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INTERGERATIONAL SOLIDARITY AND ATTITUDE TO HEALTH IN THE CENTER REGION OF PORTUGAL

SOLIDARIEDADE INTERGERACIONAL E ATITUDE FRENTE À SAÚDE NA REGIÃO CENTRO DE PORTUGAL

SOLIDARIDAD INTERGENERACIONAL Y ACTITUD HACIA LA SALUD EN EL CENTRO DE PORTUGAL

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ABSTRACT

Introduction: The concept of solidarity is simultaneously descriptive and normative and can be present in small communities or whole societies and remain or change with the aging of the population. Our objective was to characterize individuals over 65; identify forms of solidarity in the family and relate the perception of health/illness with the perceived solidarities.

Methods: Observational, multicenter and exploratory study integrated in the PerSoParAge project (POCI-01-0145-FEDER-023678). Information obtained by questionnaire in public places between June 2018 and January 2019, in the regions of Castelo Branco, Guarda and Portalegre in individuals aged 65 and over.

Results: The 323 individuals aged 65 to 99 years, 178 women and 145 men, average age 77.1 years, 50.8% married or in a de facto union and 4 years of schooling perceived their health as normal. In the family they hope to find help with the disease and its management, especially in their daughters and wives.

Conclusion: The elderly perceive their illnesses as normal and rely mainly on the female members of the family to obtain the necessary help, stressing the need for new policies that allow maintaining solidarity and providing adequate assistance to people, thus reducing gender asymmetries.

Keywords: Attitude Towards Health; Health of the Elderly; Relationship Between Generations; Solidarity.

RESUMO

Introdução: O conceito de solidariedade é simultaneamente descritivo e normativo e pode estar presente em pequenas comunidades ou em sociedades inteiras e manter-se ou modificar-se com o envelhecimento da população. Os objetivos foram caracterizar os indivíduos com mais de 65 anos, identificar formas de solidariedade na família e relacionar a perceção de saúde/doença com as solidariedades percecionadas.

Métodos: Estudo observacional, multicêntrico e exploratório integrado no projeto PerSoParAge (POCI-01-0145-FEDER-023678). A informação obtida por questionário em locais públicos entre junho 2018 e janeiro de 2019, nas regiões de Castelo Branco, Guarda e Portalegre em indivíduos com 65 e mais.

Resultados: Dos 323 indivíduos inquiridos, com idades entre 65 e os 99 anos, 178 mulheres e 145 homens, média das idades 77,1 anos, 50,8% eram casados ou em união de facto, 4

anos de escolaridade e percecionaram a sua saúde como normal. É na família que esperam encontrar ajuda na doença e na sua gestão sobretudo nas filhas e esposas.

Conclusão: Os idosos percecionaram o seu estado de saúde como normal e contam sobretudo com a família, mais os elementos do sexo feminino, para obter a ajuda necessária, salientando a necessidade de novas políticas que permitam manter as solidariedades e proporcionar assistências adequadas às pessoas diminuindo também as assimetrias de género.

Palavras-chave: Atitude Frente à Saúde; Relação entre Gerações; Saúde do Idoso; Solidariedade.

RESUMEN

Introducción: El concepto de solidaridad es simultáneamente descriptivo y normativo y puede estar presente en pequeñas comunidades o sociedades enteras y permanecer o cambiar con el envejecimiento de la población. Nuestro objetivo era caracterizar a las personas mayores de 65 años; Identificar formas de solidaridad en la familia y relacionar la percepción de salud/enfermedad con las solidaridades percibidas.

Métodos: Estudio observacional, multicéntrico y exploratorio integrado en el proyecto PerSoParAge (POCI-01-0145-FEDER-023678). Información obtenida por cuestionario en lugares públicos entre junio de 2018 y enero de 2019, en las regiones de Castelo Branco, Guarda y Portalegre en personas de 65 años o más.

Resultados: Los 323 individuos de 65 a 99 años, 178 mujeres y 145 hombres, edad promedio 77,1 años, 50,8% casados o en una unión de hecho y 4 años de escolaridad percibieron su salud como normal. En la familia esperan encontrar ayuda con la enfermedad y su manejo, especialmente en sus hijas y esposas.

Conclusión: Las personas mayores perciben sus enfermedades como normales y dependen principalmente de las mujeres miembros de la familia para obtener la ayuda necesaria, lo que enfatiza la necesidad de nuevas políticas que permitan mantener la solidaridad y proporcionar asistencia adecuada a las personas, reduciendo así las asimetrías de género.

Descriptores: Actitud Hacia la Salud; Relación Entre Generaciones; Salud del Anciano; Solidaridad.

INTRODUCTION

In ageing societies and in demographic transition such as the Portuguese, characterized by a significant decrease in birth rates and mortality associated with processes of lower fertility and the systematic use of means to fight mortality[1] the achievement of quality life years is fundamental. Both the World Health Organization (WHO) and the United Nations (UN) have argued that successful ageing requires a society based on solidarity and cooperation between generations, considering solidarity to be the fundamental element of a society for all ages[2] and at the same time an important prerequisite for social cohesion and sustainable development[3].

The solidarity between generations is also contextualized in the study of the territories of the interior regions of Portugal, their inhabitants, as well as in how they respond to the aging of their population and their problems and needs to contribute to develop proposals to meet the challenges of these regions.

The National Institute of Statistics (INE) predicts that by 2080 there will be 317 elderly per 100 young people[4] which means an increase to more than double the number of elderly people in relation to the current number. And although the aging is due to lifetime[5] the impact of a very aged population and the challenges that the rapid increase in the proportion of older people in a single generation can cause to existing infrastructures such as health and social support services, cannot be denied.

The term solidarity refers to a plural notion of variable configuration and degree[6] and is closely associated with the concepts of the common good and the idea of justice[7]. (Other meanings, both descriptive and normative[8] that include the connection with other people, the actions, motivations and attitudes more or less in solidarity, or the description and explanation of normative social integration in societies as opposed to chaos or order[8].

Solidarity presupposes the presumption of shared reciprocity according to the norms of each country[6,8] and this normative dimension is particularly relevant in the case of the family[9]. Family solidarity can be understood as affection, loving and/or shared support in family networks, it is based on the role of caring and has legitimacy among academics and politicians because it is altruistic and effectively develops this function[10]. In other words, inherent in family or family solidarity, there is a kind of readiness and care in helping[6], accompanying and defending our own or our equals, readiness that assumes relevance when the elderly begin to face difficulties related to illness or loss of functional capabilities and therefore need help from others to meet their health and well-being needs.

As inter generational solidarity is assumed today as a paradigm that refers to the relations between the younger and older generations in different countries[10], it can help to answer some questions related to the aging of the population and the provision of aid, it is more expressive in family societies[10]. These are thus designated as attitudes centered on the importance of the family and the elements of it that are involved in the forms of exchange[11].

Assistance benefits among family members, although common in Europe, are formalised in the laws on family responsibilities[3]. The literature review suggests that in modern societies the responsibility for both the youngest who do not yet have independence and the oldest when they begin to lose it is shared by the state and the family and families are highly involved in the provision of care, even in states where state support is more generous[11].

Inter generational solidarity thus presents both a private and public dimension capable of creating varied expectations[12] and can reflect six dimensions that are designated as structural solidarity, associative solidarity, affective solidarity, normative solidarity, consensual solidarity and functional solidarity[10,13].

Structural solidarity designates the structure of opportunities for inter generational relationships and reflects the number, type and geographic proximity of family members. Associative solidarity refers to the frequency, patterns of interaction and types of activities in which family members engage. Affective solidarity is the type and degree of (positive) feelings maintained towards family members and the degree of reciprocity of these feelings. Normative solidarity can be seen as the strength of commitment to play family roles and fulfill family obligations. Consensual solidarity refers to the degree of agreement with values, attitudes and beliefs, and functional solidarity refers to the degree of support and exchange of resources among family members[10,13].

Living longer means being exposed to a set of chronic and/or long-term illness situations that determine the need for continuous health care by limiting the activities of people's daily life[14] and traditional models of care in the family may not be adjusted and sustainable in view of the large number of elderly people who may need such care.

A significant number of people between the ages of 70 and 85 may have health conditions that are not captured by traditional disease classifications, which raises questions about what health means at these ages and how it can be measured[15]. Although subjective, the perception of health also assumes relevance and the perception of positive health is associated with the person's physical resources[16] but also with psychological and social factors. The level of education also influences the self perception of health and more educated elderly people present a better perception of old age and health when compared with

others with low schooling[17,18]. In view of the above, the objectives of this article are to characterize individuals over 65 years of age in the central interior region, to identify the forms of solidarity in the family and to relate the perception of health and disease management with the solidarities perceived in the expectation of being able to contribute to the development of proposals capable of responding to the challenges of the interior regions of Portugal.

MATERIAL AND METHODS

An observational, multicenter study integrated in the PerSoParAge project (POCI-01-0145-FEDER-023678) co-financed by the Programa Operacional Competitividade e Internacionalização (COMPETE 2020) and which had as objectives from the assessment of the territory, to analyze the aging processes of the regions of the interior of Portugal; to analyze how the communities deal with the aging processes and to build proposals and tools of analysis and intervention capable of helping in the response to the challenges of the aging regions of the interior of Portugal.

The information was obtained from a questionnaire, anonymous and comprehensive of closed questions, that included questions related to the socio-demographic characterization, level of education, cognitive abilities, social resources, economic resources, perception of health and activities of daily life, mental health, health resources and use of information technologies and knowledge, indirect administration to the population aged 65 and over, living in the community and with cognitive ability to respond. The inquirers recorded the information provided by the respondents and they were previously trained in order to familiarize themselves with the questions.

The sample included individuals aged 65 and over, living in 6 rural and urban counties (Guarda, Sabugal, Castelo Branco, Idanha-a-Nova, Portalegre and Elvas), stratified by five--year age groups and by gender, with a 95% confidence interval.

The calculation of the groups was based on the 2011 census and the 2016 population estimates, published by INE. The information was obtained in the street or public places between June 2018 and January 2019 and was analyzed using descriptive statistics in order to synthesize values of the same nature and thus obtain a global view of these values.

The general study was designed and carried out taking into account the Code of Conduct for Researchers, Universities, Research Institutions, Funding Institutions of the Office of Ethics and Scientific Integrity, of the Foundation for Science and Technology, as document available at https://www.ua.pt/file/52253 and for this article only the questions that allowed to answer the objectives of the same were selected and analyzed.

RESULTS

The study included 323 individuals aged between 65 to 99 years, 178 women and 145 men from the regions of Castelo Branco, Guarda and Portalegre participated (Table 1), the average age was 77.1 years. In terms of marital status, there was a predominance of married or cohabiting individuals (50.8%) and widowers (41.2%) with an average number of 1.4 children. Regarding literacy, most respondents (53.6%) reported 4 years of schooling, 13.3% of respondents reported not being able to read or write. Only about 5% of respondents reported secondary schooling and a similar percentage of higher education.

Table 1 – Distribution of the sample by region, sex and age.

Age group		Women		Men		Total
		N	Mean ± Standart Dev	N	Mean ± Standart Dev	
65-79 years	Castelo Branco	49	72.86±4.359	42	71.36±4.113	
	Guarda	29	72.72±4.503	25	72.80±4.349	
	Portalegre	33	72.06±4.235	28	72.39±4.756	
80 years and more	Castelo Branco	37	87.11±4.875	25	86.88±5.093	
	Guarda	16	86.31±5.029	14	84.00±3.700	
	Portalegre	14	85.21±4.371	11	83.18±3.683	
						323

When asked about their state of health most study participants (50.5%) considered their health status in the last 6 months to be normal or good (14.9%) but 26% considered their health status to be poor only and a small number considered very bad (2.5%), and 97 of the 323 respondents reported taking medications regularly for one or more health problems. The perception of the ability to perform activities of daily living (ADL) was identical to those with health. About half of respondents (49.8%) reported feeling some limitation in performing ADL because of their health, physical problems and 40.2% of respondents reported not feeling limited to perform these activities.

Satisfaction with life is a good indicator of health status and almost half of the respondents (45.8%) considered their life interesting, opinion converging with the perception of normal health reported by half of the participants, however, 37.2% considered that their life was dull and 15.8% considered it boring. Concern about things, in general, was common in this sample and reported by 47.7% of respondents.

Concerning perceived help, 41.8% of respondents considered they had someone able to help them go to the doctor or prepare a meal when needed, but 37.2% felt they had no help for these activities. Regarding the frequency with which aid or benefits would or could occur, the majority (41.2%) considered that aid occurs whenever necessary, with lower percentages being those who considered that aid occurs or may occur, but only slightly (9.6%) or only sometimes (6.8%).

Faced with a specific illness or disability situation in the question "is there anyone who can help you if you become ill and disabled" (Table 2) the overwhelming majority of respondents said yes (84%) and only 10.8% answered no. The analysis of the answer to this question by age group showed that the percentages did not vary much between the groups.

Table 2 – Perception of help in case of illness or disability by age group.

Idade		65-74		75-84		≥85	
		Freq.	%	Freq.	%	Freq.	%
Valid	Yes	119	86.2	101	84.2	52	80
	No	12	8.7	16	13.3	7	10.8
	Total	131	94.9	117	97.5	62	95.4
Missing	DnK/DnR*					3	4.6
	Sistem	7	5.1	3	2.5	3	4.6
Total	323	138	100	120	100	65	100

Note: *Dnk/DnR – Does not know/Does not respond.

Regarding the sources of help, they were identified from the question "Who usually cares for their care" the answers focused mainly on the spouse and descendants, but when asked "who was the greatest help in the family relationship", to which only those participants who perceived an effective need for help replied (134), despite a wide dispersion in the answers, respondents reported resorting mainly to descendants, sons and daughters (20.3%) or the spouse, wife or partner (13.6%). Only 6 respondents referred to receiving or to be receiving help from a paid person and the number of people who referred to receiving help from others without pay was very low. The greatest help in the family relationship is referred to as coming from wives first, followed by sons and daughters, but also from daughter-in-law and granddaughters (Table 3) highlighting the importance of the functional dimension of solidarity from the family members.

Besides the functional dimension of solidarity, the affective dimension was also perceived by respondents. Almost all (92.6%) reported having someone to trust and half said they rarely or never felt alone (53.9%). Only 16.1% expressed feeling alone, always or often and 27.2% sometimes. The perception of positive feelings in the relationship with family members found some lack of reciprocity since 41.8% of participants reported that they do not see family members as often as they would like.

And when asked who their greatest help is, the answers centered on the daughter or daughters and wife as the most helpful relatives but also on the daughter-in-law and granddaughters (Table 3).

Table 3 – Perception of greater aid in care, other aid besides the main aid and third aid.

Bigger help famil. rel. Valid 134			2nd help beyond the largest Valid 55			3rd help beyond main Valid 21		
	Freq.	%		Freq.	%		Freq.	%
Female comp/ male companion	3	0.9	Maid/Institution	4	0.6	Daughter/s	6	1.8
Wife	23	6.8	Daughter/s	14	4	Son	4	1.2
Spouse	19	5.9	Son/s	23	7.1	Sister	1	0.3
Maid	6	1.8	Son in law	1	0.3	Brother	1	0.3
Daughter/s	42	12.7	Sister	2	0.6	Grand daugther	2	0.6
Son/s	29	7.6	Grand daugther	5	1.5	Grandson/s	3	0.9
Sister	3	0.3	Grandson	1	0.3	Daughter in law	3	0.9
Neighbor/ Other	9	2.7	Neighbor/Other	5	1.5	Neighbors	1	0.3

DISCUSSION

Despite the geographical dispersion, the participants of this study had in common the fact that they reside in the interior central region of the country, rural and urban áreas from Guarda, Castelo Branco, and Portalegre where still seems to persist what Boaventura Sousa Santos calls a providential society constituted by "networks of relations of inter knowledge, mutual recognition and mutual aid based on kinship and neighborhood ties" through which they exchange goods and services on a non-market basis and in a logic of reciprocity[19]. Relations between generations in recent decades have been influenced by demographic and social changes to which social researchers have been attentive, not proving a decline in mutual support, but rather stating that the family remains the main source of help for older people, although friends and neighbours may also provide some assistance[20]. The concept of family is present in legal and social institutions as well in individuals' minds as data have highlighted[21]. It is in the family that the elders expect to find help if they need it and as they have expressed it, it is the family that mostly takes care of them when they need it. It is mainly the family members they trust. This is why the ageing of populations is not related and cannot refer only to older people, because it affects people of all ages and shapes the different contexts in which family relationships occur among different generations[22].

The changes that occur with aging are complex and influence health, and a significant percentage of participants in this study (26%) considered their health to be poor or very bad (2.5%). Even so, most respondents perceived their health as normal or good, highlighting the great heterogeneity of the elderly group and recognizing that many people aged 70 and over may still have levels of physical and mental capacity comparable to those of younger individuals as WHO[17] advocated but also emphasizing the importance of the activativation of the capacities of each one and the recognition and attention that must be given to their individual needs.

Attitudes towards health and disease vary throughout the life cycle and health perception is influenced by the level of education recognizing that more educated people perceive higher levels of health[1]. Despite the small number of years of schooling in this sample (mostly 4 years), in most participants the education variable does not seem to have significantly influenced the perception of health as did the perception of ability to perform activities of daily living (ADL). Although the perception of poor health can develop during aging, this perception can also be attributed to other causes[18] and the fact that all these elderly people still live in their homes and in the community may also have positively influenced their perception of health. On the other hand, the perception of relative (non-severe) limitation in the performance of ADL, present in almost half of the sample reinforces the complexity of health and functional status of older people and simultaneously calls for a greater questioning about what health means at these ages and how it can be measured, promoted and maintained while not disregarding psychological resources and subjective perception of health[15-16,18].

The vast majority of respondents trust that in the event of illness or disability there is someone in the family network who can help them, unequivocal perception of solidarity on the part of the family, especially of their descendants, sons, and daughters or their spouse or partner, who are perceived as the main providers of help. The high percentage of respondents who believe that someone in the family network can take care of themselves in the event of illness or disability suggests a strength of commitment in family roles and fulfilling obligations that may be understood as a normative imperative that is not questined[9,13].

The affective dimension of solidarity characterized by the type and degree of positive feelings held towards family members and expressed in the participants' confidence in their family network[9,13]. Almost all respondents said they had someone to trust, but the number was reduced when the question was whether they felt alone. To this question little more than half (53.9%) said that they almost never or never felt alone, although in another question they mentioned not seeing family members as often as they would like, fe-

elings that are present in 41.8% of the participants and that may suggest some lack of reciprocity in the affective dimension of solidarity.

Although there is no evidence in this stample of the decline in family solidarity and intergenerational mutual support[20], some of the dimensions of solidarity may be compromised by the tendency that exists in today's families, diversified in the form and number of individuals that compose them, lacking time for older generations[12].

In the replies about sources of aid, which have the functional dimension of solidarity implicit[9,14], respondents who reported receiving it made it clear that free support is distributed asymmetrically between the sexes as other studies have evidenced[11,20]. And this asymmetry can also have different effects on affection and conflict, depending on whether it occurs in a poor society or in a more resourceful society[1]. The perception of concrete help fell on the daughter or daughters and wife and daughters-in-law making functional solidarity a gender issue.

WHO[15] has warned that gender norms are changing. Women are increasingly performing other functions, which provide them with greater security at present also give them confidence at an advanced age. But the right to diversify into other roles also limits their ability and the ability of families to provide care for the elderly both in terms of quantity and differentiation. This change in behaviors requires taking into account this normative dimension of solidarity and revising old models of family care because they are not sustainable.

The solidarities identified in this study can also be considered "general or desired" solidarity[6] calls since it allows to suppress "market failures". In other words, given the perceived need for help and the absence of structured responses from the state, individuals place all expectations in the family. However, the individualization of society has changed the ways of life of families that are now broader[22] especially for women.

The social rules that have defined the structure and roles of family members in the past, and which were a role to be played by women almost exclusively and with no alternative, the role of caring, in a family-oriented life model, is not currently verified. In Portugal, women have similar employment rates compared to men, that are increasing in recent years[24] illustrating their desire and right to have a career of their own.

But since family obligations are long-term commitments that help define and strengthen family roles[21] interdependencies between generations and between men and women in families are built and reinforced by legal and political provisions that reward or disincentive certain standards[22] therefore requiring other laws and policies.

It is proven that the existence of public provisions does not damage relationships or diminish solidarity[25], so the aid and assistance to the elderly, due to its complexity, benefit from professional providers able to take regular physical care and thus free the families, especially the feminine elements, from functional solidarity leaving space and time to the family, to the more spontaneous and less demanding affective solidarity and so that both men and women can fully realize themselves[25].

Study limitations

Although this study has generated ideas about this population, the non-probabilistic sample does not allow the generalization of results.

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Protection of Human and Animal Subjects: The authors declare that the procedures followed were in accordance with the regulations of the relevant clinical research ethics committee and with those of the Code of Ethics of the World Medical Association (Declaration of Helsinki).

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