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Socioeconomic and health conditions associated with the family function of older adults

Condições socioeconômicas e de saúde associados à funcionalidade familiar de idosos

Condiciones socioeconómicas y de salud asociadas a la funcionalidad familiar de los mayores

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ABSTRACT

Objective: To verify the association of socioeconomic conditions, life habits, and health conditions to the family function of older adults assisted by a Family Health Team (FHT) in the city of Manhuaçu/Minas Gerais.

Method: This is an analytical, cross-sectional, observational study carried out with 166 older adults assisted in an FHU, with data on their socioeconomic profile, lifestyle, and health conditions. The family function was assessed with the Apgar Family and classified as good family function or moderate/high dysfunction. The Chi-square test was applied.

Results: Good function was found in 89.7% of the families. Age between 60-69 years, being married, having 3-4 children, not being a pensioner, and being independent were associated with good family function ($p<0.05$).

Conclusion: Families have good function and socioeconomic and health conditions were associated with family function, which reinforces the importance of studying families in order to promote better aging in the population.

Keywords: Aged. Family relations. Family health strategy. Nursing.

RESUMO

Objetivo: Verificar a associação das condições socioeconômicas, hábitos de vida e condições de saúde com funcionalidade familiar de idosos assistidos por uma Unidade de Saúde da Família (USF) de Manhuaçu/Minas Gerais.

Método: Trata-se de estudo observacional analítico e transversal realizado com 166 idosos de uma USF com dados do perfil socioeconômico, hábitos de vida e condições de saúde. A funcionalidade familiar foi avaliada com o Apgar Familiar e as famílias classificadas em boa funcionalidade ou moderada/alta disfunção. Realizou-se o teste do Chi-quadrado.

Resultados: Verificou-se boa funcionalidade em 89,7% das famílias. Ter entre 60-69 anos, ser casado, possuir 3-4 filhos, não ser pensionista e ser independente se associaram à boa funcionalidade familiar ($p<0,05$).

Conclusão: As famílias possuem boa funcionalidade e condições socioeconômicas e de saúde, as quais se associaram a funcionalidade familiar, o que reforça a importância de estudar as famílias a fim de promover um envelhecimento de maior qualidade para a população.

Palavras-chave: Idoso. Relações familiares. Estratégia de saúde da família. Enfermagem.

RESUMEN

Objetivo: Verificar la asociación de condiciones socioeconómicas, hábitos de vida y condiciones de salud con la funcionalidad familiar de personas mayores atendidas por una Unidad de Salud de la Familia (USF) en Manhuaçu / Minas Gerais.

Método: Se trata de un estudio observacional analítico, transversal, realizado con 166 ancianos de una USF con datos sobre su perfil socioeconómico, estilo de vida y condiciones de salud. La funcionalidad familiar se evaluó con la Familia Apgar y las familias clasificadas como de buen funcionamiento o disfunción moderada / alta. Se realizó la prueba de Chi-cuadrado.

Resultados: Se encontró buena funcionalidad en el 89,7% de las familias. Tener entre 60 y 69 años, estar casado, tener 3-4 hijos, no ser pensionista y ser independiente se asociaron con una buena funcionalidad familiar ($p<0,05$).

Conclusión: Las familias tienen buena funcionalidad y condiciones socioeconómicas y de salud, las cuales están asociadas a la funcionalidad familiar, lo que refuerza la importancia de estudiar en familia para promover un envejecimiento de mejor calidad de la población.

Palabras clave: Anciano. Relaciones familiares. Estrategia de salud familiar. Enfermería.

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INTRODUCTION

The phenomenon of aging is a current challenge that requires a lot of reflection to understand the factors that may influence it. Understanding how socioeconomic factors, life habits, and cultural aspects influence the aging process is important for social and health planning. In addition, as the increase in life expectancy is associated with the physiological changes of aging, older adults tend to require more attention[1].

Aging is a process that involves multiple factors and is not synonymous with disease. However, some health problems become more frequent and can impair individuals' independence and functional capacity, becoming a determinant of their health-disease process[2]. In this context of loss of independence and functional decline, older adults may need support from a caregiver to manage their own lives and to perform activities of daily living, which can sometimes lead to caregiver burnout[3].

In addition, older adults may need to readapt when dealing with stressful situations caused by illness and loss of family members and people in their social life[4]. It is observed that the main source of support for older adults is their family, which may also be facing these challenges. This can affect the older adult's health and their family functionality. In addition to health consequences, aging is also associated with changes in social roles arising from the older adult's relative withdrawal from social life, changes in intergenerational relationships, and changes in family structure and function[5].

The way family members interact with one another and with others allows them to be classified as functional or dysfunctional when assessed by specific questionnaires, such as the Family Apgar. This instrument was developed in 1978 and is based on a family member's perception of the family's function. According to the score obtained in questions about satisfaction regarding adaptation, partnership, growth, affection, and resolve, the families can be classified as functional (7 to 10 points) or dysfunctional (0 to 6 points)[6,7].

Therefore, older adults were included and studies[5,8,9] using the Family Apgar have shown that family function is influenced by the dependence of the older adult and the difficulty of adapting to this dependence[5]; and by the family structure and the presence or absence of a partner[8]. Another study assessed the Apgar properties in Chilean older adults and found that this instrument was reliable and effective when applied to older adults, especially in rural areas[9].

Therefore, based on the elements listed above, the following guiding question was used in the master's thesis of the same author, from which the present study derived: how are socioeconomic conditions, life habits, and health conditions associated with the family function of older adults assisted by a Family Health Team (FHT)? In this sense, the following objective was designed: To verify the association of socioeconomic conditions, life habits, and health conditions to the family function of older adults assisted by a Family Health Team in a city in the state of Minas Gerais.

METHODS

This is an analytical, cross-sectional, observational study, carried out with older adults assisted by the Family Health Team "São Vicente", located in the urban area of Manhuaçu, a city in the state of Minas Gerais.

The city of Manhuaçu had a population of 8,008 older adults in the year before the beginning of the research, according to data from the Brazilian Institute of Geography and Statistics[10]. The São Vicente Family Health Team, in turn, had 748 registered older adults in November 2018, including all individuals over 60 years of age of both genders. Based on this number, a random probability sample was drawn according to a sample calculation for different prevalences, with a margin of error of 0.05 and an estimated proportion of 0.5, which resulted in the desired n of 255 older adults.

The inclusion criteria were older adults and family members who both showed interest in participating in the study. Those who died or were hospitalized during data collection, moved away from the study site, or lived alone were excluded. After applying the inclusion and exclusion criteria, the final number of older adults interviewed was 166.

For data collection, the individuals eligible for the study were drawn according to the sample size calculation. Interviews with older adults and family members were carried out from February to July 2019. Specific instruments to observe and meet the objective of the study were also applied.

The instruments used in the study were applied at the older adult's household and included a data collection form to assess the profile of the older adults, the Lawton-Brody Scale to evaluate the instrumental activities of daily living of the older adults, and the Family Apgar, which was applied to another family member to assess family function from the perspective of someone close to the older adult.

The following socioeconomic variables were used to describe the profile of the older adults: gender, age group (60 – 79

years or 80 years or older), ethnicity (white or brown/black), marital status (married, single/widowed, others), number of children (0, 1 to 2, 3 to 4, 5 or more), multigenerational home, whether retired, pensioner or working, personal income (<1 minimum wage (MW), 1.1 to 3 MW, 3.1 to 5 MW, 5.1 to 7 MW, >7 MW, did not respond), religion (Catholic, Evangelical, others). The variables related to life habits and health conditions evaluated were: physical activity and leisure activities, smoking and alcohol consumption, self-perceived health, hospitalization in the last 12 months, presence of chronic diseases, and the functional dependence evaluation by the Lawton-Brody scale.

The Lawton-Brody Scale allows measuring the autonomy of the older adult in instrumental activities of daily living, such as: using the telephone, food preparation, housekeeping, doing their own laundry, handling finances, taking medication in correct dosages at correct times, and going to distant places. The questionnaire is composed of 9 questions with scores ranging from 1 to 3, where "1" means complete dependence, "2" partial dependence, and "3" independence. The final score of the scale can vary from 9 to 27 points, where 27 points indicate total independence, 26 to 18 points indicate partial dependence and less than 18 points indicate complete dependence[11]. However, for the statistical analysis in the present study, the scores were divided into: 27 points: total independence and ≤ 26 points: some degree of dependence.

To evaluate family dynamics, the Family Apgar was applied to another family member. This instrument has five domains: Adaptation, Partnership, Growth, Affection and Resolve. Each domain has a statement and 3 response options: "2" Always, "1" Sometimes, and "0" Never. At the end of the instrument, the scores are added up. A final score of 7 to 10 points indicates good family function, 5 to 6 points indicate moderate family dysfunction and 0 to 4 points indicate high family dysfunction[7]. For this analysis, the final score was divided into two groups: good family function (7 to 10 points) and moderate or high family dysfunction (0 to 6 points).

Descriptive analysis was expressed in absolute and relative frequencies for nominal variables. Pearson's Chi-square test and Pearson residuals were used for the inferential analysis, considering occurrences above 1.96. The Statistical Package for the Social Sciences (SPSS) version 25 was used to verify the data. The level of significance was set at $p<0.05$, with a confidence interval of 95% (95%CI) for all analyses. The general profile of the older adults was considered an independent variable, while family function was considered the dependent variable.

The study is part of a primary project called "Profile of the older adults assisted at an FHU in Manhuaçu, MG: vulnerability, polymorbidity, polypharmacy, functional capacity x family function", which was approved by the Ethics and Research Committee of the Escola Superior de Ciências da Santa Casa de Misericórdia de Vitória – EMESCAM (CEP/EMESCAM), under the reference number 2851034. The norms established in the Regulatory Guidelines and Norms for Research Involving Human Beings of Resolution 466/12 were respected in all stages of the study.

RESULTS

The analysis of the profile of the older adults showed that most were female (61%), aged between 60 and 79 years (78.5%), white (58%), married (60%), with 3 to 4 children (43%), lived in a multigenerational home (54%), were retired (78.5%), were non-pensioners (77%), did not work (85%), had an income between 1.1 and 3 minimum wages (38.5 %) and were Catholic (64.5%). Regarding life habits and health conditions, it was observed that most did not engage in any physical (68.5%) or leisure activities (61.5%), did not use alcohol (86%), did not smoke (92%), had good self-perceived health status (46.5%), had not had a hospitalization in the last 12 months (85%), had chronic diseases (79%) and were classified as independent in the Lawton-Brody Scale (56%).

The evaluation of family function showed that most (89.7%) of the families that participated in this study had good family function. The results also showed moderate family function in 6.6% of families and high family dysfunction in 3.6% of families.

The evaluation of the characteristics and socioeconomic conditions of the older adults showed an association between moderate or high family dysfunction and age group, marital status, number of children, and whether the elderly person is retired or a pensioner. (Table 1).

Regarding the age group, there was an association between age and moderate or high family dysfunction, indicating that the risk of family dysfunction was greater in families of older adults over 80 years of age. There was also an association between single or widowed older adults and moderate or high family dysfunction. The number of children was also associated with family dysfunction, indicating that not having children can increase the risk of moderate or high dysfunction in the family of the older adult. On the other hand, having 3 to 4 children was associated with good family function.

Table 1 – Socioeconomic condition of the older adults and Family Function of families assisted by a Family Health Team. Manhuaçu, Minas Gerais, Brazil, 2019

Socioeconomic Condition	Family Function				*p*
	Good Family function n =149		Moderate/high family dysfunction n = 17		
Gender					
Male	58	(39%)	6	(35.5%)	0.771[1]
Female	91	(61%)	11	(64.5%)	
Age					
60-79 years old	120[2]	(80.5%)	10	(59%)	**0.040[1]**
80 years old or more	29	(19.5%)	7[2]	(41%)	
Ethnicity					
White	83	(55.5%)	13	(76.5%)	0.100[1]
Brown/Black	66	(44.5%)	4	(23.5%)	
Marital status					
Married	95[2]	(64%)	4	(23.5%)	**0.005[1]**
Single/Widowed	45	(30%)	10[2]	(59%)	
Others	9	(6%)	3	(17.5%)	
Number of children					
0	9	(6%)	4[2]	(23.5%)	**0.008[1]**
1 to 2	32	(21.5%)	2	(12%)	
3 to 4	69[2]	(46.5%)	3	(17.5%)	
5 or more	39	(26%)	8	(47%)	
Multigenerational Home					
No	66	(44.5%)	10	(59%)	0.255[1]
Yes	83	(55.5%)	7	(41%)	

Table 1 – Cont.

Socioeconomic Condition	Family Function				*p*
	Good Family function n =149		Moderate/high family dysfunction n = 17		
Retirement					
No	29	(19.5%)	7[2]	(41%)	**0.040**[1]
Yes	120	(80.5%)	10	(59%)	
Pension					
No	119[2]	(80%)	9	(53%)	**0.012**[1]
Yes	30	(20%)	8[2]	(47%)	
Job					
No	125	(84%)	16	(94%)	0.264[1]
Yes	24	(16%)	1	(6%)	
Personal income					
(<1 MW)	43	(29%)	6	(35.5%)	0.712[1]
(1.1 – 3 MW)	58	(39%)	6	(35.5%)	
(3.1 – 5 MW)	14	(9.5%)	3	(17%)	
(5.1 – 7 MW)	4	(2.5%)	0	(0%)	
(> 7.1 MW)	6	(4%)	1	(6%)	
Did not answer	24	(16%)	1	(6%)	
Religion					
Catholic	95	(64%)	12	(70.5%)	0.660[1]
Evangelic	48	(32%)	5	(29.5%)	
Other	6	(4%)	0	(0%)	

Source: Own elaboration
[1]Pearson's chi-square. SD= standard deviation
[2]Adjusted residual of $x^2 > 1.96$

Another factor that was associated with family dysfunction was being a pensioner, suggesting that getting a pension is associated with moderate or high family dysfunction. Non-retirement was also associated with family dysfunction.

The evaluation of the health conditions and life habits of the older adults (Table 2) revealed an association between functional dependence according to the Lawton-Brody Scale and moderate or high family dysfunction.

Table 2 – Life habits, health conditions, and Family Functional of families assisted by a Family Health Team. Manhuaçu, Minas Gerais, Brazil, 2019

Life habits and health conditions	Family Function				*p*
	Good family function n =149		Moderate/high family dysfunction n = 17		
Physical activity					
No	101	(68%)	13	(76.5%)	0.464[1]
Yes	48	(32%)	4	(23.5%)	
Leisure activities					
No	90	(60.5%)	12	(70.5%)	0.414[1]
Yes	59	(39.5%)	5	(29.5%)	
Alcoholism					
No	(128)	(86%)	15	(88%)	0.792[1]
Yes	(21)	(14%)	2	(12%)	
Smoking					
No	(137)	(92%)	16	(94%)	0.752[1]
Yes	(12)	(8%)	1	(6%)	
Self-perceived health					
Excellent	26	(17.5%)	3	(17.5%)	0.114[1]
Good	71	(47.5%)	6	(35%)	
Regular	47	(32%)	5	(29.5%)	
Poor	4	(2.5%)	2	(12%)	
Terrible	1	(0.5%)	1	(6%)	

Table 2 – Cont.

Life habits and health conditions	Family Function				*p*
	Good family function n =149		Moderate/high family dysfunction n = 17		
Hospitalization in the last 12 months					
No	124	(84%)	16	(94%)	0.260[1]
Yes	24	(16%)	1	(6%)	
Chronic diseases					
No	32	(21.5%)	3	(17.5%)	0.714[1]
Yes	117	(78.5%)	14	(82.5%)	
Lawton-Brody Scale					
Independent	89[2]	(59.5%)	4	(23.5%)	**0.004[1]**
Some degree of dependence	60	(40.5%)	13[2]	(76.5%)	

Source: Own elaboration
[1]Pearson's chi-square. SD= standard deviation
[2]Adjusted residual of $x^2 > 1.96$

It was observed that 59.5% of the older adults with good family function were considered independent according to the Lawton-Brody scale, while 76.5% of the older adult with moderate or high family dysfunction showed some degree of dependence, evidencing the association between functional impairment and changes in family function.

DISCUSSION

Age between 60 and 69 years, being married, having 3 to 4 children, not being a pensioner, and being independent were associated with good family function, while being 80 years or older, being single or widowed, not having children, not being retired and/or a pensioner and having some degree of functional dependence were associated with moderate/high family dysfunction.

Most of the families assessed in the present study had good family function, which is corroborated by other authors[9,12–13] who found good family function in 74% to 76 .3% of families. A similar study carried out with older adults assisted by the Family Health Strategy (FHS) sought to verify the association between socioeconomic and health profiles and found that living alone, being single, having only one resident at home, having poor/very poor self-perceived health, and having moderate/severe functional impairment were associated with family dysfunction[9].

The older adults evaluated in the present study were in good health, as they had not had any falls in the prior 2 months, had good self-perceived health, and did not have unhealthy lifestyle habits. This good health status may be related to the good family function found in the present study and in others, which reveal that the population's health conditions can play an important role in maintaining good family function[12].

As for family function and age group, there was an association between being 80 years or older and moderate or high family dysfunction. This was also observed in another study, which demonstrated a significant association between age and family function by showing that family dysfunction was more common in older age groups[12].

As for marital status, there was an association between single or widowed older adults and moderate or high family dysfunction. This association was also observed in another study[13], which also found that having a partner and having an intergenerational family structure can be protective factors for good family function, while that living alone can be considered a risk factor for comorbidities and falls. This same study also found that, in addition to the absence of a partner, in 70% of the cases, the absence of children was one of the factors that led to family dysfunction. It is argued that the absence of children can mean that the older adult has no support network, no help in daily activities, and no safety net. This argument supports this result, which corroborates those of the present study, indicating that the presence of children is associated with good family function, while their absence is associated with moderate or severe family dysfunction[13].

Another factor that was associated with family dysfunction was being a pensioner, suggesting that getting a pension is associated with moderate or high family dysfunction. A possible explanation for this relation is that, in Brazil, the pension is available after the death of a spouse, which leaves the surviving spouse in a state of widowhood. This reinforces the importance of companionship for good family function.

A study investigated the factors associated with family support and found that the financial dependence of the older adult was one of the factors that most affected the quality of family support received, as it is one of the obstacles to family care. In this case, the authors considered that lack of money can change family dynamics and be associated with aggressive behavior and anger among family members[14].

In the present study, the economic situation was evaluated through different variables, such as being retired, getting a pension and/or working, and the personal income in minimum wages. Regarding the income, most older adults reported an estimated monthly income of up to 3 minimum wages. The analysis of personal income and purchasing power of older adults allows understanding their ability to provide for their expenses with daily needs and health care without family help. According to the Lawton-Brody scale, the ability to manage their own money is one of the factors that influence the maintenance of older adults' independence and, therefore, it must be evaluated and preserved. Studies[15–16] have identified that most of the older adults could manage their own money, according to the Lawton and Brody scale, and the dependence found was mostly partial.

In the present study, functional dependence was associated with family dysfunction. The evaluation of the degree of independence of the older adult in the most complex activities of daily living revealed that 56% of the sample was considered independent according to the Lawton--Brody Scale. These data are consistent with the literature, which indicates that older adults are, for the most part, functionally independent, even though they have some mobility limitations[13,17].

The association between family function and functional dependence among older adults was also observed in another study, which found that, among older adults who had some degree of dependence, family function was more altered. This led to the reflection that the task of caring can lead to moments of stress and conflict within the family, affecting family function[17].

The literature shows high rates of caregiver overload[3]. In addition, health professionals already recognize the importance of the family in the care of older adults. Therefore, older adults and their families require special attention from these professionals, especially in the FHS, aiming to provide quality and humane care for the population.

It is worth noting that some situations that affect family function can be prevented and treated, such as functional dependence, which can be modified through qualified, committed multidisciplinary care and early intervention. Other situations, however, involve aspects that are the result of life history and personal choices.

CONCLUSION

The data analyzed showed significant issues related to family function. Even though most families can react and adapt to different situations, with good family function, some characteristics related to the older adult can make this process difficult, such as being single or widowed, not having children, not being retired/getting a pension and being functionally dependent.

Some limitations were found during the study, such as the fact that a large number of older adults lived alone and at different distances from their families, making it impossible to collect data. In addition, it is important to highlight that, due to the cross-sectional design of the study, it is not possible to determine any causal relationship between the variables studied. Despite the limitations, the present study is considered of great value for the identification of factors that affect the family health of the target audience. This will enable the evaluation of professional conduct with older adults and their family, and thus strengthen the assistance provided to this population, contributing to more decisive conduct in the planning of the actions of health professionals and managers.

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