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Sociodemographic factors and support network of institutionalized elderly people by region of Brazil

Fatores sociodemográficos e rede de apoio de pessoas idosas institucionalizadas por região do Brasil

Factores sociodemográficos y red de apoyo de ancianos institucionalizados por región de Brasil

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Abstract:
Objective: to analyze the sociodemographic factors and support network of residents of Long-Term Care Facilities for the Elderly registered in the Unified Social Assistance System (*Sistema Único de Assistência Social*) by region of Brazil. **Methods:** cross-sectional, descriptive, quantitative study conducted with elderly people living in institutions registered in the Unified Social Assistance System, in the five regions of Brazil. Data were collected in loco, between 2015-2018, with a questionnaire for cognitive and sociodemographic data assessment. Stata™ software, version 15, was used for analysis. **Results:** 4,250 elderly people were evaluated, mostly men, 80 years of age or older, with a predominance of mixed raced or white people, Catholics, with low education, single, without children, with income equivalent to up to one living wage, from retirement. The average time of residence in the institution was 4 years, with institutionalization being mainly related to the need for care. Elderly people did not usually leave the institution and received visits from family members. **Conclusion:** the results found show that a differentiated look at this population is necessary, according to region, given the regional differences, their sociodemographic characteristics and the availability of social assistance and health services, since institutionalization often constitutes the only housing and care option for some elderly people.
Keywords: Sociodemographic factors; Social support; Aged; Aged, 80 and over; Homes for the aged.

Resumo:
Objetivo: analisar os fatores sociodemográficos e a rede de apoio dos residentes de Instituições de Longa Permanência para Idosos cadastradas no Sistema Único de Assistência Social por região do Brasil. **Método**: estudo transversal, descritivo, quantitativo, realizado com pessoas idosas residentes em instituições cadastradas no Sistema Único de Assistência Social, das cinco regiões do Brasil. Os dados foram coletados *in loco*, entre 2015-2018, com questionário para avaliação cognitiva e de dados sociodemográficos. Utilizou-se o software Stata®, versão 15, para análise. **Resultados**: foram avaliadas 4.250 pessoas idosas, na maioria homens, com 80 anos e mais, com predomínio de pardos ou brancos, católicos, com baixa escolaridade, solteiros, sem filhos, com rendimentos de até um salário mínimo, proveniente da aposentadoria. O tempo médio de moradia na instituição foi de 4 anos, sendo a institucionalização relacionada, principalmente, à necessidade de cuidados. As pessoas idosas não costumavam sair da instituição e recebiam visitas de familiares. **Conclusão:** os resultados encontrados evidenciam que é necessário um olhar diferenciado, segundo região, para essa população, dadas as diferenças regionais, suas características sociodemográficas e de disponibilidade de serviços socioassistenciais e de saúde, uma vez que a institucionalização constitui, muitas vezes, a única opção de moradia e cuidado para algumas pessoas idosas.
Palavras-chave: Fatores sociodemográficos; Apoio social; Idoso; Idoso de 80 anos ou mais; Instituição de Longa Permanência para Idosos.

Resumen:
Objetivo: analizar los factores sociodemográficos y la red de apoyo de los residentes en Instituciones de Larga Estancia para Ancianos registradas en el Sistema Único de Asistencia Social por región de Brasil. **Método:** estudio transversal, descriptivo y cuantitativo de ancianos residentes en instituciones registradas en el Sistema Unico de Asistencia Social en las cinco regiones de Brasil. Los datos se recogieron *in situ* entre 2015 - 2018, utilizando un cuestionario para la evaluación cognitiva y datos sociodemográficos. Para el análisis se utilizó el software Stata®, versión 15. **Resultados:** se evaluaron 4.250 ancianos, en su mayoría hombres, de 80 años o más, predominantemente pardos o blancos, católicos, con bajos niveles de educación, solteros, sin hijos, con un ingreso de hasta un salario mínimo de jubilación. El tiempo medio de vida en la institución era de 4 anõs, y la intitucionalización estava relacionada principalmente con la necesidad de cuidados. Los ancianos no solían salir de la institucipon y recibían visitas de familiares. **Conclusión:** los resultados muestran que es necesario considerar a esta población de forma diferente según la región, dadas las diferencias regionales, sus características sociodemográficas y la disponibilidad de asistencia social y servicios sanitarios, ya que la institución es a menudo la única opción de alojamiento y cuidados para algunos ancianos.
Palabras-clave: Factores sociodemográficos; Apoyo social; Anciano; Anciano de 80 o más años; Hogares para ancianos.

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INTRODUCTION

Population aging is a global phenomenon and represents one of the greatest challenges to be faced by society in the coming years. The rapid increase in the elderly population has a direct impact on social assistance and public health services[1,2], highlighting the urgent need for new perspectives on the needs of this group, which requires the reorganization of current public policies[3].

Data published by the Pan American Health Organization in 2020 estimates that, in 2030, 1 in every 6 people in the world will be 60 years of age or older[4]. In Brazil, according to the 2022 Census, the elderly population corresponds to 15.7% of the general population, which reflects an increase in relation to the data from 2012, ten years earlier, in which the population aged 60 years or older corresponded to 11.3% of the general population[5].

Despite being a natural and dynamic phenomenon, aging is accompanied by a progressive loss of the individual's ability to adapt to the environment, since it is accompanied by a set of morphological, physiological, biochemical, psychological, social and environmental changes, which directly impact the general state of health of the elderly person and their functionality[6,7].

Approximately 25% of the elderly population in Brazil requires support in performing Basic Activities of Daily Living (BADL), requiring a part-time or full time caregiver[8]. In this context, many families find it difficult to perform this function, both due to the level of attention required and the difficulty in finding someone who will be responsible for carrying out the essential care[9].

In view of this, aging can result in the need for a care network, including Long-Term Care Facilities for the Elderly (LTCFEs)[10]. The absence of an effective care network can compromise the well-being of elderly people and their aging with dignity.

ILPIs are defined as governmental or non-governmental institutions, of a residential nature, intended for the collective residence of people aged 60 or over, with or without family support, in conditions of freedom, dignity and citizenship[11].

The number of ILPIs in Brazil has increased. They emerged as social assistance facilities to house vulnerable people and, as a result of the demands for specialized health care, in addition to social care, there have been changes in their nature[12]. However, even with these transformations, public, private or non-profit ILPIs are still recognized as social assistance institutions, according to RDC 502/2021, of the Brazilian National Health Surveillance Agency (*Agência Nacional de Vigilância Sanitária* - ANVISA)[11].

In Brazil, many studies on the elderly population living in ILPIs have been carried out, but there are no nationwide investigations aimed at them.

In 2012, the Brazilian Ministry of Social Development and Fight Against Hunger instituted the annual Census of the Unified Social Assistance System (*Sistema Único de Assistência Social* - SUAS), which includes the collection of data on social facilities, such as registered Brazilian public or philanthropic LTCFEs. The SUAS Census data aims to obtain information on the services, programs and benefits that are being implemented by public administrators and by entities and organizations registered with the Municipal Social Assistance Council[13].

This study is relevant because it assesses residents of the five regions of Brazil, through face-to-face interviews in their place of residence, contributing to the understanding of the specific needs of this population. Its objective is to analyze the sociodemographic factors and the support network of residents of Long-Term Care Facilities for the Elderly registered with the Unified Social Assistance System by region of Brazil.

METHODS

This is a cross-sectional and descriptive study, with a quantitative approach, which used data from the survey "Study of the sociodemographic and epidemiological conditions of elderly people living in long-term care facilities for the elderly registered in the SUAS Census"[14], carried out throughout the country.

A census of the institutions registered in the SUAS in 2014 was carried out (n=1,451), with the exclusion criterion being LTCFEs with fewer than 10 residents. The regional sample was obtained by drawing 50 LTCFEs per region and 20 elderly people in each institution. The elderly people drawn could not be replaced when the interviews were conducted, totaling approximately 1,000 residents/region, with the exception of the North region where, due to the smaller number of existing institutions, all existing institutions were used. The final sample consisted of 4,250 elderly people with regional representation.

The data were collected on-site, from 2015 to 2018, by a team of trained professionals using a questionnaire specifically designed for this study. The interviews were conducted with the elderly and, in the case of the presence of impeding physical and cognitive conditions, with a proxy respondent.

To assess the cognitive conditions of the elderly, a version of the Mini Mental State Examination (MMSE) was used, which reduced the impact of education on the results, and which had a cut-off point for positive screening for cognitive decline of 12 points or less.

The selected variables were: sex; age group; self-reported religion and race/color; education; marital status; income and its characteristics; previous residence and main reason for institutionalization; time of institutionalized and assessment of the support network (living children and visits).

The data were stored in an electronic spreadsheet and analyzed using descriptive statistics, with the distribution of relative and absolute frequencies for each region of the country, with the aid of the statistical software Stata™, version 15. Variables that did not receive a response (missings) were excluded from the analyses.

This study was submitted to the Research Ethics Committee of the School of Public Health, and was approved under opinion no. 1,077,982, on May 25, 2015, with CAAE: 44953415.6.0000.5421, and was financed by the Ministry of Health and monitored by the Ministry of Development and Fight against Hunger.

RESULTS

A total of 4,250 interviews were conducted, of which, depending on the region, approximately 53% to 65% were conducted with a proxy respondent due to physical and/or cognitive disabilities of the elderly. The sample distribution was: North region – 736 participants; Northeast region – 890 participants; Central-West region – 887 participants; South region – 912 participants; and Southeast region – 825 participants.

There was a predominance of male residents in all regions, with the exception of the Northeast region. The predominant age group was 80 years and over, except in the South region, where the majority were between 70 and 79 years old. The minimum age was 60 years and the maximum was 115 years. There was a predominance of the Catholics and mixed race/color in the North, Northeast and Central-West regions and white in the South and Southeast regions. Between 44% and 55.7% of the elderly did not attend school. The majority were single and reported having no living children (Table 1).

Table 1. Elderly people living in Long-Term Care Institutions for the Elderly registered in the SUAS, according to sex, age group, self-reported religion, self-reported race/color, education, marital status, presence of living children and region of the country, Brazil, 2015-2018.

Variables	Brazilian Regions				
	North %	Northeast %	Central-West %	South %	Southeast %
SEX					
Male	59.5	37.9	61.9	51.9	51.8
Female	40.5	62.1	38.1	48.1	48.2
AGE GROUP					
60-69 years	21.6	17.5	26.2	26.1	24.1
70-79 years	32.7	32.0	36.5	37.5	35.2
80 years or more	45.7	50.5	37.3	36.4	40.7
SELF PROCLAIMED RELIGION					
Catholic	75.0	83.8	72.8	81.6	79.0
Protestant	2.7	1.8	1.2	3.0	2.0
Evangelical	10.6	7.7	15.0	10.2	12.2
Other	0.9	1.3	2.0	0.8	3.4
None	10.8	5.4	9.0	4.4	3.4
SELF REPORTED COLOR/RACE					
White	26.8	27.7	40.0	66.6	57.3
Black	11.5	15.3	11.2	5.9	16.2
Mixed	57.5	54.8	45.1	24.9	25.2
Others	4.2	2.2	3.7	2.6	1.3
EDUCATION					
Did not attend school	53.8	51.5	55.7	47.3	44.0
Incomplete Primary education	31.4	32.7	38.6	44.8	47.4
Complete Primary education	5.9	4.9	1.9	4.2	3.5
Secondary education	4.3	8.1	2.1	2.3	2.7
Higher education	4.4	2.8	1.7	1.3	2.2
Post-graduate education	0.2	---	---	0.1	0.2
MARITAL STATUS					
Single	60.9	53.3	49.1	45.5	50.6
Widowed	19.4	26.9	19.4	33.1	26.7
Divorced	14.5	12.1	19.2	12.8	14.0
Married/Civil union	5.2	7.7	12.3	8.6	8.7
HAS LIVING CHILDREN					
Yes	41.5	46.6	53.3	45.9	44.0
No	58.5	53.4	46.7	54.1	56.0

Before institutionalization, most elderly people reported living with family or friends. The need for health or care appears as the main reason for institutionalization. There is a predominance of elderly people living from 1 to 10 years in LTCFEs, with an average length of residence of 4 years. It was also observed that the majority do not usually leave the long-term care institution, and those who do leave do so sporadically. In addition, elderly people receive visits from family, friends and volunteers (Table 2)..

Table 2. Elderly people living in Long-Term Care Institutions for the Elderly registered in the SUASm, according to where they lived before living in the ILPI, main reason for institutionalization, length of residence in the ILPI, habit of leaving the ILPI, frequency of exits, receiving visits, who usually visits and region of the country, Brazil, 2015-2018.

Variables	Brazilian Regions				
	North %	Northeast %	Central-West %	South %	Southeast %
LIVED BEFORE LTCE					
Own home, alone	26.5	23.9	23.9	21.7	18.5
With family/friends	29.6	50.4	53.6	63.9	42.4
Home of others	23.8	16.6	10.2	5.4	25.6
Public shelter	3.0	0.4	1.6	2.1	0.8
Street	7.3	3.1	1.8	1.7	5.0
Other LTCE	3.6	3.1	2.4	4.2	4.6
Other	6.2	2.5	6.5	1.0	3.1
MAIN REASON FOR INSTITUTIONALIZATION					
Lived alone	9.7	14.6	10.6	9.5	9.4
Had nowhere to live	8.2	5.6	9.5	3.6	5.5
Health/care	38.4	46.2	60.5	62.3	57.8
Personal choice	9.5	8.3	4.1	3.8	5.4
Finance	1.3	1.2	4.0	1.2	1.5
Taken to LTCE	20.4	19.5	9.3	16.6	14.6
Other	12.5	4.6	2.0	3.0	5.8
TIME LIVING IN LTCFE					
< 1 year	15.1	14.8	14.3	13.1	14.0
1-10 years	69.3	71.1	67.7	61.3	70.5
> 10 years	15.6	14.1	18.0	25.6	15.5
HABIT OF LEAVING LTCFE					
Yes	33.7	27.8	37.7	27.4	36.2
No	66.3	72.2	62.3	72.6	63.8
FREQUENCY OF EXITS OF LTCFE					
Daily	10.4	3.4	8.1	7.2	11.6
Weekly	14.4	17.4	24.1	25.6	18.4
Monthly	20.9	24.5	25.9	30.9	27.7
Occasionally	54.3	54.7	41.9	36.3	42.3
HAS VISITORS					
Yes	64.9	79.4	77.6	75.6	72.0
No	35.1	20.6	22.4	24.4	28.0
WHO USUALLY VISITS					
Family	57.9	83.4	77.5	84.8	80.4
Friends	36.0	29.9	34.0	26.9	27.2
Volunteers	24.8	17.2	31.0	17.1	11.4

LTCFE: Long-Term Care Facility for the Elderly.

When assessing the frequency of visits received by elderly people, it was observed that, among family members and volunteers, there is a predominance of weekly visits and among friends, monthly visits (Central-West and South regions) or sporadically (North, Northeast and Southeast regions) (Table 3).

Table 3. Frequency of visits received by elderly people living in Long-Term Care Facilities for the Elderly registered in the SUAS by region of the country, according to type of visitor, Brazil, 2015-2018.

Frequency of visits	Brazilian Regions				
	North %	Northeast %	Central-West %	South %	Southeast %
FAMILY					
Daily	2.6	4.6	3.5	3.9	5.6
Weekly	29.8	34.2	31.3	30.8	36.0
Monthly	28.7	27.7	29.9	29.7	27.2
Yearly	4.0	5.1	7.9	5.6	1.9
Occasionally	34.9	28.4	27.4	30.0	29.3
FRIENDS					
Daily	2.3	6.2	3.3	1.7	0.6
Weekly	18.8	31.1	28.0	24.7	32.5
Monthly	30.0	25.8	35.1	36.8	26.1
Yearly	6.5	1.9	4.7	4.1	1.9
Occasionally	42.4	35.0	28.9	32.7	38.9
VOLUNTEERS					
Daily	14.4	23.1	6.5	23.7	9.4
Weekly	55.9	57.1	60.4	49.1	78.1
Monthly	17.8	9.1	15.9	13.2	3.1
Yearly	2.6	---	1.3	3.5	1.6
Occasionally	9.3	10.7	15.9	10.5	7.8

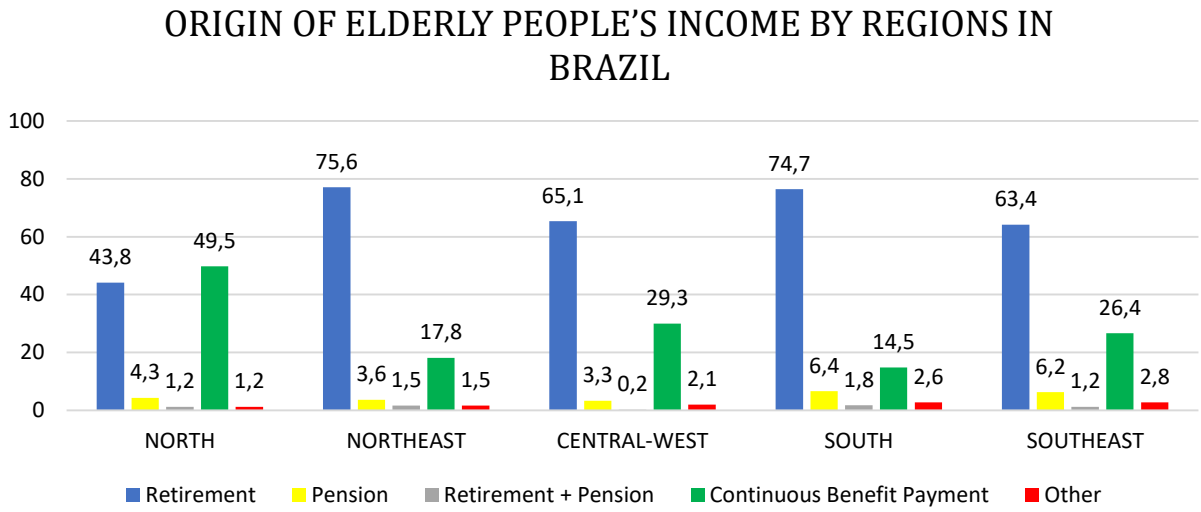
More than 95% of the interviewed population had some type of income, regardless of the region assessed. This income, in most cases, was withdrawn by the institution itself; and part of it was kept by the institution. The amount received by the majority was up to 1 living wage (Table 4).

Table 4. Elderly people living in Long-Term Care Institutions registered in the Unified Social Assistance System, according to region, income characteristics and their use, Brazil, 2015-2018.

Income	Brazilian Regions				
	North %	Northeast %	Central-West %	South %	Southeast %
HAS INCOME					
Yes	98.0	96.6	95.4	95.9	95.3
No	2.0	3.4	4.6	4.1	4.7
VALUE OF INCOME					
< 1 living wage	3.2	4.4	7.5	16.9	3.6
1 living wage	90.4	88.6	89.2	71.0	92.7
1 to 2 living wages	3.9	3.3	2.4	9.2	1.9
> 2 living wages	2.5	3.7	0.9	2.9	1.8
WHO WITHDRAWS INCOME					
The elderly person	12.0	3.6	10.8	4.1	5.0
The institution	73.8	74.9	74.3	74.3	78.8
A family member	9.6	19.5	13.0	18.8	15.2
Other	4.6	2.0	1.9	2.8	1.0
LEAVES PART OF INCOME TO LTCE					
Yes	65.6	96.8	88.6	88.6	93.3
No	34.4	3.2	11.4	11.4	6.7

Regarding the source of income, only in the North region did the majority report that it came from the Continuous Benefit Payment (*Benefício de Prestação Continuada* - BPC). In all other regions, the majority of income came from retirement (Graph 1). A small number of elderly people have more than one source of income.

Graph 1. Elderly people living in Long-Term Care Institutions for the Elderly registered in the SUAS, according to income source and region of the country. Brazil, 2015-2018.



The financial resources not retained by the institution were used to purchase medicines, food and personal hygiene materials.

DISCUSSION

In general, there is a predominance of females in the characterization of the institutionalized community, as found only in the Northeast region, corroborating a study that deals with the sociodemographic aspects, quality of life and health of elderly people[15] and a study that addresses the patterns of aging and longevity related to the biological, educational and psychosocial aspects of institutionalized elderly people[16], among others. This occurs because women are more likely to reside in an LTCFE, they are the majority in the population, they achieve greater longevity than men and are more concerned about themselves[5,6,9,10,17].

The results of the present study showed the predominance of male residents in all regions, except in the Northeast region. This finding is found in few studies[18], as observed in a study carried out with elderly people in an LTCFE in the state of Mato Grosso do Sul, which showed a predominance of males in 57.1% of the participants[19] and in another carried out with residents of a city in the North of the state of Minas Gerais, where 60.3% of the elderly people are male[20].

The findings regarding the age group, with the exception of the South region, are similar to those found in a study that deals with the evaluation and factors associated with the functional incapacity of elderly people living in Long-Term Care Institutions for the Elderly, in which there was a predominance of elderly people aged 80 or over, representing an approximate percentage of 48% of the participants[21]. They also corroborate the results of a study that analyzed the use of medications in institutionalized elderly people, in which 41.3% of the participants were in this same age group[19]. These data differ from the findings in the 2022 Census, in which a greater predominance of elderly people in the age group between 60 and 69 years was observed in the general population[5].

Regarding the minimum age of 60 years and the maximum of 115 years found in this study, similar findings were observed in a study that clinically and epidemiologically characterized elderly people living in an ILPI in the North of Minas Gerais, where the minimum age of the participants was 60 years and the maximum was 107 years[20].

Regarding self-reported race/color, among residents of LTCFEs in the North, Northeast and Central-West regions, the predominant race/color was mixed, and in the South and Southeast regions it was white, reflecting the data for elderly people in general, released by the 2022 Census[5].

The self-reported religion of most elderly people, in all regions, was Catholic, similar to that found in two studies carried out in the state of Ceará, which dealt with the social and health profile of institutionalized elderly people, where 83.1% of the participants were Catholic[1,10.]

With regard to the educational level of elderly people, it was found that the majority did not attend school, followed by those who had attended but not completed primary school, except in the Southeast region where the findings were reversed. Thus, the predominance of low education levels among the elderly individuals evaluated is evident, corroborating the study that highlights that this low education level may be related to the social conditions of the elderly, with lack of access to formal education and poverty[9]. It is noteworthy that the low education level factor is a very frequent finding when evaluating philanthropic institutions, since it results from the previous reality of discrimination in educational opportunities for these elderly individuals[10].

Validating these findings, another study conducted in the city of Campo Grande/MS found that most elderly people did not complete elementary school, highlighting that low or no schooling are factors considered predisposing to institutionalization[2]. Schooling directly reflects the socioeconomic conditions of elderly people and their access to goods and services.

It was observed that the predominant marital status among residents of LTCFEs is single, ranging from 45.5% to 60.9% across the five regions of the country. This finding is similar to other studies[1,6,22].

The number of single elderly people institutionalized may indicate a reduced or non-existent family network. This condition is one of the predisposing factors for the institutionalization of elderly people. In addition, the isolation of elderly people from society as an option may lead some of these individuals to seek LTCFEs for decent housing[1].

As for the presence of living children, most elderly people reported not having any (except in the Central-West region). Similar data were found in a study conducted with residents of public LTCFEs in the city of São Paulo, where 52.6% of the elderly did not have children[22]. The absence of children may be another factor that characterizes a diminished support network and that may lead them to reside in LTCFEs.

The majority of the elderly, before residing in LTCFEs, lived in their own homes with family or friends, which is similar to other jobs[1,10]. This fact is striking when questioning the reason why these residents did not remain in their homes, with their family/social support network.

The results show that the main reason for institutionalization was the need for health and/or care (with a variation between 38.4% and 62.3%). This transfer of responsibility for care from family and/or friends may occur due to the fact that in many cases, the support network can no longer take on the care of the dependent/sick person and refers them to an LTCFE[23]. In many cases, the decision to institutionalize is due to a lack of time to care for a dependent person, followed by the inability to care for an elderly person with physical and health problems that require professional care and full-time attention.

It was also observed that the second most common reason for institutionalization reported by elderly people was having been referred to an LTCFE by other people (with a variation between 9.3% and 20.4%), showing that institutionalization can still be an unwanted situation for them. This reason was the predominant one in a study conducted with elderly people living in six different LTCFEs in the interior of the state of São Paulo, in which 76% of residents decided to move to an LTCFE through the intervention of other people and without their own will[15.]

The majority of elderly people live in LTCFEs for between 1 and 10 years, which corroborates a study that analyzed the use of medication in institutionalized elderly people, in which 65.7% of residents have been in the LTCFE for the same period of time[19]. The average time of institutionalization of residents was 4 years, the same as the average time of

institutionalization found in a study conducted with institutionalized elderly people in São Paulo[15].

As for the habit of residents leaving the LTCFE, it was found that between 62.3% and 72.6% of elderly people do not usually leave the LTCFE, and those who do leave do so sporadically. It is important to emphasize that elderly people often leave the institution regardless of their will, and depend on the specific policies and rules of each institution, as well as on the health conditions and autonomy of each elderly person[24].

In many cases, residents can go out for external activities, trips or visits to family, as long as it is safe and appropriate for them. However, it is important to check with the institution's administration about the guidelines and procedures to be followed. The fact is that the institution seems to be a world apart, disconnected from the outside world for the vast majority of residents[24].

Between 64.9% and 79.4% of residents receive visits, with frequencies that vary according to the region of the country. The majority are made by family members, followed by friends and volunteers. Similar data are found in other studies, in which approximately 60% of institutionalized elderly people receive visits[1,10].

It was observed that family members and volunteers visit their institutionalized elderly people weekly, while visits by friends occur monthly or sporadically, depending on the region, that is, the frequency of visits can vary significantly, depending on who makes them.

In institutionalization, the support network is essential in helping the elderly person adapt to the LTCFE, as well as in improving their well-being and quality of life[10]. A study on the evaluation of LTCFE in Brazil registered in the SUAS Census, carried out in 2023, showed a positive result for the promotion of family ties, with low regional disparities, suggesting that Brazilian LTCFEs would be recognizing the importance of family ties and promoting actions to reduce the feeling of abandonment and loneliness[25]. It is also recommended that it is important that family ties with the elderly be encouraged and strengthened[10].

A study that deals with the importance of the presence of family in the daily lives of institutionalized elderly people reports that visits by family and friends, people with whom residents had a bond before institutionalization, decrease over time, a fact that generates a negative stimulus in the lives of institutionalized elderly people, interfering with the preservation of their social life, the maintenance of their affective relationships and their autonomy[26].

The frequency of visits to the institution by family members and/or friends can be characterized, above all, in two terms: monthly (45% of cases) and almost never (35% of cases),

and the family members who visit most are the children. Furthermore, according to the research participants, the reason why family members do not visit them more regularly is mainly due to lack of time and financial issues[26].

It is important to note that when these visits start to happen with greater intervals of time or when they no longer happen, the institutionalized elderly person begins to have a "lonely" experience in relation to adapting to the changes caused by both the aging process and the process of adapting to the environment, and creates a distance between these residents and their family members and/or friends, which can lead to a breakdown in social support networks, harming the well-being, quality of life and health of the elderly person[26].

To alleviate these issues, the great challenge is to encourage institutionalized elderly people to seek to develop new social relationships, especially with other residents of the institution. It is important to establish new emotional bonds and for residents to feel welcomed and familiar with their space and the people there. In this context, the interprofessional team is responsible for supporting these residents in their institutionalization process and providing social, emotional, physical and mental support[10].

The data regarding income show that the vast majority of elderly people, that is, more than 95%, have an income, with the majority receiving 1 living wage per month. These findings are similar to a study that assessed the quality of life of institutionalized elderly people, where 87.5% of residents had the same income[6].

The income generally came from retirement, and was withdrawn by the institution itself, and most elderly people left part of this income at the LTCFE. These data are similar to those found in a study that estimated the prevalence of frailty syndrome and characterized the clinical and epidemiological profile of institutionalized elderly people, where 80.6% of residents are retired and did not manage their own income[27].

The fact that this study was conducted in LTCFEs registered with SUAS points to a clientele of people in greater social vulnerability and who have BPC as the second most predominant source of income.

Brazilian LTCFEs live mainly on resources from the residents themselves and/or their families. In a study that deals with the costs in long-term care facilities for the elderly, it was reported that the financial problems faced by the institutions are serious. Approximately 57% of the revenue comes from the income of the residents themselves, 20% comes from public funding and 12.6% comes from the institution's own resources[28].

Since most of the elderly people in this study leave part of their income to the institution, it is necessary to observe and comply with the provisions of the Brazilian Statute for the Elderly,

updated by Law 14,423 of 2022, which determines that LTCFEs are required to enter into a service provision contract with the elderly person living there, and are allowed to charge the elderly person for their share of the institution's costs, which cannot exceed 70% of the social security or welfare benefit received by the resident[29]. Regarding this fact, this study did not aim to assess whether LTCFEs comply with the provisions of the Elderly Statute.

Regarding the use of financial resources by residents, it was found that they spend the most on medicines, followed by food and personal hygiene materials. Somewhat similar data were observed in a study that identified the representation of health costs in the finances of an LTCFE, and found that the main expenses of residents were the payment of caregivers who provided services, followed by medication and food[30].

CONCLUSION

The sociodemographic profile of residents in LTCFEs registered in SUAS showed a predominance of elderly males, aged 80 or over, self-reported race/skin color of mixed race or white, Catholics, who did not attend school, were single and had no living children. Before institutionalization, they lived in their own homes with family members/friends, and the need for health/care was the main reason that led them to live in LTCFEs.

Most elderly people have lived in LTCFEs for 1 to 10 years. They receive weekly visits from family members and volunteers. They have financial income in the amount of 1 minimum wage, usually from retirement or BPC, withdrawn and used by the institution itself. These resources are generally used to purchase medicines.

With regard to the limitations of this study, it is worth noting that the cross-sectional approach used does not allow for an evolutionary overview and the descriptive design does not establish causal relationships between the variables analyzed. Another limiting factor was the use of a proxy respondent, in the case of the presence of physical and/or cognitive conditions that prevent elderly people from responding, despite its importance as a resource to avoid non-response.

The regional sample allows comparison between different regions of the country, but does not allow for the national profile of residents in LTCFEs to be drawn up. In addition, the vast majority of studies that address the population of institutionalized elderly people were conducted in specific institutions, municipalities or states, making discussion and possible comparisons and/or correlations between variables difficult.

In turn, the results found show that a differentiated look at this population is necessary, according to region, given the regional differences in population characteristics and the

availability of social assistance and health services. In the case of those assisted by LTCFEs registered in SUAS, in particular, LTCFEs are often the only option for housing and care.

It is expected that this study can contribute significantly to the planning and development of demands related to the living and health conditions of residents of public and philanthropic LTCFEs registered in SUAS, and can also guide public policies on social assistance, health and education due to the progressive growth of this segment of the population.

It is also suggested that new studies be carried out in this area, at a national level, aiming, above all, to identify knowledge gaps and direct efforts towards the continuous improvement of care for institutionalized elderly people.

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