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Original Article

Care needs of the elderly who live alone: an intersectoral perception*

Necessidades de cuidado de idosos que vivem sozinhos: uma visão intersetorial

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ABSTRACT

Objective: to understand the perception of health and law professionals regarding care for frail elderly people who live alone. **Methods:** qualitative research, carried out through interviews with health and law professionals, using a vignette as a trigger, presenting the description of the story of a frail elderly woman who lived alone. Data were submitted to the thematic analysis technique. **Results:** the 23 professionals pointed out that the family members should be the responsible ones for the elderly; that institutionalization should take place as the last option; stressed the importance of multi-professional and intersectoral work; and recognized the limitations of the state. The professionals reported the appropriate interventions for the case. **Conclusion:** in care for the elderly who live alone, there are limitations for families, social care, and health services for the elderly, as well as the State, with the need to strengthen legally guaranteed resources.

Descriptors: Frail Elderly; Intersectoral Collaboration; Patient Care Team; Aged Rights; Aging.

RESUMO

Objetivo: compreender a visão de profissionais da área da saúde e do direito acerca do cuidado a idosos fragilizados que vivem sozinhos. **Métodos:** pesquisa qualitativa, realizada por meio de entrevistas com profissionais da área da saúde e do direito, tendo como disparador uma vinheta, contendo a descrição da história de uma idosa fragilizada que vivia sozinha. Dados submetidos à técnica de análise temática. **Resultados:** os 23 profissionais apontaram que a família deveria ser a principal responsável pelo idoso; que a institucionalização deveria ocorrer como última opção; ressaltaram a importância do trabalho multiprofissional e intersetorial; e reconheceram as limitações do Estado. Os profissionais relataram as intervenções apropriadas para o caso. **Conclusão:** na atenção ao idoso que vive sozinho, existem limitações das famílias, dos serviços de atenção social e de saúde ao idoso, bem como do Estado, havendo necessidade de fortalecimento dos recursos legalmente garantidos.

Descritores: Idoso Fragilizado; Colaboração Intersetorial; Equipe de Assistência ao Paciente; Direitos dos Idosos; Envelhecimento.

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Introduction

The rise in longevity in contemporary societies is happening dramatically. In Brazil, in 2015, the elderly population accounted for 14.3%. In 2050, this percentage is expected to be 29.0%, which represents major challenges for society and public policies[1]. The morphophysiological and functional changes inherent to the aging process alter the patterns of morbidity and mortality, also increasing the possibility of weaknesses, which demands a new approach to health care services, consequently, implying challenges to health and public management[2].

Frailty is a syndrome characterized by the lack of strength, resistance, and changes in physiological functions, increasing the person's physical vulnerability, leading to functional disability[3]. Elderly people in this condition need constant support and care.

According to the law, the one in charge of ensuring the basic rights of the elderly person is the family, to guarantee a better quality of life[4]. However, changes in family arrangement, decreased birth rates and an evident values change also affect the rupture of intergenerational ties, compromising the offer of family care[5]. Also, some elderly people prefer privacy, choosing to live alone, which makes them even more vulnerable.

In Brazil, the National Household Sample Survey showed that 15.3% of people aged 60 and over live alone, with a higher prevalence of women aged 75 and over and, although reaching a higher proportion in high-income regions, this condition most intensely affects the lives of the low-income elderly people. The same research showed that these elderly people have worse health conditions and habits related to health care[6].

Given this context and considering that public policies direct the assistance to the elderly to occur essentially at home, it is observed that especially the contingent of elderly people who live alone finds it difficult to preserve the right to good living and health conditions, thus, there is an intersectoral concern, in the search for assistance adequate to the needs of the elderly who live alone.

Thus, comes the questions: how do professionals from different areas of education perceive care for frail elderly people who live alone? What are the possible interventions in the face of vulnerability for the elderly? Therefore, the objective was to understand the view of health and law professionals regarding care for frail elderly people who live alone.

Methods

Qualitative research carried out in a city in the interior of the state of São Paulo, Brazil, with near 216,745 inhabitants, of which 13.6% are elderly[7]. Data were collected from health professionals in the primary health care network, comprising 12 Basic Health Units and 39 Family Health Units, and from law professionals, including the Judiciary, the Public Ministry, members of the Public Defender, lawyers enrolled in the Subsection of the Brazilian Bar Association of the municipality and chiefs of the Civil Police.

For the sample definition of health professionals, three Family Health Units were chosen, which serve the largest number of elderly people, in which 31 professionals work, also those who make up the Family Health Support Center team, accounting for 37 professionals. For law professionals, the variety of sectors was sought. This a convenience sample, seeking to contemplate the different professional categories, both in health and law fields.

The inclusion criterion was to deal with situations that involved the elderly daily. A total of 23 professionals were included: a judge, a prosecutor, a police chief, a conciliator, a public defender, five lawyers, four nurses, two doctors, a physiotherapist, two nursing assistants, two dentists and two social workers. The sample was composed using the theoretical saturation strategy, that is, the data was collected until no new or relevant data concerning any theme emerged, exploring the properties, dimensions and interlocutions of the categories[8].

Telephone calls were made with those in charge of each service, who were interviewed or asked to suggest a suitable professional for the study criteria. After defining the participant, day and time were settled, according to availability, and there were no refusals. The interviews were conducted from January to March 2019, in rooms arranged by the participants, to ensure that the interview was not interrupted. Participant sociodemographic data were collected and then the vignette technique was applied.

For this study, the elaboration of the story of the vignette was based on a real situation, experienced by one of the authors, as follows: "An 87-year-old woman lives alone in her own home and has a pension of two minimum wages. She is hypertensive, has a visual impairment and reports lower back pain, besides, she has difficulties walking to the health unit in her area. He has two sons, one that lives in São Paulo and visits her once a year and another who lives in the same city, who has a drinking problem. Her home is in poor hygiene. She uses her medications irregularly and her blood pressure is usually around 200x100 mm of mercury. She was suggested to have a person to support her in the activities and she was extremely irritated".

After the professionals read the vignette, the following guiding question was asked: how would you deal with this situation? All interviews were conducted by one properly trained author. A voice recorder and digital media filing were used. The interviews were recorded on audio, after the professionals' approval, and transcribed in full. The analysis and representation of the collected material were carried out using the content analysis technique[9].

The project was approved by the Research Ethics Committee with Human Beings of the proposing institution, with a Certificate of Presentation for Ethical Appreciation No. 98637118.9.0000.5413 and opinion No. 2,912,279/2018, in compliance with Resolution 466/2012, and also appraised by the management bodies of the divisions of each professional. Participants signed the Informed Consent Form. To present the results, the professionals were identified by E, followed by the identification of the area of operation and increasing numerical sequence (IH1 ... IH11; IL1 ... IL10).

Results

A total of 23 professionals were interviewed, 12 from the law field and 11 from the health field, aged between 29 and 56 years; mean of 40.2 years, being 21 female and 17 professionals with no training on aging.

The following thematic categories emerged from the participants' statements: family responsibility concerning the care, institutionalization as a possibility, intersectoral and multi-professional work, limitations of the State and complexity of interventions.

Family responsibility concerning care

Overall, the professionals interviewed indicated that the family should be the one in charge of the elderly's care, and it is necessary to recognize the condition of family members and try to strengthen the bonds. If there is no agreement, legal measures that oblige the family member to provide the resources for reasonable care are suggested, as evidenced in the statements: *As a law professional, I would first try the family ties approach, as this lady's vignette is, I would try to have one of the sons take her in. If it is not possible... to require paying a pension* (IL 4). *So, in this situation, what to do being a health service? And, in this care, I mean, in the sense that it needs to influence, it needs to impress this family* (IH 2). *The son, he has civil responsibility for the parents* (IH 6). *Since she lives alone and has several health problems, then I would try to have a son take her in* (IL 5). *I would get in touch with the children, because she needs care ... since the children are distant* (IL 14).

Institutionalization as a possibility

The study participants understood that, in some cases, there is a need for institutionalization, especially when the elderly individual is at risk of aggra-

vating health conditions, as is the situation of the elderly woman reported in the vignette. However, they considered institutionalization as the last choice, since it involves loss of bonds, belongings and housing, leading the elderly to become even weaker, as expressed in the statements: *Evidently, she is at risk of health and life because she is taking medication, it would be the case of institutional care. But, institutional care, on the other hand, causes a loss of bond with the home, with belongings, her personal information and she weakens from 40.0% to 50.0%, so we have to be careful with that , it is a hard decision* (IL 2). *That she should go to some long-term facility, so that she can have this care, because she alone is no longer able to have autonomy and take actions on her own and is risking her health and well-being* (IL 4). *Since she doesn't want to have anyone in the house, I would ask if she would like to go to a nursing home, because then, she would live with other people, with other elderly people, she would have leisure, something that does not seem to have here. She would have the necessary care, medication, hygiene, food, which she does not have here* (IL 14). *The possibility would be a nursing home, to provide this assistance, so, in that sense, I think I would involve the family* (IH6). *As for the elderly embracement, for example, in an institution, they have to be vulnerable, because otherwise they say that they do not want to go, and you will not make them go* (IL 2).

Intersectoral and multi-professional work

The professionals highlighted the importance of multi-professional and intersectoral work, so that the elderly care can be improved, since this contributes to creating bonds, making them aware of the real situation and trying to find an articulated solution to improve the living conditions of the elderly. However, there is a perception that care networks are weakened, especially regarding intersectoral actions, as shown by the statements: *We realize that when the elderly person is assisted with multidisciplinary care, it is more common for them to come back in the future and ask for help. Or, at first, he still doesn't feel ready to make a complaint and he wants to ask questions and talk, but he comes back after being attended by the team, he creates a bond, he becomes confident* (IL 5). *The care network does not exist. It is all very fragile, if from the health service I need to go to another service, for education, for the social assistance, for the legal, everything is so bureaucratic, everything is so difficult that, unfortunately, the user feels the consequence* (IH 2). *I would involve other responsible bodies to provide this assistance and not operate it in such conditions* (IH6).

Limitations of the State

The interviewees also recognized that when the family is unable to meet the needs of the elderly, the State should be requested. However, they addressed its limitations, showing that it is necessary to go beyond what the State offers: *Because we know that the State has limitations. It is often flawed and there is no way to meet the demand of this elderly woman* (IL 4). *Nowadays, children abandon their parents and it is our responsibility to provide support for this elderly person, for this family, it is the State's duty, we should provide this support for this person* (IH 8). *There is an increase in the elderly who live alone, and they are unable to manage their lives. So, the country is aging, and the State cannot supply this new demand* (IL 5).

Complexity and limits of interventions

In the participants' speeches, it emerged that this is a complex situation and that there are limits to interventions. They revealed that, in the absence of a mental disorder, there is no way to interdict an elderly person. They recognized that, in the cases presented, there would be no way to place them in a long-term facility, as there is a need to respect the elderly's autonomy. When they asserted that they would not be able to meet such need, they considered it as a legal issue: *If she does not have it* (mental disorder), *there is nothing that can be done in the legal issue, we cannot interdict a person because she does not see well, but she would need assistance* (EJ 1). *And as a professional, I cannot intervene much in this, I cannot intervene in anything.* (EJ 10). *The Social Assistance Reference Center itself filed a lawsuit with the prosecutor, went after the prosecutor and judicialized a case so that we could get an intervention* (ES 3).

Discussion

As a limitation we highlight the fact that it was carried out only with professionals the primary care

health team and legal professionals, as those from other areas, such as social services who are also responsible for this care, could contribute to reflections on the theme. It is suggested, therefore, that complementary studies be carried out, to deepen the discussions concerning the frail elderly who lives alone, and this condition tends to increase and involves the interest of different professionals.

This study, however, contributes to clinical nursing practice, since it points to the complexity that this care represents, and prominence and reflections about the elderly who live alone, since it enabled to identify the importance of combination between health and the law professionals for comprehensive care for the elderly.

There were connections among the perceptions of the interviewed professionals when considering the family's responsibility for such care. Family care is important for any population group, being considered, therefore, as the best way of care for frail elderly. According to the Federal Constitution, it is the State and family's duty to guarantee the well-being and promote citizenship for elderly individuals, establishing responsibility for the adult children to support their parents in old age, in need and cases of illness[10]. Even though the family is the first core of interaction and support for the elderly, there is an understanding that the large number of elderly people living alone symbolizes a significant change and a paradigm shift[11]. Given this, there is the aggravating factor that society and, especially, the services responsible for elderly care are not properly prepared to deal with this reality.

For the professionals interviewed, adult children should be approached and responsible for taking care of their parents, according to the Brazilian legislation, which, among other aspects, considers that abandoning the elderly person in a fragility condition is a crime.

Nevertheless, in many circumstances, the family is insufficient, such as in situations where the person who should take care of the elderly is experiencing physical and/or mental health problems, is an alcohol or drug user, or is seen as a greater risk to the elderly. This reality is experienced by several elderly people in a family context, which creates greater complexity in solving the problem[12]. Therefore, it is questionable to accuse and blame family members for the neglect and abandonment of the elderly, as they sometimes have difficulties, even in caring for themselves.

Another relevant aspect concerning the elderly embracement by family members is the existence of conflicts, which indicates the need for efforts in the recovery and strengthening of the affective bonds. Thus, it is clear that when dealing with conflict situations, from a legal point of view, there should be a negotiation between the elderly and family members, based on the argument and demonstration that reaching a consensus is beneficial for both parties[12].

When there is no support from family members, institutionalization becomes an alternative. However, it is pointed out that the institutionalization process significantly affects the lives of the elderly. Although, in some cases, it may be the only option that the elderly person has to ensure that basic needs are met. The organization of the work process in this scenario is based on meeting basic needs, such as food and hygiene, reproducing the assistance model, making it difficult to promote comprehensive care. Also, they follow rules and routines that often change the identity of residents, compromising independence and autonomy[13-14].

There is also the understanding that the absence of a partner to help with daily activities makes the elderly's life not so healthy, therefore, great effort is needed to train those who live alone to develop instrumental activities of daily living[15]. Therefore, health services need to play an active role in promoting autonomy and preserving the independence of these people[6].

The lack of communication and the conflicts between social, health and legal services, especially in the most complex and difficult to solve cases, causes deficiencies to the care for the elderly, which shows

the need to improve interventions, in the intersectoral perspective[16].

The value of improvements in health promotion is also recognized. A systematic review and meta-analysis found strongly significant effects between educational actions and intergenerational contact, about the decline of the aging process, regarding changes in habits, knowledge, comfort and anxiety[17]. Although such actions can be established with low-cost technologies and that, in Brazil, primary health care has a structure designed for this purpose, care processes still take place in a fragmented way and focused on the disease. Advances in the idea of health promotion imply the need for professionals to have a closer relationship with reality, to understand and transform it[18].

It is observed, so, that the cases of greater complexity, in which the elderly person lives alone, is fragile and cannot count on the family's support, impact great challenges to professionals, because, although there is a law that guarantees good life and health conditions for the elderly, little investments were made by the State, to provide the necessary protection[19].

For the interviewees, the State is responsible for assisting the elderly and should provide more qualified services with appropriate dynamics, besides minimizing bureaucracies that make this assistance even more complex. This complexity is strongly related to the difficulties met in the flow of care to these people[16].

Another aspect to be considered is the respect for autonomy, since elderly people want to take care of themselves, maintain self-determination and be involved in decision-making, no matter how sick or fragile they may be. Even though they are aware that dependency changes over time, it is common for them to feel that they can take responsibility for their safety and well-being. It is recommended, therefore, that they are supported in decision-making and maintenance of autonomy, which may generate a sense of control in everyday life[20].

Conclusion

The care for the frail elderly who lives alone should have as a starting point the readjustment of the family's possibilities to provide this care, since it is a legal responsibility, suggesting that, in the case of conflicts, the best solution would be negotiation and, even, judicialization. Institutionalization was considered as an existing resource, if there is no other way, to keep the elderly person at home protected from risks of aggravating health conditions. Considering this, it is necessary to recognize that the elderly's autonomy must be respected, especially in the absence of mental disorder, as in the case described in the vignette. Multi-professional and intersectoral action was recognized as necessary, in complex situations.

Collaborations

Cardoso GP, Damaceno DG, Alarcon MFS and Marin MJS contributed to the conception and design, analysis, and interpretation of data, writing of the article, relevant critical review of the intellectual content and final approval of the version to be published.

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