ISSN: 2318-8413 DOI: 10.18554/refacs.v5i0.2262

REFACS
Revista Família, Ciclos de Vida e Saúde no Contexto Social

Hospitalization of elders: study of a socioeconomical profile
Internação de pessoa idosa: estudo do perfil socioeconômico
Internación de personas ancianas: estudio del perfil socioeconómico

Received: 09/09/2016
Approved: 01/04/2017
Published: 03/08/2017

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This investigation aims to know the socioeconomic profile of the elders hospitalized in a federal public hospital, identifying their social reality as a way to contribute to the actions of Social Workers. This is a quantitative research that used an interview and a semi-structured form. It was noted that most elders live in their own house, are white, male, married, young elders, and catholics. Their support network includes: partners, children, siblings, daughters-in-law, and most of them are retired, and earn an average of one minimum wage. It was found that "frail" social, economic and cultural factors contribute to the sickening of the elders, and make it more difficult for them to have an active and healthy aging process.
Descriptors: Demographic aging; Health; Aged; Health profile.

Esta investigação tem como objetivo conhecer o perfil socioeconômico dos (as) idosos (as) internados(as) num hospital público federal, identificando a realidade social destes, como forma de contribuir para a atuação do profissional do Serviço Social. Esta é uma pesquisa quantitativa que usou entrevista e formulário semiestruturados. Destaca-se que a maioria reside em casa própria, são brancos, sexo masculino, casados, jovens idosos, e católicos, tendo como rede de suporte informal: cônjuge, filhos, irmãos, noras; aposentados; rendimento médio de um salário mínimo. Constatou-se que os fatores sociais, econômicos e culturais "fragilizados" contribuem para o adoecimento e dificultam o envelhecimento ativo e saudável.
Descritores: Envelhecimento da população; Saúde; Idoso; Perfil de saúde.

Esta investigación tiene como objetivo conocer el perfil socioeconómico de los ancianos internados en un hospital público federal, identificando la realidad social de estos, como forma de contribuir para la actuación del profesional del Servicio Social. Esta es una investigación cuantitativa que usó la entrevista y formulario semi-estructurado. Se destaca que la mayoría reside en casa propia, son blancos, sexo masculino, casados, jóvenes ancianos, católicos, teniendo como red social de apoyo informal: cónyuge, hijos, hermanos, nueras; jubilados; rendimiento promedio de un salario mínimo. Se constató que los factores sociales, económicos, culturales "fragilizados" contribuyen a la enfermedad y dificultan un envejecimiento activo y saludable.
Descriptores: Envejecimiento de la población; Salud; Anciano; Perfil de salud.

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INTRODUCTION

The aging process of the Brazilian population has been one of the most commonly approached subjects in the discussion about human development, health and life expectancy. There are those who still believe that Brazil is a country of young people, due to a past where big families were common; however, factors such as scientific and technological evolution and changes in family patterns caused both natality and mortality rates to drop, leading to an increase of life expectancy, thus contributing for the growth of the elder population.

This aging process has started to develop more strongly in 1960, with a decline in the natality of the most developed regions in Brazil. In 1980, the Brazilian pyramid already showed the narrowing of its base, caused by the drop in natality rates, which started to decline in the second half of the decade of 1960. Among the most relevant factors for such a decline are the invention of the contraceptive pill in 1963, and with it, the insertion of women in the work market and their search for a better quality of life[1].

Recent studies show that the economic aspects that involve the search for quality of life are one of the main factors that motivate the diminution in the size of families. The Brazilian family increasingly chooses to plan for a family where only one or, at most, two children will be had[2].

The fast extension of the demographic and epidemiological transition process which the country has been traversing brings on its wake a number of concerns for health system managers and researchers, generating repercussions for the whole society, especially in a setting of accentuated social inequality, poverty, and weak public institutions[3].

In Brazil, the Ministry of Health determined that the health of the elder should be included as a priority in the health plans of the country, establishing the promulgation of a new national policy for the health of senior citizens. This policy aims, within the Unified Health System (SUS), to guarantee integral health care for elders, offering especially a healthy and active aging process, based on the paradigms of functional and multidimensional capabilities. However, there is a remarkable degree of disarticulation inside the health system, which can make it impossible to operationalize any logic based on an evaluation that needs to involve all the aspects of the life of an elder.

The theoretical basis for this multidimensional approach has the support of the World Health Organization (WHO), through the adoption of the document "Active Ageing: A Policy Framework", whose content presents the greatest challenges regarding populational aging, highlighting the fact that health can only be created and maintained with the participation of different sectors. In this context, the WHO also recommends that health policies targeted at the care for elders consider the health determinants from their entire life cycle, including social, economical, behavioral, personal and cultural aspects, in addition to the physical environment and to the access to services, especially emphasizing issues such as gender and an aggravating social inequality.

In spite of the legal documents, one of the greatest challenges of the health sector is the organization of the system, so that it can offer an adequate care for the elderly population. Regarding society as a whole, it is necessary to review concepts and attitudes related to the elder person, organizing movements against prejudice and disrespect to this populational segment, and considering all aspects of their physical, mental, emotional and social integrity.

Due to this challenge - the health of the elderly person - a question was raised: What is the situation of the senior citizen hospitalized in a public hospital? In addition, getting to know the socioeconomic profile became relevant for the development of programs and projects to care for the elders, focusing especially in the actions of the Social Worker in the area of health.

Therefore, this investigation aims to know the socioeconomic profile of elders hospitalized in a federal public hospital, identifying their reality as a way to

contribute to the actions of the Social Worker professional.

METHOD

The investigation took place in a Federal Public Hospital, located in the Triângulo Mineiro region (UFTM), Minas Gerais/Brazil, considered one of the most developed regions in the Minas Gerais State, in the Southeast of the country. It is situated between the Grande and Paranaíba rivers, which later join to form the Paraná River. It is composed of 66 municipalities, among which stand out: Uberlândia, Uberaba, Araguari, Patos de Minas, Araxá, Ituiutaba and Patrocínio[4].

This is an exploratory, quantitative research, guided by a dialectic look at the reality studied, whose aim was to build and rebuild a critical view regarding such a reality. Researcher actively discover the meaning of the actions and relationships that hide among social structures, as Chizzotti points out:

> *the "valuing of the dynamic contradiction of the observed facts and the creative actions of the subject who observes the contradictory positions between whole and part and the links between knowing and acting with the social life of men"[5].*

Therefore, critical capabilities, and above all, self-criticism, were sought: what is "destroyed" and what is "built". The aim was contributing to the understanding of the socioeconomic profile of the senior citizen who is cared for in a public hospital, to later contribute in the elaboration of internal policies for the care of the elder, focusing on the real needs of this populational segment.

After the present investigation was approved by the Committee of Research Ethics at UFTM (protocol nº 2135), the field research was conducted. The participants of the investigation were 60-year-old or older people from both genders who were hospitalized in the Medical Clinic of the aforementioned public hospital. The exclusion criteria were: refusal to participate and/or to sign the Free and Informed Consent Form; cognitive deficit; hearing or speaking impaired in a way that made it impossible to conduct an interview.

The interview was conducted with the aid of a work instrument, the global evaluation conducted by the multiprofessional elder health team of the Integrated Multiprofessional Residency Program. The aspects that involved Social Services were: ethnicity; gender; age; marital status; religion; occupation; income; monthly family income; family composition, children; support network; receiving of social security or welfare; whether or not is the elder responsible for the expenses of the house; the source of medication and food; whether the elder has and what is the origin of his water, light and telephone; residence location; type of residence; water supply; social equipments used; participation in socialization groups; social and family interaction.

The time frame selected for the investigation was a period of five months, in the second half of 2013, reaching a total of 50 global evaluations.

In the moment of the interview, the Free and Informed Consent Form was read and given to the participants, assuring them of their anonymity regarding any data they provide for the research. The research was developed according to all ethical standards, as per Resolution nº 466/12.

RESULTS

In this study, from the elders hospitalized in the Medical Clinic, it was found that: 58% were men and 42% were women.

The age of the seniors hospitalized varied from 60 to 99. Most of them were young elders (42% - 60 to 69 years of age), followed by 40% from 70 to 79 years of age. Regarding ethnicity, it was found that 76% of them consider themselves to be white.

Regarding their marital status, most seniors were married (54%). Concerning religion, 76% are practicing members of a religion, and from those, 46% are catholic.

Regarding the number of people living in the same house, it was found that most elders live with one person, generally their partner (wife/husband; unmarried partner) or an only child. On the other hand, 22% live with five people, in most cases sons or

daughters who are married and their families.

Regarding the number of children, 22% had between 2 and 4. Most of them have, as an informal support network: partners, children, siblings or daughters-in-law. Frequently, in the period of hospital discharge, it is decided who is going to care for the elder. Among the members of the family, their sons and daughters are the main support network and main responsible for their care (58%), since they are daily accompanying their parents in their difficulties or in their lack of abilities to execute activities from their everyday life. 92% of them claimed to have a good family relationship.

Regarding their occupational situation, 72% stated to be retired, but do not know exactly the modality of their retirement (age, contribution time or disability). 74% of them receive one minimum wage as their income. A small part of the elder population (4%) in this research has access to the Continued Welfare (BPC) - a minimum-wage welfare given to elders who cannot work for themselves nor have family members capable of helping them.

90% of the elders buy their own food when they live alone and contribute to the expenses of the family when they live with them. Only 8% receive donations from children, neighbors, churches, or resort to the food bank of the Social Assistance Reference Center (CRAS). Any necessary medication is provided to 76% of them through the public health care network. It was found that 58% of the interviewed are responsible for domestic expenses.

These participants 92% live in an urban area, and 78% reside in their own houses, followed by 12% who live in rented houses. It was also found that most elders interviewed financed their houses through government housing programs and have paid them through monthly installments during a period of 20 or 30 years, or in some cases, received their houses as inheritance.

80% use the social equipment "primary care units" and the programs and projects that these offer. On the other hand, 56% do not participate in socializing groups.

DISCUSSION

There were more males than females hospitalized, which is due to the fact that men often build their masculinity upon paradigms that try to generate an image of self-sufficiency, and fail to perceive their own frailty. This leads them not to spend the adequate care to their health, becoming obstacles in the access of medical services, since they believe that this attribution is the responsibility of the woman[6].

The greatest index of hospitalization among men happens due to a number of intrinsic cultural and educational issues. Society still sees men as invulnerable and strong, immune to any type of disease, thus contributing for them not to take as much care of their health as women, as well as to expose themselves to more risks than women do.

The prevalence of married people is a result of the age group in which they are inserted, since the institution of marriage has started its decline only during the decade of 1990, due to an increase in the number of stable unions and consensual relationships characterized by an absence of civil or religious marriage[7].

Religion, on the other hand, tries to provide answers to many issues brought by aging itself, since faith is considered responsible for the elders' ability to overcome difficult moments in their lives[8].

The economic and job crises in Brazil, during the last decades, have provoked changes in the life conditions of Brazilian families. Many people, married and with their families, go back to their parents houses because they cannot afford their own expenses[9,10]. As a result of this economic crisis, the parents/grandparents have become partially or even completely responsible for the domestic expenses, or for aiding their children and grandchildren, greatly contributing to family income.

During hospitalization, the presence of family members that accompany the elder becomes necessary. It also helps them to be

able to provide future care, if their health situation requires it. As a result, most health professionals are in direct contact with the support network of the elders during hospitalization, as this is the moment when they prepare those who will be caring for the elder after hospital discharge.

The links established with family members were found to be paramount for the well-being of the elders, especially if they can find in their day-to-day lives the support they need to face the situations they go through in this period of their lives. The feeling of belonging, the protection to the elder, the intergenerational socialization, as well as emotional, affective, social and care-related help are essential for their quality of life.

The income of elder people in Brazil is too low regarding both their needs and their contribution to the economy of the country. Such a situation reveals one of the inequalities that are predominant in the country, and how urgent are policies that promote fair income distribution[9,10].

The monthly gross family income is proof of the situation of economic vulnerability dealt with by the elders hospitalized in this Medical Clinic. Most elders in Brazil are poor and poverty is increasing[11]. Conditions that are not different from those of most Brazilians. The economic situation of the elder is connected to that of the general population. In a global perspective, Latin American countries in general, and especially Brazil, stand out due to their high income distribution inequality[12]. It is certain that this inequality meaningfully compromises the health of the population segment being researched.

The BPC is a right that is specific for people with disabilities or elders who are 65 years old or older, and prove that they cannot maintain themselves, nor be maintained by family members. It is one of the "benefits" that are part of Brazilian welfare, and it is a right guaranteed by the constitution. In the process of conquest of social rights, this constitutional guideline changed and strengthened welfare in Brazil, providing what was once just a moral guideline with adequate juridical validity[13,14].

Nowadays, however, as unemployment rates grow and work relations become more precarious, many Brazilian families face great difficulties to achieve financial stability, frequently depending on the elders, who contribute to the family income, even if they, sometimes, have insufficient income from retirement or BPC[15,16].

One of the essential elements of the Unified Health System (SUS) is to assure the access to medication. It is the guiding axis for public policies established in the area of Pharmaceutical Welfare, and is currently one of the areas with the greatest financial impact from SUS.

The financing of the Pharmaceutical Welfare is a responsibility of the three spheres of SUS management: Union, State and Municipality. According to what was established in the Decree GM/MS nº 204/2007, the federal resources are provided in the form of financing packages. Therefore, the elders have been receiving medicine as long as these are part of the list of medicines made available by the public health network. If the medicines required are not part of the Ministry of Health protocol, it becomes necessary for a relative to pursue legal action.

This is due, mostly, to the rural exodus process triggered from the decade of 1950, a period that favored industrial development and intensified the growth of cities[17]. Thus, the population was seeking better life conditions in the great urban centers.

The issue of the elder interaction can be achieved in the socialization groups, that can be seen as instruments for collective organization and incentives to social participation, representing and possibly being a space to discuss claims and interests.

The social participation in socialization groups, when well coordinated and guided, is relevant, as it legitimates democracy and realizes that which is stated by the Only Paragraph of the first article of the Brazilian Constitution, that states:

"*All power emanates from the people" and that Brazil is a "Republic" and a "Legal Democratic State*""[18].

Considering the contributions to Social Services, it was found that the law 8.662/93, which regulates the profession, states in its 4th article, item 11, that are responsibilities of the Social Worker: "conducting socioeconomic studies with users for reasons related to welfare and social services with other direct and indirect public administration organs, private companies and other entities"[19]. Thus, one of the contributions of this study was the possibility of "*capturing what is social regarding health issues*"[20].

CONCLUSION

The results found point out the social situation of the elders, and the developments of this investigation confirm the relevance of the theme.

Therefore, the analysis allowed by the study indicated that the sickening of the user goes beyond physiological, nutritional, and psychological factors, showing that when social, economic and cultural factors are "frail", they are obstacles for the achievement of a health and active aging process.

The data found allows for an understanding of the needs of elders, contributing for the social worker to intervene when it comes to expressions of social issues through the elaboration of health projects and programs aimed at answering the social needs of the users, needs which are constructed and reconstructed socially, due to social, economic and political determinants that surround the lives of people in the society they are inserted. The data also contributes for the building of a collective project in which, beyond Social Services, other professions can be inserted.

To do so, a competent performance from the social worker in health is also necessary, which includes a commitment to the quality of the services offered to the users, including, among other factors: the publishing of institutional resources and the instruments for the democratization and universalization, and, above all, an opening for institutional decisions and for the participation of users.

Certainly, projects beyond the routine interventions conducted by Social Workers will strengthen health promotion and health care, in the search for defending and guaranteeing the rights of users regarding health policies and the effectiveness of the SUS, aiming at providing better conditions to care for elder citizens, thus improving their quality of life.

From this point of view, much still need to be built and many are the challenges that the professionals still have to face. This investigation is a reflection for the professionals which will allow the Social Worker to analyze health issues from a different point of view.

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CONTRIBUTIONS
All authors contributed equally in the conception, design, writing and critical review of the article.

How to cite this article (Vancouver):
Rios TI, Farinelli MR. Hospitalization of elders: study of a socioeconomical profile. REFACS [Internet]. 2017 [cited in: *insert day, month, and year of access*]; 5(Supl 2):297-304. Available in: *Access link and DOI*

How to cite this article (ABNT)
RIOS, T. I.; FARINELLI, M. R. Hospitalization of elders: study of a socioeconomical profile. **REFACS**, Uberaba, v. 5, p. 297-304, 2017. Supl. 2. Available in: <*access link*>. Access in: *insert day, month and year of access*. DOI:

How to cite this article (APA)
Rios, T. I., & Farinelli, M. R. (2017). Hospitalization of elders: study of a socioeconomical profile. *REFACS,* 5(Supl 2), 297-304. Recovered in: *insert day, month and year of access* from *insert access link and DOI.*