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Original Article

VISITA DOMICILIAR A IDOSOS: CARACTERÍSTICAS E FATORES ASSOCIADOS

HOME VISIT TO ELDERLY: FEATURES AND ASSOCIATED FACTORS

VISITA DOMICILIAR A LOS ANCIANOS: CARACTERISTICAS Y FACTORES ASOCIADOS

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RESUMO

Objetivo: analisar os fatores associados à visita domiciliar na população idosa e suas características segundo os preceitos da Estratégia Saúde da Família. **Método:** estudo transversal de base populacional com amostra representativa de 340 indivíduos com 60 anos ou mais residentes na zona urbana de São Paulo, SP. **Resultados:** a única variável que apresentou efeito estatisticamente significativo na visita domiciliar foi "passar em consulta médica na UBS" (p-valor = 0,0022). O *odds ratio* estimado para essa variável foi de 2,369, com intervalo de 95% de confiança. **Conclusão:** os resultados do presente estudo mostraram que os idosos avaliados eram mulheres na faixa etária de 60 a 69 anos, com baixa escolaridade, renda familiar insuficiente, vivendo sem cônjuge, dependentes do Sistema único de Saúde, havendo presença de doenças crônicas com destaque para hipertensão arterial e incapacidade para desempenho de atividades instrumentais da vida diária.
Descritores: Atenção primária à saúde; Visita domiciliar; Envelhecimento da população.

ABSTRACT

Objective: to analyze the factors associated with home visits in the elderly population and their characteristics, in accordance with the principles of the Family Health Strategy. **Method:** A cross-sectional population-based study with a representative sample of 340 individuals aged 60 years or older residing in the urban area of São Paulo, SP. **Results:** The only variable that presented a statistically significant effect on the home visit was a medical visit at the UBS (p-value = 0.0022). The estimated odds ratio for this variable was 2,369, with a 95% confidence interval. **Conclusion:** the results of the present study showed that the evaluated elderly were the women in the age group of 60 to 69 years, low schooling, insufficient family income, living without spouse, dependents of the Single Health System, with the presence of chronic diseases with a prominence for hypertension arterial, inability to perform instrumental activities of daily living.
Descriptors: Primary health care, Home visit, population aging.

RESUMEN

Objetivo: analizar los factores asociados a la visita domiciliaria en la población anciana y sus características, según los preceptos de la Estrategia Salud de la Familia. **Método:** Estudio transversal de base poblacional con muestra representativa de 340 individuos con 60 años o más residentes en la zona urbana de São Paulo, SP. **Resultados:** La única variable que presentó efecto estadísticamente significativo en la visita domiciliaria fue pasar en consulta médica en la UBS (p-valor = 0,0022). El *odds ratio* estimado para esta variable fue de 2,369, con un intervalo de confianza del 95%. **Conclusión:** los resultados del presente estudio mostraron que los ancianos evaluados eran las mujeres en el grupo de edad entre 60 y 69 años, baja escolaridad, ingreso familiar insuficiente, viviendo sin cónyuge, dependientes del Sistema Único de Salud, presencia de enfermedades crónicas con destaque para hipertensión, incapacidad para el desempeño de actividades instrumentales de la vida diaria.
Descriptores: Atención primaria a la salud, Visita domiciliar, Envejecimiento de la población.

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INTRODUCTION

The process of human aging has been a topic of discussion in almost every country in the world, and in Brazil, it has taken on alarming proportions, since the population's life expectancy has increased significantly. This is due to improved living conditions, basic sanitation, work, education, as well as the technological conditions that have made it possible to live longer and with better quality[1].

Elderly people have special characteristics regarding the nature of their diseases, the way they become ill and the use of health services, which requires a large re-dimensioning of health practices to meet the new demands imposed by the growing population of long-lived people. Priority is given to the implementation of innovative, short-effective services and programs that incorporate new paradigms of health care with a focus on the functional capacity far more than on the disease[2].

Although aging does not mean directly falling ill and being dependent, it undoubtedly indicates a greater fragility and vulnerability that increases as the individuals' chronological age is more advanced, allied to the social and environmental context in which the elderly person lives. In most cases, the responsibility for caring for the frail elderly is assumed by the family, who is not always ready for such a condition. This care materializes in the daily actions of daily life and involves functional, social, economic, material and affective support[3].

The challenge of aging in relation to health care depends on the close relationship between the use of health services and age. Therefore, health spending grows in an aging population. To estimate the impact in Brazil, the Institute of Supplementary Health Studies (IESS) calculates the annual expenses and their variation for a total of 1.1 million beneficiaries of individual health plans, distributed in the ten age groups of the regulation[4].

One of the strategies adopted by the services to relieve the State and modify the traditional way of production in health is the inclusion of the home visit in the list of care modalities. This kind of visit is characterized by the health team visit to the user's home with the objective of assess your family´s and your needs, considering the availability of the service and consisting of care plan and guidelines. The home visit presupposes a complex action, requiring some technique and periodicity of the health team, according to the evidenced needs[5].

This modality has resulted in greater comfort and safety for the elderly and their family, as well as providing humanized care and quality of life, when compared to institutional care. But the concretion of this perspective requires a situational diagnosis favoring quantitative and qualitative information that effectively contribute to the knowledge of the health reality of the elderly population and their domiciliary and family dynamics. The guidelines provided by this information allow decision making, so that health service planning is organized according to the principle of equity, giving priority to those who need care most[6].

In Brazil, in the 1990s, the concept of Primary Health Care (PHC) was also renewed. With the regulation of the Unified Health System based on universality, equity and integrality and on the organizational guidelines of decentralization and social participation, to differentiate itself from the selective conception of PHC, we used the term basic health care, defined as individual and collective actions at the first level, focused on health promotion, disease prevention, treatment and rehabilitation[7].

The Family Health Strategy (ESF) comprises a health care model in the context of Primary Health Care, which is structured in the work perspective of multi professional teams in an adjoining territory, developing actions based on the knowledge of the local reality and population needs of this territory[7].

The objective of the present study was to analyze the factors associated with home visits in the elderly population and their features, according to the principles of the Family Health Strategy, which constitutes a strategy to reorient the care model.

METHODS

A population-based cross-sectional study, conducted from January to March, 2012. The sample was selected for convenience and consisted of 340 individuals aged 60 years or older residing in the area covered by the Santa Catarina Basic Health Unit located in the municipality of São Paulo.

We used structured questionnaires with pre-coded questions, after conducting a pilot study. In case of partial incapacity, the answers were given by a responsible family member or by the main caregiver.

The dependent variable 'home visit' was defined as an external activity to the health unit characterized by the use of light technology, allowing health care in a more humane, welcoming way, establishing trust between professionals and users, family and community. The question asked was: 'Do you usually receive a visit from the health team in your home?' (Yes/no).

The demographic and socioeconomic variables studied were: gender, age (60 to 69 years, 70 to 79 years, 80 years or more); marital status (married, single, divorced, or widower); skin color (white, black, brown); can read / write (yes, no); Per capita income (in minimum wages: up to 1, from 2 to 3, from 4 to 6); private health plan (yes; no); in case of sickness demand (pharmacy, hospital, health unit); goes to medical consultation at the UBS (yes, no); hospitalization in the last year (yes, no). Among the morbidity indicators, the following variables were used: medical diagnosis of hypertension (yes, no); diabetes (yes, no); dyslipidemia (yes, no); low back pain (yes, no); depression (yes, no); Insomnia (yes, no). Functional assessment scales were used to establish functional disability in the elderly[8-9].

In order to respond to the objective of the study, a Logistic Regression model was used in which the dependent variable was the home visit (binary variable, type 'yes' or 'no') and the independent variables were the 18 information mentioned above. All hypothesis tests developed considered a significance of 5%, that is, the null hypothesis was rejected when p-value was less than or equal to 0.05. The logistic regression technique is used when there is the interest in modeling a binary dependent variable as a function of a set of independent variables. The general model, for the case of only one independent variable, can be written as follows:

$$\pi(x) = \frac{e^{\beta_0+\beta_1 X}}{1+e^{\beta_0+\beta_1 X}}$$

As being $\pi(x)$ the probability of occurrence of the interest event and, therefore, receives values between 0 and 1, X is the independent variable from which we try to predict the occurrence of the interest event, β_0 is a constant that represents the general average, denominated intercept, and β_1 is a constant that, in an exponential way, influences the probability of success according to the independent variable X value.

This is part of the results extracted from the doctoral thesis entitled: Attention to the Elderly in Basic Care and the Nurses' skills, defended on 08/28/2014.

The project was approved by the Research Ethics Committee of the Federal University of São Paulo (Opinion 2012/11) and the Municipal Health Department of the city of São Paulo (Opinion 378/11). The ethical principles were assured, using the Term of Free and Informed Consent.

RESULTS AND DISCUSSION

The majority of the elderly were female, 211 (62%). Age ranged from 60 to 85 years, mean of 69 years with standard deviation of 7.25. There was predominance for brown skin color 143 (42%). Less than half were widowers, 115 (34%). Low schooling was frequent and the sample consisted predominantly of incomplete elementary education. The highest proportion of elderly had a family income of one to three minimum wages, 264 (78%). The majority did not have a private health plan, 280 (82%). In the case of illness, 154 (46%) sought the reference hospitals. Arterial hypertension was the main morbidity referred to, followed by diabetes. The majority passed in medical consultation at the Basic Health Unit, 219 (64%). Inability to develop instrumental activities of daily living was present in 295 (87%). Less than half 90 (27%) had an inability to perform basic activities of daily living (Table 1).

The only variable that presented a significant statistically effect on the home visit was the variable 'go in a medical consultation at the UBS' (p-value = 0.0022). The estimated *odds ratio* for this variable was 2,369, with a 95% confidence interval between 1,364 and 4,115. Thus, we can conclude that going to a medical consultation at the UBS increases the chance of receiving a home visit by 2,369 times, and this value can vary, with 95% confidence, between 1,364 and 4,115. No other variable had a statistically significant effect on the home visit, since p-value was higher than 0.05 in all other cases (Table 2).

Table 1 - Socioeconomic and demographic features of people aged 60 years and over, enrolled in a Basic Health Unit - São Paulo, São Paulo (2013).

Variables	n	%
Gender		
Female	211	62,0
Male	129	38,0
Age (years)		
60 to 69	210	61,7
70 to 79	90	26,4
80 or more	40	11,9
Skin Color		
Brown	143	42,0
White	108	32,0
Black	89	26,0
Marital status		
Widower	115	34,0
Maried	103	30,0
Not married	83	24,0
Divorced	39	11,0
Can read and write		
Yes	177	52,0
No	163	48,0
Income *per capita* (minimum wages)		
1 to 3	264	78,0
4 to 6	76	22,0
Private Health plan		
No	280	82,0
Yes	60	18,0
Morbidities		
Arterial hypertension		
Yes	254	75,0
No	86	25,0
Diabetes		
Yes	132	39,0
No	208	61,0
Dyslipidemia		
Yes	89	26,0
No	251	74,0
Low back		
Yes	73	21,0
No	267	79,0
Depression		
Yes	37	11,0
No	303	89,0
Insomnia		
Yes	54	16,0
No	286	84,0
Medical appointment		
Yes	219	64,0
No	121	36,0
Hospitalization		
No	220	65,0
Yes	120	35,0
AIVD Disability		
Yes	295	87,0
No	45	13,0
ABVD Disability		
No	249	73,0
Yes	90	27,0
Home visit		
Yes	231	68,0
No	109	32,0

Source: research carried out with elderly people from January to March 2013.

Table 2 - Logistic regression for home visit, followed by *odds ratio* calculation and the respective confidence interval - São Paulo, São Paulo (2013).

Variable	GL	Wald	p-value	Odds Ratio	95%CI Odds Ratio (lower)	95%CI Odds Ratio (superior)
Age group	2	3.8429	0.1464	-	-	-
Sex	1	0.7899	0.3741	-	-	-
Skin color	2	0.2068	0.9018	-	-	-
Marital status	3	2.1592	0.5400	-	-	-
Can read and write	1	0.8994	0.3429	-	-	-
Family income	2	0.8016	0.6698	-	-	-
Private health plan	1	3.5410	0.0599	-	-	-
In case of illness looking for	2	0.2560	0.8798	-	-	-
Hypertension	1	0.5841	0.4447	-	-	-
Diabetes	1	1.7325	0.1881	-	-	-
Dyslipidemia	1	0.1060	0.7447	-	-	-
Low back	1	0.5398	0.4625	-	-	-
Depression	1	0.2643	0.6072	-	-	-
Insomnia	1	0.2985	0.5848	-	-	-
Go to medical appointment at UBS	1	9.3708	0.0022	2.369	1.364	4.115
Hospitalization	1	1.0359	0.3088	-	-	-
AIVD Disability	1	0.3672	0.5445	-	-	-
ABVD Disability	1	2.5837	0.1080	-	-	

Source: research conducted with the elderly in the period from January to March 2013.

In this study, we observed a high percentage of elderly women classified as young elderly women aged between 60-69 years. Recent studies indicate that women constitute the majority of the elderly population in all regions of the world and estimates are that women live, on average, five to seven years longer than men[10].

The education of the elderly in this study was low, constituting an unfavorable social condition to them since it has influence on access to health services, on opportunities for social participation and on their treatment understanding and self-care, among others. Illiteracy can, by itself, be considered a limiting factor for survival and quality of life. Differences in the level of literacy between the sexes reflect the social organization of the beginning of the century that blocked access to school for the poorest and women. The broad access to the means of literacy, besides a question of citizenship, could allow greater receptivity on the part of these elderly people to health education programs and also some protection against the cognitive dysfunctions that frequently affect them[11-12].

In addition to low schooling, socioeconomic disadvantages were observed. While acknowledging the limitations of the present study with regard to the generalization of results, other studies have pointed to the elderly in similar conditions. In a study conducted in the city of São Paulo, 57% of the elderly in the sample had financial conditions that were close to the reality of this study[13]. In Campinas-SP, about 53% of the elderly had a monthly income of one to three minimum wages[14].

It was observed in this investigation that 82% of the elderly had the Single Health System as a reference for treatment of diseases. With the growing increase in the elderly population, associated to multiple chronic pathologies, it leads to greater use of the health system, and thus constitutes the great challenge for the health system[15].

The main cause of elderly mortality and morbidity in Brazil are chronic diseases, which usually have slow development, last for long periods and have long-term effects that are difficult to predict. Similar to other rich countries, research suggests that complex conditions, such as hypertension, diabetes and depression, will impose an even greater burden in the future[16].

In our study, we observed an expressive percentage of elderly patients with a history of hospitalization. Although in some circumstances hospitalization is the only possibility for the elderly treatment, it has the effect of reducing functional capacity, slower and longer recovery,

the demand for high-cost technologies - increasing health care expenses - and the need for trained human resources. It is also worth noting the difficulty in continuing care after discharge, considering that the majority will need some way of assistance for basic daily care in primary care[17].

The evaluation of the functional capacity of the elderly by the health services in Brazil is a recommendation of the National Policy of Attention to the Health of the Elderly[18]. According to this, the evaluation should be done in an integrated way involving different health professionals. Thus, it is relevant that the multiprofessional and interdisciplinary team involved can develop actions that promote the redirection of care practice, with a view to offering a health care focused on their reality and what the elderly actually present as needs, in order to promote effective care in the application of technologies and the promotion of health[18].

The evaluation of the functional capacity is fundamental to determine the commitment and the necessity of aid for the activities of maintenance and promotion of the own health and of the management of the home environment by the elderly, being able to guide the public politics of attention to the health and the social policies to this segment[19]. It was observed a higher prevalence in the AIVD than in the ABVD, which is in agreement with other researches[20]. Hierarchically, losses occurring from instrumental activities of daily living to basic activities of daily living due to AIVD require greater physical and cognitive integrity when compared to ABVD[21-22].

In this study, the only variable that presented a statistically significant effect on the home visit was the fact that they went to a medical appointment at the Basic Health Unit, indicating that elderly people who passed for medical visits at the Basic Health Unit were more likely to receive a home visit.

When elderly individuals are unable to attend the health service because of some disability, the home visit - an activity outside the Basic Health Unit (BHU)[22] carried out by the health team - is crucial because it allows to know *in loco* the reality and families and their members needs. It is a tool for health care and promotion, for active search and identification of repressed demand, for local diagnosis and for planning actions based on reality, for mediation between families and health teams[23].

A study carried out with 1,593 elderly people in the municipality of Bajé, RG, Brazil, in 2008, showed that the Nursing team was responsible for 78% of home visits performed to provide some care[24]. Among the activities carried out by the nurses is the home visit that allows to know the social context and to identify the families attended by these professionals health needs, enabling a closer relationship with the determinants of the health-disease process. Therefore, it is believed that this is a promising space for health promotion[25]. The home visit is "used to subsidize intervention in the people health-disease process or in planning actions aimed at promoting the community health"[25].

FINAL CONSIDERATIONS

In summary, the results of the present study showed that the elderly evaluated were women in the age group of 60 to 69 years old, with low schooling, insufficient family income, living without spouse, dependent on the Unified Health System, presence of chronic diseases, highlighting hypertension, and inability to perform instrumental activities of daily living. The elderly who passed in medical appointment at the Basic Health Unit tend to receive a home visit from the health team. The home visit has been one of the instruments most historically used in community nursing and currently in the daily life of the family Health Strategy. Such action places the family as the center of care, attending every stage of the life cycle.

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