

Fostering health care for the elderly private

Despite remarkable growth of the elderly population, Brazil will still have for some time a large share of young people in its population. This situation differs significantly from countries in the Northern Hemisphere. In those countries, the number of young people is smaller, more stable or this number has been showing a tendency to decrease for decades, whereas the older share of the population continues to grow.

The growth pattern of the Brazilian population has different characteristics from central countries. Brazil faces a great challenge: the allotment of resources to assist both age groups, elderly and young. Both groups are in need of resources and demand a great deal of services. Thus, funding for social programs should be designated not only to reverse, for instance, the high infant mortality rate and malnutrition. Funding for social programs should also be designated for educational programs, to combat chronic diseases such as arthritis, heart, degenerative diseases, cognitive changes and other illnesses typical of the elderly. In addition to health problems, there are benefits and pension expenses from the social security system to which all elderly people are legally entitled. In terms of economic impact, there is an enormous difficulty: two economically inactive groups demand meager resources from a poor country with a big tradition of low investments in health care and social security.

Perhaps the greatest similarity between Brazil's elderly population and the elderly population from central countries resides in the problems faced by elderly women. The marital situation of elderly people in Brazil shows that 68% of the people without a companion (unmarried, widowed or divorced) are females. Due to cultural factors, the woman marries at an earlier age than man. Women's life expectancy is longer, therefore, women are more likely to be alone in the later years. Women marry earlier and live longer. The scenario grows even gloomier when living alone is also accompanied by poverty and chronic diseases. The combined effects of loneliness, poverty and illness affects a large share of the elderly female population. Like in the central countries, this situation is also seen in the majority of the aged Brazilian women.

Research in epidemiology in Brazil is, with some exceptions, very modest. Therefore, an increase in epidemiology research is necessary. The paper herein portrays a draft proposal for a study in epidemiology. This proposed study is based on another recently concluded investigation that yielded information to shape medico-social policies for elderly women. Additionally, this original research produced some hypotheses to be confirmed in subsequent studies.

The aforementioned draft study proposal - "Prevalence Studyö - despite its limitations, has as its objective to shape a profile of elderly subjects residing in a large urban area in Brazil, namely, Rio de Janeiro. Due to socio-economic discrepancies within Rio de Janeiro, the authors did not consider the city as a whole, which would have been a desirable technique in order to obtain records reflecting the life conditions in the poorer and wealthier social classes. Instead, the authors surveyed some city areas separately. This was done to allow a more accurate record of region-specific realities (Ramos et al., likewise performed a study in São Paulo city).

Therefore, Rio de Janeiro was assessed in "homogenous areas", that is, neighborhoods and social classes displaying similar facilities.

Epidemiology, as a science, has been demonstrated to carry powerful instruments to produce critical data for planning, implementation, and assessment of social services. Priorities can also be determined with the help of epidemiology. Regarding the elderly population, several studies employing data collection by means of questionnaires, have been shown to have significant value in determining events and in the control of social and health problems.

The definition of the draft instrument is important when planning an inquiry. Despite operational burdens, home interviews are by far the best method in the study of an elderly population.

In the present study, an instrument called BOAS was developed. BOAS is a multi-dimensional questionnaire devised for elderly people, and it was grounded in several other instruments with acceptable validity and reliability. BOAS

is composed of nine sections. Being a multi-dimensional questionnaire for the third age, it is long because it is meant to cover a wide range of features in the lives of elderly people. Thus, the questionnaire draft proposal is to approach wider range of diagnosis. It does not explore specific features, but constructs a profile of the elderly person. The multi-dimensional questionnaire is not meant to obtain detailed information. It respects time limitations as well as taking into consideration the fact that it is an interview with an elderly population. At any rate, no research instrument should exceed 60 minutes of application.

Three areas within Rio de Janeiro were selected for the study: Copacabana, MÚier and Santa Cruz. These areas were selected in keeping with socio-economic and demographic data. Initially, a four-month-long enumeration was performed. The BOAS application began in July 1988 and it was concluded in August 1989. The response rate was excellent, 93.3% in Copacabana, 93.8% in MÚier and 93.1% in Santa Cruz.

The use of morbidity indexes to assess the health status in the study of an elderly population, despite its clear importance, does not have the same predictive meaning as in other age groups. From 60 or 70 years of age, the majority of the people have one or more chronic illnesses. This (the presence of chronic illnesses) gives the identification of a health problem a distinct degree of importance as opposed to the other age groups.

In this age range (60 to 70 years), it is more important to record if an illness is limiting the performance of a daily routine in an independent and autonomous manner than to identify the presence of an illness. For instance, it is more important to document how a diagnosis of an arthritic condition is limiting walking (loss of independence) or if the person's activities are only made possible with the help of a wheelchair pushed by a third party (not autonomous) than recording the specific features of an arthritic condition.

Therefore, in the multi-dimensional questionnaires created for the elderly individual, the section named activity daily living (ADL) as a tangible indicator in the definition of life quality for the elderly person. It is also a valuable index to be taken into account in the planning of health policies.

Another important item analyzed in this study is the mental health of elderly subjects. In this present study, that authors will present and discuss the results of the study of the

prevalence of Organic Cerebral Syndrome (OCS-dementia) and depression. The authors will also discuss the methodological features involved in the reliability study as well as validation of the BOAS mental health segment. A description of the procedures used in the pilot study is also approached.

The BOAS instrument carries a mental health segment that is a Portuguese translation of the short-CARE. The short-CARE Portuguese translation employed was the Guys Hospital and Age Concern Psychogeriatric Research Project's version. This version was steered by Dr. Elaine Murphy and it is an adaptation, with few changes, of the original instrument developed by Garaland. The questionnaire possesses scales for assessment of Organic Cerebral Syndrome (OCS) and depression (Dep). SCO carries 12 items with scores ranging from 0 to 9 points. There are 31 items for depression, and scores range from 0 to 28 points. The pilot study belongs to a body of quality assurance measures aiming at the next step in the research. In this next step, the instrument was assessed for reliability and validity, with the subsequent prevalence study. Once this initial draft was selected, a small number of interviews were done for the pilot study with no statistical analysis performed. These interviews focused on the case-to-case basis (quality), aimed at priming the instruments as well as the procedures to be employed in the next step of the study. In summary, this pilot study can be considered as a fine-tuning stage, previous to the study itself.

There are five features regarding the BOAS mental health segment study that deserve comment. First, it is necessary to observe that the majority of the studies to validate the estimated sensibility and reliability values display a wide confidence interval. This is because of the small sub-sample employed in these validation studies.

This feature (wide confidence interval), although receiving little attention in the majority of the papers on validation of diagnostic instruments, is of paramount importance. This wide confidence interval is important for the decision about the cut points to be adopted. It is also important in appraising the prevalence rates corrected from these studies. These features manifest themselves by means of abrupt changes in the sensibility and specificity when the cut point is shifted to the next point. Thus, the selection of these cut points should be made rather carefully because one cannot state with a high reliability degree that the rate of false-negatives and false-positives are distinct for adjacent cut points.