# SOCIOECONOMIC AND DEMOGRAPHIC CHARACTERISTICS AND HEALTH CONDITION OF ELDERLY PEOPLE FROM A FAMILY HEALTH PROGRAM IN PORTO ALEGRE, BRAZIL

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*This epidemiological and exploratory-descriptive study aimed to identify the socioeconomic and demographic features, as well as the health and disease condition of elderly people from a Family Health Program in Porto Alegre, Brazil, with the purpose of contributing to the planning of health actions for this population. Data from 98 elderly people were collected through a home survey by means of a semistructured instrument. The mean age of the interviewed subjects was 69.5. Sixty-one participants (62.2%) were women; 40 (40.8%) were married and 77 (78.6%) did not have remunerated work. Most men (64.9%) had a companion, against 26.2% of women with a partner. As to health, 80.6% reported suffering from some pathology, especially diseases of the circulatory system, reported by 55.1% of the interviewees. Although the collected data are in line with other studies, knowledge about them is important to adapt health actions by the Family Health Program team under study, in order to offer better care to these elderly people.*

*DESCRIPTORS: nursing; aged; family health program; aging; aging health; community health nursing; family health*

# CARACTERÍSTICAS DEMOGRÁFICAS, SOCIOECONÓMICAS Y SITUACIÓN DE SALUD DE ANCIANOS DE UN PROGRAMA DE SALUD DE LA FAMILIA DE PORTO ALEGRE, BRASIL

*Se trata de un estudio epidemiológico, exploratorio-descriptivo, que tuvo como objetivo identificar las características demográficas, socioeconómicas y la situación de salud y enfermedad de ancianos de un Programa de Salud de la Familia en Porto Alegre, Brasil, con la finalidad de contribuir para el planeamiento de acciones de salud a esta población. Se colectaron datos de 98 ancianos a través de encuesta domiciliaria, utilizándose un instrumento semi-estructurado. Se observó que la edad promedia de los sujetos era de 69,5 años. Del total de ancianos, 61 (62,2%) eran mujeres; 40 (40,8%) casados(as) y 77 (78,6%) no poseían trabajo remunerado. La mayoría de los hombres (64,9%) tenía compañera, contrastando con el 26,2% de mujeres con compañero. En cuanto a la salud, 80,6% reportó alguna patología, destacándose enfermedades del aparato circulatorio en el 55,1% de los encuestados. Se concluye que, aunque los dados aquí citados sean semejantes a otros estudios, conocerlos es de real importancia para adecuar las acciones de salud del equipo del PSF estudiado, con objeto de ofrecer así una mejor atención a esos ancianos.*

*DESCRIPTORES: enfermería; anciano; programa salud de la familia; envejecimiento; salud del anciano; enfermería en salud comunitaria; salud de la familia*

# CARACTERÍSTICAS DEMOGRÁFICAS, SOCIOECONÔMICAS E SITUAÇÃO DE SAÚDE DE IDOSOS DE UM PROGRAMA DE SAÚDE DA FAMÍLIA DE PORTO ALEGRE, BRASIL

*Estudo epidemiológico, exploratório-descritivo que objetivou identificar as características demográficas, socioeconômicas e a situação de saúde/doença de idosos de um Programa de Saúde da Família de Porto Alegre, Brasil, a fim de contribuir para o planejamento das ações de saúde a esses. Coletou-se dados de 98 idosos através de inquérito domiciliar, utilizando-se de instrumento semi-estruturado e multidimensional. Verificou-se que a média de idade dos entrevistados era de 69,5 anos. Do total dos idosos: 61 eram mulheres; 40 casados(as) e 77 não possuíam trabalho remunerado. A maioria dos homens (64,9%) tinha companheira, contrastando com 26,2% de mulheres com companheiro. Quanto à saúde, 80,6% relataram alguma patologia, destacando-se as doenças do aparelho circulatório em 55,1% dos entrevistados. Conclui-se que, embora os dados encontrados assemelhem-se a outros estudos, o conhecimento desses é fundamental para a adequação das ações de saúde da equipe do PSF estudado, com vistas à melhor atenção a esses idosos.*

*DESCRITORES: enfermagem; idoso; programa saúde da família; envelhecimento; saúde do idoso; enfermagem em saúde comunitária; saúde da família*

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## INTRODUCTION

It is known that Brazil has been suffering a change in the demographic profile of its population. This phenomenon - also called demographic transition - reflects some factors, such as the decrease in maternal fecundity and infant mortality, the reduced number of deaths caused by infectious-contagious diseases, increased life expectancy and progressive population aging.

Thus, Brazil has been losing its profile as 'a country of young people' - the number of elderly has considerably increased at an increasing pace - and conquering the characteristic of an aged country. In 1991, the elderly corresponded to 7.3% (10.7 million) of the Brazilian population; according to the 2000 census, this ratio rose to 8.6% (14.5 million). Projections indicate that, in 2020, 12.6% of the Brazilian population will consist of aged persons and that, in 2050, this rate will reach 16%[1]. In its policies, Brazil adopts the World Health Organization's (WHO) recommendation to use the age of 60 as a cut-off point to define old age in developing countries.

Concerned about this growing increase in the global elderly population, since its 27th Directing Council, the Pan American Health Organization (PAHO) has stimulated its member countries to establish national programs and services for the elderly. Since 1996, the 'aging and health' theme has been part of the Health Promotion and Protection Division's Family and Population Health Program, aimed at elaborating plans and integrated actions on 'aging and health' for the Americas[2].

In Brazil, the creation of the National Policy for the Elderly, in 1994, was a landmark. More recently, in October 2003, the Federal Senate approved the Statute of the Elderly, with a view to guaranteeing senior citizens' social rights. The document guarantees their access to health and social care services; integral health care through the Single Health System (SUS); home care and/or hospitalization for elderly with locomotion disabilities and free medication, as well as other treatment-related resources. Another important point is the State's obligation to guarantee protection of life and health to the elderly, through public policies that allow for healthy and dignified aging, with a comfortable and adequate life[3]. This requires health actions for the elderly to aim for, among other factors, maintaining them in the community, with family support, based on the home care model.

In this sense, the creation of the Family Health Program (FHP) strategy in 1994 was essential, delivering care at Family Health Units (FHU) and at home, through prevention, health promotion and recovery actions.

In this strategy, the work of health professionals, oriented towards integral and permanent care for families linked with the FHU, appears in each phase of their life cycle, in view of their family and social context. This innovative health care model demands a close relation between health professionals and the population they are responsible for, through bonding and joint responsibilities that enable health actions to change the reality and health conditions of the individuals they deliver care to. This makes it fundamental to adapt professionals' actions to the epidemiological profile of the population they attend, with special attention to the elderly, due to their needs and progressive increase in numerical terms[4-5].

Considering the above, research about the characteristics of aged people, their aging process and the social context they live in is essential to support health professionals' actions in FHU.

Hence, the **aim** of this study was: to identify the demographic and socioeconomic characteristics and health situation of elderly people in an FHP area located in Porto Alegre (Brazil), thus contributing to the planning of health promotion actions for these clients.

## MATERIAL AND METHODS

We carried out an epidemiological, cross-sectional, exploratory and descriptive study with a quantitative approach. The research derived from the partnership between the Study Group on Education and Health in Family and Community (NEESFAC) and the Porto Alegre Municipal Government and was developed in the FHP of a poor community in the same city. This FHP provides a practicum area for students from the Rio Grande do Sul Federal University School of Nursing (EE/UFRGS). The study was jointly constructed by health service professionals and faculty, masters and undergraduate students from EE/UFRGS.

The study population/sample included all elderly persons registered at the place of study. The following inclusion criteria were used: age of 60 or older and accepting to participate in the study. Exclusion criteria were: having moved outside the FHP coverage area or not being found at home after three

visit attempts by the researchers. For the sake of this study, people aged 60 or more were considered as elderly, in accordance with the age criterion adopted by the Statute for the Elderly[3].

Initially, 137 seniors were selected, 98 of whom participated (losses or refusals: 28.4%). Reasons for loss were: not being found at home after three visit attempts in 22 cases (16.1%); change of address in 8 (5.8%) and death in 8 cases. One person (0.7%) refused to participate.

For data collection, we used a semistructured instrument adapted from another study[6], consisting of 50 questions. These were grouped per dimension and covered the following variables: socioeconomic data; housing conditions; leisure activities; use of health services and health/disease situation.

After approval by the UFRGS Ethics Committee, data collection occurred between September 2003 and March 2004, through home surveys with the help of Community Health Agents from the same FHP. Ethical principles were respected according to the National Health Council's guidelines established in Resolution 196/96[7]. Data were typed and explored through SPSS 13.0 software, which makes it possible to insert, organize and analyze data statistically and provides results as tables and graphs. Data analysis was guided by descriptive epidemiology. Findings were presented through frequencies and central tendency and dispersion measures.

## RESULTS

The study population was predominantly female, corresponding to 62.2% (61) of the interviewees. The women's mean age was 69.9 years (± 6.8), against 68.8 years (± 4.8) for men.

As to the participants' social characteristics, we found that 40 (40.8%) elderly were married or lived with a partner. The remainder was widowed (30.6%) and single, separated or divorced (28.6%). When relating gender and marital status, 64.9% (24) of men had a partner, against only 26.2% for women.

With respect to education, we found important differences among the 98 elderly. A majority (40.8%) possessed between 01 and 04 years of education, and 29.6% between 05 and 09 years. Twenty-five (25.6%) participants were illiterate, 17 of whom were women.

What their income was concerned, 74 (75.5%) elderly received retirement or pension benefits, while 14 (14.3%) did not. Twenty-one persons (21.4%) were active in some kind of paid work, although some of them had already retired. It is remarkable that, in 31 residencies (31.6%) where the elderly lived with (an)other persons(s), (s)he was the family's only source of income.

We found an average of 3.1 (±1.8) individuals per home, including the elderly. Twelve (12.2%) of the 98 participants lived alone; 40 (40.8%) with one other person; 16 (16.3%) with two and 30 (30.6%) with three or more persons.

As to their participation in recreation and/or leisure activities, we found that 64 seniors (65.3%) regularly attended religious services: 45 (45.9%) were catholic; 15 (15.3%) evangelical; 04 (4.2%) spiritist; 04 (4.2%) other religions and 04 (4.2%) indicated more than one religion. Other leisure activities included balls (6.1%) and sports (11.2%).

Table 1 - Distribution of elderly in the FHP according to health service visit. Porto Alegre, 2004

| Variables | n | % |
|---|---|---|
| **Visit to the health service** | | |
| Routine | 46 | 46.9 |
| When necessary | 48 | 49.0 |
| No visit | 04 | 4.1 |
| **Participation in the HIPERDIA group** | | |
| Yes | 33 | 33.7 |
| No | 65 | 66.3 |

According to Table 1, 46 (46.9%) elderly routinely attended some kind of health service, while 48 participants (49%) only turned to health services when necessary. We also found that 33 (33.7%) seniors participated in the group for hypertensive and diabetes patients (HIPERDIA) promoted in the same FHP.

An analysis of participants' self-reported health situation revealed the results shown in Table 2.

Table 2 - Distribution of elderly in the FHP according to self-reported health situation. Porto Alegre, 2004

| Variables | n | % |
|---|---|---|
| **Health problem(s)** | | |
| Yes | 79 | 80,6 |
| No | 19 | 19,4 |
| **Main health problems*** | | |
| Circulatory system | 54 | 55,1 |
| Musculoskeletal system and connective tissue | 22 | 22,4 |
| Endocrine, nutritional and metabolic | 20 | 20,4 |
| Respiratory system | 12 | 12,2 |
| Digestive system | 10 | 10,2 |
| Nervous system | 09 | 9,1 |
| Eye and annexes | 08 | 8,2 |

* The sum of the answer columns for 'n' and '%' is higher than 98 and 100%, respectively, due to the possibility of multiple answers

We also found 49 (50%) hypertensive and 16 (16.3%) diabetic elderly, ten of whom presented both diseases at the same time. When associating these two diseases with participation in the HIPERDIA group, 26 (47.3%) of the 55 hypertensive or diabetic patients did not attend this group.

With respect to medication use, 71.4% (70) of the FHP seniors took some kind of medication, 97.1% (68) on a doctor's prescription. As to regular medication use, 22.9% (16) of these 70 seniors did not take it according to the prescription, with absence of symptoms, forgetting, adverse effects and lack of financial resources as the main causes.

The most consumed medication types were: antihypertensives (41.8%), followed by diuretics (32.6%), analgesics/antipyretic (22.4%), anti-inflammatory (17.3%) and hypoglycemic (11.2%) medication.

## DISCUSSION

These study results are important for analyzing and understanding the aging process of the population registered in the studied FHU, as it is known that there does not exist one single old age, but multiple and diverse forms of living this phase in human development, which is personal, unique and heterogeneous.

However, some generalizations can be made, to the extent that these research findings reflect the Brazilian reality found in similar studies[8-9].

More than half (62.2%) of the interviewees were women, with an average age of 69.9 years, characterizing what literature calls the 'womanization of old age'[8], especially based on higher mortality rates in the male population. These higher survival rates among women can be understood by their more limited exposure to occupational risks, lower mortality rates due to external causes and different attitudes related to diseases, as they use health services more frequently[10]. Only 26.2% of women in this study had a partner, referring to the so-called 'pyramid of solitude' as, the older they become, the more alone they will be[11]. We also found more illiterate women[17], evidencing the social discrimination practiced in the last century, as they were responsible for housework and were consequently excluded from the school environment.

Figures change among men, as 64.9% had a partner, which can be explained on the basis of social and cultural issues in our society, in which men should not be alone and marriage with younger women is considered positively.

Although a large majority of the elderly mainly depends on retirement and pension benefits, it is known that these revenues are often insufficient to attend to their needs standard. This is evidenced in 21.4% of the study population's reports, who reported they performed some kind of paid work to complement their monthly income. Moreover, as age increases and diseases appear, this group needs to spend a large part of its financial resources on purchasing medication and essential health maintenance devices. In this sense, we found that most interviewed seniors (80.6%) reported some health problem.

What medication is concerned, 71.4% of the elderly needed some kind of medication, especially antihypertensives, diuretics, analgesics/antipyretics, anti-inflammatory and hypoglycemic agents, which reflected the study population's health situation, with a significant amount of non-transmissible chronic conditions, including hypertension, diabetes and musculoskeletal diseases, some of which concomitantly. According to the Brazilian Institute of Geography and Statistics[12], about 50% of seniors gain a personal income of one minimum wage or less. This information is a source of concern to the extent that half of the Brazilian population spends the equivalent of 25% of its revenues on medication. Moreover, due to high unemployment rates in younger social groups, many elderly have to share their income with other family members, often turning them into the only or main responsible for family maintenance. We found that the elderly were the only source of income in 31 households where they lived with other persons.

Another worrying result in this study is the seniors' family composition: 12 lived alone, 40 with one other person and 30 with two. In Brazil, due to the lack of formal support, a significant part of socially and financially less favored aged persons partially or exclusively depend on informal support, especially by family members[13]. On the whole, existing family arrangements (many family units with few persons) are incapable of attending to the seniors' needs, making them more vulnerable to certain situations[14]. Therefore, living with other persons, mainly their

children, is extremely important to attend to these persons' needs, to the extent that this substantially increases their probability of receiving help/care in their activities/diseases[13].

Recreation and leisure activities (balls and sports) stand out as fundamental elements in the seniors' lives as - when they no longer need to work - some of these elderly become concerned about how to spend their free time[15]. In this respect, we highlight the importance of encouraging and offering these activities to this public, as they are an effective strategy to decrease isolation, insert these persons in the social environment and develop new skills, which can directly reflect in improved self-esteem, quality of life and health conditions[10].

Moreover, data in this study revealed that seniors find it relevant to attend group activities, highlighting their participation in religious services. This choice is often related to individuals' need to be welcomed by social groups. This is in line with other authors[16] who emphasize that aged persons' participation in religions favors their well-being and quality of life and decreases, among other things, stress and depression. It also serves as social support and a way of interpersonal involvement, filling the void produced by retirement, solitude and/or widowhood.

The discussion about the elderly population's access to the health system is also extremely relevant as, according to our data, more than 90% of the interviewees used the health services on a regular basis. However, there were differences in the frequency of service use, as 46.9% routinely visited the health service, while the remained only used it in case of need or health problems. This reveals the direct relation between aging and greater use of health resources, as the growing aged population directly affects health system use, due to the increase in complex and/or long-term problems, whose adequate care requires the use of expensive technological devices[17].

In this respect, it should be highlighted that the demographic transition process brought about fundamental changes in the epidemiological panorama of the Brazilian population's morbidity and mortality. Although not yet totally solved, incidence levels of infectious-contagious diseases (ICD) have decreased, as opposed to the prevalence of non-transmissible chronic diseases (NTCD), that is, a larger part of seniors suffer from diseases like hypertension, diabetes, arthrosis and others - characteristics found among the study participants[9]. This fact generates what is called a 'double disease burden', revealing the need to organize a double health care agenda, rethinking current policies and including innovative care forms, such as gerontological[18] and home care.

From a practical viewpoint, today, controlling NTCD has become a far more complicated problem than treating ICD, considering that there are no highly effective preventive measures (such as vaccines) for the former, as the existing alternatives tend to be educational[9]. In this sense, achieving good NTCD treatment adherence levels in populations with the characteristics of the elderly in this study (low income and education level) is a hard task, to the extent that it mainly involves reeducation of living habits and medication use. This fact is shown in the research findings, where 22.9% of the interviewees did not use medication according to the doctor's prescription.

Another relevant treatment fact is these seniors' relative participation in the main health education activity offered by the FHP: HIPERDIA. We found that about 1/3 of the study population attended this group, observing that a considerable part (47.3%) of diabetes and/or hypertension patients did not participate. This indicates that, for many elderly, in a way, HIPERDIA is not accessible, whether due to lack of knowledge, lack of interest or even personal difficulties to meet with the group. Nevertheless, participating in educational activities can develop skills and knowledge that collaborate in the individual's autonomy as well as in critical reflections about his/her choices. In this perspective, it is fundamental to discuss the importance of formal and informal education practices, as groups are collective spaces where the elderly have the opportunity to elaborate questions originated in the conflict of 'being elderly'. This is also an opportunity to experience other ideas, values and realities that will play a decisive role in the incorporation of new attitudes into their daily reality[15].

## FINAL CONSIDERATIONS

Initially, an important conclusion of this study is that the proposed objectives were achieved. The results we found demonstrate that the elderly in the FHP under study present similar characteristics in comparison with similar studies, that is: more

women, low education level, low income, presence of non-transmissible chronic diseases, fragile social support network and low treatment adherence, among others.

We believe the main difference in the collected and analyzed data appears when we associate them with the context these elderly are living in, understanding this element as culture, life style, beliefs and values. This is the only way for figures to demonstrate the diversity found in society in terms of the aging process. This association is possible when an FHU is selected as a study/work area, that is: to put faces on the data, so as to better understand the reality health professionals are inserted in.

When they are confronted with data about the FHU population, these professionals visualize the lack of preparation to attend to the seniors' peculiarities and complexities, often resuming them to the expression 'patients with multiple complaints'. This reveals the urgent need for professional training in the basic health network, as well as for the creation of geriatrics and gerontology referral centers, with a view to providing quality care to the aged population. However, this requires budget resources destined at public policies to take into account the aging theme, without abandoning efforts in the field of child health and education actions. This will construct a society prepared for quality aging.

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