

Renato Peixoto Veras¹
Célia Pereira Caldas¹
Denizar Vianna Araújo^{II}
Rosana Kuschnir^{III}
Walter Mendes^{III}

Demographic characteristics of elderly people provided with supplementary health care

ABSTRACT

OBJECTIVE: To assess health coverage of elderly people receiving supplementary health care and these users' sociodemographic characteristics.

METHODS: Descriptive study of elderly population living in Brazil and in the states of São Paulo and Rio de Janeiro in 2006. Data was collected from the National Supplementary Care Beneficiary Information System and the National Household Sample Survey. The following variables were studied: gender, age, distribution by federal unit, category of health insurance, type of contract and plan segmentation.

RESULTS: Higher coverage of the general population was seen in the age groups 70-79 years (26.7% and 80 years and more (30.2%). Of those aged 80 years and more, 33% had private health plans among women and 25.9% among men. Nearly 80% of health insurance beneficiaries were living in southeastern and southern Brazil, of which 55% were in Rio-São Paulo axis. Health maintenance organizations covered a higher proportion of younger compared to elderly population (39% and 34.5%, respectively) and self-management care plans covered a significantly higher proportion of elderly compared to younger population in Brazil (22.8% and 13.8%, respectively).

CONCLUSIONS: Elderly health care coverage was significantly high and age groups over 70 years showed the highest coverage rates among the Brazilian population, especially among women.

DESCRIPTORS: Aged. Health Services for the Aged. Health Maintenance Organizations. Supplemental Health. Socioeconomic Factors. Epidemiology, Descriptive.

INTRODUCTION

In our time reaching old ages is a reality even for people living in poor countries. Although the significant advances seen in health in the 20th century are not equitably distributed among countries with distinctive social and economic conditions, aging is no longer a privilege of a few. Any society aspires to a longer life; however, it represents an actual achievement only when it is not simply extended survival but rather a full life with quality. Despite being numerically nearly more than 10% of the Brazilian population, the elderly accounts for a third of all costs in health, and they have been increasingly high.^a

The World Health Organization (WHO)^b is currently examining the following:

¹ Universidade Aberta da Terceira Idade.
Universidade do Estado do Rio de Janeiro.
Rio de Janeiro, RJ, Brasil

^{II} Departamento de Economia da Saúde.
Universidade Federal de São Paulo

^{III} Escola Nacional de Saúde Pública.
Fundação Oswaldo Cruz. Rio de Janeiro, RJ,
Brasil

Correspondence:

R. São Francisco Xavier 524
Bloco F sala 10.150 – Maracanã
20559-900 Rio de Janeiro, RJ, Brasil
E-mail: veras@uerj.br

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^b Organização Mundial da Saúde. Envelhecimento ativo: um marco para elaboração de políticas. Rio de Janeiro; 2002. [acesso em: 01/04/07]. Disponível em: http://www.crde-unati.uerj.br/doc_gov/destaque/Madri.doc.

how to remain independent and active while aging; how to strengthen health prevention and promotion policies, especially those targeting the elderly; and how to maintain and/or improve quality of life with aging. The WHO supports that the core of elderly care cannot be reduced to mere welfare. Countries are required to develop comprehensive intersectoral policies for ensuring their population a healthy aging.

In Brazil most efforts have still been punctual and uncoordinated. The Brazilian Ministry of Health has recently identified elderly health as a priority in its health agenda issuing a new national health policy for the elderly based on a multidimensional approach to the paradigm of functional capacity. However, practical results have yet to be achieved. Brazilian health system is still marked by strong welfare dependency and uncoordinated actions, which hinder operationalization of any rationale based on multidimensional approach.

The theory framework of the present study is the WHO document, *Active aging: a policy framework*.^a It presents the Organization's official stand on the main challenges posed by population aging and highlights the fact that health can only be created and maintained with the involvement of different sectors. Additionally, WHO recommends that aging-related health policies take into consideration health determinants throughout life (social, economic, behavior, personal, and cultural factors as well as physical environment and access to services) with special emphasis to gender issues and social inequalities.

The objective of the present study was to describe health coverage of elderly people provided with supplementary health care and to assess these users' sociodemographic characteristics so that to provide input for the development of health policies focusing on prevention and therapeutic programs and including approaches for more efficient and effective management of care provided to the vulnerable elderly, a population group suffering from multiple conditions.

METHODS

Data here analyzed were collected in the first phase of a large study supported by the Brazilian National Supplementary Health Agency (ANS). This study intended to provide input for the development of policies and strategies for the design of elderly care models focusing on prevention and therapeutic programs and early detection of health conditions, which would

allow for more efficient and effective management of care provided to the vulnerable elderly suffering from multiple conditions. For that, care provided to the elderly in the supplementary health system was assessed. The assessment consisted of two steps: first, users of private health plans were profiled; and then practices and programs particularly provided to this population group were identified and evaluated.

This descriptive study explored the following variables: gender, age, distribution by federal unit, category of health insurance, type of contract and plan segmentation.

A non-systematic search of data and information was carried out in ANS documents and website, including the Beneficiary Information System (SIB). A second source of information was the National Household Sample Survey (PNAD).^b Data were analyzed based on relevant information on elderly over 60 years nationwide and in the states of Rio de Janeiro and São Paulo. The most recent data available in December 2006 regarding June 2006 were included.

Average data were analyzed nationwide and in the states of Rio de Janeiro and São Paulo. Rio de Janeiro has the largest national proportion of elderly and São Paulo has the largest absolute number of elderly in Brazil and both states have together the largest elderly population covered with private health insurance.^{3,c,d}

Tables were created based on data available from ANS TabNet, a tool using SIB/ANS as information source, and PNAD.^b Tables and figures included only health insurance beneficiaries (with and without dental coverage) and beneficiaries of dental plans only were excluded.

RESULTS

There are a total of 36,153,500 health insurance beneficiaries in Brazil, i.e., 19.3% of all Brazilian population. The coverage rate varied between different regions, states and cities according to local economic activities and income. Higher coverage rates were found in southeastern and southern Brazilian states. São Paulo and Rio de Janeiro are the states with highest coverage rates, 37.2% and 29.9%, respectively.

Coverage rates were significantly different within the same state according to the cities' local characteristics. In the cities of São Paulo and Rio de Janeiro, coverage rates were 56.8% and 49.2%, respectively.

^a Organização Mundial da Saúde. Envelhecimento ativo: um marco para elaboração de políticas. Rio de Janeiro; 2002. [acesso em: 01/04/07]. Disponível em: http://www.crde-unati.uerj.br/doc_gov/destaque/Madri.doc.

^b Instituto Brasileiro de Geografia e Estatística. Pesquisa Nacional por Amostra de Domicílios (PNAD): síntese de indicadores. Rio de Janeiro; 2004. [acesso em 01/04/07] Disponível em: <http://www.ibge.gov.br/home/estatistica/populacao/trabalhoerendimento/pnad2004/default.shtm>

^c Malta DC, Jorge AO. Breve caracterização da saúde suplementar. In: Ministério da Saúde. Agência Nacional de Saúde Suplementar. Duas faces da mesma moeda: microrregulação e modelos assistenciais na saúde suplementar. Rio de Janeiro; 2005. p. 37-60. (Série A. Normas e Manuais Técnicos).

^d Instituto Brasileiro de Geografia e Estatística. Censo 2000. Rio de Janeiro ; 2000. [acesso em 01/04/07] Disponível em: <http://www.ibge.gov.br/censo/>

Coverage rates were higher among women. Nationwide, 20.4% of women compared to 18.3% of men had health insurance plans. In São Paulo and Rio de Janeiro, 39% and 31.3% of women, and 35% and 28.4% of men, respectively, were insured.

Among older women aged 80 years and more in the country, 33% had private insurance, compared to 25.9% of men. In São Paulo and Rio de Janeiro, in this same age group, 54.6% and 58.2% of women compared to 47.9% and 56.8% of men, respectively, had insurance plans.

As for coverage by age group, the lowest rates were found among children (14.2% in those aged 0 to 19 years). Increasing rates were seen in the economically active group (27.1% in those aged 50 to 59 years), and then they decreased at the end of active life (23.5% in those aged 60 to 69 years) to increase again in the elderly. The highest coverage rates were seen among those aged 70 to 79 years (26.7%) and 80 years and more (30.2%) (Figure 1).

Of all health insurance beneficiaries in Brazil, almost 80% were in the southeastern and southern regions, of which 55% were in Rio de Janeiro and São Paulo, especially in the latter state (42% of total population). With respect to 11.1% of beneficiaries aged 60 years and more (around 4 million people), 39% were living in São Paulo (more than 1.5 million) and 17% in Rio de Janeiro.

In absolute numbers, São Paulo had the largest number of elderly beneficiaries but the proportion in this state (10.2%) is lower than the national average. On the other hand, Rio de Janeiro had the highest proportion of elderly beneficiaries (14.8%). Besides that, this state had the highest proportion of people in older age groups compared to São Paulo and nationwide.

Prepaid group practices and medical cooperatives accounted for 50% of coverage of all beneficiaries in Brazil. Group practices had a larger share in São Paulo and accounted for 49% of all beneficiaries compared to 41% in Rio de Janeiro.

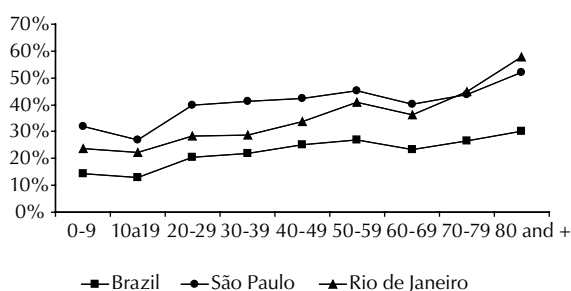


Figure 1. Health insurance coverage by age groups. Brazil, States of São Paulo and Rio de Janeiro, 2006.

Specialty health providers had also a larger proportion of beneficiaries in both states (15%) compared to the national average (12%). In regard to medical cooperatives, the situation was the opposite: a proportion of beneficiaries of nearly 23% in both states and 32% nationwide. As for managed care plans, the proportion of beneficiaries in São Paulo (7.6%) was almost half of the national average (14.8%) while in Rio de Janeiro (21.2%) was significantly higher than the national average. On the other hand, charity care plans were virtually unimportant in Rio de Janeiro (0.2% of all beneficiaries) compared to the proportions found in São Paulo (4.2%) and nationwide (3.6%) (Figure 2).

Elderly beneficiaries nationwide showed a significantly different distribution pattern by category of health insurance when compared to the population up to 59 years of age. Medical cooperatives provided care to a large share of younger than elderly population (39% and 34.5%, respectively) and, in particular, managed care plans covered significantly more elderly than younger people (22.8% and 13.8%, respectively).

These differences are even more pronounced when the distribution of elderly beneficiaries is compared by category of health insurance in Brazil, São Paulo and Rio de Janeiro. In São Paulo, the majority of elderly beneficiaries were covered by prepaid group practices (45.7%) while this category accounted for the coverage of 30% of all elderly in Brazil and Rio de Janeiro. Both in São Paulo and Rio de Janeiro, the proportion of elderly beneficiaries of medical cooperatives (26.2 and 22.2%, respectively) was lower than that found nationwide (34.6%), while the proportion of beneficiaries of specialty health plans was higher in both São Paulo (9.1%) and Rio de Janeiro (9.3%) than the national average (7%).

Along with charity care, managed care plans had the highest proportion of elderly among their beneficiaries nationwide (16.7% and 17%, respectively). In Rio de Janeiro, managed care plans had a significantly higher proportion than the national average (26.3%), while in São Paulo this proportion was lower than the national average (15.1%).

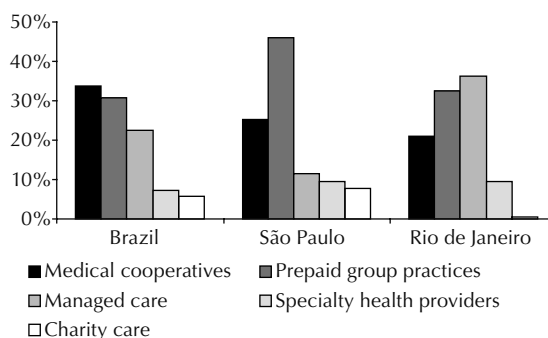


Figure 2. Percent of elderly beneficiaries by category of health insurance. Brazil, States of São Paulo and Rio de Janeiro, 2006.

Prepaid group practices and specialty health providers showed the lowest proportion of elderly among their beneficiaries (8.8% and 6.6% nationwide, 9.4% and 5.9% in São Paulo and 10.9% and 9.3% in Rio de Janeiro, respectively). Charity care plans were also of minor importance in the elderly in absolute terms (5.5% nationwide, 7.6% in São Paulo and 0.6% in Rio de Janeiro). Though charity care plans account for only 0.6% of the elderly beneficiaries (around 4,000 people) in the state of Rio de Janeiro, 35% of them are 60 years old and more. In Rio de Janeiro, the proportion of elderly among of private health insurance beneficiaries was higher than the national average in managed care, prepaid group practice and specialty health plans.

In regard to type of contract – collective or individual/family –, information was available for 91.1% of all beneficiaries. For the remaining 8.9%, there was missing information on plans in effect prior to Law 9656/98 (older plans), which were not reported by insurance providers to SIB/ANS. Figure 2 illustrates the profile of health plan beneficiaries, by category of health insurance.

DISCUSSION

Coverage rate was higher among women than men nationwide. This finding corroborates other studies showing that not only coverage, but health services utilization as well, are higher in women.^{2,a}

The fact that there were seen increasing rates in the economically active group (50–59), followed by decreasing rates by the end of the active life (60–69) to increasing rates again in older ages can be explained by the weight of collective health plans: about 75% of all contracts are collective and 25% are individual. While the proportion of collective contracts in active groups formally involved in the labor market is over 80%, at older ages, the proportion of individual contracts increases.

In São Paulo, distribution by age groups is closer to the national average, though a slightly higher proportion of beneficiaries are seen among those aged 60 to 69 years, where as in Rio de Janeiro the highest proportion of beneficiaries was found in older age groups. This finding is possibly associated, at least in part, to the different distribution of elderly beneficiaries by category of health insurance, with a predominant coverage of managed care among elderly population in Rio de Janeiro.

Higher prepaid group practice coverage in São Paulo is a result of the establishment of the automobile industry in the ABC area in the state of São Paulo in 1950s. American companies found public health care provided to their workers inadequate and implemented in Brazil an alternative health coverage plan. A similar rationale is behind the implementation of health maintenance organization in the US east coast where group practices were organized to work together with hospital's owners and/or shareholders.^b

Lower coverage of medical cooperatives in the states studied is possibly due to high coverage of group practices in São Paulo and managed care in Rio de Janeiro. Medical cooperatives preferably operate in middle-size cities, indicating that they provide coverage in areas where large insurance companies of the supplementary care system are not available, i. e., urban areas other than capitals and large inland cities.

The significantly higher contribution of managed care plans in Rio de Janeiro compared to the national average can be explained by high coverage of direct and indirect public servants. Rio de Janeiro's capital once was Brazil's Federal District and there remain a large contingent of people still working in public service.

Although charity care coverage was to some extent available nationwide and higher in São Paulo, it was virtually insignificant in Rio de Janeiro. This is possibly because the capital city provides high public health coverage – a legacy of the Federal District era –, and is home to the national welfare institutes.

About the proportion of elderly beneficiaries covered, it shows that insurance plans provided full coverage, suggesting that they are actually targeted to high-income population who can afford higher premiums.

However, although access to hospital and outpatient care seems guaranteed, this does not actually mean that elderly beneficiaries are receiving care adequate to their age-specific needs.

The literature¹ have showed growing investments in day-hospitals, home care, and chronic disease management, prioritizing investments in beds providing more intensive care either in public or private sector.

Nevertheless, there is no systematic knowledge on the type of intervention proposed by health plans. There is a need to discuss and develop policies to promote care models toward dehospitalization – either home care, chronic disease management or others.

^a Malta DC, Jorge AO. Breve caracterização da saúde suplementar. In: Ministério da Saúde. Agência Nacional de Saúde Suplementar. Duas faces da mesma moeda: microrregulação e modelos assistenciais na saúde suplementar. Rio de Janeiro; 2005. p.37-60. (Série A. Normas e Manuais Técnicos).

^b Macera AP, Saintive MB. O mercado de saúde suplementar no Brasil. Brasília: Secretaria de Acompanhamento Econômico do Ministério da Fazenda; 2004.

It is not known whether actions and models already implemented or being proposed take into consideration major variables for approaching the elderly. For this reason, it is crucial for framing policies to understand the specific characteristics of each target population. The gerontology literature shows there should be distinct approaches for the elderly aged between 60 and 69 years and those over 80 years, as well as for males and females.⁴

By 2025, a large proportion of the population will be of elderly people, mostly women, since they have greater

life expectancy. But, although they live longer than men, women have higher morbidity. Thus, in the next decades, women's health needs will grow in importance, requiring more attention from health care services.

The concentration of elderly in Rio de Janeiro and São Paulo defines a starting point for exploring health insurance actions targeting this population group. Likewise, the concentration of beneficiaries in one plan category (e.g., group practices in São Paulo or managed care plans in Rio de Janeiro) helps prioritizing insurance plans to be explored in further studies.

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