Original article

Living and health conditions of elderly people over 80

Condições de vida e de saúde de idosos acima de 80 anos

Condiciones de vida y salud de personas mayores de 80 anos

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ABSTRACT

Objective: This article proposes to describe demographic data and health conditions of elderly people at age 80 or more.
Method: Quantitative-descriptive study of 95 elderlies from five units of the Family Health Strategy in the period from September to December 2013, using script with general data of the living conditions and health, including validated scales in geriatrics and gerontology.
Results: The average age was 85.4 years. There was a predominance of women. Most were widowers with family income, more frequently between 2 or 3 minimum wages and economic participation is for means of sharing responsibility. They present dependency for many of Daily Living Instrumental Activities and, on average, reported 2.2 diseases. Fear of falling, decreased vision and hearing as well as pain in different body regions are reported.
Conclusion: It appears that they have more intense needs than the elderly in general, requiring new ways of organizing their health care.
Keywords: Determination of health care needs. Elderly of 80 years or more. Social conditions.

RESUMO

Objetivo: Propõe-se a descrever dados sociodemográficos e as condições de saúde de idosos com 80 anos ou mais.
Método: Estudo quantitativo-descritivo realizado com 95 idosos de cinco unidades da Estratégia Saúde da Família, no período de setembro a dezembro de 2013, utilizando roteiro com dados gerais das condições de vida e de saúde, incluindo escalas validadas em geriatria e gerontologia.
Resultados: A média de idade foi de 85,4 anos. Houve predomínio de mulheres. A maioria viúvos com renda familiar, mais frequente, de 2 a 3 salários mínimos, e a participação econômica é a de dividir responsabilidade. Apresentam dependência para muitas das Atividades Instrumentais de Vida Diária e, em média, referiram 2,2 doenças. Referem medo de cair, diminuição da visão e da audição, além de dor em diferentes regiões do corpo.
Conclusão: Depreende-se que eles apresentam necessidades mais intensas dos que os idosos em geral, demandando novas formas de organizar seu cuidado em saúde.
Palavras-chave: Determinação de necessidades de cuidados de saúde. Idoso de 80 anos ou mais. Condições sociais.

RESUMEN

Objetivo: Se propone a describir las condiciones de vida y la salud de las personas mayores de 80 años o más.
Método: Estudio cuantitativo-descriptivo realizado con 95 personas de cinco unidades de la Estrategia Salud de la Familia, mediante un guión con los datos generales de las condiciones de vida y de salud, incluyendo escalas validadas en geriatría y gerontología.
Resultados: La edad promedio fue de 85,4 años. Las mujeres predominaron en la mayoría de los viudos, el ingreso familiar más común es de 2-3 salarios mínimos. La dependencia actual de muchas de las actividades instrumentales de la vida diaria, en promedio 2.2 enfermedades reportadas y medicamentos utilizados 4.3 / ancianos. Mencionan el miedo de caerse, disminución de la visión, y dolor en diferentes regiones del cuerpo.
Conclusión: Parece que tienen necesidades más intensas de las personas mayores en general, lo que requiere la preparación de la sociedad para cumplir con la misma eficacia.
Palabras clave: Evaluación de necesidades. Anciano de 80 o más años. Condiciones sociales.

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INTRODUCTION

In Brazil, the aging process has been characterized as one of the most significant social phenomena for society in general[1], interfering, especially in the economic aspects and those linked to health care, which require new arrangements to meet the needs of this segment of the population.

In this context, the population with an age of 80 and over is the fastest growing and projections indicate that while the population aged 60 and over will triple by 2100, to people aged 80 or more is expected to increase nearly seven times the same period. In absolute numbers, it can exceed 120 million people in 2013 to 830 million in 2100[2].

Based on the realization that the more advanced the age, the higher the tendency of changes and problems resulting from this process, we can deduce that the difference between the health conditions of the younger and older elderly, with the latter being more vulnerable to fragility and functional limitations[3].

Faced with the lack of preparedness of society to deal with the condition of social, biological and psychological vulnerability of the elderly, where their everyday becomes permeated with intense problems involving the devaluation of pensions, the lack of assistance and leisure activities, misinformation and the precariousness of public investment to meet the special needs of the age group[4]. In health, despite policies aimed towards the elderly, strategies that meet the real needs of these people are still lacking, with the purpose of planning actions that are appropriate to their situation.

In the Brazilian reality, there are few studies that specifically approach that age range. Thus, the studies that seek to expand knowledge about the living conditions and health of seniors of 80 years or so are justified, for, when making their needs evident, they will contribute to the care planning and decision making of professionals working in primary care, mainly of nurses who are assigned essentially to care for individuals, families and communities.

In face of this, the present study begins with the following questions: How are the living conditions and health of the elderly, against the vulnerability they face? To what extent has the increase in life expectancy been accompanied by the maintenance of autonomy for instrumental activities of daily living and cognitive ability? What are the most prevalent diseases in this population?

The study aims to describe sociodemographic data and health conditions of elderlies aged 80 or more.

METHOD

It is a cross-sectional study conducted in the city of Marilia, located in the Midwest Paulista region, with approximately 220,000 inhabitants. The primary care of the municipality has 12 Basic Health Units (UBS) and 34 Family Health Units (USF). The USF serve approximately 110,000 people, representing around 50% of the population of Marilia.

The study population consisted of seniors aged 80 and over. According to the City Health Department, in 2013, 1996 elderlies were registered in the health units. Considering the total population of seniors over 80 years of age in the city and using the sample calculation with a 95% confidence interval, taking into account 10% error, we obtained a sample of 92 elderlies.

Inclusion criteria was: being 80 years or older and residing in urban areas, where those who were not found in the home after two attempts were excluded.

The catchment areas covered five USF, selected through raffle and identified with the letters A, B, C, D and E. These units counted with 229 elderly in the interest age group. To meet the sample calculation, the proportion of elderlies over 80 years old in the selected units was respected and around 40% of the elderlies of each unit were interviewed and / or visited. Thus, 95 individuals were interviewed, where 17, 39, 15, 10 and 14 were from units A, B, C, D and E, respectively. To locate them, we used a list provided by Community Health Agents (ACS), sequentially.

The data collection instrument verified demographic data that give indicative living conditions, such as age, sex, marital status, religion, education, financial resources and economic participation within the family income. The self-health perception was assessed with the question: how do you consider your health? With this question, there were six possibilities of response (excellent, good, regular, bad, bad and do not know / no answer).

To check the health conditions, the instrument had self-reported questions about the occurrence of falls in the last year, fear of falling, vision, hearing, chewing and the presence of these diseases. To assess the presence and pain graduation, we used a one-dimensional scale - Behavioral Scale (EC)[5]. The scale of Instrumental Activities of Daily Living, developed by Lawton and Brody[6], consisting of seven domains, followed by a description that allows us to conclude if there is total dependency, partial dependency or independency for each activity; the Geriatric Depression Scale[7], consisting of fifteen items with a yes or no answer according to the way the elderly have been feeling lately with five cut-off points and the Mini Mental State Exam-

ination, validated in Brazil[8] with scores 0-30, having a cut grade of 18, given the low level of education of respondents, aims to trace the cognitive level of the elderly.

Data collection occurred from September to December 2013, in home of the elderly itself, and was conducted by the principal investigator. Each interview lasted an average of 30 minutes. If the elderly presented speech difficulty or difficulty in understanding of the questions, the primary caregiver was asked to provide the information. It is noteworthy that, on the pain assessment, depression and mental state scale, if the respondent was unable to answer, the instrument would not be applied.

After collecting the data, they were coded and entered into an Excel spreadsheet for statistical analysis using SPSS v. 17.

The study counted with the approval of the Ethics and Human Research of the Faculdade de Medicina de Marília, Opinion No. 259 969 and CAAE 14742813.6.0000.5413. Participants were informed about the purpose and procedure of the study, data collection was performed after the conditions were agreed to and the Free and Informed Consent Form was signed.

RESULTS

Among the 229 elderly, 180 (78.9%) were visited; of these, 34 (18.9%) were not found at home after two attempts; 26 (14.5%) refused to participate; 13 (7.3%) had an address that could not be found; 7 (3.9%) had moved and 5 (2.8%) had died. Thus, the data were collected from 95 elderly.

The age of the elderly ranged from 80 to 102 years, with an average of 85.4 years. There was a predominance of women 62 (65.2%); the majority, 55 (57.9%), lives without a partner (a) and is Catholic 69 (72.6%). Of the interviews, 19 (20%) were answered by the principal or family caregiver. Family income of 48 (50.5%) elderlies was 2 to 3 times the minimum wage. The economic role of the elderly within the family income was that of sharing responsibility for 50 participants (53.2%), as shown in Table 1.

In Table 2, data of the health conditions of the elderly, which were obtained through self-report. On self-rated health, 37 (39%) defined it as good. In the year preceding the study, 37 (38.9%) of respondents reported having experienced one or more falls. As for vision, 29 (30.5%) reported not seeing at the time and 40 (42.1%) said they had difficulty hearing. Regarding the presence of pain, 56 (58.9%) responded affirmatively.

During the verification of instrumental activities (Table 3), it is emphasized that most of the elderly had some de-

Table 1 – Socio-demographic characteristics of the elderly over 80 years of age. Marilia, São Paulo, 2014

Variables	N (%)
Age	
80 – 84	49 (51.5)
85 – 89	32 (33.7)
90 – 94	7 (7.3)
95 – 99	5 (5.3)
100 +	2 (2.2)
Sex	
Female	62 (65.2)
Marital status	
Living alone	6 (6.3)
Living with partner	32 (33.7)
Widower	55 (57.9)
Divorced	2 (2.1)
Religion	
Catholic	69 (72.6)
Evangelical	18 (18.9)
Others	8 (8.5)
Education	
Illiterate / Incomplete Elementary School	77 (81.0)
Completed Elementary School	7 (7.4)
High School Incomplete / Complete	6 (6.3)
College Incomplete / Complete	5 (5.3)
Family income	
Up to 1 MW*	17 (17.2)
From 2 to 4 MW	48 (50.5)
From 4 to 5 MW	10 (10.7)
Above 5 MW	11 (11.8)
Does not know / did not answer	9 (9.68)
Senior Citizen Income Origin	
Retirement / Pension	82 (86.3)
Others	13 (13.7)
Economic participation of the elderly in family income	
Sole / most responsible	36 (38.3)
Divides responsibilities	50 (53.2)
No participation	9 (8.5)

Source: Survey data, 2014.
* Minimum wage - value in 2014 = BRL 724.00

Table 2 – Health characteristics of the elderly over 80 years of age. Marilia, São Paulo, 2014

Health conditions	N (%)
Self-perception of health conditions	
Great.	17 (17.9)
Good	37 (39.0)
Regular	18 (18.9)
Bad	5 (5.3)
Awful	6 (6.3)
Does not know / did not answer	12 (12.6)
Falls	
No	58 (61.1)
1 to 2	30 (31.6)
3 to 4	5 (5.2)
5 or +	2 (2.1)
Fear of falling	
Yes	67 (70.5)
No	28 (29.5)
Vision	
Excellent	2 (2.1)
Good	28 (29.5)
Regular	36 (37.9)
Bad	16 (16.8)
Awful	9 (9.5)
Does not see	4 (4.2)
Hearing	
No problems	37 (39.0)
Hears with some difficulty	23 (24.2)
Hears with difficulty	17 (17.9)
Hears with a significant amount of difficulty	13 (13.6)
Does not hear	5 (5.3)
Mastication	
Never has difficulty	61 (64.2)
Rarely has difficulty	8 (8.4)
Frequently has difficulty	5 (5.3)
Sometimes has difficulty	11 (11.6)
Always has difficulty	10 (10.5)
Pain complaint	
Yes	56 (64.2)
Does not know / did not answer	7 (7.4)
Pain assessment**	
Zero	6 (6.8)
Three	22 (25.0)
Six	15 (17.0)
Eight	9 (10.2)
Ten	4 (4.6)
Does not know / did not answer	32 (36.4)
Depression Scale Rating	
Suspected depression and loneliness	28 (29.5)
Cognitive assessment	
Mini Mental State Examination	
Grade Below 18	18 (19.0)

Source: Survey data, 2014.
* The question allowed more than one answer, ** Among those who answered the question (N = 88)

pendency, most frequent being to take trips alone 4 (4.2%) and to perform heavy tasks, 11 (11.6%).

The diseases listed by the elderly are in Table 4, where those of the nervous, circulatory and digestive system were the most prevalent. An average of 2.2 diseases per individual were reported.

DISCUSSION

In order to characterize demographic data and health conditions of the elderly over 80 years in this study, it became clear that some aspects make them more vulnerable to limitations in living conditions and depending on other people, although in other respects they resemble the elderly of other age groups.

A significant proportion of women were found among such elderlies, highlighting their predominance in this stage of life. The fact that women are less exposed to violence and accidents, besides being more careful with their health, seeking health services more often are some of the explanations for this greater longevity[9].

As for marital status, most of the sample lives without a partner, as has been shown in studies with the elderly population in general, but to a lesser extent. One study [10] performed with elderlies, in Paraná, showed that approximately 34% of respondents were widowed. In those who are age 80 and over, this figure rises to 63% or so.

Regarding the level of education, it appears that the majority of respondents have not finished elementary school, which confirms national study[10-11]. Associated to this, it has been found that the highest concentration of illiterates is among people of higher age, and in Brazil, the elderly have on average of 4.2 years of educaton[12].

This study, unlike what the IBGE reveals[12], showed that only a small portion of this population lives with an income at or below the minimum wage. Even if in this study it has been found that most live on less than 2 to 3 minimum wages, this data proves a condition of economic need, given that elderlies above 80 years of age have become more vulnerable and have specific needs in regards to the maintenance of good living conditions, including transportation, housing, recreation and food, among others. Moreover, a large proportion of respondents, even those over the age of 80, are the sole or main responsible for the household, which corroborates with the reality found in the IBGE survey.

With regard to self-perceived health, a condition resulting from determining factors such as age, gender, family support, marital status, education and employment opportunities, income, functional capacity, health and lifestyle,

Table 3 – Dependency for instrumental activities of daily living of the elderly over 80 years of age. Marilia, São Paulo, 2014

Activity	Dependency level	N (%)
In relation to the phone	Receives and make calls	51 (53.7)
	Needs assistance to make phone calls	15 (15.8)
	Does not have the habit or is unable to use the phone	29 (30.5)
In relation to travel	Travels alone	4 (4.2)
	Only travels with company	37 (38.9)
	Does not have the habit or is unable to travel	54 (56.9)
In relation to shopping	Goes shopping, when transport is supplied	25 (26.3)
	Only go shopping when they have company	14 (14.7)
	Does not have the habit or is unable to shop	56 (59.0)
In relation to meal preparation	Plans and cooks full meals	30 (31.6)
	Only prepares small meals or when they receive help	20 (21.1)
	Does not have the habit or is unable to cook meals	45 (47.3)
In relation to domestic work	Performs heavy tasks	11 (11.6)
	Performs light tasks, needing help with heavy tasks	38 (40.0)
	Does not have the habit or is unable to perform housework	46 (48.4)
In relation to medication use	Makes use of medications without assistance	46 (48.4)
	Needs assistance or reminders	26 (27.4)
	Is unable to solely control the use of medication	23 (24.2)
In relation to handling money	Fills out checks and pays bills without aid	41 (43.1)
	Needs assistance for handling checks and bills	13 (13.7)
	Does not have the habit of dealing with money or is unable to handle money, bills ...	41 (43.2)

Source: Survey data, 2014.

Table 4 – Diseases reported by the elderly over 80 years of age. Marilia, São Paulo, 2014

Diseases *	N (%)
Systemic Arterial Hypertension	62 (65.2)
Diabetes Mellitus (1 and 2)	17 (17.9)
Arthrosis	14 (14.7)
Osteoporosis	14 (14.7)
Cataract	8 (8.4)
Previous stroke history	8 (8.4)
Glaucoma	8 (8.4)
Alzheimer Disease	4 (24,)
Arthritis	3 (3,1)
Gastritis	3 (3.1)
Others	63 (66.3)

Source: Survey data, 2014.
* The elderlies gave more than one answer

among others [11-13], was considered good or excellent by most respondents.

With regard to falls, we observe numbers close to those found in another study in Santa Catarina[14], with seniors 80 years old or more, in which approximately 44% of the people interviewed had at least one episode in the last 12 months.

With regard to vision, it is known that with aging, there are changes in visual acuity, causing limitations in development activities capacity and that bring negative consequences to the quality of life[11].

In hearing ability assessment, it was found that most had some difficulty. The elderly with this kind of difficulty is seen as confused, disoriented, distracted, and uncommunicative. In addition to these consequences, depression, anxiety and social isolation can also arise [15].

The oral health problems, in turn, are very common in the elderly. In this survey, 64.2% of respondents have no

difficulty in chewing, a fact that is very important for the quality of food intake, given that preserving oral health aggregates welfare, as well as improves nutrition, self-image and quality of life [16].

Among the changes in the health conditions of the elderly over 80 years of age, pain was present in most statements. The pain can be a limiting factor for function, capable of increasing agitation, emotional stress, and the risk of mortality. The affected individual may have their daily activities compromised, leading to physical and functional disability, dependency, social withdrawal, changes in family dynamics and economic imbalance [17]. The pain is therefore configured as a public health problem that should be valued and assessed, especially in the elderly, given that in this stage of life, many complaints of pain are attributed to age and / or own aging and are usually not treated [17].

The proportion of elderlies depression signs found in this study shows resemblance to what happens to the elderly in general. Negative events, social problems, presence of physical illness and incapacity, common to this age group, in turn, increases the chances of developing depression [18].

In the cognitive assessment, the proportion of elderly people with deficit was similar to the survey of elderlies who were 80 years or older, who had 2.45 more chances to present it, compared to younger elderly [19].

In daily living activities examination, it is emphasized that the dependency is presented in activities that are more instrumental. Among the items evaluated, the ability to shop is the one that causes the most dependency, because it requires greater physical and cognitive effort. In addition, studies have shown association of this difficulty with the low education of the elderly [20].

The elderly studied had an average of 2.2 comorbidities, the most prevalent being Arterial Hypertension and Mellitus Diabetes, which does not differ from the evidence found in studies conducted with elderly in general [9].

CONCLUSION

As for the limitations, because it is a local study, is not possible to generalize the results. In addition, data were collected in five ESF units that, although selected by lottery, cannot represent all of the units. Additionally, the elderly and families provided the data, with the possibility of recall bias. The presence of disease was also information given by the elderly or family and may differ from the actual number. Still, the study provides an approach to aspects involving this population, which may contribute to greater understanding of this phase of life.

Data obtained between 96 seniors over 80 years, reveal living conditions and health disadvantageous to a quality survival, including little or no schooling, widowhood, the presence of dependency for the Instrumental Activities of Daily Living, the auditory and visual decline and the presence of pain in different body regions.

It is concluded that at this stage of life, it is unlikely that the elderly can manage their own life without depending on others, which to our reality, is usually a placement occupied by a family member. As such, it seems appropriate that the policies be strengthened towards the elderly, so that they are ensured dignified care at this stage of life, as family support is not always sufficient.

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