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ORIGINAL ARTICLE

SOCIODEMOGRAPHIC AND CLINICAL CHARACTERIZATION OF ELDERLY ASSISTED IN PRIMARY HEALTH CARE

CARACTERIZAÇÃO SOCIODEMOGRÁFICA E CLÍNICA DE IDOSOS ATENDIDOS NA ATENÇÃO PRIMÁRIA DE SAÚDE

CARACTERIZACIÓN SOCIODEMOGRÁFICA Y CLÍNICA DE MAYORES SERVIDOS EN LA ATENCIÓN PRIMARIA DE SALUD

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ABSTRACT

Objective: identifying the sociodemographic and clinical profile of the elderly attended in Primary Health Care. ***Method:*** a descriptive, cross-sectional study developed with 368 elderly in the city of João Pessoa-PB. Data collection occurred from February to April 2014. Data analysis was by descriptive statistics. The study had the project approved by the Research Ethics Committee, CAAE: 23958013.0.0000.5188. ***Results:*** prevailed female elderly, aged between 60-69, married, schooling between four and eight years of study and average family income between 1,1 and 3 times the minimum wage. Of the respondents, 44% rated their health as fair, 84% had three or more health problems, foremost among them: changes in vision, hypertension and varicose veins. ***Conclusion:*** recognizing the sociodemographic and clinical profile provides the situational diagnosis of the population, enabling the planning of health actions focused on its specificities. ***Descriptors:*** Aging Health; Socioeconomic Factors; Family Health.

RESUMO

Objetivo*:** identificar o perfil sociodemográfico e clínico dos idosos atendidos na Atenção Primária de Saúde. ***Método: um estudo descritivo, transversal, desenvolvido com 368 idosos do município de João Pessoa-PB. A coleta dos dados ocorreu de fevereiro a abril de 2014. A análise dos dados foi por meio da estatística descritiva. O estudo teve o projeto aprovado pelo Comitê de Ética em Pesquisa, CAAE: 23958013.0.0000.5188. ***Resultados***: prevaleceram idosas do sexo feminino, faixa etária entre 60 a 69 anos, casadas, com escolaridade entre quatro e oito anos de estudo e renda familiar média entre 1,1 e 3 salários mínimos. Dos entrevistados, 44% avaliaram sua saúde como razoável, 84% apresentaram três ou mais problemas de saúde, destacando-se entre eles: alterações na visão, hipertensão arterial e varizes. ***Conclusão***: conhecer o perfil sociodemográfico e clínico fornece o diagnóstico situacional da população, possibilitando o planejamento de ações em saúde voltado para as suas especificidades. ***Descritores***: Saúde do Idoso; Fatores Socioeconômicos; Saúde da Família.

RESUMEN

Objetivo: identificar el perfil sociodemográfico y clínico de los ancianos atendidos en Atención Primaria de Salud. ***Método:*** un estudio descriptivo, transversal, desarrollado con 368 ancianos en la ciudad de João Pessoa-PB. La recolección de datos ocurrió entre febrero y abril de 2014. El análisis de datos fue mediante estadística descriptiva. El estudio tuvo el proyecto aprobado por el Comité de Ética en la Investigación, CAAE: 23958013.0.0000.5188. ***Resultados:*** predominaron hembras de edad avanzada, con edades comprendidas entre 60 a 69 años, casadas, con escolaridad entre cuatro y ocho años de estudio y renta familiar media entre 1,1 y 3 veces el salario mínimo. De los encuestados, 44% calificaron su salud como regular, el 84% tenían tres o más problemas de salud, sobre todo entre ellos: cambios en la visión, hipertensión y las venas varicosas. ***Conclusión:*** conocer el perfil sociodemográfico y clínico proporciona el diagnóstico situacional de la población, lo que permite la planificación de acciones de salud adaptadas a sus especificidades. ***Descriptores:*** Salud de Mayores; Los Factores Socioeconómicos; Salud de la Familia.

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INTRODUCTION

Aging is a world-wide phenomenon that began in the XIX century, with a so-called demographic transition, characterized by the decrease in mortality and fertility rates with a subsequent rise in life expectancy. With the exception of some African countries, all the other nations are experiencing some stage of this transition. Statistics projections suggest that in the XXI century, the amount of people aged 60 or over in the world population will triple, going from 606 million to 2 billion of people.[1]

In 1900, the elderly occupied less than one percent of the world population. In 1992, that number grew to 6,2% and in 2050 will be more than 20% of the total population. In the United States, in the 80s, the number of people over a hundred years old has grown over 160%; in 2040 it may reach 40 million people of 85 years old or over. In Brazil, the demographic transition is occurring at a faster pace as in 1940 the elderly population corresponded to 40 million people and by 2050 could reach 200 million people aged over 65.[2]

Demographic changes resulting in population aging are also followed by the epidemiological transition, which reveals the changes in morbidity and mortality patterns occurring over time. This phenomenon results in considerable increase in the use of services by the elderly as well as high costs for the health sector, since the senescence is often associated with multiple health problems related to chronic conditions of illnesses, social, affective and financial losses.[3]

The next thirty years, the number of very old elderly (those over 80 years old) will also experience a significant increase, further increasing the demands of support for this sector. Thus, the greatest challenges to health in this century are: the delay diseases and maintaining health, independence and autonomy of the elderly. These aspects awaken for the need of restructuring care service for this population, providing a comprehensive and preventive care, and it is guided into the specifics of these individuals.[3-5]

More and more it has been discussed in the gerontological literature the need for assistance to the elderly be directed to health promotion and disease prevention, as well as proposes the Family Health Strategy, aimed at healthy and active aging. In addition, for more effective and contextualized with every day of the elderly in community and family environment assistance, primary care professionals should take over the situational diagnosis of the living conditions of the population who provides care, allowing a greater bond and consequent recognition of needs of the elderly, as well as the identification of aspects that favor the decline of health conditions.[3]

Knowing the profile of users of primary health care is of great importance, for it enables the definition of priorities, action planning and evaluating the impact of interventions, which results in reduction of disease and improvement in quality of the elderly life. Given the above, the present study aims to:

- Identifying the sociodemographic and clinical profile of the elderly attended in Primary Health Care.

METHODOLOGY

It is a household survey with descriptive, observational cross-sectional design, developed among the elderly assisted by Family Health Strategy of the Municipality of João Pessoa, Paraiba.

The study population consisted of all individuals over 60 years old registered in the Information Basic Attention Municipality of that system, corresponding to 24.328 of the elderly enrolled in 56 Family Health Units and five health districts. For the sample, we considered the following formula: n = Z2 PQ/d2, where n = minimum sample size; Z = reduced variable; P = probability of finding the phenomenon studied; Q = 1-P; d = desired accuracy, calculated based on an error margin of 5% and p = 50%. The proportional stratified sampling technique was used that took into account the five (5) health districts as strata.

There has been adopted as inclusion criteria elderly of both genders, which exhibited cognitive conditions preserved, so that they were able to answer the research questions, as well as those living in the health district searched. They excluded those with hearing deficits and problems with speech that strongly hamper communication and impaired their performance evaluation. Considering these aspects, the sample consisted of 368 elderly.

Initially, it performed reading and signing the Informed Consent by each elderly. Then data collection that took place between February to April 2014 for graduate research fellows with the logistical help of Community Health Agents with exercise labor activity in the health units of the selected family. The gathering took place at a unique moment in their homes of the elderly, by structured interview. In order to make information gathering, there was used a questionnaire

covering socio-demographic variables (age, gender, marital status, and years of schooling, family income) and clinical data (self-assessment of health and morbidity).

Data analysis was carried out on a quantitative approach, using descriptive statistics univariate nature for all variables, including frequency measures of position and dispersion. For this analysis we used the computer system Statistical Package for Social Sciences - SPSS version 20.0, to be appropriate to achieve the objectives of the study and enable the accuracy and generalization of the results.

It should be noted that throughout the process of research, especially at the stage of collecting empirical data, the ethical aspects that regulate research involving human subjects, arranged in Resolution 466/2012 of NHC/MOH/BRAZIL were observed, especially secrecy and the confidentiality of information.[6] It is worth noting that the research project has been approved by the Research Ethics Committee of the Health Sciences Center of the Federal University of Paraiba, under protocol number 0658/13 and CAAE: 23958013.0.0000.5188 of December 10th, 2013.

RESULTS

Regarding sociodemographic characteristics, of the 368 seniors who participated in the study, 253 (68,8%) were female and 115 (31,3%) male. Age ranged between 60 and 103 years old, average age of 71.4 years old and predominance of elderly aged between 60 and 69 (45,9%). Regarding marital status, 147 (39,9%) are married with schooling between four and eight years of education (32,6%) and average household income between 1.1 and 3 minimum wages (80,3%) as shown in Table 1.

Table 1. Distribution of sociodemographic characteristics of the elderly. João Pessoa/PB, Brazil, 2014 (n = 368).

Variable	Categories	n	%
Gender	Female	253	68,8
	Male	115	31,3
		Average ± SD	71,4 ± 7,9
Age	60 - 69	169	45,9
	70 - 79	141	38,3
	80 or older	58	15,8
Marital Status	Married	147	39,9
	Widower	141	38,3
	Single	80	21,8
		Average ± SD	3,8 ± 3,8
Years of schooling	None	116	31,5
	1 - 3	79	21,5
	4 - 8	120	32,6
	9 or over	53	14,4
Family income	Less than 1 minimum wage	13	3,7
	1,1 to 3 minimum wages	286	80,3
	3,1 to 5 minimum wages	46	12,9
	5,1 to 10 minimum wages	11	3,1

As shown in Table 5, 44% of seniors rated their health as fair, 84% had three or more health problems, among them: changes in vision (21,1%), hypertension (19,23%), varicose veins (13,73%) and rheumatism (11,12%).

Table 2. Distribution of the elderly as the self-assessment of health and problems referred to health. João Pessoa/PB, Brazil, 2014 (n = 368).

Variable	Categories	n	%
Self-assessment of health	Excellent	20	5,5
	Very good	32	8,7
	Good	123	33,4
	Reasonable	162	44,0
	Bad	31	8,4
Number of diseases listed	None	01	0,2
	One or more diseases	58	15,8
	Three or more	309	84,0
Self-referred diseases	Vision problems	307	21,1
	Hypertension	280	19,23
	Varicose veins	200	13,73
	Rheumatism	162	11,12
	Memory problems	119	8,17
	Diabetes mellitus	109	7,48
	Hearing problems	101	6,95
	Cardiopathy	95	6,52
	Depression	83	5,70
	Total	1456	100

DISCUSSION

Considering the sociodemographic characteristics in the context of aging, it was found that, in the present study showed a higher proportion of women (68,8%). This finding guard line with other similar surveys, which indicate the prevalence of women among the elderly.[7-8] In the Brazilian context, a ratio of 96 men for every 100 women is evident, accentuating the historical trend of female dominance relative to the total number of men. Particularly among the elderly, it is shown that women account for about two-thirds of the population of this age group. Global data find that, in developed countries, like Japan, the female quantity is more than double the number of men, while in Russia this figure is 45 men for every 100 women, exposing one of the lowest gender ratios of the world.[9]

In this sense, the gerontological literature named this phenomenon of "feminization of old age", highlighting the differences in biomarkers of aging associated with personal lifestyle (physical activity, diet rich in vitamins, protein and fiber, check-ups) and exposure the detrimental health issues (obesity, alcohol consumption, smoking, and others) as collaborative factors for this phenomenon (48). In addition, the greater prevalence of older may be justified by them become more concerned about health care of while men are more susceptible to violence, mainly due to accidents and homicides, and the smallest search for medical care, only reduced to emergency situations.[10]

Although women represent the majority among the elderly population in many parts of the world, factors such as vulnerability of women to social inequality, high maternal mortality, discrimination and gender violence results in life expectancy similar to that of men.[11] The greater longevity is always accompanied by a healthy life expectancy, since, on the one hand, the aging means a win for women overcome the mortality from infectious diseases, chronic complications, and reproductive conditions, on the other hand, it may represent an isolation period social and often economic hardship, especially for women living alone with fewer resources and less support.[11]

It is clear that health services are still guided by the reproductive and maternal health, without emphasis on chronic conditions and the specific needs of women over the years, such as heart and bone diseases, which influence their health and well-being. It is emphasized that the feminization of aging requires an overhaul in the planning and delivery of health care guided by a broader approach on gender services.[11]

Regarding the age, there was a significant percentage of elderly between 60-69 years old (45,9%). Due to the profound demographic transition that Brazil is going through recently, highlights the change in the age structure, which, over the next four decades, will form a population of aged profile.[12]

Currently, population-based studies show that 55,12% of the Brazilian elderly population belongs to the age group 60-69 years old; however, it is estimated to occur most rapidly developing among individuals aged 80 years old or over, similar to the trends observed in developed countries.[9,12]

Due to improvements in living conditions and health, it becomes evident the significant increase of elderly people who are above 80 years of age, changing the group's own internal composition and revealing heterogeneity characteristics of this population segment.[13] Data from surveys conducted in 30 developed countries showed that in 1950 the probability of surviving 80-90 years old was on average 15-16% for women and 12% for men, while in 2002 the figures were 37% and 25%, respectively.[11] In this age group, individuals can have greater development of chronic diseases, tendency to isolation and vulnerability to social factors, requiring adequate social and health supports.[11,14]

Regarding marital status, it was found predominance of married elderly (39,9%). However, it was identified a significant percentage of widowed individuals (38,3%), data similar to pertinent.[15] Research literature indicates that the after 60 years old marriage rates obtained for the males are more than twice that of women rates. Therefore, due to male mortality, especially at older ages, there is a higher proportion of women in the population, making smaller the chances of marriages of elderly compared to men. Moreover, it is noticed that younger elderly - predominant in this study - are often married and older, mostly women exhibit higher percentage of widowhood.[9]

Concerning education, the elderly prevailed with only four to eight years of education (32,6%), followed by those who have never studied (31,5%). Such data are corroborated by population-based study, in which 32,2% of the elderly were illiterate, showing thus the low level of education of the elderly population, especially in the Northeast.[9] It is emphasized that this fact is a reflection education policies and social inequalities that prevailed at the beginning of the last century, where access was restricted to school, especially among women, to the detriment of the cultural pattern that prevailed earlier in that women should stay at home to care for housework.[16] There is also the reduced educational level of individuals in this age group can negatively affect aspects of health, socioeconomic and cultural, considering that the higher the education, the greater the knowledge, enjoyment of goods and social inclusion, culminating with the improvement in quality of life.[17]

In the present study, it was found that the family income of the elderly was on average 1.0 to 3 times the minimum wage. Research has shown that, with advancing age, older people have great difficulty in entering the labor market and come to depend on sources of income as retirement or pensions, especially for women become widows, usually with monthly income a minimum wage.[9,18] However, the monthly remuneration does not constitute a guarantee that will have financial stability, since most seniors realize low wages, which, added to high spending on treatments end up not having their needs met fully.[18] In addition, the income associated with the fact that the elderly own their own homes, has provided them greater family support capacity, causing many children and grandchildren become financially dependent, culminating in the abdication of their wages for the sake of ensuring the livelihood of their families.[19]

The French population aging process becomes essential inquiries about the health of the elderly. In this context, comes the self-assessment of health, which has been widely used as a leading indicator of individual and collective well-being and can influence the motivation and the quality of life for the aging process.[20] This is an individual measure of subjective judgment on the quality of physical and mental health, based on personal and social criteria also being employed as ponderous predictor of morbidity, disability, depression and mortality.[21-2]

It constitutes a reliable indicator because it is directly influenced by conditions such as: medical diagnosis; physiological indicators, such as pain, fatigue and loss of strength and energy; information obtained by symbolic means and the myths and stereotypes about health in old age.[20] Analyzing the health self-assessment in the present study, it was found that 44% of elderly measured their health as "fair" and 33,4% rated as "good", showing similar findings to the relevant literature.[20] It is noteworthy that negative self-assessments are predictive of less involvement with self-care and less adherence to drug treatment and rehabilitation, raising primordially a specific assessment in order to identify mitigation measures and reversal of these findings.[20]

Due to the sharp rise in the older population, it highlights the gradual change in the health profile of the population, the prevalence of longevity-related problems,

such as chronic noncommunicable diseases and their complications. Thus, the morbidity is a major concern, especially for diseases that are not available effective prevention and rehabilitation mechanisms, since the prevalence of NCDs weakens the elderly, resulting in greater reliance to carry out their daily activities.[23]

The results showed that, for the self-reported morbidities, the highlights were the elderly who cited three or more co-existing health problems (84%), with prevalence of diseases related to visual impairment (21,1%) and hypertension (19,23%), inter-related morbidities have an extended period of evolution and functional restrictions lead. It is recognized that despite the growing demand of eye diseases and attachments, these remain invisible to public health, since it does not figure among the leading causes of death and hospitalization. However, deficits in visual acuity, field of vision of the restriction, increased susceptibility to light, and poor depth perception and even blindness resulting from the aging process, causing disabilities can cause negative impact on maintenance of quality of life the elderly, such as decreased motivation and participation from society.[23-4]

Hypertension constitutes one of the most prevalent health problems among the elderly. Identified as significant risk factors for the development of cardiovascular diseases, especially the coronary heart disease, cerebrovascular and heart failure, cardiovascular diseases in Brazil accounted for about 20% of all deaths among individuals older than 30 years old; 40% of early retirements and economic cost estimated at about 475 million.[25] Thus, it is crucial to develop early diagnostic measures, since it is estimated that about one third of hypertensive become aware of the disease only after a serious disease, such as acute myocardial infarction or strokes.[26]

Due to the multifactorial genesis of morbidity, such as older age, black race, obesity, excessive alcohol consumption, physical inactivity, dyslipidemia among others, it is essential the association between control of their risk factors and adherence to the proposed treatment, as pressure control and drug therapy.[27] Please note that the construction of a careful line must not be seen only by the individual logic, but as a network of services that can support the arising demands and involving the whole of society, the family and the user himself at the heart of care production.[28-9]

CONCLUSION

The study included the proposed objective, allowing identifying the sociodemographic and clinical profile of elderly assisted in primary health care in the city of João Pessoa-PB. In respect for sociodemographic characteristics, prevailed the elderly female, aged between 60-69, married, with schooling between four and eight years of study and average family income between 1.1 and 3 times the minimum wage. As regards the clinical variables, 44% of respondents rated their health as fair, 84% had three or more health problems, foremost among them: changes in vision, high blood pressure, varicose veins and rheumatism.

Recognizing the sociodemographic and clinical profile of the elderly is of great importance, as it provides the situational diagnosis of the population, enabling the planning of health actions focused on their specificities. From this perspective, it considers the data obtained in this study as an awakening to the knowledge of managers and health professionals living conditions of the population who provides care, providing a greater bond and consequent recognition of the real needs of this population. It is noteworthy that the findings of this study are limited to a specific reality. Thus, it is suggested to carry out further investigations of this nature, in new scenarios in order to achieve a better understanding of the health of the elderly in the community context.

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