugs concerning home hospitalization were lower than the same costs for hospital care. One of the problems related to the sector involves the issue of negotiations being done through packages, in addition to the difficulty in the specific language to meet the requirements of the ANS regarding specifying procedures on the payment slips of health insurance plans with the HIPOs⁽²⁹⁾.

It is worth stressing that the modality of HC mentioned here is related to Home Care and not Home Hospitalization, a fact that distinguishes it in relation to expenses with daily rates, charges and rent, etc., in addition to being related to the execution of outpatient procedures, medical and nursing visits, besides serial therapies by the multidisciplinary support team^(2,5,14).

Considering these variables present in the composition of the hospital stay bill, the values found in this study were: average hospitalization cost of R\$ 1.648,00, with an average length of stay of 5.65 days. In the same year, in the private system, in the self-management health segment, the average hospitalization cost was R\$ 12.167,33, and the average length of stay was 4.9 days, with the value of 738.31% being above, and the length of hospital stay 13.28% being below our findings⁽²⁹⁾.

Moreover, in the composition of the hospital bill of the patients in this research, who were in HC and were admitted to hospital, the expenditures with materials and drugs were higher than the expenditures with materials and drugs from hospitalizations in supplementary health in the same period; OMSP expenses stood -2.44% below, and expenses with daily stays, -9.13% above. In addition to the percentage differences, it is necessary to identify other variables that influence the variation in the costs, such as care complexity and treatment modality (clinical or surgical) for comparison purposes⁽²⁸⁾. That said, when comparing the costs of HC with

the cost of hospital care for patients who were in HC, a significant difference is noted, since the average patient/HCS cost was R\$ 28,26, while the average patient/hospital stay was R\$ 294,46.

In this research, there was a 1,041% difference between the cost/patient/day in HC compared to hospital care, much higher than that found by the private market in the segment. It is possible that these hospitalizations could be intercepted by the regulation system and referred to a backup/transition hospital in order to lessen the financial impact for the SUS. A study in England in 2019 estimated that HC saves around £ 1,000 per person for its health care system when it comes to home rehabilitation services. Furthermore, this saving was related to the fact that the home care plan is customized in accordance with the characteristics of the type of care provided (home care service, not home hospitalization) that are capable of rehabilitating the patient⁽²⁹⁾.

In Brazil, an assessment of the HCS of the SUS concerning hospital expenses identified a decrease in hospital admission costs in public hospitals in the municipalities where the HCS was implemented. It also revealed the effectiveness of the service for risk groups (high-risk pregnant women and the elderly), as well as for expenses related to hospital admissions, whether elective or not, proving to be an efficient policy, which highlights the justification and the findings of this research⁽²⁴⁾.

We judge pertinent to argue that the COVID-19 pandemic brought as a consequence the need to reorganize health systems. In Brazil, Primary Health Care (PHC) and HC teams are relevant for keeping people safe at home, avoiding risk exposure, maintaining a role of surveillance and care for those who depend on HC. They can organize the continuity of care that people with chronic diseases need during the pandemic, making it possible to integrate online and on-site, individualized health care tools. Also, for patients who were hospitalized and progressed satisfactorily, it is possible to assess the continuity of care at home under the supervision of PHC and HC⁽³⁰⁾.

We did not find any scientific literature that could provide a wider range of analysis and discussion, which was a limitation of the study, as it restricts the analysis of results. On the other hand, if research with such a focus is still scarce,

we have somehow contributed to unveiling a little of the theme in our country.

CONCLUSION

In accordance with the objective defined in this research and its results, it is possible to conclude that the elderly were the main HCS users. From the viewpoint of HC costs,

personnel expenses were the component that most impacted the total cost. Furthermore, the much lower costs of the home system compared to hospital care reiterates the feasibility and importance of the HCS linked to the SUS, with a view to make a better use of resources in the public health system. Future investigations on the costs involved in HC are suggested in order to further develop the addressed theme.

ANÁLISE DE CUSTOS DE UM SERVIÇO DE ATENÇÃO DOMICILIAR PÚBLICO E O PERFIL DOS PACIENTES ASSISTIDOS

RESUMO

Introdução: A Atenção Domiciliar Pública no Brasil, integrada à Rede de Atenção à Saúde, abrange ações prestadas em domicílio, tais como, a prevenção de agravos e a promoção à saúde. Visa principalmente a desospitalização, resultando em humanização da assistência ao usuário e a redução dos custos. **Objetivos:** Investigar junto a um Serviço de Atenção Domiciliar, o perfil de pacientes assistidos e os custos relacionados à assistência domiciliar e na ocorrência de internações hospitalares. **Material e Método:** Pesquisa quantitativa, descritiva e de corte transversal, conduzida em um Serviço de Atenção Domiciliar público, em um município paulista. Para coleta de dados utilizou-se de três fontes de informações: prontuário do paciente, base de dados eletrônicos do centro de custos do departamento de regulação e controle da secretaria municipal de saúde, dos pacientes atendidos no Serviço de Atenção Domiciliar, no ano de 2014. O tratamento estatístico descritivo foi utilizado para a análise dos dados. **Resultados:** Um total de 856 pacientes constituíram a amostra; 791 apenas com Atenção Domiciliar e 95 (12,4%) foram hospitalizados. Houve predomínio de homens; usuários idosos; casados ou viúvos; analfabetos e com origem do setor primário de saúde. O custo médio paciente/dia do atendimento domiciliar foi de R\$ 28,26 - dp4,10 (US\$ 12.03 – dp1.74), enquanto o custo médio paciente/dia de internação hospitalar foi de R\$294,46 - dp308,69 (US\$ 125.30 – dp131.36). **Conclusões:** Os idosos foram os maiores usuários do serviço; o componente que mais impactou o custo total foram as despesas com pessoal. O total dos custos muito menores do sistema domiciliar em relação ao hospitalar reitera a viabilidade e a importância do Serviço de Atenção Domiciliar vinculado ao Sistema Único de Saúde, sob a perspectiva para um melhor uso dos recursos públicos.

Palavras-chave: Assistência Domiciliar. Custos e Análise de Custos. Gestão em Saúde. Avaliação de Programas e Projetos de Saúde. Sistema Único de Saúde.

ANÁLISIS DE COSTES DE UN SERVICIO DE ATENCIÓN DOMICILIARIA PÚBLICA Y EL PERFIL DE LOS PACIENTES ASISTIDOS

RESUMEN

Introducción: la Atención Domiciliar Pública en Brasil, integrada a la Red de Atención a la Salud, abarca acciones prestadas a domicilio, tales como, la prevención de agravios y la promoción a la salud. Pretende principalmente la “desospitalización”, resultando en una humanización de la asistencia al usuario y la reducción de los costos. **Objetivos:** investigar juntamente a un Servicio de Atención Domiciliar, el perfil de pacientes asistidos y los costos relacionados a la asistencia domiciliar y en la ocurrencia de internaciones hospitalarias. **Material y Método:** investigación cuantitativa, descriptiva y de corte transversal, conducida en un Servicio público de Atención Domiciliar, en un municipio de São Paulo-Brasil. Para la recolección de los datos se utilizaron tres fuentes de informaciones: registros médicos del paciente, base de datos electrónicos del centro de costos y el departamento de regulación y control de la secretaria municipal de salud, de los pacientes atendidos en el Servicio de Atención Domiciliar, en el año de 2014. El tratamiento estadístico descriptivo fue utilizado para el análisis de los datos. **Resultados:** un total de 856 pacientes constituyeron la muestra; 791 solo con Atención Domiciliar y 95 (12,4%) fueron hospitalizados. Hubo el predominio de hombres; usuarios ancianos; casados o viudos; analfabetos y con origen del sector primario de salud. El coste medio paciente/día de atención domiciliar fue de R\$ 28,26 - dp 4,10 (US\$ 12.03 – dp 1.74), mientras que el coste medio paciente/día de internación hospitalaria fue de R\$294,46 - dp 308,69 (US\$ 125.30 – dp 131.36). **Conclusiones:** los ancianos fueron los mayores usuarios del servicio; el componente que más impactó en el coste total fueron los costos del personal. El total de los costos mucho menores del sistema domiciliar en relación con el hospitalario reitera la viabilidad y la importancia del Servicio de Atención Domiciliar vinculado al Sistema Único de Salud, bajo la perspectiva para un mejor uso de los recursos públicos.

Palabras clave: Atención domiciliar de Salud. Costes y análisis de coste. Gestión en salud. Evaluación de programas y proyectos de salud. Sistema Único de Salud.

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Submitted: 15/09/2020

Accepted: 26/02/2021

FINANCIAL SUPPORT

The present work was carried out with the support of the Coordination for the Improvement of Higher Education Personnel Brazil [Coordenação de Aperfeiçoamento de Pessoal de Nível Superior] (CAPES), Brazil.