HEALTH NEEDS OF ELDERLY RESIDENTS IN MONTEVIDEO HOUSING COMPLEXES

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ABSTRACT

Population aging impacts social and health services. Objective: To understand the perception of the health needs of elderly people living in Social Security banking complexes. Methodology: Qualitative study. 27 people over 65 years of age participated, Montevideo. Information collection technique: semi-structured, individual interviews. Targeted content analysis. Results: Family Relationship and Social Support Category, a protective factor in old age, perceived as weak or almost non-existent. Loneliness and Depression Category, 14 experience loneliness. Category Need for good living conditions, need for family financial support or cash loans. Access to Health Category, belong to the National Integrated Health System, with multimorbidity. Category Autonomy Physical limitations, some independent in daily activities, others need help. Final thoughts: The health system for the elderly requires effective policies to improve care.

Keywords: Aged. Need for health. Barriers to access to health services. Qualitative research.

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INTRODUCTION

One of the major challenges worldwide is the sustained increase in the proportion of older people. In the Region of the Americas, by 2025 they will represent 18.6% of the total population, doubling this amount in the next 25 years.1

There are several ways to measure health needs, from individuals' perception, to objective measurements of physical and mental function and other determinants. There are those who define it as the degree of health-disease where there is a relationship between the basic needs that an individual may have, and the intermediate needs such as nutrition, education, housing, work, economy, among others.2 To understand the broad concept and complexity of health needs, Matsumoto (1999) uses a taxonomy that divides them into 4 major groups: Good living conditions, Access to health technologies and prolongation of life, Bond with health professionals and team and, finally, the need for autonomy and self-care. caution.3,4

Considering these four groups, in Uruguay there are policies that aim to realize the rights and improve the living conditions, as well as the health needs of the elderly. In this sense, the Social Security Bank (BPS) is responsible for coordinating the State's social security services and organizing social security. Among the social programs it develops is Housing Solutions for Retirees and Pensioners, framed in Uruguay's housing policy. With this, the housing needs of the retired elderly or pensioner, contributors to the Agency, and who meet the conditions established in Law No. 17,217, are met.

Housing complexes for retirees and pensioners are one of the components of the Program. They are houses of the individual housing type, in buildings of one or two floors or apartment towers, they have drinking water, electricity, sanitation, most have green spaces for common use, meeting rooms, for accessibility in some ramps have been placed, elevators for those who have more than one floor. The houses have a kitchen with sink and tap, bathroom, bedroom. An average of 5,752 elderly people across the country live in these complexes.5

Another policy that is being developed is through the National Integrated Health System (SNIS), which guarantees the right to health and provides comprehensive care to the entire population of the country through Law No. 18,211 (2007).

The Ministry of Public Health, the body responsible for health issues, hosts the National Program for the Elderly, responsible for managing health programs aimed at this population group. In the context of social development, the Ministry of Social Development (MIDES) is part of the National Institute of the Elderly, responsible for actions related to old age in the country. (CIEN; 2020).24

This research aims to understand the perception of health needs by elderly people living in housing complexes of the Social Security Bank.

With this data, it is possible to support the development of public health and social assistance policies consistent with the needs of this population.

METHODOLOGY

This is a qualitative research, allowing an approach of information that cannot be quantified, used to understand the universe of meanings, beliefs, motivations and values of those who participate in the study.6

For the selection of the three housing complexes for BPS retirees and pensioners in the city of Montevideo, Uruguay, the following criteria were used: geographic location of the complex and accessibility to health services; to have developed the teaching of care for the elderly in the training of Nursing Graduates of the Faculty of Nursing of the University of the Republic continuously for 3 years, 1 year and less than 6 months.

The fieldwork was carried out between September and December 2022, starting after obtaining authorization from the Social Security Bank. The invitation was made in each of the complexes through posters in the elevator and in the spaces for common use by the residents, with the purpose of making them aware of the research and having equal opportunities to participate in it.

The interviewees were 27 elderly people. Intentional type sample. The inclusion criteria were: person aged 65 years or older, living in the BPS housing complex for more than one year. The exclusion criterion was elderly people who have difficulty communicating. To define the sample size, the saturation point methodology was used: after a certain amount, new cases repeat or saturate the content of previous knowledge.7

The technique used to obtain information was the semi-structured individual interview, coordinated day and time. The anonymity of the participants was used by the researcher with the letters CH, B, C indicating the housing complex in which they live and by number in the order in which the interview was conducted. The number of interviews conducted per complex was CH eight, in complex B ten and complex C nine. Most of the interviews took place in the participants' homes. Simple observation notes were made during the research process. It contained descriptive notes such as portraits of the participants, events or activities, feelings, impressions.

The participants gave their informed consent, it was explained to them that they could participate in the study voluntarily, anonymously, confidentially, knowing the objectives of the research, the use of the data for scientific purposes, taking into account the full

protection of the human being subjects of a research in accordance with Decree 158/019. The study was approved by the ethics committee and the research project was registered through the General Directorate of Health, Division of Health Evaluation, at the Ministry of Public Health under the number 5218709.

RESULTS

CHARACTERIZATION OF HOUSING COMPLEXES

A key was used to identify the selected complexes

Complexo CH. It is located in the central area of the capital, with a large flow of traffic and public transport to various areas of the capital, with connection to health services. Some health care providers are about 6 blocks (600 meters) away and the farthest are 35 blocks away. Complex B. It is located in the most vulnerable neighborhood of the capital. The nearest health services are 600 metres away and the farthest 12 km away. Complex C. Located in the east of the city, about 200 meters from important avenues with access to public transportation by bus, the nearest health services are 450 meters away and the farthest 13 kilometers.

The characterization of the participants was carried out with the following components: gender, age, health status, health provider, education, number of people living in the household and presence of pets, time of residence in the household.

The elderly who participated in the research were 27 years old, aged between 67 and 92 years, and of these, 9 were over 80 years old. Of the total number of interviewees, 20 were women, 6 of them over 80 years old. In complexes there is a higher proportion of women compared to men. All participants reported comorbidities, some of them with cardiovascular conditions, followed by osteoarticular, metabolic, psychological and oncological conditions. The presence of comorbidity can mean several adverse events such as functional deterioration, disability, and dependence, affecting their quality of life. Among the pathologies reported by the interviewees were arterial hypertension, metabolic, oncology, stroke, osteoarticular and depression. Suffering from non-communicable diseases has long-term consequences, involving pharmacological and nutritional treatment, periodic check-ups, among others. Several people have limitations and some are helped with mobility with walking aids. All participants have a health provider and choose which one to belong to, most are users of public health services and a smaller number of private ones.

Another characteristic is the level of education: of the 18 people who completed elementary school, only half managed to complete it. Some reported that the reason for dropping out was due to their socioeconomic situation, prioritizing work in childhood. Those

who reached the secondary level were 8 and only three completed it. Of the interviewees, 19 live alone. In the category about the length of residence in the complex was between 1 and 20 years, 9 of the participants have between 5 and 10 years.

In the directed analysis of the interviews, five categories were identified: Family and social support relationship: Loneliness and depression; Need for good living conditions; Access to health; Autonomy and physical limitations. Each of these is linked to the four components of Matsumoto's taxonomy. The first three categories mentioned are related to the Need for good living conditions; access to health with the Need for access to all technologies and the Need for bonding with health professionals and teams, with the category autonomy and physical limitations with the Need for autonomy and self-care.

Family relationships and social support

As biopsychosocial beings, people need the support and companionship of others throughout their lives. This support network changes over time, in the phase of old age its importance as support intensifies in the presence of vulnerability to economic insecurity, health problems, dependence. In the study we tried to get to know this social network with family, friends and neighbors and even for some the importance of having a pet at home.

"I have my daughter who is the only family I have... my daughter who calls me several times every day" (CH2)

"My family is my two daughters and my granddaughter and my son-in-law" "My daughters are always present" (B2)

"Perfect! Well, with (your son's name) and my daughter-in-law I go every Saturday and Sunday" (B4)

In general, for the elderly, family means a lot in life and even more so when there are children and grandchildren. Your loved ones are present in the stories, especially when there are good ties.

Note Note: In the decoration of their homes, there is usually a space where photos of their loved ones and shared moments are kept.

Close ties with the family do not happen in most cases and this is evident in non-verbal expression, lack of support in activities of daily living and even in economic issues.

"I haven't had contact for a year, I haven't seen her, the other day she was a year" (with her daughter)... My son has been 15 years since I don't know where they are, I don't know anything. He doesn't worry either, you know, I love those who love me" (B6)

"I am sad, because I have my daughters, all very far away and I heard from them and now I don't have them anymore" (C4)

There are those people who have no bond with their children, nor do they mention the presence of friends. In the stories, they reveal a relationship with family members and especially with children, poor or non-existent. Contact is lost, the need for affection is present, not being able to develop the role of grandparents or parents.

Note of observation: A change of mood is observed in his expressions when talking about this theme where sadness, pain, accompanied by crying are noted.

Friends can be chosen in life, they are bonds that are created by common interests and shared activities, resulting in support of great importance in people's lives and even more so in old age, and can even contribute to care issues, health behaviors (seeking medical help, mood, self-esteem). They are links where there are spaces to accompany each other, to laugh, to exchange support. In the stories, some expressed having friends. The people who will live in these complexes often had to give up many things when moving from their old home, neighborhood, neighbors, friends, family.

Loneliness and depression

Of the interviewees, more than 14 elderly people report loneliness. During aging, a series of experiences and changes occur that can generate a feeling of loneliness.

"When I lost my sister who lived here... and I was alone (pause) I felt alone... The truth is that I was so alone" (CH1)

“... I feel bad, emotionally I don't feel like doing anything, I do things because I'm alone, I have no one (CH3)

"There are times when I have low points... because I lived with my daughter when I came here, I have to adapt to being alone and. And take care of myself and not make it difficult for anyone" (CH6)

Several people report having lived the experience of loneliness, feeling alone. It is mostly expressed by women, which does not mean that men do not experience this feeling. Some express having suffered the loss of loved ones (siblings, spouse). In other situations, loneliness is due to the fact that your loved ones are far away and you don't have physical contact with them. The stories reflect feelings of anguish, sadness, reluctance, perhaps a sense of abandonment.

There are diseases that can accompany old age, such as depression. There are people who have been diagnosed with Depression, others have elements of this disease, characterized by persistent sadness and disinterest in carrying out activities of daily living.

"I'm going to take her, I have depression problems" (CH6)

"I had a great depression.... It's not the same thing as talking on the phone or texting (with the family), it's not the same thing as being able to hug and touch" (B8)

The depression manifested by those who have been diagnosed and are undergoing treatment has generally been in women, who in most cases live alone and who suffer from other types of health problems. In some cases, having a pet helps them stay active and be able to carry out activities of daily living.

"If it wasn't for my dog I don't know where I would be... he's my companion, it's the only thing I have" (CH3)

For those who love animals, having a pet is positive for them. In those who age, they experience a series of changes and new situations where deficiencies, new needs, loneliness, diseases, sedentary lifestyle, among others, begin to appear, and having a pet can help to face these situations.

NEED FOR GOOD LIVING CONDITIONS

Within this category are family financial support, the use of loans, help with medicines and housing. People living in the complexes have social security coverage, it is a condition they must have to be beneficiaries of a house, and this pension or BPS pension is one of the lowest. Knowing the perception of the elderly about the need for good living conditions allows us to know if their income helps them to be self-sufficient to cover their expenses, when it is known that health problems and consequently costs increase in old age. People's circumstances are different from each other, there will be those who need help in their social relationships, others who use the loan system and others who can solve with the income they receive. Some people receive financial support from family members.

"Payday was coming, but I was very short on money like almost everyone here... Then that... She brought me an assortment (referring to her daughter). It's hard for me to get to payday" (B8)

"No, if I don't have money, I have a son who is a sun, who doesn't let me lack anything. No, the income I have is not enough for me" (C1)

There are several people who depend on their social support network to cover monthly living expenses. In most cases this support is not sporadic but monthly, and in most cases it is the children who provide the help.

People who don't have a social network and need financial support take out loans or use credit cards.

"Everything is very expensive... I have to get the OCA card (credit card) because I can't afford it. And it's kind of complicated... the issue of food is tough" (CH6)

"No, I didn't have a penny and I'm alone. Nobody gives it to me and I don't get credit anywhere. What happens is that I make loans very well" (C2)

In some stories they express the increase in the cost of things, for example, food. Not having support from other people close to them, they end up resorting to monetary loans. A minority of the elderly say they are able to cover their expenses with the income they receive. In some situations, the economic income of that household is higher than that of a person. It should be taken into account that the economic budget of each household is different due to various health factors, the health provider to which they belong, their morbidity and, therefore, the treatment they must carry out, among others.

From the above, the people interviewed suffer from pathologies and several of them have more than two. This is accompanied by pharmacological treatments and, therefore, has its cost.

“… They help me with the medication. It doesn't work for me, it's not enough for me because there are several medications that I take" (B2)

“... He is involved with loans... medicines are deadly" (CH5)

"Yes, because sometimes we don't receive it, we have half of it there, so sometimes I prolong the trip to the hospital to get the medication. Because without money you won't go anywhere" (CH8)

In the stories, there are those who, due to their pathologies, have continuous drug treatment, giving rise to the existence of a geriatric syndrome such as polypharmacy. In the stories they express how expensive access to medicines is and some express the postponement of their purchase due to lack of money. Depending on the health operator, it may or may not have a lower cost. Other difficulties are that there are professionals who prescribe medicines that are not available at your doctor and must be obtained abroad, at a different price.

Within the Need for good living conditions is housing, recognized as a right and an aspect considered according to the socioeconomic situation of the person. The housing has the purpose of contributing to your quality of life, knowing what the participants think about it is important.

"Yes, because I lived on a farm, it rained like outside. I'm right here (C2)

"I never had my own house or anything. This well-being that I have, I never had. It's the first time (B4)

"But I like it, because I've always dreamed of my apartment and I've always liked to be organized" (CH8)

The vast majority of people like to be able to have a house and feel that it is theirs, it dignifies them, it gives them a space of privacy, they feel like owners of their house, even though they know that it is for use. For some, moving meant a challenge, having to adapt to a new place, leaving environments of trust, support from family and friends, and relearning how to live with strangers.

Access to health

The elderly are part of the National Integrated Health System (SNIS), and it is up to them to choose to stay with a private or public provider. In the stories, they refer to 17 participants who are part of the public health network. All interviewees suffer from some type of disease and often live with more than one person. Health care is divided into specialties. The stories allow us to know how the elderly perceive this theme.

"There aren't so many specialists, I really need to do the queue thing, that's annoying because the truth is that, because sometimes you have to wait and sometimes you can't stand it so much, it's no use" (C8)

"I'm all deformed, in October last year I went to the rheumatologist who sent me a CT X-ray and until now I'm waiting to see the result" (CH3)

"... always in the long term and even more so the specialists, they are giving me specialists almost 3 by 3, for 3 months" (CH7)

"I respect medical care like this, like now we would need this, I would need to go to the doctor many times and sometimes I'm lucky, sometimes not... Now I've been waiting for the Ophthalmologist for four months" (B3)

Health care is fragmented, depending on the pathology and the specialist treating it. A person may need consultation with several specialists. Some express the need for more specialized medical professionals. The waiting time exceeds two months. Consultations are not always for monitoring or control of the health problem, but for some decompensation, for the appearance of new symptoms, requiring timely care. They see no other way out than to wait months for the appointment. The waiting time at the health service is reiterated in the stories of the different elderly people.

"You have to wait, what are you going to do, there's no other way" (CH5)

"I wanted my doctor to treat me... But she doesn't come here. That they attended to me, faster. Wait, wait, no, no one likes to wait, it seems to me" (CH6)

"I say this, to take care of an elderly person, so similar to us... not so much waiting. You go and stay for an hour, two hours, 3 hours suddenly and waiting for the doctor to attend you stay more than an hour every time" (B10)

The scheduling program continues to be used in most services. Everyone agrees that they have a waiting time and that it is excessive. Some are resigned to the fact that they have to wait, others say that sometimes they have to wait in conditions that their health does not allow.

Autonomy and physical limitations

There are several factors that can lead a person to dependence. This category is linked to the need for autonomy and self-care. In addition to suffering from illness, it is important to know if there are limitations to maintaining this physical autonomy and to the ability to carry out activities that allow them to take care of themselves and continue to live independently. There may be increased physical frailty, mobility problems, and deterioration, which generate respiratory, cardiovascular, and osteoarticular problems. Of those who manage to carry out the activities independently, they report the following in their stories.

“… I go to Gimnasia downstairs, I have a club that I go to... And well, I dance and do gymnastics." (C2)

“… I do it, I am alone, I take a shower alone and I do everything myself, I cook and I do everything myself." "I'm painting, I'm painting because I love it" "I love reading" (B4)

"I like to organize everything. I do my things, I go out to run errands, I go for a walk, I go to the gym" (CH6)

Of the interviewees, some people are able to perform basic and instrumental activities independently and even in an advanced way. But there are those who manage to carry out the activities but who manifest difficulty when performing them.

“… I can do everything without any problem... I do it slower... it takes me a little longer to do it, before I did a task that I did in half an hour, now in forty minutes, I have tremendous osteoarthritis in my knees, that I can barely walk" │laughs│" (CH2)

“... I do my best to clean up, it's hard... when my son arrives he goes" (to do something) (Ch4)

“... I come from the supermarket, then I get tired... I have to stop because I get a little tired... I have difficulty bending down too much... Washing the floor, bending over, something is difficult for me. Or I get tired, for example, sometimes putting on my sneakers, I get agitated" (B1)

"I fell and, um, I broke + and now I have a prosthetic femur... It's been 7 years since I've been out on the street. There's one thing I can't do, ..., which is to raise my arms" (CH1)

In the stories, they express limitations in the performance of basic and even instrumental activities. There are those who have the support of a child to clean and run

errands. These limitations, in some cases, limited them to instrumental activities. Those who are dependent or who need other people to carry out these activities, some have to do with those related to self-care and others with instrumental ones.

"For me it is very difficult to walk alone, I always walk with one of my daughters because I get tired. I have to walk slowly... I pay a girl..., eh I washed the floor because it makes me sick" "I don't like dirty houses." (B2)

"Exactly, they gave me a bath and everything now, with the therapy I started to shower alone, but my head can't always hurt" "I'm afraid of falling... I'm not going anywhere (B6)

"I take a shower" "So I don't have stability" "No, I don't run errands or cook... there are times when I lose the mobility of my fingers" (C9)

Some have the possibility of the help of another person to collaborate in these activities. Limitation in the satisfaction of activities that allow you to live independently and autonomously may be at risk. These situations generate fear in people, of feeling insecure, of losing stability, of reducing their mobility, of feeling limited.

Many people stated in their stories that they have limitations when traveling on public transport, such as buses, having to use a taxi to perform procedures and go to the health service. The complexes are geographically located in neighborhoods where there is public transportation, but not everyone can use it, even if it means a lower cost for having the benefit of being retired. People express the following.

"By taxi, because I can't take the bus, I can't do it" (CH5, uses a walker)

"And I ride a taxi... it doesn't make me feel safe... It's not safe for a big person. To avoid these things I prefer to take a taxi" (B7)

Despite having a higher cost, they use taxis to travel long distances. Their stories reflect that they feel limited in their use of the bus.

DISCUSSION

In Uruguay, for decades there has been a constant growth of the over-60s and in facing the social determinants that condition health and well-being due to socioeconomic, political, cultural and environmental factors. Ending situations of poverty, ensuring a healthy life, promoting the well-being of all, at all ages, is part of the Sustainable Development Goals of the 2030 Agenda.[8]

The results of this survey show some characteristics common to the elderly population of the country. There is a feminization of aging in the residents of housing complexes, with more women than men, at advanced ages. In other countries in the region,

ageing is also a process marked by gender, as is the case in Chile, where the proportion of women is higher than that of men.[9]

In the country, a universal right to have decent and adequate housing is recognized, as is the situation of the elderly who are part of the research. , among others.

The allocation of housing through the BPS Housing Solutions Program seeks to contribute to the improvement of the quality of life of the elderly who have elements of social vulnerability before entering. The aim of the research is not to focus on whether housing conditions meet the needs for autonomy and independence, as contributors to the well-being of the elderly, to the promotion of health and quality of life. An attempt was made to find out how they felt when living in these houses; The expressions of the participants were mostly positive. For the elderly it is of great value to have their own space, to feel like they own their home, where it provides them with privacy, autonomy and peace.[10]

When analyzing the education and occupation of the participants, a large number of elderly people with little education were verified, perhaps due to the difficulties in accessing school when they were children and due to the precarious socioeconomic conditions, therefore, of low income. Similar data were found in a study carried out in a Long-Term Care Institution for the Elderly in Rio Grande do Sul-Brazil: low education, low professional qualification and income, in addition to chronic health conditions.[11.12]

Research indicates that those with low levels of education have a higher proportion of chronic diseases, use health services more and need support in their daily activities. This also affects the degree of understanding and assimilation of health care.[13]

For the analysis of health needs, we started from the need for good living conditions with the family category and social support relationship. In the lives of individuals, a network is created, the result of interpersonal relationships of reciprocity between the elderly, family members and members of the community. These networks are considered protective sources of health and well-being for this population, being essential when there are elements of vulnerability such as the interviewees. What is extracted from the stories reflects networks that are limited and weak in many cases, in some cases non-existent. Similar results are found in another study that refers to social support for the elderly, where old age is accompanied by deterioration in health, the economy and the weakening of social networks.[14]

In relation to the family, there are stories that express that they are present in their lives, but in others they say that they lost contact a long time ago. The cause that generated this distancing is unknown; There are those who claim that there were conflicts that were not resolved. Other causes that may have affected this network are the need to move from

a neighborhood to live in a complex, that is, people having to learn and accept the changes, live alone, be retired and what this implies (loss of roles and bonds).), overcoming the loss of loved ones due to death, affecting the size and strength of the support network. The situations that these people had to live are in line with a study that mentions these factors or causes for the dissolution of the family, loss of friends, colleagues.[14]

The value of a social support network in old age is mentioned by a study that highlights the advantages. It refers to the fact that, in the old age of men and women, having a support network provides economic security, protection, support in daily domestic and personal activities, care and affection.[15] Not having it leaves the person without support, without protection, generating the question of who cares for these elderly people with elements of vulnerability when their informal support network is weakened or absent.

In the different complexes there are those who have pets, and express in their expressions the affection they feel for it, resulting in a stimulus, generating in people the responsibility of taking care of the other, favoring the feeling of feeling useful and of being accompanied. What was found here is similar to a study that deals with elderly people in poverty, with limitations in family support and support networks. The objective was to understand the bond between the elderly and the pet in everyday life and its implications for health, concluding that this bond had its effect on health promotion.[16]

Living alone may have been a choice of the elderly. In some people's history, this was not an option and they had to accept having to live alone due to various circumstances in life. In several stories they express the feeling of loneliness, accompanied by words and expressions of sadness, longing, anguish, demotivation. Those who most express this feeling in their stories are women. These stories coincide with the study carried out on Loneliness in the Elderly, where it says that there are risk factors that can lead to the feeling of loneliness, being of advanced age, being a single woman, divorced or widowed, having a lower level of education, with a lower socioeconomic level, low, good quality of life.[12.17]

Among the participants, there are those who expressed a diagnosis of Depression, some reported that the beginning was during the COVID-19 pandemic due to the circumstances experienced in that emergency process and the health recommendations entrusted to the population and especially to the elderly. Depression is a common mental health problem in older people. One study showed that it is more common in women, with a low level of education. It points out that studying in youth can be a protective factor against cognitive deterioration in the elderly, but there is no consensus between schooling and emotional deterioration in this population.[18]

Another condition that may be linked to the Need for good living conditions is the category that includes income, the subcategory is family financial support, loans, help with medicines, and housing. People who live in the complexes to be beneficiaries of the houses must receive a minimum retirement or pension (12 Adjustable Units = $U 1,596.82, Central Bank of Uruguay, June 2023). The income that a person has affects in most cases their ability to meet their basic needs, access services and products that contribute to a better quality of life.

In the stories, most people express their situation of vulnerability, dependence, and subordination by needing the help of others, in most cases, their children. This coincides with a study that states that the need for support from their social network makes them dependent, having in common that the reason is the low social security coverage for the elderly living in poverty.[19]

For those who do not have enough income and do not have a family support network to help them, they resort to credit. The economic and debt-generating issue is one of the factors that causes the most stress and anguish to a person, especially when their situation and the system do not allow them to obtain higher income through, for example, work. The loan option that might seem like a solution exposes them to receive, during the period in which they must repay the loan, a smaller amount of their retirement or pension. There are situations in which a snowball is generated, when the person wants to pay off the debt and continues to make new loans and so on.[20]

The Need for Access to all technologies could be linked to the Category-Access to health. Access to health services, the costs of medical care, consultations, medications, treatments and hospitalizations would be considered, conditions that can affect their health.

The values of the National Integrated Health System are the right to health, universality, equity, solidarity, and dignity. All participants are integrated into the country's health system like the rest of the population (URUGUAY, 2007). Within the 2030 National Health Goals, in third place is the improvement of the quality of health processes and in fourth place is the creation of conditions for those who take care of their health to have a positive experience.[21]

Of the health problems identified, the 15 most critical were prioritized, with the difficulty of access to services for people with disabilities and care for vulnerable elderly people in thirteenth place. Five strategic objectives have been proposed, the third refers to Improving access to and health care throughout life, the fifth expresses Moving towards a care system centred on people's health needs. It was intended to promote an

approximation with Primary Health Care (PHC) strategies, with emphasis on the first level of care (MSP, 2015).

Participants mention self-perception of the health care provided by the system, regardless of whether the provider is public or private. In the stories, they express accessibility difficulties, there are barriers when they need the health service. There is a long wait for a medical appointment and even longer with a specialist of up to two months, waiting for the day of the medical appointment in conditions that are not comfortable and this also happens to get the medication. The person has geographical and economic difficulties.

In the stories, most must use some means of transport, having to choose the one that gives them security, even if it is more expensive. Another attribute that must identify people's health needs and provide answers through the system is called comprehensiveness. The old paradigm of care persists in which the individual is passive and focused on the disease and the cure. A study carried out in Brazil mentions that health systems based on PHC obtain better results. The existence of access barriers limits other attributes such as longitudinality, exhaustiveness and coordination. These frail elderly, whose way of organizing health services, may find it difficult to get medical appointments and achieve satisfactory longitudinal and comprehensive care.[11]

All the people interviewed suffer from chronic diseases and in most cases more than one. Chronic diseases are characterized by a longer duration, do not resolve spontaneously, and once they appear, they rarely disappear completely. The main conditions are hypertension, arthritis and other musculoskeletal system problems, heart disease, and diabetes, some of which can lead to disability. The health situation of these elderly people and their difficulties are also found in other studies, which indicate that many do not undergo medical examinations at the established times and are seen when they are sick. The study also mentions the lack of personnel and the overload in certain professions, which can affect the quality of care, negatively affecting the health situation of the elderly. The elderly do not have priority care in the services and home visits are not carried out.[22]

Currently there is a paradigm shift in relation to the issues of old age and aging, the Healthy Aging Program of the Pan American Health Organization states that the specific health needs of the elderly must be known.1 Respecting these people as subjects of rights implies that health services must be evaluated so that they are adapted to them and sensitive to their needs, considering their particularities, risks and circumstances.[9]

The last category is Autonomy and Physical Limitations, it is linked to the Need for Autonomy and Self-Care.

The health of the elderly should be measured in terms of function and not disease. Frailty is one of the geriatric syndromes that may be present and is a relevant clinical condition, a state of great vulnerability, which generates difficulties in the functional and homeostatic reserve, leading to adverse consequences for the health of the elderly.23 Incorporating the concept of frailty in the care of the elderly would facilitate the understanding and analysis of health inequalities in relation to the elderly population.[11]

The elderly interviewed have risk factors that can lead them to develop the frailty syndrome or already have it. There are biological factors such as being 80 years old or older or being a woman; the presence of relevant multimorbidity; psychosocial factors, socioeconomic deficit, widowhood for less than a year, social isolation, poverty; hospitalization in the last year, recent institutionalization; functional decline. The latter has to do with the person's ability to carry out activities of daily living and maintain their autonomy.[23]

Aging is a heterogeneous process and has an impact on the planning and delivery of health services. A system is expected to ensure that it does not generate health inequalities for those who are in a state of great vulnerability, that does not allow them to suffer systematic disadvantages in access and quality of care. In a study on frailty in the elderly and perception of problems in PHC attribute indicators, he talks about the importance that this level of care must be well structured to offer adequate care to the frail elderly, optimizing health resources. [11]

These are people who live old age, one of the longest phases of life, in which deterioration and health problems coexist. The elderly studied have little or no participation in community activities, impairing their social bonds, generating difficulties in the development of social and occupational roles, which will help them generate feelings of belonging to the community, identity and value. Stories show that not everyone is fragile to the same extent. They are people who mostly practice little physical activity, some with mobility restrictions, risk factors that increase frailty. The conditions observed in the interviewees coincide with the elements found in a study that also considers the social relationships of the elderly and their effects on health through psychosocial mechanisms, which influence their psychological or cognitive state.[14]

People living in housing estates are not exempt from suffering the same problems as the rest of the elderly population; There are factors that increase their vulnerability, according to the stories told to the interviewees, and their social support networks, their economic situation, access to health through a system that does not recognize their needs

and how they are conditioned by the existence of physical limitations and elements of fragility that can affect their autonomy and self-care.

FINAL CONSIDERATIONS

The results obtained in this study aimed to understand the perception of the health needs of the elderly living in housing projects of the Social Security Bank in Montevideo, Uruguay.

Knowing the health needs from their perception allowed us to understand their concerns, interests and difficulties, how the various factors interact at this stage of life, highlighting the need for changes to have preventive measures, identification and treatment of diseases or chronic conditions, direct attention to a comprehensive approach and not to their division as it continues to be done, This makes it clear that more resources are being allocated to meet current needs. They are people with vulnerabilities of all kinds and who lack or are weak in their social network of family, friends, neighbors and community.

There are policies that comprehensively target ageing, but the situation shows that they work separately in institutions linked to economic security and health.

The approach to care must be personalized, to provide appropriate care, prevent diseases, treat chronic conditions and improve your quality of life. It is necessary to rethink that care programmes for the elderly and health methods must address the challenges of old age and the deficiencies that they must face in their health problems.

Knowing health needs and recognizing their rights implies taking into account access to education, adequate understanding of their needs and participation. Public policies for elderly people and environments should promote physical environments within the home, complex and community, public, social and health services, mobility, autonomy, independence, safety and care, avoiding their isolation, contributing to the construction of stronger and more lasting social relationships. hammocks in old age.

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