

Social support, health and oral health promotion in the elderly population in Brazil

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ABSTRACT

The world people increasing aging, including Brazil, emphasizes the importance of measure to deal with this situation. In Brazil, the majority of elderly is woman, lives in houses with other generations, is economic reference in these houses, is in the low economic level, has at least one chronic disease, is independent to do daily life activities, doesn't have teeth, and look for health care services in the Unified National Health System (SUS). Brazilian elderly have exposed the social vulnerability situations, they are submitted to direct interference of the social determinants in the health-disease process. The Social Support includes social policies and networks, that plays a role the agent to join the elder and the society, it is decreasing the risks of social exclusion and consequently the damages to his/her health through Health Promotion measurements. This article concerns the Social Support and some of its aspects like: Type and place of residence, Transport and Financial Support; in Brazilian elderly and its relation between the Health Promotion.

Key words: social support. elderly. health promotion. oral health.

Introduction

The demographic transition is a worldwide phenomena mainly characterized by the decline of the fecundity rate, decrease in the older ages mortality rates and the increment in life expectancy rates therefore generating a changing into the age bracket structure (aging). The phenomena had been observed for sometime in developed countries but now it also started to occur, in a very fast way, in developing countries including Brazil and in a smaller proportion in the underdeveloped ones (Pereira, 1995; Higgs, 1997; Carvalho, Garcia, 2003).

In Eastern societies elderly people are considered wise and respected by the younger generations (Goyaz, 2004). In western societies the increment in the number of elderly people in the population has been followed by the stigma of dependency what leads the society towards a prejudicial view on the elderly who might somehow to be seen as a social and economic burden by some segments of the society not only due to their removal from labor market but also for the increment in the its prevalence for Chronic Degenerative diseases and a higher risk of incapability.

With the aging process comes along a questioning about the meaning of the word health for most of the elderly people are carriers of some chronic disease. The central aspect regarding aging is autonomy being that a decisive factor for a healthy life for the elderly. "Healthy Aging is nowadays the outcome of the multidimensional interaction of physical and mental health, daily life autonomy, social integration, family support and economic independence" (Ramos, 2003, p. 794). The beneficial effects of a social support net depend above all on its capability of supplying several resources to the individual, which means; social supporting (Hanson, Liedberg e Öwall, 1994).

The social support aims at integrating the elderly person into the society by minimizing the social exclusion risks whether through the social support nets or the creation and viability of public policies therefore being the aim of this study to accomplish a revision of the literature on social support and its impact upon the organization and the promotion of the elderly people's health in Brazil.

Elderly people in Brazil

The number and life conditions of the Brazilian elderly drastically vary from region to region, state to state and city to city. Those characteristics depend on the local social economic development (Telarolli Júnior, Machado e Carvalho, 1996). A household survey carried out among 667 elderly people in the city of Fortaleza (CE) has revealed that 66% of them were women, 48.1% were married, 36.8% were widows and widowers and 15.1% were single however 67.2% of the women were living without their husbands. The overwhelming majority of the elderly (75.3%) lived in a multigenerational household and only 6.3% lived by themselves. The elderly with a better social economic level have the propensity to live in a unigenerational household or by themselves thus having a greater level of autonomy (Coelho Filho e Ramos, 1999).

A study based on data gathered by a Household Sampling National Survey (PNAD) from 1998 has profiled the Brazilian elderly. The average revenue was in the order of R\$ 332.56 (\pm 30.75) being 64% of the elderly a reference in the household however the lowest income levels were most frequently found amongst the elderly women, the ones older than 75 years of age, those with lowest education, and the ones who lived alone. Nevertheless, these data contradict the aforementioned study.

Only 22.8% of the elderly have reported that their health was good or very good, but only 15% of them have affirmed to have stopped doing their routine activities due to health problems. The majority of the elderly mentioned to have at least one chronic disease, to be independent in which concerns the carrying out of their daily life activities, to have been to over three medical appointments within the last 12 months, and to have attended to an odontological consultation more than three years ago. 26.9% out of the elderly interviewed had a private health insurance plan. The best health conditions, physical capability, and access to health services were related to the elderly people with better revenue levels (income larger than 67% minimum wage, which was during the time of the survey, equals to R\$130.00). The expenditures on medicine corresponded to 23% of the minimum wage (Lima-Costa, Barreto, Giatti, 2003; Lima-Costa et al., 2003).

As for the inclusion into the labor market most of the elderly living in ten Brazilian metropolitan regions undertook informal activities with working hours equal or superior to 40 hours per week, were autonomous for the services rendering sector, and had up to seven years of education. Out of the group of the elderly who worked 57.35% belonged to the age group between 65 to 69 years old. Nevertheless, in the group of the retired elderly 36.85% were 75 years or older and 35.36% were from 65 to 69 years of age. The income average in the households of retired elderly was about R\$ 350.00 however 24% of them received less than R\$ 130.00. Nevertheless, the average amongst those who were working was in the order of R\$ 610.00. The retired elderly presented greater frequency of chronic disease, less autonomy level, and physical mobility (Giatti; Barreto, 2003).

In the biomedical literature from the period comprised between 1998 and 2002 there have been gathered data on poverty, famine and destruction. According to the data 47% out of the total of the deaths by undernourishment happened among elderly people over 65 years of age. The South and Southeast regions presented a higher mortality rate due to malnutrition among elderly individuals at 75 years of age or older. The type of malnutrition to which the elderly individuals had been victims of was not the lacking one (food shortage) but instead the abandonment one (food deprivation).

The Epidoso Project, a longitudinal study undertaken in 1991 on elderly people who lived in community, in the city of São Paulo (SP), identified factors related to health ageing and mortality risk

factors. The mortality risk factors in that group of elderly individuals were: sex (masculine), advanced age, hospitalization, cognitive deficit and daily activities dependence (Ramos, 2003).

Social inequalities in the health of the Third Ageism Individuals

In order to talk about social inequalities in health it is necessary to admit the influence of the social determinants upon the whole health-disease process. According to Chammé (2002), health rewards the conditions experienced by the body of the individual and their living quality level. The author sees disease as an outcome of the lack of interest in the social economic determinants of the disease itself hence generating sick individuals who are the result of exclusion and exploitation.

The human-being is complex and consisted of the interaction of biological, social, psychological, and spiritual factors mutually influencing each other. Regarding the action of those factors it is hard to determine precisely to what extent they influence upon the health-disease process (Palácio e Vasquez, 2003). According to Ludermir and Melo Filho (2002), the relation between the social classes are not passive and stable instead they have their proper dynamics which goes beyond the differentiation by social economic factors that way enabling explanations on the distribution of disease into the communities.

“The social economic determinants are related to the capability of obtaining health services that meaning that they embody the economic and cognitive capability of obtaining health goods and services therefore incorporating them into their personal hygiene and environmental habits which favors on the obtaining and maintenance of good health conditions” (Paes-Sousa, Ramalho e Fortaleza, 2003, p.28).

There are three theories which try to explain the social inequalities in health through the interaction of the social, economic, and environmental factors: Analysis of the Course of Life, the Salutogenic model, and the Social Capital. The theory of the analysis of the course of life explains that there is an interaction between biohazard and social and psychological factors leading to the development of chronic diseases throughout the individual lifetime; being the current disease a result of the past social position of the individual. According to the Salutogenic model there is a relation between the way people deal with stressing events in life and their health state that theory proposes the

identification and posterior modification of the social economic factors which influence upon the health state of the communities (the creation of salutogenic spaces). The social capital theory is very hard to define and includes citizenship, trust in others, cooperation, and social commitment. The Social capital is related to the social support nets and social supporting. The health state of the individuals and the collectiveness is explained by the different levels of social capital present being poverty and the lack of base and structural material related to a low social capital thus contributing for health inequalities (Watt, 2002).

Elderly people with the least social economic level present greater social needs, higher levels of physical and mental morbidity. The results of a survey carried out in Fortaleza (Ce) have demonstrated that elderly people who lived under the worst material conditions presented more chronic diseases, higher level of dependency, worst mental conditions, and difficulty to have access to health services than those from a better social economic level (Coelho Filho e Ramos, 1999).

A study undertaken in a rehabilitation center, in the city of Araraquara (SP), on the perception of the Oral health in low-income, education up to the fourth year of the fundamental school, and little professional qualification, has demonstrated that oral health was considered as regular by those elderly individuals however the data gathered through clinic examination indicated that there was no match in between self-perception and the oral health actual condition (Silva; Fernandes, 2001).

In a Oral Health National Epidemiologic Survey (SB Brasil) using a sample of 5,349 elderlies it was verified that the number of missed, with decayed, and filled teeth through the DMFT index increases according to the ageing process leaping from a 20.1 average in the 35 to 44 years of age group to a 27.8 average in the 65 to 74 years of age group. The lost component was responsible for approximately 93% of the DMFT in the elderly people. Nevertheless, the World Health Organization (WHO) and the FDI World Dental Federation aim for the year 2000 is 50% of the elderly population with 20 teeth or more in the mouth. The prevalence of root caries in this age bracket was low due to dental losses although the decayed component represented only 12.19% of the teeth examined. The need of superior dental prosthesis occurred in 32.40% of the elderly individuals examined and 56.06% needed inferior dental prosthesis. Despite that 46% of the elderly considered their dental health good. As far as access to dental services is concerned almost 70% of the researched elderly have over three

years since their last dental consultation and 5.83% of them had never had one. Regarding the type of service used 40.50% reported public service and 40.26% liberal private service (Brasil, 2004).

Among the North American elderly, edentulism is associated with the following conditions: over 65 years of age, poverty, white and self-perception of dental health state as bad. The use of removable partial dental prosthesis and the presence of dental veneers were related to the possibility of the elderly individual to afford the payment of the dental assistance fact which has made impossible the access to those treatments by the poorer ones (Dolan et al., 2001).

The dental loss is seen as an ageing consequence however there is an association between dental loss and life negative events (such as widowhood), low occupational prestige levels, less help from the family and friends, and the presence of depressive symptoms (Drake, Hunt, Koch, 1995).

Social Support and Health Promotion

The term exclusion hardly seems to be sufficient to define a dynamic process not limited to the removal of the productive means but it also involves the non participation into social protection nets and systems. The fight against social inequalities goes through the re-establishment of social bonds, interdependency, and solidarity among the individuals (Magalhães, 2001).

Social Support includes policies and social support nets (family, friends, and community) that have as their goal to contribute for people's well-being mostly those in the exclusion position. In that case, the social support through the equality of its actions makes possible the exercise of citizenship.

According to Valla (1999, p.10), "social support is defined as any information spoken or not and with financial aid or not offered by groups and/or people who know each other resulting in emotional effects and/or positive behavior". The function of the social relations comprehends behavioral and qualitative aspects of the relationships including social support, social anchorage and relational effort (emotional support). It is worth to highlight the fact that with the ageing process the social relations undergo changes (Avlund, 2003).

Due to social economic and health conditions the elderly is subject to social vulnerability. The National Policy for The Elderly (Brasil, 2003) affirms that is responsibility of the family, the society, and the State to insure the elderly's citizenship, their participation in the community, dignity, well-

being and right to life. The Elderly Statute (Brasil, 2004c) grants to that part of the population priority in the elaboration and execution of social policies as well as it ratifies the right to: life, health, food, education, culture, sport, leisure, work, citizenship, liberty, dignity, respect, and the coexistence with family and the community.

The creation of policies which will include all society, elderly support nets for the elderly dependent on the family (training of the caretakers by health professionals), assistance to the elderly who are not taken care of by their families or programs aiming at the prevention of a posterior dependency by elderly people who are at the present moment independent, are means to promote health in the Third Ageism (Telarolli Júnior, Machado e Carvalho, 1996; Caldas, 2003).

The growth of the old population is simultaneous to the expansion of the need of support. A study carried out, in Guadalajara (Mexico), among low-income hospitalized elderly people showed that married individuals and widowers received a greater number of supporting activities. The emotional support was the of support type with the highest prevalence, followed by economic and instrumental support (support of daily activities). The size of the support net was of 7.5 components average. Elderly women received a support net bigger and a bigger proportion of supporting activities than men comparatively (Robles, et al., 2001).

Social support improves people's health and well-being while acting, in some situations, as a protection factor as well. Besides that the support can be used as a tool towards the autonomy of the individuals because after they have learned they will share the ways to deal with the health-disease process into the community (Valla, 1999). Health promotion gives emphasis on the reduction of the inequalities in health through the actions upon the social determinants of the health-disease process, injury and incapacity, as well as through the adoption of measures that favor on the development of healthy environments (Watt, 2002).

Although elderly women represent the majority of the population over 60 years of age in Brazil and face specific social situations such as widowhood and health conditions, as osteoporosis, more prevalent among women every elderly person demands an adequate social and sanitary support (Telarolli Júnior, Machado e Carvalho, 1996).

The elderly person needs diverse types of resources to supply their daily life necessities and to be able to make healthier choices. Those resources include psychological aspects, education, financial and social support (Hanson, Liedberg, Öwall, 1994).

The State must be active in order to promote and help family's support besides that to grant full access to the elderly person to the Unified National Health System (SUS). The Family Health Program functions as a link between the elderly person and the health services that way making home care possible, for the dependent elderly, consequently valuing the community care with emphasis on family care and the Health Basic Attention (Silvestre, Costa Neto, 2003). "The active participation into local councils might stimulate the sense of belonging to and community spirit while even increasing the social support within the community" (Watt, 2002, p.245).

The facilitation of the access to dental services in health centers or home service or through mobile units along with the understanding by the caretakers about the importance on keeping good oral conditions are important resources in the search for support towards the maintenance of the autonomy and a betterment on the general situation of the elderly individual.

Social-demographic factors mainly the social relations aspects are considered predictors of oral diseases in elderly persons such as root caries (Gilbert et al., 2001; Avlund et al., 2003). "... weak social relations influence in the developing of dental cavities through inter-related biological and behavioral mechanisms" (Avlund et al., 2003, p.460).

The Dentistry must actuate into this context as a social integration agent promoting social support while maintaining the elderly's oral health this way allowing them to have a pleasant appearance, better self-esteem, and a higher phonation capability besides contributing for the integration of the elderly person into the society.

The Common Risk Factor Strategy in the Health Promotion actuates on the prevention of diverse chronic diseases which have the same risk factors as diet, smoking, alcohol use, stress, trauma, and sedentariness. Diet for instance has influence on obesity, diabetes, and caries (Sheiham e Watt, 2000). Such strategy may be used with elderly people with the purpose to prevent the appearance of chronic diseases associated or not with its complications.

Health promotion may be accomplished in multigenerational environments such as families due to the fact that most elderly people live in community, places such as church, associations, and the Open University for the Third Ageism, schools where they can interact with children and adolescents in order to share with them their knowledge while stimulates a greater autonomy regarding their health.

Type and Residence Location

The elderly might live in the community or institutions and the residence types may be different: geriatric, shelter homes for elderly people, Long-term Care Hospital, and households. The geriatric residences are private condominiums with all the health and other services infrastructure where the elderly person can live alone or with a spouse. They have a high maintenance cost.

The shelter homes may be philanthropic, public, or private depending on the type of financing. Those institutions have community rooms normally divided by sex while the other areas are of common use. The Long-term Care Hospital shelters dependent elderly persons who need constant medical-hospital assistance. Nevertheless, in the households they live in community with their families, friends, and spouses or by themselves.

“The family and the friends are the first care source. The major indicator for sheltering and other types of long-term institutionalization among elderly persons is the lack of family support” (Caldas, 2003, p.776).

In Brazil, the elderly person tends to live in multigenerational households with their spouses and/or progenies, sons-in-law, daughters-in-law, and grandchildren (Coelho Filho e Ramos, 1999). In Brazil, the elderly caretaking is focused on the family and mostly done by women. In Araraquara (1993), for instance only 0.75% percentage point of the elderly persons is institutionalized (Telarolli Júnior, Machado e Carvalho, 1996).

Those data are similar to the data from England where just a small percentage of the English population live in shelters homes for elderly people or geriatric hospitals even being of advanced age (Higgs, 1997).

The advanced age factor is not in itself determinant for the sheltering. The factors that increase the risk of sheltering are: the presence of chronic-degenerative diseases and their sequels, recent hospitalization, dependency, living alone, precarious social support, low-income, and decrement on the number of family caretakers (Chaimowicz; Greco, 1999).

According to the Elderly Statute (Brasil, 2004c), they have preference during real estate acquisition in housing programs financed by public funds, urbanism and proper architecture, and their own financing criteria.

Elderly people residing in flats with flash of stairs or in slams or “vilas” with narrow paths may face locomotion difficulties mainly if those elderlies needed support or wheelchairs which would restrict the access to a bigger social support net including health services therefore making health and dental home service fundamental.

Transportation

According to the International Classification of Functioning, Disability and Health (ICF) (2004) transportation is inserted into the general social supporting service. Transportation is also an important component factor for the health promotion into the third age group indirectly acting to avoid the social exclusion of those individuals.

In Brazil, the law of the Elderly Statute (Brasil, 2004c) ensures the gratuity of urban and semi-urban collective transportation with the exception of the special and selective lines when rendered paralleled to regular services. In the case of elderly people belonging to the 60 to 65 years of age group it will be subject to the local legislation criteria the establishing of the conditions for the gratuity of public transportation.

This gratuity appears as a facilitating mechanism for healthy choices, while stimulates leisure, the participation in conviviality groups, education therefore resulting in the persons empowerment whilst fighting social isolation and depression.

The elderly people who use that kind of transportation are usually characterized by their independence, to live in the community, and not to need help in order to maintain functional making

use of the traditional health services, some of them requiring the locomotion of the elderly person, for example, dental or private services.

In what regards to the elderly persons, are considered fragile those carrying a chronic disease or with some emotional, medical or physical inadequacy being only able to maintain their independency in the community due to continuous assistance, along with the functionally dependent ones who besides the aforementioned problems are incapable of keeping their independency and see the transportation as a barrier to the access of most diverse services being dental service one of them (Dolan e Atchison, 1993). Cazarini (2002) has also demonstrated that one of the causes for the elderly persons not to join in a group for people with diabetes mellitus was the difficulty of access to transportation.

For elderly persons considered fragile and functioning dependent that need oral health care there are new alternatives such mobile units, and home care. In the mobile units a clinic is installed and maintained in a SUV or Van which moves around going to as near as possible of the individuals. In home care service the individuals have no means to leave the house so the dentist goes to the place carrying portable equipment (sometimes with some limitations) but granting access to the service (Lee, Thomas, Thuy Vu, 2001). The financial cost is one of those limitations (Fiske, Gelbier, Watson, 1990) where the majority is still in private services mostly home care.

In Brazil, the Family Health Program (PSF) expands its access range to beyond the Health Units through the home visit, which aim at attending to individuals who in their majority are fragile elderly persons or functioning dependent trying to keep them with their family preventing or postponing the hospitalization (Silvestre e Costa Neto, 2003). The professional who works with oral health at the PSFs practices a new health assistance concept, home care, going to the house of the disabled individual and through the betterment of their oral health they achieve the reestablishment of the overall health. The mobile units are resources used to render service in the rural and outlying areas where the access to health services is really limited.

Another matter to be discussed is the one related to car crashes involving elderly persons. The elderly victims of lesions due to external causes are generally independent. Nevertheless, after the accident that condition is usually changed harming their mental and physical health. The road traffic is

more harmful to the elderly for they are most vulnerable to traumas, have a slow recovery time, and register more hospitalization time in case of trauma and severe lesions (Gawryszewski, Koizumi, Mello-Jorge, 2000).

A study carried out in Londrina (PR), which analyzed the characteristics of the victims of road traffic accidents verified that the highest coefficients of incidence of offences and mortality were related to young motorcyclists between 15 and 29 years of age (33 to 38.3 per 100 thousand inhabitants), to elderly people between 60 and 69 years of age (28.1 per 100 thousand inhabitants) and for elderly people between 70 and 79 years of age (39.4 per 100 thousand inhabitants) (Andrade, Mello-Jorge, 2000).

A quality public transportation adapted to the needs of that population, decrement in the barriers to the access to health service through home care and mobile units, driving autonomy continuance, programs that help keeping the elderly into their family and city appropriate physical structures for elderly people are allies in the maintenance of their living quality.

Financial Support

According to Higgs (1997), a landmark that indicates in several countries, the reaching of the third age, is the retirement. That is a controversial fact thus can not be generalized due to the fact that in some African countries mostly the poorer ones people wait for retirement at the age of 40 years old. The increment in the number of retirements in industrial societies has propitiated the appearance of theories on the position of the elderly person in the society. The exclusion theory refers to the removal of the elderly people from the economically active population through retirement not being limited to the working environment, but family as well. The structured dependency theory demonstrates that when the elderly is removed from the formal job market they begin to depend solely on the pension being that dependency established by public policies. According to the Third Ageism theory retirement is seen as a turning point which makes possible to the elderly to do other economic and social role valorization activities. The elderly could invest their time into education, change of profession, tourism, etc...

In Brazil through the Lei Orgânica da Assistência Social (Welfare Organic Law) the elderly person do not have the necessary resources to survive or whose family do not intervene in their maintenance are entitled to a monthly minimum wage as a benefit (Brasil, 2004a).

The pension offered by the State should not be inferior to minimum wage neither superior to the maximum contribution limit of 10 minimum age salaries. In order to avoid, in a few years time, a collapse in Brazilian Social Security system due to the growth of the number of the elderly persons and the life expectancy increment. One of the adopted solutions was to increase the retirement limit age from 60 to 65 years of age for men and from 55 to 60 years of age for women. Rural workers may apply for age retirement 5 years before: 60 years of age men and 55 years of age women. It was also established an 11% contribution to Social Security for those who receive over 60% of the maximum limit affixed for the general regime benefit of the Social Security (Brasil, 2004b; Brasil, 2004c).

An adequate financial support minimizes health inequalities. In what concerns to oral health the economy decisively contributes towards an elaboration of a oral health profile as well as to oral care hygiene habits amongst the people (Hanson, Liedberg e Öwall, 1994).

When elaborating a plan focusing on the recuperation of oral health in third Ageism the cost should be taken under consideration mostly because the oral rehabilitation services, specifically the prosthetic ones, are the most demanded and onerous services. That fact excludes the majority of the elderly population from obtaining those services. Little by little that reality tends to be modified with the implantation of the National Oral Health Policy which aims at the expansion and training of the Basic Care through the inclusion of more complex procedures, such as prosthetic rehabilitation into its services range (Brasil, 2005).

Conclusion

Brazil is a country with great social and economic contrasts and within that context the populational ageing raised as a matter to be discussed due to the increment in the number of elderly persons living under precarious social economic conditions with the highest prevalence for chronic-degenerative diseases and an elevated dependency risk. An adequate social support and Health Promotion as at macro level – Public Policies, as for nuclear family units must be structured and made

viable in order to supply the elderly citizens' necessities therefore improving their living quality. The presence of support nets, a dignifying financial support, proper housing, and good quality transportation are some of the elements necessary for the construction of better living conditions.

The Health and Oral Health Promotion amongst the Brazilian elderly population shall be stimulated in all different social environments into health services as well as in the nuclear family units thus promoting the elderly autonomy this way making possible the consolidation of the undeniable relationship between Social Support and Health Promotion for while implementing the first health is also being promoted.

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