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Considerations on Research Design in Studies on the Elderly Population in Brazil

Renato P. Veras*

Until recently, having a substantial contingent of older people in the population was a mark of more developed societies, that is, in North America, Europe, and Japan. But this situation was altered as of the 1970s when the relative ranks of elderly also began growing in Third World nations. The dispersion of data on increasing proportions of older people in Third World countries, and especially in those of larger territories, brings forward the need to gather more information on their aged. Brazil is a good example. Of all nations projected to have over 16,000,000 elderly by the year 2025, Brazil displays the greatest growth rate - that is, 1,514% (see Table 1). Because some authors [7, 20, 21] believe current fertility and mortality rates are lower still than official estimates, they contend that these projections are conservative. If they are right, Brazil's aged population will exceed the 31,800,000 figure shown in Table 1 for 2025. It is important to note that during this same period the Brazilian population overall will grow five times, while those in the 60 and over bracket will multiply by fifteen [16, 15].

Despite this sharp growth, the academic community in Brazil has produced little on the topic. In some fields, particularly the social sciences and demography, a number of quality studies have appeared.** In the area of health,

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** The following are worthy of note among the main contributions in these two areas: Lins e Barros [17], Filizzola [9], Bosi [6], Salgado [29], Berquó [3], Fraiman [10], Haddad [13], Magalhães [19], Pena [24], Queiroz [25], and França [11].

especially epidemiology and planning, production has been limited, with a few rare exceptions [26, 8, 4, 5, 1].

In a country battling a decade-long economic crisis, research funds are scarce. But just as serious as the scarcity of financial resources are the quite equivocal stances of those who defend the thesis that investments should be allocated to other areas, using the argument that international academic production on senior citizens, especially in the US and England, is quite extensive and enough to provide an overall outline of the aging situation and to therefore subsidize decision making.

Table 1:
Projected growth of population over 60 for selected populous nations, 1950-2025

Region	Population 60 & over (millions)				Increase (%)
	2025	2000	1975	1950	1950-2025
China	284.1	134.5	73.3	42.5	668.5
India	146.2	65.6	29.7	31.9	429.3
USSR	71.3	54.3	33.9	16.2	440.1
USA	67.3	40.1	31.6	18.5	363.8
Japan	33.1	26.4	13.0	6.4	517.2
Brazil	31.8	14.3	6.2	2.1	1,514.3
Indonesia	31.2	14.9	6.8	3.8	821.1
Pakistan	18.1	6.9	3.6	3.3	548.5
Mexico	17.5	6.6	3.1	1.3	1,346.2
Bangladesh	16.8	6.5	3.3	2.6	646.2
Nigeria	16.0	6.3	2.6	1.3	1,230.8

Source: UNO, DIESA, The world aging situation, 1985.

This point of view must be contested. Brazil's demographic growth has its own particular characteristics and these must be captured through investigative studies and designs regarding specific realities, geared to correctly subsidize the implementation of programs that fit Brazilian reality.

Indicators that reflect the whole of a nation with characteristics like those of Brazil can be quite misleading. For example, some regions of the country are poverty-stricken, comparable only to the world's poorest nations, while significant portions of the populations residing in certain Brazilian cities enjoy access to a variety of First World conveniences. Although its rich are few, Brazil is one of the ten largest economies in the world. Furthermore, even though its distribution of income is marked by inequity and the concentration of wealth, in absolute terms a sizeable quantity of its nearly 145,000,000 citizens are highly affluent.

The current ranks of elderly Brazilians are formed of individuals who have managed to survive in highly adverse conditions and who thus constitute a differentiated social and biological selection. A look at the spatial distribution of the aged reveals a concentration in large metropolises and in neighborhoods offering more urban conveniences, that is, areas inhabited by those with greater buying power. This does not mean that the elderly are part of the wealthy. Those who survive into old age are on the average less poor than the overall population. It should be stressed, however, that this picture is tending to change. It must be considered that in a Third World country with practically no health services or programs for the elderly, those in lower income brackets tend to experience more health problems and to die sooner. Ramos, in a study conducted in São Paulo, used as a socioeconomic indicator the number of older people residing

in the neighborhoods of that city.* The same method proved valid when applied in Rio de Janeiro [30].

Examining a nation like Brazil in terms of mean averages thus constitutes a methodological error with grave consequences for planning, as research designs that do not take into account a nation's heterogeneity, or the heterogeneity of its large cities, will be incapable of correctly capturing the real needs and demands of different social groups.

Bearing in mind the aging process of Brazil's senior citizens, other aspects must likewise be considered when designing investigative studies:

- Despite the very notable growth of the number of aged in Brazil, the country has a vast number of younger people, and will have for some time to come.** This differs substantially from Northern nations, where for several decades the number of younger people has been small, stable, or even dropping, whereas the elderly population, above all in the oldest age brackets, has maintained steady growth. Population growth in Brazil displays characteristics quite distinct from those of First World nations, meaning that Brazil will have to cope with a major challenge: the obligation of allocating resources so as to meet the requirements of both the young and the old, two needy groups with heavy demands for services. This means that social program resources must be earmarked not only to fight high infant mortality rates and malnutrition and sustain educational programs but also to fight chronic health problems such as arthritis, cardiopathies, degenerative diseases, cognitive disorders, and other infirmities typical of old age. Add to health issues the question of social security benefits and the pensions to which all senior citizens have a right, and in economic terms you have a major challenge

* See this discussion on page 6.

** For the purposes of the present study, 'young' refers to those between the ages of 0 and 14 while 'elderly' refers to those of 60 or more.

indeed: two economically non-productive groups putting demand pressure on the scant resources of a needy country with a weak tradition in medical-social investments. Cost-benefit analysis and cost-effectiveness are, for example, two fields of investigation that should be encouraged if funds are to be used efficiently.

- Another Brazilian peculiarity related to the rising share of elderly - one that distinguishes this nation from the First World - is the fact that a large percentage of Brazilian senior citizens are relatively young, that is, between 60 and 69. In European or North American nations greatest growth has been recorded among those over 70 [14, 18, 22, 23].

The latest Brazilian census* points to the states of Paraíba and Rio de Janeiro as having the greatest proportions of aged people (about 9%). But the makeup of this growth must be analyzed. In Paraíba, the aging trend is mainly a consequence of wretched living conditions, which have driven large portions of the productive population to other states in search of work. In other words, the aging of Paraíba's population is linked to migration, allied to high mortality rates. The population of Rio de Janeiro is more stable, and fertility and mortality rates have been falling for some years. So it is for quite different reasons that the populations have been aging in these two areas of Brazil. Research studies must capture such differences. As much as Paraíba is located in a region where social ties are quite fraternal and mutual aid is a significant cultural factor, any program based on social and/or family support is unrealistic and tends to meet with failure given the state's misery, poverty, and migration. Rio de Janeiro, on the other hand, more closely mirrors the aging patterns registered in Europe and First World nations in general (that is, declining fertility and mortality rates) and, yet, it too has its own special characteristics. Like all of Brazil, Rio de

* Preliminary results from Brazil's 1991 census.

Janeiro displays sharp economic and social idisparities, and this must be kept in mind when drawing up projects that will subsidize medical-social action.

Meant to subsidize the planning of medical-social policies, a recently completed study [30] profiled Rio de Janeiro's senior citizen, based on certain presuppositions.

As mentioned earlier, Brazil contains pockets of absolute misery while other of its areas are more developed and industrialized, creating a tapestry of gaping regional inequalities. The dimension of these distortions is visible, for example, in life expectancies at birth. Brazil as a whole behaves neither like the country's richest regions, such as Rio de Janeiro and São Paulo, nor like its poorer states, where life expectancies at birth are incredibly lower, due to the poor living conditions [2, 12, 28].

Mimicking the rest of Brazil, the Municipality of Rio de Janeiro presents socioeconomic disparities from population to population. In poverty-stricken neighborhoods legions of low-income families have inadequate access to essential services like basic sanitation, transportation, health-care assistance, and others. In contrast, some neighborhoods are virtually immune to such hardships or confront them in less intense form. The same city thus presents precarious, inadequate living conditions alongside modern conditions of bounty, similar to those seen in some rich areas within developed nations.

Given Rio de Janeiro's social and economic discrepancies, rather than looking at the city as a homogenous whole and thereby arriving at results that do not reflect the living conditions of the poorest sectors - nor even of the wealthiest - the present study deemed it more appropriate to observe some regions separately. This more painstaking study was intended to capture

specific realities, much as the São Paulo study conducted by Ramos [27]. Rio de Janeiro was thus evaluated by *homogenous areas*, that is, by neighborhoods and social segments displaying similar standards of conveniences.

Against such a background, the discussion of suitable criteria for selecting the most efficacious sampling indicators takes on special relevance. The definition of these criteria for classifying the homogenous areas by similar characteristics will underpin the representativity of the areas and assure that social reality is more accurately captured.

A detailed discussion of the choice of socioeconomic indicators and the method used for selecting and weighting each neighborhood, as well as information on other aspects of this study, can be found in previously published papers [37, 34, 32, 30, 33, 35, 36, 31].

If this concern with design is not taken into account, final results will be of meager efficaciousness in health-sector planning. The study in question chose three neighborhoods of Rio where residents are predominantly rich, middle-class, or poor. Results confirmed the validity of the adopted strategy. Investigated in all three regions, the rate of dementia, for example, proved much greater in the poor neighborhood than in the rich.* Analysis of results proved that only by dividing the city into homogenous regions can greater data precision be assured. By examining Rio in this fashion it was possible to ascertain that although dementia is more prevalent in the poor neighborhood, the elderly there are younger on average than those in the rich. Ergo, it can be supposed

* Results were: Copacabana, the wealthier neighborhood, 5.95% and Santa Cruz, poorer, 29.75%, with middle-class Meier in between. The result, however, will not be used for this article. It is important to stress that these values refer to cognitive deficiencies in general and not just to dementia.

that the bulk of dementia cases in the poor neighborhood represent initial-stage cognitive disorders. In order to postpone progression of this chronic disease for as long as possible, planning measures and health-care services should devote top priority to primary care, in the form of home visitation, social activities, counseling, monitoring, and health-care posts equipped with geriatric physicians. The richest neighborhood is home to older senior citizens, and although dementia rates are lower there, those afflicted display more advanced cognitive disorders, demanding such care as specialized physicians, medication, nursing homes, etc. The approach must thus be distinct in each case, both in terms of the organization of health-care services and personnel training as well as in terms of financial outlays.

This example is meant to underscore the need for studies that take into account social inequities and disparities, for only in this way is it possible to in one same city detect such different rates of disease, and consequently such different health-care demands, reflecting each population's social and demographic profile. It is well known that health-care for the elderly is quite expensive, and in this sense epidemiological research can provide the most adequate tools for achieving maximum efficiency in the definition of priorities and resources.

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