

Older adults living alone: demand analysis for social and health services

Pessoas idosas que moram sozinhas: análise de demanda para os serviços sociais e saúde

Personas ancianas que viven solas: análisis de la demanda de servicios sociales y de salud

Abstract

Objective: To analyze the social, demographic, economic, living, and health conditions, social support, and care of older adults who live alone. **Method:** Cross-sectional study with a quantitative approach using a semi-structured questionnaire interview with older adults. A univariate analysis was carried out with the chi-square test, multiple correspondence analysis and cluster analysis with a non-hierarchical procedure. **Results:** There was statistical significance among the variables sex ($p=0.013$), marital status ($p<0.001$), financial head of the household ($p<0.001$), contribution to family support ($p=0.038$), indebtedness ($p=0.034$), kidney disease ($p=0.009$), and all the social support and care variables ($p\leq 0.05$). Four groups were found in which longest-lived adults have comorbidities (pulmonary and respiratory disease) and need help regularly, older adults have no support, men have more support, and women are more independent of support and care. **Conclusion:** This diagnosis of the situation of older adults living alone supports the implementation of public support and care policies.

Descriptors: Aged; Residence characteristics; Psychosocial support systems; Comprehensive health care.

Resumo

Objetivo: Analisar as condições sociais, demográficas, econômicas, de vida e saúde, de apoio social e cuidado de pessoas idosas que moram sozinhas. **Método:** Estudo transversal com abordagem quantitativa por meio de uma entrevista com questionário semiestruturado com idosos. Utilizou-se uma análise univariada a partir do teste qui-quadrado, de análise de correspondência múltipla e de *cluster* pelo procedimento não hierárquico. **Resultados:** Foram encontrados quatro principais agrupamentos de pessoas idosas que moram só, sendo eles: o primeiro, dos mais longevos com comorbidades respiratórias e que precisam de ajuda regularmente; o segundo, de idosos sem apoio a que recorrer; o terceiro, composto por homens com mais apoio; e o quarto, de mulheres mais independentes de apoio e cuidado. **Conclusão:** Esse diagnóstico da situação de pessoas idosas que vivem sozinhas evidencia um impacto direto e indireto nos serviços sociais e de saúde, subsidiando reformulações e implantações de políticas públicas de apoio e cuidado.

Descritores: Idoso; Características de residência; Sistemas de apoio psicossocial; Assistência integral à saúde.

Resumen

Objetivo: Analizar las condiciones sociodemográficas, económicas, de vida y de salud, de apoyo social y cuidado de las personas mayores que viven solas. **Método:** Estudio transversal, con enfoque cuantitativo, que utilizó entrevista con cuestionario semiestructurado aplicado a adultos mayores. Se utilizó un análisis univariante basado en la prueba de chi-cuadrado, análisis de correspondencia múltiple y análisis de clústeres mediante un procedimiento no jerárquico. **Resultados:** Se encontraron cuatro principales clústeres de personas mayores que viven solas, que son: el grupo de los más longevos con comorbidades respiratorias y que necesitan de ayuda regularmente; el de las personas mayores que no tienen a quien les asista; el grupo de hombres que tienen más apoyo; y el de las mujeres independientes de apoyo y atención. **Conclusión:** Este diagnóstico de la situación de los ancianos que viven solos muestra un impacto directo e indirecto en los servicios sociales y de salud, lo que apunta a la necesidad de reformulaciones e implementaciones de políticas públicas de apoyo y cuidado.

Descriptores: Anciano; Características de la residencia; Sistemas de apoyo psicossocial; Atención integral en salud.

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INTRODUCTION

The world population is experiencing a growing and important phenomenon characterized by a significant drop in mortality and fertility, which has led to significant changes in the pace of population growth, resulting in the process of population aging and the continuous increase in longevity⁽¹⁾. The longevity revolution takes place in a scenario of constant change, guided by an interaction between risk and opportunity⁽²⁾, contributing to the social vulnerability of this population, in addition to affecting their well-being, retirement, income, discrimination, social and family isolation, and lack of public policies for support. These factors influence social relationships and, consequently, intensify the state of vulnerability and fragility of elderly people⁽²⁻³⁾.

In this context, population aging and the increase in Brazilian life expectancy have been happening so quickly that seniors are faced with a lack of planning for this new reality, whether at family, social, or political level, interfering with the effective social protection of old people. This situation is accompanied by new patterns of behavior and living arrangements, and often by widowhood and divorce, among other conditions that destabilize family functionality, interfering positively or negatively in the structure of life and care of the elderly person⁽⁴⁻⁶⁾. Therefore, it is important to understand aging as a heterogeneous process that is profoundly influenced by social conditions, resulting in the intensity of social vulnerability of this population. It is also significant to highlight that among the factors that weaken the elderly, home arrangements stand out, being emphasized as an aspect of quality of life⁽⁷⁻⁸⁾.

Home arrangement is understood as the way people organize themselves in the same physical space (home)⁽⁸⁾. It is crucial to mention that the decisions regarding the type of household arrangement adopted are not always exclusively the elder's or the family's,

as they depend on sociocultural, political, and even economic factors, thus contributing to good or bad quality of life⁽⁷⁻⁸⁾. During the aging process, families play a significant role in social support, so that older adults can live this period of their lives with quality and better physical and social conditions. The literature shows that deficiencies in family coexistence and support can negatively impact the functionality and harmony of the family, as well as the aging process⁽⁹⁻¹⁰⁾. There are three most common types of arrangements: single parent, couple without children, and single person⁽¹¹⁾.

In Brazil, 15.3% of elderly people live alone, mainly in the richest regions, being more common among women, older people (over 75 years old), and poorer people⁽⁴⁾. Family is considered the main form of support for elders, having a significant impact on their quality of life and being able to cause positive or negative changes to their health and well-being⁽¹²⁻¹³⁾. Single-person arrangements promote greater autonomy and tranquility⁽¹²⁾; however, these arrangements can cause functional decline due to the lack of assistance with care needs and daily activities, or, on the other hand, they can improve functional performance, considering that it can be a fundamental characteristic for living alone⁽¹⁴⁾. Loneliness and replanning of monthly income are negative factors that accompany this type of housing^(4,12-13,15). Another relevant aspect for those who live alone is the expansion of the support network, such as neighborhoods, friends and social organizations, and the attachment to spirituality that ends up providing emotional support, impacting physical and mental health⁽¹²⁾.

Given the above, this study hypothesizes that elderly people who live alone are women, over the age of 75, with greater financial difficulties, vulnerable without a support network, and more ill, directly impacting the demand for support and care services. This article aims to analyze the social, demographic, economic, life and health conditions, social support, and care of elderly people who live alone.

METHOD

This is a cross-sectional study with a quantitative approach, developed from August 2019 to March 2020. It is part of a project entitled “São José do Rio Preto: Cidade Para Todas As Idades”, in English, “São José do Rio Preto: City for All Ages”, in partnership with Centro Internacional de Longevidade Brasil (ILC-BR) and with the private higher education institution in the interior of São Paulo: União das Faculdades dos Grandes Lagos (Unilago).

The study was carried out in the municipality of São José do Rio Preto, located 451 km from the capital, São Paulo. It has a population, estimated in 2019, of 460,671 inhabitants, with 79,452 of these inhabitants aged 60 or over, that is, 17.2% elderly. The municipality is in Group 1 of the state of São Paulo (elite group), with good levels of wealth, longevity, and education⁽¹⁶⁾. The Municipal Human Development Index (MHDI) was 0.797 in 2013, and the Firjan Municipal Social Development Index (IFDM), referring to the base year 2018, was 0.8753, which ranks São José do Rio Preto in 9th place among municipalities of São Paulo state and in 14th place in Brazil. (<http://www.firjan.org.br/ifdm/consulta-ao-indice>).

An interview was conducted using a semi-structured questionnaire consisting of five blocks, divided into questionnaires and scales that were constructed based on existing surveys of elderly people⁽¹⁷⁻¹⁹⁾. The five blocks are Block A (identification and socioeconomic conditions); Block B (mental health: mental state, depression, and memory); Block C (conditions, habits, and use of health services); Block D (functional capacity and social protection network); and Block E (condition of the physical and social environment). The questionnaire was adapted to an application (Censo RIO Preto), developed by a company hired by the ILC-BR team, and installed on each interviewer's cellphone, optimizing the survey time from 60 minutes to approximately 40 minutes.

The inclusion criteria used were all individuals over 60 years of age, of both genders and who reached the minimum score on the Mini-Mental State Examination, following the classification of Brucki et al., which considers scores according to the education level (illiterate = ≥ 17 ; 1 to 4 years of schooling = ≥ 22 ; 5 to 8 years of schooling = ≥ 24 ; and 9 or more years of schooling = ≥ 26)⁽²⁰⁾. There were no exclusion criteria. The variables included in this study were based on socioeconomic and demographic conditions.

The variables considered were: age group, gender, marital status, race/color, years of education, employment status, type of work, retirement, financial responsibility for the family, contributions to the family's support, owner of the residence, enough money to cover expenses, in debt. For living and health conditions: comorbidities (heart disease, systemic arterial hypertension – SAH, diabetes mellitus – DM, cerebrovascular accident – stroke, kidney disease, cancer, arthritis or rheumatism, lung disease, and Parkinson's disease), fall in the last year, how many times you fell, drinking alcohol and taking medications. For social support and care: needs help regularly, has someone to help with activities of daily living, has family and close friends available to take care of the house and shopping, has someone if in need of money or objects to borrow, can help other people when requested and cares for or helps care for an elderly person. As a variable of interest, elderly people who live alone were considered, and the variables were dichotomous (yes and no)

In the research, 618 elderly people participated, preliminarily identified by the municipal register, with numbers randomly selected from the regions of the municipality (territorial division into ten regions), age (between 60 and 69 years old, between 70 and 79 years old, and aged 80 or more), and gender (male and female), including interviews with elderly people selected randomly, complemented by spontaneous search based on dissemination of the research in the regions.

Initially, a sample calculation was carried out taking the previous particularities into account. The recruitment strategy was changed due to difficulties related to updating registration or refusals on account of insecurity because of the pandemic. In March 2020, interviews were stopped as a consequence of the COVID-19 pandemic with the imposition of social isolation by the municipal authorities, in accordance with the decision made by the São Paulo State Government.

The interviews were carried out at home or in previously defined locations, such as public health or social assistance facilities, which were accessible and with which the elderly were familiar, considering the specificities of each territory. Thus, the approach was conducted in Basic Health Units (UBS), sports centers, senior living centers, churches, and/or the home itself. The initial sample criteria were maintained, by age group gender, in the different regions. After the introduction of the evaluators, followed by an explanation of the reason for the interview and their contribution to obtaining data, the Free and Informed Consent Form (TCLE) was read, which the individual and the evaluator signed, and only then began the interview.

Data analysis was carried out in two stages, starting with the univariate, using descriptive statistics using frequency and the Pearson and Fisher chi-square test when necessary, with $p \leq 0.05^{(21)}$ being considered as statistical significance. Subsequently, a multivariate analysis was conducted, using multiple

correspondence analysis (MCA) represented by a two-dimensional graph, demonstrating the interrelationship between the categorical variables. Afterward, a cluster analysis was carried out using the non-hierarchical procedure (*K-means*), which classifies the variables according to a previous definition of the number of clusters⁽²²⁾. Variables with $p \leq 0.10$ were included. The data were stored in the Microsoft Excel® program, and the tests were conducted using SPSS version 20.0 and Minitab.

The study complies with the ethical precepts of Resolution n° 466/12, being approved by the Unilago Research Ethics Committee under Opinion n. 3.429.122 and CAAE: 16552319.0.0000.5489.

RESULTS

Table 1 shows the distribution of characteristics among social, economic, demographic, and living conditions and health of elderly people who live alone. It is observed that, of the 618 elderly people interviewed, 24.8% of them live alone. There was statistical significance between the variables gender ($p=0.013$), marital status ($p<0.001$), financially responsible for the family ($p<0.001$), contributing to the family's support ($p=0.038$), indebted ($p=0.034$), and kidney disease ($p=0.009$). Among the elderly people who live alone in the municipality, 71.2% are women, 94.1% are without partners, 96.1% are financially responsible for the Family, 1.3% contribute to the family's support, 34.0% are indebted and 5.2% have kidney disease (Table 1).

Table 1 – Distribution of social, economic, demographic, and living and health conditions variables, according to the elderly person's residence. São José do Rio Preto, SP, 2020

Variables (n=618)		Lives alone				p-value	Total	
		No		Yes			N	%
		N	%	N	%			
Gender	Male	182	39.1	44	28.8	0.013*	226	36.6
	Female	283	60.9	109	71.2		392	63.4
Age group	60 to 75 years old	348	74.8	105	68.6	0.082*	453	73.3
	> 75 years old	117	25.2	48	31.4		165	26.7

(Continues)

Variables (n=618)		Lives alone				p-value	Total	
		No		Yes			N	%
		N	%	N	%			
Marital Situation	With a partner	296	63.7	9	5.9	<0.001*	305	49.4
	Without a partner	169	36.3	144	94.1		313	50.6
Race	White	346	74.4	114	74.5	0.536*	460	74.4
	Other	119	25.6	39	25.5		158	25.6
Years of education	Never went to school or didn't complete a school year	43	9.2	13	8.5	0.961†	56	9.1
	Elementary School	292	62.8	97	63.4		389	62.9
	High school or higher education	130	28.0	43	28.1		173	28.0
Work	No	339	72.9	104	68.0	0.142*	443	71.7
	Yes	126	27.1	49	32.0		175	28.3
Type of work	Volunteer	22	4.7	6	3.9	0.503†	28	4.5
	Sporadic	25	5.4	13	8.5		38	6.1
	Regular and formal	38	8.2	11	7.2		49	7.9
	Regular and informal	40	8.6	18	11.8		58	9.4
Retiree	No	124	26.7	40	26.1	0.495*	164	26.5
	Yes	341	73.3	113	73.9		454	73.5
Family's financially responsible	No	222	47.7	6	3.9	<0.001*	228	36.9
	Yes	243	52.3	147	96.1		390	63.1
Contributes to family support	No	53	11.4	4	2.6	0.038*	57	9.2
	Yes	165	35.5	2	1.3		167	27.0
Owner of the house	No	89	19.1	29	19.0	0.484*	118	19.1
	Yes	372	80.0	117	76.5		489	79.1
Enough money to cover expenses	No	90	19.4	30	19.6	0.533*	120	19.4
	Yes	371	79.8	123	80.4		494	79.9
Indebted	No	344	74.0	101	66.0	0.034*	445	72.0
	Yes	120	25.8	52	34.0		172	27.8
Heart Disease	No	338	72.7	115	75.2	0.271*	453	73.3
	Yes	127	27.3	37	24.2		164	26.5
HBP	No	178	38.3	64	41.8	0.258*	242	39.2
	Yes	285	61.3	89	58.2		374	60.5
Stroke	No	425	91.4	142	92.8	0.272*	567	91.7
	Yes	40	8.6	10	6.5		50	8.1
Kidney disease	No	407	87.5	144	94.1	0.009*	551	89.2
	Yes	56	12.0	8	5.2		64	10.4
Cancer	No	419	90.1	143	93.5	0.136*	562	90.9
	Yes	46	9.9	10	6.5		56	9.1
Arthritis or rheumatism	No	286	61.5	93	60.8	0.450*	379	61.3
	Yes	177	38.1	60	39.2		237	38.3

(Continues)

Variables (n=618)		Lives alone				p-value	Total	
		No		Yes			N	%
		N	%	N	%			
Lung disease	No	421	90.5	145	94.8	0.087*	566	91.6
	Yes	42	9.0	8	5.2		50	8.1
Parkinson's disease	No	452	97.2	151	98.7	0.239*	603	97.6
	Yes	13	2.8	2	1.3		15	2.4
Falls in the last year	No	332	71.4	107	69.9	0.401*	439	71.0
	Yes	133	28.6	46	30.1		179	29.0
Number of falls	1	64	13.8	19	12.4	0.160†	83	13.4
	2	31	6.7	7	4.6		38	6.1
	3 or more	36	7.7	19	12.4		55	8.9
Alcohol consumption	No	349	75.1	112	73.2	0.361*	461	74.6
	Yes	116	24.9	41	26.8		157	25.4
Medication use	No	59	12.7	20	13.1	0.499*	79	12.8
	Yes	406	87.3	133	86.9		539	87.2
Total		465	75.2	153	24.8		618	100.0

*Fisher test; † Pearson chi-square

Source: Own preparation (2023)

Table 2 shows the distribution of elderly people living alone and the variables on social support and care. There was statistical significance in all analyzed variables. Among those who live alone: 17.6% need help regularly; 37.9% do not have someone to help with daily living activities; 24.2% do not have family and

close friends available to take care of the house and shopping; 21.6% have no one to turn to in times of distress; 27.5 do not have help if they need money or objects to borrow; 13.7% are unable to help other people when asked; and 16.3% care for or help care for an elderly person (Table 2).

Table 2 – Variables distribution on social support and care according to elderly people who live alone. São José do Rio Preto, SP, 2020

Variables		Lives alone				p-value	Total	
		No		Yes			N	%
		N	%	N	%			
Needs help regularly	No	346	74.5	126	82.4	0.027†	472	76.4
	Yes	119	25.6	27	17.6		146	23.6
Have someone to help with daily living activities	No	140	30.1	58	37.9	0.046†	198	32.0
	Yes	325	69.9	95	62.1		420	68.0
Family and close friends are available to take care of the house and shopping *	No	52	11.2	37	24.2	<0.001†	89	14.4
	Yes	410	88.2	116	75.8		526	85.1
Have someone to turn to in times of distress*	No	45	9.7	33	21.6	0.001†	78	12.6
	Yes	418	89.9	119	77.8		537	86.9

(Continues)

Variables		Lives alone				p-value	Total	
		No		Yes			N	%
		N	%	N	%			
Have someone to help if in need of money or an object to borrow	No	67	14.4	42	27.5	109	17.6	
	Yes	394	84.7	111	72.5			
Can help others when asked *	No	33	7.1	21	13.7	54	8.7	
	Yes	432	92.9	132	86.3			
Care for or help care for an elderly person*	No	341	73.3	128	83.7	469	75.9	
	Yes	123	26.5	25	16.3			
Total		465	75.2	153	24.8	618	100.0	

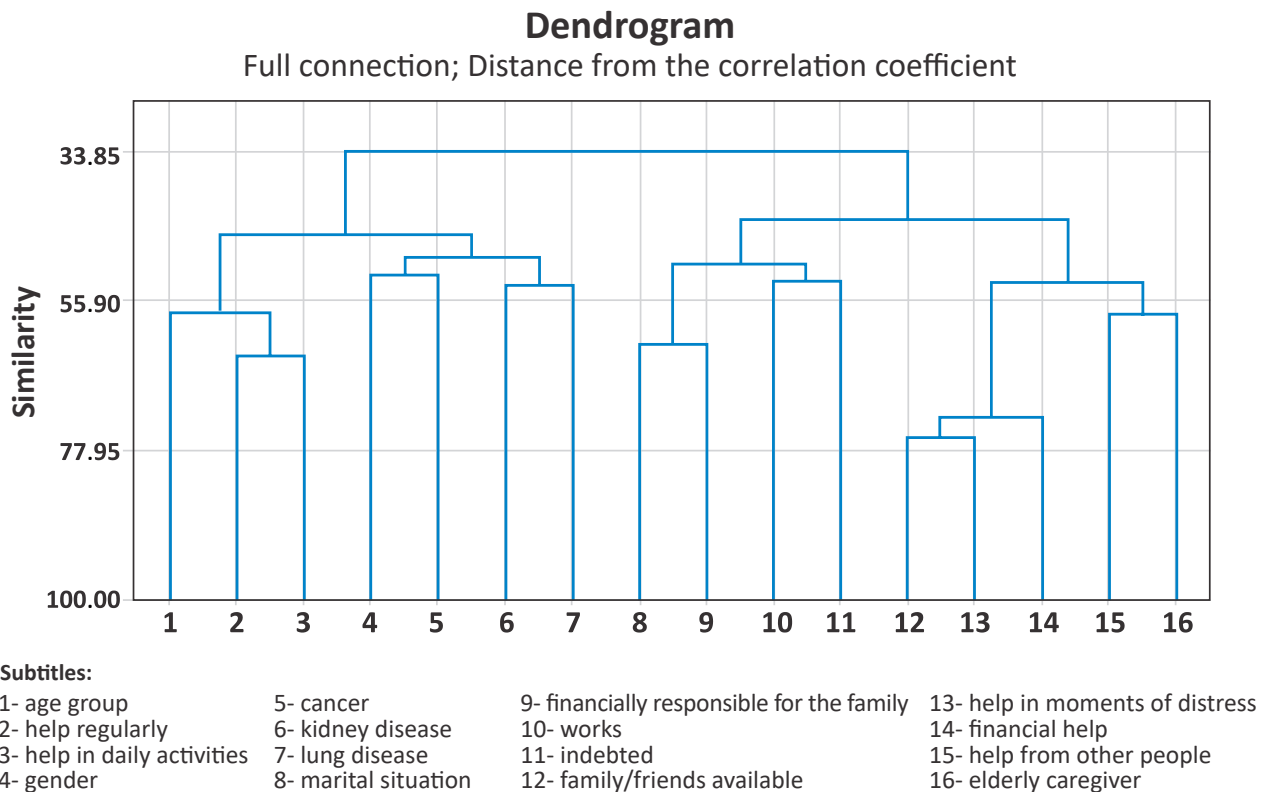
*Exclusion of answers: Don't know/Didn't answer; † Fisher test; ‡ Pearson chi-square

Source: Own elaboration (2023)

Figure 1 shows the dendrogram, indicating the final participation of four clusters, demonstrating a similarity of approximately 56%. The first cluster comprises variables such as age group, need for help regularly, and reliance on someone for daily activities. The second cluster includes gender and comorbidities (cancer, kidney disease, and lung disease). The third includes marital status,

financial responsibility within the family, work, and debt. The fourth cluster consists of variables related to the availability of family and close friends for household chores and shopping, having someone to turn to in times of distress, the ability to rely on assistance when in need of money or borrowing an object, can help others when asked, providing care or assistance care to elderly individuals.

Figure 1 – Dendrogram of selected variables. São José do Rio Preto, SP, 2020

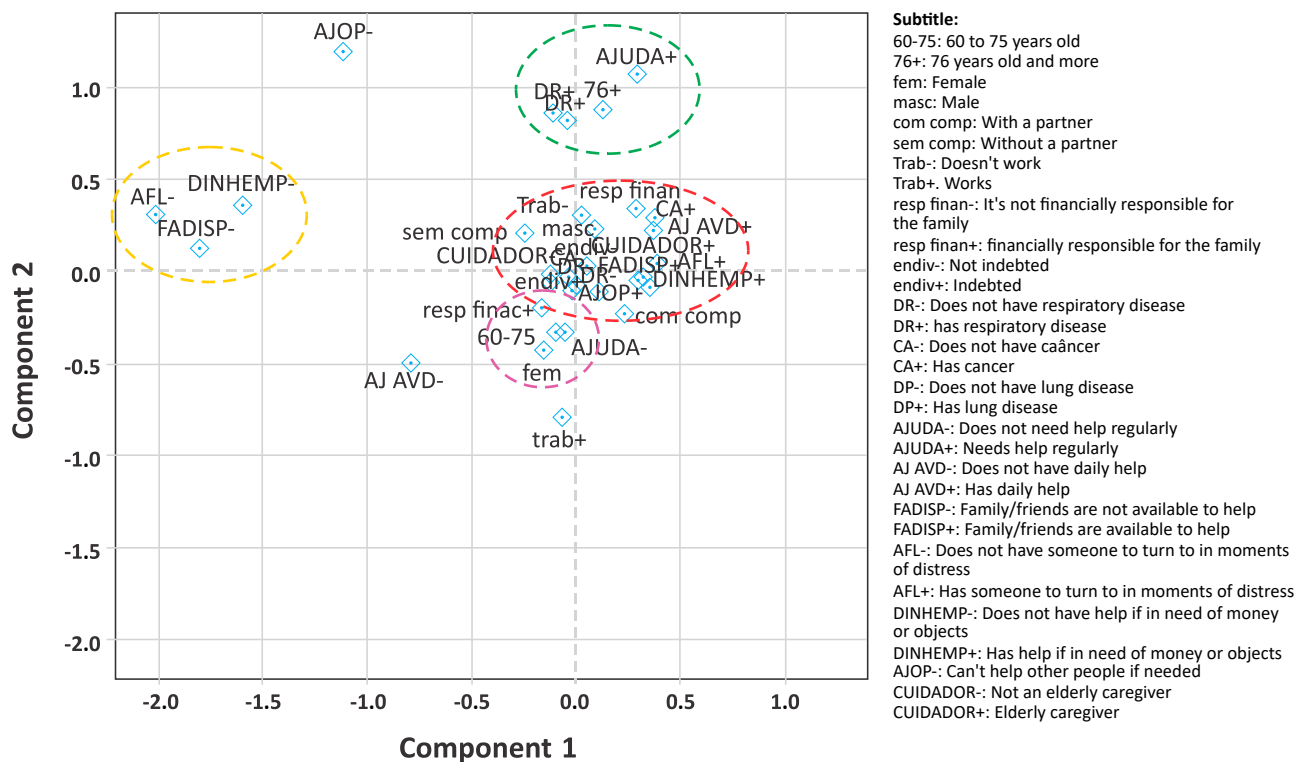


Source: Own elaboration (2023)

Figure 2 shows a two-dimensional graph of the variables, showing four groupings. The first one, identified with green, corresponds to elderly people aged 76 or over, with lung and respiratory disease who need help regularly. The second, in orange, comprises the elderly who have no one to turn to in times of distress, family and close friends who are not available to take care of the house or shopping and have no one to count on if they need money or an object to borrow. The third, the largest group, represented by red, regardless of marital status,

whether they are in debt or not, whether they care for or help care for an elderly person, males, who do not work, have someone to count on if they need money or an object to borrow, is not financially responsible for the family, has cancer, has help with activities of daily living, can help other people when asked and has someone to turn to in times of distress. The last group, represented by the color purple, corresponds to the age group between 60 and 75 years old, female, financially responsible for the family, and who do not need help regularly.

Figure 2 – Two-dimensional distribution of Multiple Correspondence Analysis of selected variables. São José do Rio Preto, SP, 2020



Source: Own elaboration (2023)

DISCUSSION

This study showed that elderly people who live alone have greater difficulties in providing support and care, especially for the oldest with comorbidities, such as lung and respiratory diseases. Men have greater support, while younger women are more self-sufficient. These results are important for a diagnosis of the elderly population,

which has been growing gradually every year and requires public policies based on the main support and care needs so that health and social assistance services can be structured to meet demand.

Despite facing challenges in interviewing elderly people, especially at a time when the COVID-19 pandemic was beginning, this study persevered. Social isolation measures

necessitated the interruption of the study. Despite this, the characteristics of the sample population are equivalent to those found in the last census by the Brazilian Institute of Geography and Statistics (IBGE)⁽²³⁾.

The proportion of elderly people living alone in this research corroborates others, in which the prevalence found was 15.3% to 20.3%^(4-5,23), and, in richer regions, this percentage was higher, such as 15.9% in the Southeast⁽⁴⁾. Women also had higher percentages^(7,9,23-24), with this population having a loneliness rate 2.6 times higher than men⁽²⁵⁾. One explanation for this is that women live longer, with a life expectancy of 81.25 years⁽²⁴⁾. Older ages, over 75 years old, were also found in the population who live alone^(15,23).

Functional disabilities, increased frailty, and dependence on activities of daily living appear with advancing age, especially in the older population⁽²⁶⁾. It is observed that the condition of living alone did not interfere with the presence of chronic diseases^(4,25). However, the presence of comorbidities may contribute to increase functional or physical incapacity. When combined with low financial conditions and education levels, this can exacerbate dependency on social and health services^(5,24). Additionally, limited education makes difficult access to healthcare and employment conditions, making this population even more vulnerable⁽²⁷⁾.

It was noted that the presence of comorbidities was correlated in the group of people aged 75 or over, showing an impact on the daily lives of those individuals. Despite this, this type of family arrangement demands greater areas, such as functional and physical capacity for the elderly person, especially among those with scarce resources, which generates a demand for support and health services that must provide long-term care^(4,25), with policies aimed at support and health services planned.

Living alone does not mean abandonment or neglect for those who have resources for subsistence, it can even represent a situation of self-knowledge and autonomy for the creation

of social bonds in the community⁽²⁸⁾. However, the knowledge that elderly people with greater dependencies require greater demands for social and health care demonstrates the need to develop public policies focusing on these individuals, requiring the planning of specific lines of care for this population⁽²⁹⁾. It is worth noting that, despite living alone, a small percentage of individuals reported having a partner, representing a positive point for building a support network that has an impact on health⁽³⁰⁾.

A social support network is understood as relationships established spontaneously and mutually between individuals that provide well-being at the individual and collective levels. It provides material, emotional, and informational help, and can be made up for people outside or within the family. Nevertheless, it is in the family where support generally occurs, mainly in financial, psychological, and social issues^(15,25). This study showed more support for men, corroborating the literature which reveals that men have a larger network of friends and family than women, resulting in lower rates of social isolation^(15,31). Another important finding is that the family relationships of elderly people living alone are weakened, contributing to a precarious support network that must be considered by support and care services to seek ways to promote and build these networks. In places where public assistance policies are insufficient or non-existent, it is important to consider cohabitation, especially with a family member, as it historically represents a protective nature for the elderly⁽⁵⁾.

The predominance of women living alone was another essential finding. The literature reveals that men are more exposed to health risk factors, as they take less care of themselves and are more dependent on care⁽³²⁻³³⁾. Women, on the other hand, are more self-sufficient, as they have been culturally taught about the role of women in taking care of the family,

work, home, children, and elders, reflecting on the issue of triple working hours^(8,34-36).

Furthermore, women use work as a way to remain active in society, maintaining their relationships as a way of ensuring social empowerment⁽³⁴⁾. Another important fact found in the literature is that income is directly related to education, with more educated women having higher incomes; however, when compared to men, there is a salary difference, which is smaller among women, revealing a need for change in these policies⁽³⁷⁾.

Active aging is understood as a healthy lifestyle, seeking quality through optimization of health opportunities, participation, and security, which is based on the decade of Healthy Aging proposed by the United Nations (UN). The term active involves a healthy, successful, productive, and positive individual⁽³⁸⁻⁴¹⁾. The construction of assertive public policies targeting elderly people must be based on a comprehensive understanding of their identity, extended beyond age-based categorization. It is necessary to consider their social, economic, demographic, and epidemiological characteristics, as well as their experiences in using the territory, both physical and dynamic, in the use of services and spaces, giving voice to this invisible population. This enables knowledge of the process of a person's age and the difficulties experienced^(39,42-44).

The initiative to build elderly-friendly cities emerged in 2007, through the launch of the Global Guide of Age-Friendly Cities, by the World Health Organization (WHO), to promote active aging, and is currently widespread in several countries that are adherents of the WHO Global Network of Age-Friendly Cities⁽¹⁷⁾. This model is complex, dynamic, and multidimensional, requiring a specific approach to the discussion and construction of policy that involves the protagonists, elderly people, civil society, and the public and private sectors. Due to this methodological complexity, its implementation faces challenges, both nationally and internationally⁽⁴⁴⁻⁴⁵⁾.

Through this perspective of friendly cities, it is necessary to establish policies that guarantee greater autonomy and opportunities so that environments enable the elderly to continue with their routine, guaranteeing quality of life and greater participation and protection, in addition to ensuring qualified services to promote health, social support, lifelong education and income guarantee for active aging^(44,46).

This study is the result of part of the diagnosis carried out by the initiative of the Friendly City Project for All Ages, initiated by the municipality. This initiative led to discussions and reformulations of public policies across government sectors, involving both civil society and government officials, with active involvement from the elderly community. Their participation was instrumental in ensuring the municipality's inclusion in the WHO Global Network.

CONCLUSION

In this article, it was observed that elderly people living alone have a direct and indirect impact on health and social assistance services, as they have difficulties in obtaining support and care. In our findings, older adults have more comorbidities and need regular help. Women, particularly older women, have less support for financial help, despite younger women being self-sufficient both in care and financially. Based on these findings, public policies targeting support and care can be planned and implemented, aiming to guarantee better living conditions for elderly individuals who live alone. This study has guided the municipality towards the reconstruction and reorganization of more comprehensive policies that provide active aging for everyone who shares the territory.

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