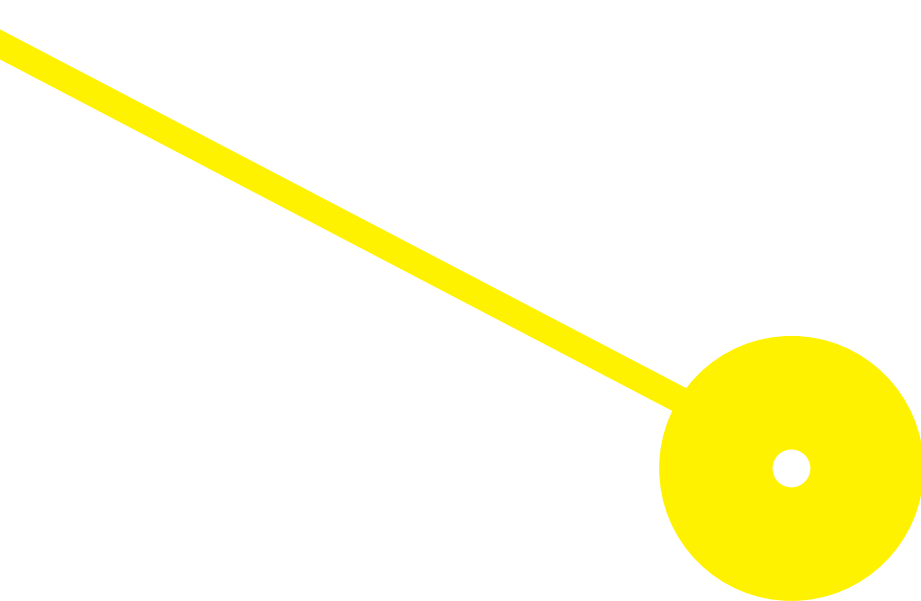




Health (dis)equalities and social isolation and loneliness in the older people: a qualitative study

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Dissertação apresentada para cumprimento dos requisitos necessários à obtenção do grau de Mestre em Terapia Ocupacional em Saúde Mental pela Escola Superior de Saúde do Instituto Politécnico do Porto.

Resumo

Introdução: Atualmente, o envelhecimento demográfico é uma forte preocupação a nível mundial e tem crescido a um ritmo acelerado e por isso importa refletir acerca dos aspetos que podem ser preponderantes no processo de envelhecer. Assim, este estudo pretende compreender a perspetiva das pessoas idosas da Póvoa de Varzim face aos fatores que influenciam as (des)igualdades na saúde, bem como o isolamento social e a solidão.

Métodos: Foi realizada uma investigação de carácter qualitativo, tendo sido recrutados no total 37 participantes para participarem em 4 focus group, através do método de amostragem não probabilística intencional. Os focus group foram analisados com base na análise temática.

Resultados: Os resultados mostram que os fatores que parecem influenciar as desigualdades na saúde estão relacionados com a acessibilidade aos serviços de saúde (funcionamento geral e consultas), bem como aspetos socioeconómicos e demográficos, que também estão no centro do isolamento social e da solidão, em simultâneo com fatores comunitários.

Conclusão: Estes resultados contribuíram para uma melhor compreensão das desigualdades existentes na saúde e da forma como as pessoas idosas percecionam o isolamento social e a solidão, possibilitando assim compreender o processo helicoide inerente à temática em estudo. Desta forma, permitiu o desenvolvimento de possíveis ações e/ou estratégias ao nível das políticas e da organização dos serviços e das comunidades, e em que também o Terapeuta Ocupacional assume um papel fundamental que contribuirá para uma transformação do paradigma do envelhecimento e para a promoção de uma vida saudável às pessoas idosas.

Palavras-chave: Estudo qualitativo; Idosos; Desigualdades em saúde; Isolamento social; Solidão

Abstract

Introduction: Demographic ageing is currently a major concern worldwide and has been growing at an accelerated pace, which is why it is important to reflect on the aspects that can be preponderant in the process of growing old. Therefore, this study aims to understand the perspective of elderly people in *Póvoa de Varzim* regarding the factors that influence (in)equality in health, as well as social isolation and loneliness.

Methods: A qualitative study was carried out and a total of 37 participants were recruited to take part in 4 focus groups, using the intentional non-probabilistic sampling method. The focus groups were analyzed on the basis of thematic analysis.

Results: Findings show that the factors that seem to influence health inequalities are related to accessibility to health services (general functioning and appointments), as well as socioeconomic and demographic aspects, which are also at the heart of social isolation and loneliness, alongside community factors.

Conclusion: These results have contributed to a better understanding of existing health inequalities and how older people perceive social isolation and loneliness, thus making it possible to understand the helical process inherent in the subject under study. In this way, it has allowed the development of possible actions and/or strategies at the level of policies and the organization of services and communities, in which the Occupational Therapist also plays a fundamental role that will contribute to a transformation of the ageing paradigm and the promotion of a healthy life for older people.

Keywords: Qualitative study; Older people; Health inequalities; Social isolation; Loneliness

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1. Introduction

Demographic ageing is one of the main concerns in the evolution of 21st century society worldwide (Pinzón-Pulido et al., 2016) and has been growing at a rapid pace in recent years (Srivastava et al., 2021). The Portuguese population has been ageing steadily over the last few decades (Pinto, 2014). According to *PORDATA*, the aging rate in Portugal has increased significantly, with a percentage of 160.5% in 2018 and 183.5% in 2022 (PORDATA, 2023).

Ageing is characterized by being a universal, biological, complex and heterogeneous process and is influenced by a number of factors that play a major role in the health of older people (Silva et al., 2022), namely the experiences of each individual in terms of physical, social and psychological functioning (Cosco et al., 2017; Wagg et al., 2021). This process is known to be closely related to an increased risk of developing diseases such as heart disease, stroke and chronic respiratory diseases. These diseases not only reduce the quality of life of the elderly, but also consume a large amount of health resources (Wu & Liu, 2020). The elderly population is considered to be vulnerable (Conejero et al., 2018), yet ageing is not in itself synonymous with illness. Nevertheless, it is known that there is a greater prevalence and predisposition to the emergence of health problems that can impair the independence and functional capacity of individuals, resulting in a progressive decline in functionality (Rudnicka et al., 2020; Silva et al., 2022).

Although the rate of ageing is increasing considerably, an increase in longevity does not mean healthy ageing (Wagg et al., 2021). Healthy ageing is characterized as the process of developing and preserving functional capacity that provides for the wellbeing of people in old age (Organização Mundial da Saúde, 2015; Roldán González et al., 2022) This can easily be achieved by minimizing health risks and providing easy access to quality health care. It is therefore important for the elderly population to feel healthy, without the disease factor being a determining factor in the ageing process (Çam et al., 2021). From this point of view, healthy ageing thus becomes a fundamental indicator that allows this population to live longer with quality of life (Roldán González et al., 2022). However, the growing proportion of unhealthy older adults in many populations is in fact a universal challenge for society (Partridge et al., 2018; Wagg et al., 2021) and it is important to reflect on and understand the factors that can influence ageing. Inequalities in health can be preponderant

in the perspective of ageing for individuals (Pan et al., 2019; Silva et al., 2022) and can be related to biological, demographic, socioeconomic conditions and also associated with health services (Pan et al., 2019).

Health inequalities are clearly avoidable and unjust and are characterized by differences in health between groups in a population (Fan et al., 2019; Pan et al., 2019; Spiers et al., 2022). Socioeconomic position reflects the person's social and economic situation/position in relation to others (Spiers et al., 2022) and such circumstances have a lasting impact on the individual's health trajectory (Letelier et al., 2021). Research shows that people in precarious economic situations are at greater risk of developing health problems (Kivimäki et al., 2020) and consequently have a greater need for access to health care (Davies et al., 2021). However, due to the disparity in health resources, these individuals with a more vulnerable economic situation have less access to health services, thus leading to unstable health outcomes (Fan et al., 2019; Pan et al., 2019; Srivastava et al., 2021).

Evidence has shown that socioeconomic status is a predictor of health literacy, i.e. older people with a higher level of education show more confidence in seeking, mastering and understanding health-related information (Li & Guo, 2021). It is also relevant to the adoption of healthy behaviors, better adherence to pharmacological therapy and better self-care, contributing to healthy aging (Wagg et al., 2021).

In addition to the negative effects mentioned above, studies show that older adults are prone to being socially isolated (Jaspal & Breakwell, 2022) even more so, for example when they are in a fragile socioeconomic situation with lower incomes (Green et al., 2021; Macdonald et al., 2018; Srivastava et al., 2021) or live far away in resource-limited rural/regional areas (Fien et al., 2022; Wang et al., 2022). These circumstances contribute to social isolation and loneliness being a common experience for older adults (Liu et al., 2016; Macdonald et al., 2018). Social isolation is characterized by the absence/scarcity of social contacts and interactions while loneliness is characterized by the discrepancy between desired and actual social relationships and is associated with a subjective feeling of anguish at being alone and cut off from others (Domènech-Abella et al., 2017; Gardiner et al., 2018; Liu et al., 2016). In turn, emotional loneliness is characterized by the lack of a close and/or desired relationship with another person. On the other hand, social loneliness is characterized by a negative subjective feeling associated with the lack of a wider social network (Fakoya et al., 2020). It should be noted that social isolation is a strong risk factor

for loneliness, however, loneliness can manifest itself without social isolation being present (Freak-Poli, Ryan, et al., 2022). It is also known that, throughout old age, older people experience unavoidable life events that can be promoters of loneliness in later life, such as retirement and the loss of partners or close friends (Liu et al., 2016).

Thus, studies claim that between 40% and 50% of adults over 65 are at risk of social isolation and experiencing feelings of loneliness, and these levels tend to increase gradually with age (Fakoya et al., 2020; Liu et al., 2016). In addition, the literature also states that loneliness is positively related to cognitive decline and mental health conditions, such as dementia and depression (Domènech-Abella et al., 2017; Donovan et al., 2017; Fakoya et al., 2020; Liu et al., 2016; Roldán González et al., 2022) and clearly has a significant impact on the health, wellbeing and quality of life of the elderly population (Iamtrakul & Chayphong, 2022; Taylor et al., 2018).

Other studies have also tried to show the importance of the active participation of older people in community programs. Providing elderly with participation thus contributes to the growing realization of the need to minimize social isolation and loneliness by implementing appealing and preventive strategies at the community level that can somehow encourage the active participation of older adults (Dare et al., 2019; Y. Zhang et al., 2022). The latest research shows that social participation is fundamental to improving the health and wellbeing of older adults, thereby also reducing the risk of social isolation and loneliness (Dare et al., 2019; Rezaeipandari et al., 2020; Rodríguez-Romero et al., 2021).

From this point of view, participation and occupational engagement are widely considered to be an integral part of healthy ageing, which becomes elementary if older people are to lead meaningful lives, cooperating with their community (Papageorgiou et al., 2016). Occupational participation in older people is sometimes or often compromised by individual or environmental factors (Orellano-Colón et al., 2015). Thus, the growing role of Occupational Therapy has been highlighted in the literature, as Occupational Therapists are the professionals qualified to enable or reinforce people's participation through active involvement in occupation and/or meaningful activities. In this way, they are fundamental to achieving the health and well-being of older people, contributing to a sense of satisfaction with life (De Coninck et al., 2017; Gomes et al., 2021).

Consequently, awareness of the need to analyze the health of the older people in a multidimensional way is essential (Donovan et al., 2017; Kivimäki et al., 2020; Wagg et al.,

2021). Thus, this study aims, to understand the perspective of older people in *Póvoa de Varzim* regarding the factors that influence (in)equality in health and social isolation and loneliness, and the extent to which these concepts can be interrelated.

2. Methods

2.1. Participants

This is a qualitative study to better understand and explore the perspective of elderly people living in *Póvoa de Varzim* regarding health (dis)equalities and social isolation and loneliness (Tavakol & Sandars, 2014). The participants were recruited using a non-probabilistic purposive sampling method, which aimed to specifically determine the participants who would take part in the study, considering the characteristics of the study (Anunciação, 2021; Pocinho, 2009). In this case, a homogeneous group of elderly people who had common characteristics and shared similar experiences (not institutionalized and who attended an Occupational Centre or cooperated with the Parish Council in their area of residence) to take part in a focus group.

That said, the participants were selected by the institutions that agreed to take part in the study and then selected through specific criteria by the study's principal investigator (Marotti et al., 2008). The inclusion criteria were: elderly people living in the community of *Póvoa de Varzim* and its parishes, aged 65 or over. Exclusion criteria also included: the possibility of having severe cognitive deficits, not understanding the Portuguese language and having incomprehensible speech. The information on the cognitive component was obtained by considering the data available in the institutions.

2.2. Procedures

Initially, a review of the most current literature on the subject was carried out in order to construct the semi-structured interview script (Appendix 1). This script, made up of semi-open questions aimed at the study's objective, was then reviewed and approved by a panel of experts on the subject. A sociodemographic questionnaire was also drawn up to obtain general information about the characteristics of each participant (such as age, gender, marital status, area of residence, household, educational qualifications, monthly income, whether they attended any institutions and health problems).

Between June and July 2023, the four focus groups and the respective selection of participants were scheduled in partnership with *LabRP* and the institutions and/or locations related to the "*O Bicho de Sete Cabeças*" project, which has been approved by the Ethics Committee of the School of Health Polytechnic Institute of *Porto*, under process number 1748. In the selection of participants, the exclusion of cognitive impairment on the part of the professionals working in the institutions was guaranteed. Focus groups make it possible to collect inductive and naturalistic information by using group dynamics to stimulate interaction between the participants by sharing points of view, experiences and suggestions, and in this way delve into the details of the research topic in question (Carey, 2016; Stalmeijer et al., 2014). The focus groups took place in person at the *Aver-o-Mar* Occupational Center on June 19, 2023 with ten participants present, at the *Rates* Parish Council on June 29, 2023 with eight participants present, at the *Lapa* Occupational Center on July 12, 2023 with nine participants present and at the *Aguçadoura* Parish Council on July 14, 2023 with ten participants present. In the initial phase of the focus group, the participants began by signing the Declaration of Informed Consent, in accordance with the "Declaration of Helsinki" (WMA, 2018). The participants then completed the sociodemographic questionnaire and, in order to characterize the sample for the study in terms of high levels of feelings of social isolation and/or loneliness, the UCLA (University of Los Angeles) Loneliness Scale was applied (Pocinho et al., 2010; Russell, 1996). This is a 20-item scale designed to determine subjective feelings of social isolation and loneliness. However, in order to validate the scale for portuguese elderly people, the authors considered excluding items 3, 6, 14 and 20 due to their poor correlation, which is why the participants completed the remaining 16 items on the scale (Pocinho et al., 2010). Participants can rate the items as 4 ("often"), 3 ("sometimes"), 2 ("rarely") and 1 ("never"). The

scale score can vary between 16 and 64 points, with values above 32 indicating feelings of social isolation and loneliness (Pocinho et al., 2010; Russell, 1996).

The group interviews then lasted approximately one hour and were only recorded in audio format, with the prior authorization of the participants, who were also guaranteed anonymity and the rest of the data. In this way, they contributed to interaction between the various participants by exchanging opinions on the subject. These moments were guided by the principal investigator, who was duly trained in conducting interviews based on the previously developed semi-structured script. However, although the orderly sequence of these questions was guaranteed, the approach of the interviewees was also ensured, allowing for reciprocity between the various players. Through this methodological process, it was possible to delve deeper into the subject of the study in question, while also contributing to a personal reflection on it (Kallio et al., 2016; Minayo et al., 2018).

2.3. Data collection

Once the focus groups were completed, data collection took place between August and September. At an early stage, the interviews were professionally transcribed in their entirety, along with certain aspects that could not be retained in the recording, such as thoughts and reactions. The interview script consists of open-ended questions related to the main areas and demands of interest about the personal experience of the various participants and is divided into two parts: the first with questions about accessibility to health services (availability and location of services, consultations and support for health management) and the second with questions about social isolation and loneliness (perception of the definition, experiences of social isolation and loneliness and responses and measures in the community that influence social isolation and loneliness). As mentioned above, sociodemographic data was also collected.

2.4. Data analysis

Once the transcripts were completed, they were analyzed using thematic analysis. This method makes it possible to identify and analyze themes in the data in an organized way, making it possible to describe the data (experiences, thoughts or behaviors) and interpret various aspects inherent to the research topic, making it richer (Braun & Clarke, 2008; Kiger & Varpio, 2020).

Initially, the study's principal investigator explored the transcripts in order to identify themes and sub-themes relevant to the research, which led to a coding system. At this stage, the method of triangulation and peer review was adopted to ensure the reliability of the data, and the coding system was approved by all the researchers. The transcripts were then analyzed by the principal investigator of the study, following this coding system. Finally, a thematic analysis was carried out using the traditional method.

3. Interpretative task

3.1. Results

In this study participate 37 older people, 34 of whom were female (89.5%) and the remaining four male (10.5%). Their ages ranged from 65 to 90, with an average age of 75 (SD=7.1). Approximately 20 participants were widowed, and the rest were married, with only one participant divorced. Household size ranged from one to six people, and educational attainment varied between primary and higher education. Most of the participants are retired or on disability, with the exception of two who receive a pension and another who survives on savings. Regarding monthly income, there was a greater prevalence of average and poor income, unlike the state of health, where there was a greater prevalence of reasonable income, although there were health problems. Participants reported diabetes, cholesterol, high blood pressure, stroke, cancer, depression, cataracts, respiratory problems, thyroid problems, joint problems and other health problems as their main health problems. The scores obtained on the UCLA Loneliness Scale show that the participants had low levels of negative feelings of loneliness, which can be explained by the fact that they attended institutions. More detailed information on the participants can be seen in the following table:

Participant	Age	Gender	Area of Residence	Aggregate Family	Number of Children	Marital status	Qualifications Literary	Occupation	Income Monthly	Center Occupational	State of Health	Problems Health	Score UCLA
1	67	Female	Aver o Mar	2	1	Divorced	Higher Education	Reformed	Good	Yes	Bad	Yes	37
2	71	Female	Aver o Mar	1	2	Widow	First cycle	Reformed	Bad	Yes	Fair	Yes	33
3	75	Female	Aver o Mar	1	2	Widow	First cycle	Reformed	Bad	Yes	Fair	Yes	35
4	78	Female	Aver o Mar	4	2	Widow	First cycle	Pension	Bad	Yes	Fair	Yes	34
5	77	Female	Aver o Mar	2	2	Married	First cycle	Retired on invalidity	Medium	Yes	Fair	Yes	35
6	78	Female	Aver o Mar	1	1	Widow	First cycle	Reformed	Bad	Yes	Good	Yes	31
7	81	Female	Aver o Mar	1	6	Widow	First cycle	Pension	Bad	Yes	Fair	Yes	27
8	72	Female	Aver o Mar	6	3	Married	First cycle	Pension	Bad	Yes	Fair	Yes	29
9	81	Female	Aver o Mar	2	4	Married	First cycle	Reformed	Good	Yes	Good	Yes	16
10	71	Female	Aver o Mar	2	3	Married	First cycle	Reformed	Bad	Yes	Bad	Yes	16
11	79	Female	Rates	2	2	Married	First cycle	Reformed	Medium	No	Fair	No	16
12	66	Female	Rates	2	2	Married	First cycle	Reformed	Medium	No	Good	No	16
13	67	Female	Rates	2	3	Married	First cycle	Reformed	Bad	No	Fair	No	19
14	69	Female	Rates	2	3	Married	Secondary Education	Reformed	Medium	No	Fair	No	19
15	85	Female	Rates	2	0	Widow	First cycle	Reformed	Medium	No	Fair	No	18
16	74	Female	Rates	1	3	Widow	First cycle	Retired on invalidity	Medium	No	Bad	Yes	18
17	78	Female	Rates	4	1	Widow	First cycle	Reformed	Medium	No	Fair	Yes	18
18	65	Female	Rates	5	5	Widow	Second cycle	Pension	Medium	No	Fair	Yes	48

19	81	Female	Póvoa de Varzim	1	2	Widow	First cycle	Pension	Bad	Yes	Bad	Yes	17
20	84	Female	Póvoa de Varzim	1	7	Widow	First cycle	Retired on invalidity	Medium	Yes	Fair	Yes	40
21	83	Male	Póvoa de Varzim	2	3	Married	First cycle	Reformed	Bad	Yes	Fair	No	23
22	86	Male	Póvoa de Varzim	1	7	Widow	First cycle	Reformed	Bad	Yes	Fair	Yes	35
23	90	Male	Póvoa de Varzim	5	3	Widow	First cycle	Reformed	Bad	Yes	Bad	Yes	44
24	78	Female	Póvoa de Varzim	4	3	Widow	Second cycle	Reformed	Medium	Yes	Fair	Yes	21
25	89	Female	Póvoa de Varzim	1	1	Widow	First cycle	Retired on invalidity	Bad	Yes	Fair	Yes	21
26	76	Female	Póvoa de Varzim	1	3	Widow	First cycle	Reformed	Bad	Yes	Fair	Yes	23
27	75	Female	Póvoa de Varzim	2	3	Widow	First cycle	Retired on invalidity	Good	Yes	Fair	Yes	32
28	70	Male	Aguçadoura	2	2	Married	First cycle	Reformed	Medium	No	Fair	Yes	17
29	67	Female	Aguçadoura	2	2	Married	First cycle	Reformed	Bad	No	Fair	Yes	16
30	76	Female	Aguçadoura	2	5	Married	First cycle	Reformed	Medium	No	Fair	Yes	16
31	67	Female	Aguçadoura	2	3	Married	First cycle	Reformed	Medium	No	Fair	Yes	16
32	66	Female	Aguçadoura	4	2	Married	Second cycle	Reformed	Medium	No	Fair	Yes	16
33	65	Female	Aguçadoura	1	2	Widow	Second cycle	Retired on invalidity	Medium	No	Fair	Yes	30
34	69	Female	Aguçadoura	2	2	Married	First cycle	Savings	Bad	No	Fair	Yes	17
35	66	Female	Aguçadoura	4	2	Married	First cycle	Reformed	Medium	No	Fair	Yes	23
36	73	Female	Aguçadoura	2	2	Widow	First cycle	Reformed	Medium	No	Fair	Yes	16
37	70	Female	Aguçadoura	2	3	Married	Second cycle	Reformed	Bad	No	Good	Yes	22

Table 1- Sociodemographic characterization of the sample

3.2. Data interpretation and discussion

Considering the exponential increase in aging and the consequent proportion of the development of associated clinical complications (Strandberg & Nieminen, 2020) the field of health becomes a challenge and therefore access to and use of services in this area are two essential factors for improving health outcomes (Faraji-Khiavi et al., 2022). In addition, loneliness and social isolation are problems related to ageing and are associated with adverse consequences for physical and mental health (Gardiner et al., 2018) and consequently an increased need for health resources (Christiansen et al., 2023). Thus, given the objectives outlined for the study and taking into account the analysis and content of the interviews, two themes emerge that aim to understand the aspects that influence accessibility to health services and the aspects that influence levels of social isolation and loneliness in older people and to interpret how these two themes are involved, with a view to developing measures that ensure healthy ageing and promote the wellbeing of older people (Kadotani et al., 2022; Oliveira et al., 2022).

The first theme is called "Accessibility to health services", which is subdivided into three subthemes: "Functioning of health services", "Functioning of health service appointments" and "Socioeconomic factors". The second theme is called "Social isolation and loneliness", which is subdivided into four subthemes "Knowledge about social isolation and loneliness", "Individual factors", "Community factors" and "Socio-demographic factors" (Appendix 2).

Theme 1- Accessibility to health services

This first theme encompasses the participants' personal experience of accessibility to health services in *Póvoa de Varzim*. In general, the participants were dissatisfied with this theme, as can be seen from the following quotes "*Unfortunately, it's sad. (P6)*"; "*In terms of health, I think it's going backwards. (P5)*"; "*The health services here in Póvoa are terrible. (P19)*"; "*Everything has been more or less fine (P21)*"; "*Our government says that everything is fine in health, everything is fine here, everything is fine there, it's not, we know it's not fine, we know it's not fine. They say it's fine because it's in their interest to say that everything is*

fine. Isn't it? But it's not all right (P34)"; "It's not all right. It's not all right, because we're ready, but it's not all that bad either, it's not all that bad either (P30)".

Subtheme– Operation of health services

With regard to the functioning of health services, it is important to highlight the availability, i.e. the existence of health services in the area of residence, with some participants being less than satisfied, as can be seen from the following quotes *"Nothing. Very few (P6)"; "Those who need it, at the moment, have to go to the private sector to pay for exams and other things to get by at first, I think it's a little bad (P13) "* and on the other hand, there are others who think the opposite, as confirmed by the following quotes *"We have everything here (P1)"; " But we have the health center here, we can't say we don't (P7) "; "Everything, everything, everything. (P25) "; "We have health centers, we have doctors, we have everything. (P33)"; "Yes, yes, for now we do. (P34)".*

Concerning the functioning of health services, it is important to highlight not only their availability, but also their location, and on this issue there are also participants who are satisfied *"We're close. It's like this, I do everything on foot (P6)."; "The doctor's surgery and the pharmacy are almost on the edge, everything is on the edge, you walk across. (P15) ".* On the other hand, some participants find themselves further away from health services, either because they live in more rural areas, or also because the Health Center and Hospital of reference are not located in their area of residence and for this reason they are dependent on third parties or public transport, as can be seen in the following quotes *"I go by bus, I don't have to go anymore, I have to go either by bus or on foot, on foot I can't, I can't stand it, it's too far, it's in Aguçadoura right at the bottom (P3)."; "Mine is in Póvoa, or I go with my husband, or I go by bus (P5)."; "Whoever has a car, whoever doesn't, the transportation here is miserable. (P17)"; "I also have it at São João, but it's at Pedro Hispano that they send to, which is here in the north. (P21) "; "I'm very sidetracked and it's half an hour's walk from my house to the church, the doctor's surgery and the pharmacy, I go back and forth, there's no public transport here, I don't drive (P15)"; "We have a bus every half hour, or every hour, so (P34) ".* In fact, literature shows that there is inequality in terms of health services between the population living in urban areas and the population living in rural areas, and that the latter suffer disproportionately from adverse health outcomes (Dodge, 2019; Guo et al., 2020).

Rural residents have less access to the use and provision of health services and care and are more likely to adopt unhealthy behaviors (Chen et al., 2019) which results in an increased hospitalization rate, poorer health with higher levels of disability and a higher mortality rate (Dodge, 2019; Guo et al., 2020) (Figure 2).

Communication is a basic skill and becomes a cornerstone of health services and their care (Hafskjold et al., 2015). The use of appropriate communication measures with older people, such as listening, empathy, the opportunity to choose, inclusion, the provision of adequate and accessible information, appreciation and understanding are fundamental to maintaining the dignity of older people (Giampieri, 2012; Hafskjold et al., 2015; Woolhead et al., 2006). Dignity is a complex term that affirms people's right to be respected, valued and treated ethically (Banerjee et al., 2021; Woolhead et al., 2006). But is this applied in health services? It should be pointed out that, in addition to the importance of the service provided by health professionals in the various health services for older people, the service provided by the secretariat in the health services is also important. However, the participants were dissatisfied, as confirmed by the following quotes *"I mean, I thought it was a very strange thing, if she saw it wrong, you can't know look wait just a second, I'm going to attend to you here and then I'll do it for you, I thought it was very badly done and it looks bad, when the person needs help it was to say look, right now I can't but wait a bit we expected it, didn't we? (P6)."; "It depends on the people who are attending to you (P9)."; "When they speak to you gently and explain everything, I'm so happy (P8)."; "That's why they should be nicer at the secretariat (P11)"; "The employees there don't want to do anything, you can get there and there's no one in the room (...) you can wait for almost half an hour, there's no one there (...) they like to see queues, then the other day I had an exam there (...) I got there and waited for half an hour.) I got there and waited for half an hour and they didn't know about the exam (...) they're not competent but they're there. (P13)"; "If a person calls there, now they don't even call, to ask for an appointment, a person calls all day long and they don't answer. (P16)"; "they could be nicer to deal with, a person doesn't understand. (P18)".*

It is also known that the consecutive increase in ageing and the fact that elderly people often experience more complex illnesses leads to an increase in the consumption of health resources, namely a greater need to use emergency services (Díez-Cascón González & Sisó Almirall, 2009; Terashima & Carter, 2018; Thwaites et al., 2019). In line with this perspective, there are participants who are relatively satisfied, as can be seen in the

following quotes *"He went to the emergency room because of his gallbladder, he was operated on there and he loved it (P10)."; "I went to the emergency room and they accepted me (P9)."; "I went last year, I felt sick, my daughter called the emergency room because I had a stroke, I went in the ambulance and went straight to the emergency room (P1).".* On the other hand, there are also participants who are unhappy with this issue, especially because of the long waiting times they have had to endure to be seen, as can be seen in the following passages *"And they've already been ill for a week with a fever and everything and they go there, and then the most serious cases are there, often stuck (P1)."; "People have also gone to the hospital (...) who go there in the morning and leave at midnight and one o'clock at night. They don't even answer, they don't even want to know (P3)."; "You have the bracelet to go in straight away and they never call you back (P3)."; "They sent me to hospital but I also spent many hours there until late at night, many hours and some with broken arms moaning all day (P14)."; "There's only one thing, that people go to the emergency room and wait for five hours, which I think is wrong (...) but it's just these delays. (P25)"; "I've been there with my head broken, inside, even watching them work, I've been waiting for six hours for once but it wasn't the first time, it's just that there are no conditions, man, there are no conditions (P22)"; "But you wait a lot of hours, you wait (P20)"; "then I was there all night and I didn't get an appointment because there were too many people (P24)".*

Subtheme- How consultations work in health services

With regard to the way consultations work in the health services, it is first important to highlight consultations with the family physician and opinions differ on this subject, with some participants being happy, as can be seen in the following quotes *"If we go to the doctor, at least the doctor I have, she tells us to do everything we need to do, I have no complaints (P8)"; "I'm very satisfied with my family physician (P1)"; "I don't have any complaints here (P8)."; "But I feel good with the doctor I have. I've been with her for a long time. I've been with her for many years. She already knows what's wrong with me (P3)."; "My doctor is good (P6)."; "I have a doctor and whenever I need a test, a specialist or anything, she always sends me (P34).".* On the other hand, it is known that in Portugal, family physician are predisposed to a defined number of users, to whom they provide the necessary health care throughout their lives. The literature has shown that due to Portugal's socioeconomic situation and the

considerable and recurring shortage of family physician (Russo et al., 2012) an increase in the number of users of family physician is necessary, and that this is associated with an overall compromise of the health services provided and consequently dissatisfaction among the Portuguese population (Maricoto & Nogueira, 2021) since the family physician is also considered a reference point for older people (Thwaites et al., 2019). Thus, this can be reflected, for example, in the reduced number of appointments made available to the family physician as evidenced by the participants' discontent in the following quotes "*I only have two a year, don't I. I have two every six months. I have two every six months. We need them (P10).*"; "*I've had one appointment for three months. (P12)*"; "*In Póvoa, the doctor only makes appointments for diabetics. (P12)*" "*It depends on the problem, if you're hypertensive or diabetic, with very high cholesterol, these people have more appointments, which is the case with my husband. He had one this time and I didn't. But because I needed it, I went. But as I needed it, I went with him to the appointment (...) but they didn't arrange it for me, they said it was only for the most urgent (...)(P14)*"; "*It's not very easy, once a year is not enough, it should be twice, when it's for tests, that's how I had it until now, but this year it's late, I'll end up having it anyway, because I had a problem, otherwise I probably wouldn't have had it. (P14)*"; "*I go routinely and she makes appointments for me every six months (P17)*"; "*We go, make an appointment, although it takes a while, but when the time comes. (P20)*"; "*At the Health Centers we have an appointment every six months, but my doctor said that if I need something urgent sometimes I should come here (P22)*"; "*There are few doctors and they earn very little. (P25)*" and, according to the participants, also by adopting new strategies and/or procedures that might in some way facilitate the work of family physician, such as for obtaining regular medication and delivering complementary diagnostic tests, as shown by the following quotes "*There are papers for medication, you fill them out with the medication you need, fold them up, there's a little box in there to put them in, so that they can come and pick them up and then give you the medication, sometimes they say eight days. (P13)*"; "*To show the tests, you have to leave them at the doctor's office, then the doctor goes to see them and sends you the answer to what you've got. (P12)*"; "*For the medication, we go to the counter and ask for the cards, they sign them and say come and pick them up tomorrow (P25)*"; "*Bring the prescription, it takes four or five days, sometimes a week. (P26)*".

The advancement of technology is becoming an important component in the healthcare system too (Tuckson et al., 2017). An obvious example of this is telehealth, which allows health services to be provided by various professionals remotely using technological means (Manocchia, 2020; World Health Organization, 2010). The American Occupational Therapy Association (AOTA) also clarifies telehealth as "the application of evaluation, consulting, prevention, and therapeutic services provided through information and telecommunications technologies" (American Occupational Therapy Association, 2018; Ding et al., 2023). This type of healthcare can be provided via cell phone, email or computer (Janjua et al., 2021). In fact, the literature has shown that telehealth aims to offer people a more convenient, brief, inexpensive and real-time healthcare option (Manocchia, 2020; Tuckson et al., 2017). In this way, the mastery of technology, especially the cell phone, also for the elderly becomes indispensable, so that their needs can be met. Recently in Portugal, but in specific areas, the health sector has faced a change when it comes to booking open appointments, as can be seen from the following quotes *"You don't have to, now you don't have to. Now you have to call the national health service (P10)."; "It's changed, it's changed. You can't just show up there and ask for an appointment (P6)."; "Now you have to call Saúde 24, which is very annoying, it leaves you waiting a long time, and sometimes you go downstairs and wait another half an hour and it's still there and that's it. (P31)".* However, it can be seen from the following quotes *"You call I don't know what it's called. (P20)"; "Not now, now it's Health 24 or 27. (P26)"; "Now we have to call I don't know where. (P34)"* that not all elderly people are properly informed about this issue. Furthermore, is the elderly population prepared to understand mobile health? They are certainly unfamiliar with this type of device and the procedures involved (Kim et al., 2014), which is why they generally express their dissatisfaction and difficulties in this area as can be seen from the following quotes *"We were doing so well with the open consultation, we needed it and we went, we showed up and we got it. But with this doctor or that one, but there was (P5)."; "I know there is such a thing, but I don't know how to do it (P6)."; "With all the difficulties there are now (P6)."; "I don't know how to do it either (P9)."; "I really need it, I've been unwell, now I've got this heel here that's got a spur, I wanted to see a doctor so much but I avoid going, I don't have the patience to spend half an hour or an hour on the phone. I really don't have the patience (P10)"; "I'm just against it. Nothing else (P10)"; "With Saúde 24 it's more difficult (P22)"; "It's more difficult now. (P27)"; "Everything is complicated. They just complicate it.*

(P28)"; *"But people need to know how to use it, don't they? Most of the people here are elderly, these elderly people know something about it, they don't know anything, they have to bother a son or a grandson to do these things, I think it's stupid. For me it is. We were doing very well and they've made us do badly, what's the point?(P34)"; "They're making things more and more complicated that they didn't need to be. Because that's the way it is. (P34)".*

Thus, the elderly population feels an injustice in terms of the advancement of technology and the adoption of measures based on technological means, due to the difficulties they face and their lack of training, as well as the inequality compared to the younger population, as can be seen in the following quotes *" That shouldn't be the case. I happen to have a daughter who writes, now I'm stuck with it, I don't know (P26)"; "I don't think they're thinking about the old people, they're only thinking about the young people - we weren't born at that time, we were born at a time when there was nothing. That's true. It's true. We were born at a time when there was nothing. Today we can pick up a cell phone and make a call, it's already very good. (P33)"; "We have to think about the old, we don't have to think about the young, the young aren't even sick yet, most of them aren't. We have to think about the old, now they're sick. We have to think about the old, now they're doing everything with electronics, all electronics, and they don't know that we don't fucking know electronics. (P33)"; "Because most of us who are here are only fourth graders, we don't know how to use technology (...) we can still read a message, but I don't even know if I can send one. (P33)"; "I just rarely use it because, for example, when I receive a message I know how to read it, I know where to press to read it, but sending a message they've already explained to me, replying to that message, they've already explained to me, but I just [...] forget about it, and that's it, I'd like to. (P36)."; "When sometimes I call a hospital and I don't know what, look if it's for x dial one, if it's for I don't know what dial two, I don't know what else dial zero, look I hang up the phone straight away. (P30)"; "Yeah, you hang up and I hang up, because we don't understand any of it. (P34)"; "It's like the electronic prescriptions, the exams are all booked online(P29); "I don't go online at all, they give me the paper if you want (P34)"; "I don't think it's accessible to many people, because many may have a cell phone but they're not suitable and many don't even know how to go to the electronic prescriptions. (P29)".* Therefore, given the advance of technology in the health sector, training and education on how to use technology becomes relevant, encouraging older people to consider the advantages for their health (Wilson et al., 2021).

With regard to specialty consultations, in general, the participants were dissatisfied, mainly because of the difficulty in accessing this type of consultation and consequently the waiting time to which they are subjected, which can be seen in the following passages *"I had an appointment at Santo António, for neurology, I've had the appointment for a year (P32)"; "In principle it's fine, now if you go there and want to go to a specialist at the time oh I hurt here or I hurt there. I'd like you to take me and send me to a specialist, the doctors say that there's a lot of time, it's not like you think and if we're upset we pay for a specialist outside and we go to a specialist outside and we pay and it's done. (P33)"; "it takes time, it can take three months, it can take four months, it can take five months according to (P34) "*

Access to health services and care are fundamental human rights (Kalánková et al., 2021) and it is known that the ageing process is associated with greater vulnerability of general health status, which implies an increased need to seek health services. However, it has been found that health care needs are not met, i.e. there is effectively a difference between the health services and/or health care seen as necessary by older people and those that are actually provided, and this may stem from the incapacity and/or scarcity of resources observed in the health system. These health inequalities experienced by older people have consequences in that they delay using the health services and care they really need and consequently suffer a decline in their state of health (Gao et al., 2022; Wu et al., 2023) (Figure 2). Research shows that easier access to health services for older people helps to promote life satisfaction and quality of life (Şahin et al., 2019).

Subtheme- Socioeconomic factors

Concerning socioeconomic factors, it is first important to highlight the importance of monthly income for the elderly and whether it effectively meets their expectations and needs (not just in terms of health). In this case, participants are very dissatisfied with this issue, as can be seen in the following quotes *"It's a disgrace (P1)."; "I've already said it, mine is very bad (P6)."; "It's terrible, there's nothing for it. If you don't squeeze it, it goes (P3)."; "I spend a lot of money on medication (P3)"; "I spend a lot on medication (P1)"; "Then we have water, we have electricity, we have gas, we have everything, so when the electricity bill arrives, the money goes in there, when the water bill arrives, the money goes in there, when the telephone bill arrives, the money goes in there, and first we have the bills and then we*

have to do our accounts for what we can afford or not (P6)"; "I spend a hundred euros on medication for myself and I'm on my own (P3)"; "We don't have to worry and with the little bit we have from our pension we can manage (P25)"; "Because it's miserable, I earn three hundred and fifteen euros and it's not enough, I pay the condominium, I pay the insurance, I pay the IMI, which is really big and there's no money, I have to stretch it. Or I have to lock up the things I need to eat and I can't do that (P25)". In addition to these quotes, it is also possible to corroborate the data obtained in Table 1, in which the participants characterize their monthly income between average and poor.

In the view of this subtheme, the fragility felt by the participants from an economic point of view should be highlighted, which can in some way condition access to health services, as can be seen in the following quotes *"A lot, whether in health or justice, for me that's what I feel, at seventy-eight that's what I feel (P6)"; "They earn more than us. They get the minimum income, more money than we get in retirement (P3)"; "People who also need it like we do and are on the minimum income and have everything and anything. I think that's wrong because it should be for people who are more needy, sometimes a needy person is embarrassed and doesn't go, they stay at home and the others go and have everything, that's what we hear isn't it (P18)"; "yes, if there's money and we're better taken care of. (P14)"; "and thank God we pay but we're well looked after (P13)"; "The biggest and most serious problem is that we work to have and now we have to support others, that's the worst thing (...) there are many people who could work and don't. (P34)"; "I don't think this is fair, because if someone has something in the bank it's because they saved and worked hard to have it, do you understand? I think that's very unfair. Anyone who sees their children have nothing left. And those who never wanted to work are given everything. I think that's an injustice of the first order. It doesn't look like a democratic country, it doesn't look like anything. It doesn't look like anything. (P34)"; "That's wrong, they shouldn't pay that (P28)"; "That's why the Health Centers and Hospitals need things and they don't have them (P36)"; "I don't have them from here either, I paid in and they won't give them to me, listen, listen, it's true, I paid in for thirteen years and they told me I wasn't entitled to anything (P34)"; "But they come here, they ask for everything and anything and the government opens its legs and gives it to them. It's true. (P33)"; "And then we have the health we have, you want money for one thing or another, there isn't any, because these people come and eat what should be distributed to all of us. (P32)"; "I worked my butt off to get it so that now I can give*

the government two thousand two hundred euros in IRS at the end of the year and I don't have a pension, only my husband does (P34)"; "Now that the doctors can't give me everything they want either, because I need physiotherapy, for example, because I have torn muscles and I need physiotherapy and they only give it to me twice a year, but it's the government that won't give it to me anymore, they only give it to me twice a year. (P34)".

The elderly population is known to be socioeconomically fragile, due to the variety of income and high monetary burdens they have, and these financial difficulties can be a barrier to accessing health services and further compromise their use (Gao et al., 2022; Leung et al., 2022; Wu et al., 2023). In short, given this socioeconomic fragility, they are often forced to postpone the use of health services and, at the same time as health inequalities, there is a decline in general health status (Gao et al., 2022; Wu et al., 2023). In addition, other types of studies highlight that people with low socioeconomic status are deprived of enjoying and participating in meaningful activities outside the home (Eronen et al., 2016) (Figure 2). The fact that older people have a lower level of education and income also results in poorer financial decision-making (Leung et al., 2022). In other words, having enough money is a major factor in the quality of life of older people (Paskulin & Molzahn, 2007).

Thus, research recognizes that high levels of social support could be a key factor in protecting older people's vulnerability (physical and mental health) (Zhang et al., 2019) as it helps them to cope with everyday life and in particular to respond to critical situations, especially in older people with health problems (Melchiorre et al., 2013). Recent studies affirm the importance of support for older people, corroborating the existence of a significant correlation between social and economic support, health, quality of life and satisfaction with life (Şahin et al., 2019). Thus, from this point of view, it is essential to clarify what support exists or does not exist in the community that can help the elderly population to manage their health and is considered an added value. As far as the existence of support is concerned, it is still scarce, as evidenced by the following quotes *"I have nothing (P3)."; "Not me either. We have the medical center, for example, but we don't pay for it(P13)"; "The council has nothing to do with health, the council doesn't interfere in anything to do with health. (P21)"; "No. That was before I had it(P26)"; "No. There's nothing. (P34)"; "I don't think there's anyone here. (P34)"* and also the elderly are often not properly informed about the existence and type of support there is in the community, as can be seen in the quotes *"No, I don't even know anyone here (P26)"; "That's what I'm not aware of. (P32)"; "I'm not aware*

of it. (P34)". From a different perspective, there were participants who needed support and felt disadvantaged, as can be seen in the following passages *"I've been to the council when it was my son's and they didn't do anything (P9)."; "I've needed help, but they only gave me help to find where I was going, but I had to go, nobody accompanied me. I needed to go to Porto, to an appointment with my son, they told me where to go and I had to go alone with him (P7)."; "Yeah, they don't go. They don't go with us or inform anyone (P3)."; "For example, you go there to do something at home and they complicate it, complicate it, complicate it (P5)."; "I paid 150 euros in no time for a CT scan, I mean, if you need it urgently you have to pay, we don't have any support. (P13)"; "No, I wanted to do physiotherapy, I told a doctor here that I can't and no, I can't walk very much, that he should get me an ambulance, but I didn't want to pay for the ambulance, because my pension is small. That he should find me a son or a daughter and take me, they have a car but they work from morning to night, money doesn't come from the sky, nor does it fall. And it didn't, and I'm not in physiotherapy because I can't walk. (P26)"; "and I lasted three months, but I lasted three months to see what I saw, to see the theft that goes on in these institutions, that the poor, who are poor, are still exploited (P22)"; "That's true. My husband was there for a month to give me a rest, which I'd been taking care of for many years, and I paid five hundred euros in a hospital like that, as you say, I paid five hundred euros for a month that he was there so that I could give my brain a rest. I paid five hundred euros, it was true. (P24)"; " That's why I'm against these charities. I'm against them because they don't help and they exploit those who have little. They exploit the poor, that's not right. (P22)". On the other hand, there are also participants who are aware of some support and who have taken advantage of it, as can be seen in the following quotes *"Now we have palliative care here in Aguçadoura (P8)."; "Actually, our assistance isn't bad, it's good (P8)."; "If you need a psychologist, there's one there (P7)."; "And there's also a lawyer if necessary(P6)."; " The council here helps us a lot and everything here (P8)."; " We have free swimming, we go to swimming (P8)."; "There's a neighbor of mine, she belongs to Amorim but she went to ask for help to put the roof on, the people from Amorim didn't help and they came here to our parish and they helped and they helped (P6)."; "We have a nurse once a week. "; "We have a nurse once a month (P8)."; "Nobody starves to death because the Parish Council gives them bags of food, they get bags of food (P8)."; "I asked him for help at the Parish Council and he helped me, I went to the doctor and they wouldn't accept it and through the Parish Council he got me help from the doctor, he's helped me, he**

helps. (P17)"; "my husband was bedridden for a long time, the people from Santa Casa went to his house to do his hygiene and everything, and the social services were very well received(P24)"; "Now the Social Services are wonderful and there are a lot of people who say bad things about them, but if you look back at what our care was like when we were younger and what it is today, it's wonderful. (P22)"; "And nurses also come to the house and they brought me a tripod but I was afraid of falling(P27)"; "But there are people, I know of a neighbor who got ready because she was taking care of her mother, I don't know what it is (...) and she was given it by a third party, I don't even know what that's like. (P26)"; "Yeah, I think she earns a hundred euros, it's a hundred euros it seems. (P25)".

Also from this perspective, the participants showed that they were aware of the differences in accessibility to healthcare in other countries, so they made comparisons with Portugal, as confirmed by the quotes *"I've been to a country and when I needed to go I would go straight away, but here it's not the same country. (P34)"; "In Canada every pensioner is entitled to free medicines (P10)."; "In many countries this happens (P1)."; "It's different from abroad, it's very different (P12)".* In fact, studies show that the process of accelerated ageing that has been taking place throughout the European Union has led to a continuous analysis of the viability of the various health systems. In fact, there has been evidence of heterogeneity in these health systems in the European Union (which includes Portugal). It is therefore important to identify solutions to the problems faced by health systems, which could include education and research in the field of health (Albulescu, 2022).

Theme 2- Social isolation and loneliness

This second theme aims to reflect on social health, which is increasingly unstable in older people and significantly affects health and wellbeing, and is becoming a worldwide concern (Freak-Poli, Kung, et al., 2022; World Health Organization, 2021). Encompasses the participants' personal experience of social isolation and loneliness and the role of the community in this issue.

Subtheme- Knowledge about social isolation and loneliness

This subtheme relates to the knowledge that older people have of what social isolation and loneliness really are. It is known that these two terms have different definitions, even though they are mentioned simultaneously, but the elderly population likens them and generalizes them into a single global concept, as can be seen in the following quotes *"Loneliness is very difficult (P6)"; "There's an old saying: 'You only see those you only wish for', you know? And with these two words, it says it all(P3)."; "I think there's a lot of loneliness, or it's the mind that doesn't help, because a lot of people don't want help, for me most of them don't want help. Don't tell them they're lonely(P10)"; "They don't want help but they need it (P6)"; "I think there are more people suffering from loneliness (P1)"; " There are more at home (P6)"; "Loneliness is very sad (P18)"; "It's halfway to death (P11)"; "Now those people who can't walk or can't leave the house, they feel alone, more isolated. It's not easy to live like that (P17)"; "For me, I'll tell you right now, loneliness is like this: what are you doing at home? Looking at the television and thinking about what happened fifty years ago, all those things come up, worms in the head, you become withdrawn. That's what I think loneliness is. But if you go out into the street and look at the shop windows on Junqueira, loneliness is over. (P25)"; "It's living alone. (P25)"; "It's that person who doesn't have anyone, I sell at the markets, so I know that person who really does live alone, who only goes out to the market to do a bit of shopping, who comes up to me and talks, talks, talks, talks, tells me they've been to the supermarket, because they have no one to talk to. (P32)"; "But that's what I mean, city life is like that. It's not for lack of money, it's not even for lack of having a nice house, let's put it that way, but they don't have a family, their family, their son is in Lisbon, their son is in France, in Canada, they don't have anyone. (P32)"; "The old people go to the edge of the beach, there's a wall there and they all sit around talking (P35) ". It is known that although these terms have different meanings, the evidence suggests a significant overlap between social isolation and loneliness and they are often used interchangeably, as we have seen (Gardiner et al., 2018).*

However, still from the perspective of social isolation and loneliness, some participants identified unpleasant feelings in the face of social isolation and loneliness, as can be seen in the following quotes *"Loneliness is when you're alone and you see yourself alone (P3)."; "Loneliness is when we're out here together, we're a family, inside the house we have the walls, it's complete loneliness (P6)."; "It's sad (P3)."; " There are moments of*

everything (P5)."; "At night, going inside is different (P6)."; "At night, you close your eyes and go to sleep (P10)."; "Sometimes, you close your eyes and sleep doesn't come (P3)."; "No, there's no loneliness here. If you go home, yes, not here, here we don't (P6)."; "You have your family, you have this, you have grandchildren. Now there's no one, no dog, no cat (P6)."; "The loneliness you left behind is there when you arrive (P7)."; "We have the walls (P7)."; "That we're alone (P3)."; "There are days when we feel lonelier, don't we? I feel it too (P1)."; "In winter, the days are short, it rains, we get up, we're alone, inside the house looking at the two walls, we're alone at the end of the day (P3)."; "I suffer, I feel alone (P3)."; "What I find hardest is Saturday and Sunday, when it's closed. I don't leave the house, I'm alone at home, thinking, go for a walk, I don't go out at all, neither on Saturday nor Sunday (P26)". On the other hand, participants also tried to ensure that they didn't experience these kinds of feelings, as can be seen in the following quotes "I don't have that with me for now, thank God (P10)."; "Now we still live together at home, there's the husband, the grandchildren when they come over, the children. (P13)"; "Some people have more complaints about this, that they're alone at home, they don't have anyone to do things, to visit, that sort of thing, now we do (P12)"; "I always try to escape loneliness (...) and then I have faith, that I'm never alone. If people believe what I say, that's fine. If they don't, they're the ones who feel the loneliness, I'm never alone (P22)".

With this in mind, it is important to reflect simultaneously on the quotes and values obtained on the UCLA Loneliness Scale, in which only approximately ten participants have feelings of social isolation and loneliness (Table 1). Are older people familiar enough with these concepts to be able to identify feelings of social isolation and loneliness? Given the above, it could be that the elderly population does not have a correct perception of the definition, considering the current definition given by the most up-to-date literature, and is not equipped with sufficient knowledge, which will be fundamental for the personal and accurate identification of these types of feelings.

More recent studies have tried to show that loneliness and social isolation are problems related to ageing and are associated with adverse consequences for physical and mental health (Pikhartova et al., 2014). However, the opposite is also true, i.e. the decline in health to which older people are more prone can lead to greater vulnerability with regard to social isolation and loneliness (Gardiner et al., 2018) (Figure 2).

Subtheme- Individual factors

This subtheme seeks to identify, at an individual level, which aspects intrinsic or extrinsic to each individual influence their life positively or negatively, in terms of social isolation and loneliness.

The support network and the respective involvement of significant people in the lives of older people is fundamental to the ageing process. The connection between family, friends and neighbors and how rewarding this is for these elderly people can be felt in the following quotes *"I like the people around me (P6)"; "But it's also like this, if we have a message and we can't read it, we have the doctors here to help us (P7)."; "We're all a family here (P3)."; "We're very spoiled here. We're very spoiled here (P6)."; "I fell ill and my daughter took me to her house and I lived there with her for two years (P1)."; "Even my colleagues here (P1)."; "We have friends who help us if we need help (P6). I ask my daughter or my son-in-law (P17)"; "Even if we have to go to Porto, we ask a son or a son-in-law and they'll come and take us. (P14)"; "That's a group I have, I have lots of groups (P17)"; "They're my friends, although they don't come to the house, but they have their own lives and I'm going to die here too (P20)"; "My daughters are like that too, they call (P24)"; "The girls help us (P25)"; "Our men die but they leave their children who look after us. The husband goes but the children stay. (P26)"; "The people are good, we have everything we need (P33)"; "Ask the children (...) if they're available, if they can't we have to wait. (P28)"; "But I have people at home who would help me (P32)"; "But that happened, because you had your granddaughter, or your daughter, or your son at home (P34)"; "So my grandchildren know how to do everything like anyone else, everyone has grandchildren who know how to do everything and so they say oh grandma it's like this come here grandma I'll explain it to you and they explain it (P36)"; "My granddaughter or my son explain it (P32)"; "When we need it we go and look for someone in the family to take us, or anything. (P34)".* Research has sought to document the importance of the support network for older people, as it plays a fundamental role in the link between physical, mental and social health. As such, people who are socially isolated do not benefit from the support and encouragement that their support network can provide them, such as friends, who play a major role in their lives (X. Zhang & Dong, 2022) and consequently have health implications (Gable & Bedrov, 2022).

From this same perspective, the spouse also plays a significant role in the lives of elderly people, as can be seen in the following passages *"As long as we're both alive, we*

keep each other company (P10). ; "It would be healthier if my wife hadn't died. (P23) ; "The male part suffers, as I do in this respect, don't I? Because the woman dies and we're left alone, aren't we? (...) I have to do things that the woman used to do. (P22) ". Studies show that after the loss of a spouse, the absence of support and companionship results in feelings of social isolation and loneliness, especially loneliness, which in the long term can influence wellbeing, contributing to a decrease in life satisfaction (Ben-zur, 2011; Yang & Gu, 2021). More specific studies show that widowed men suffer more than women (Freak-Poli, Kung, et al., 2022), as can also be seen in this study, where the last two quotes above are from male participants.

Also in this area, some participants mentioned behaviors, habits and routines that they adopt and that they consider can contribute indirectly and subjectively to combating social isolation and loneliness, as can be seen in the following passages *"Wherever I go, I say it straight away, and if I see someone alone, oh you're alone at home, come over there, over there to the Center, it's so good [...] come over there daughter, it's so good for you, come over there by our side, you're there talking to us (P8) ; "For those who can walk, I think it's better to go for a walk (...) I come here because I don't have to.) I come here because I can't walk, if I could walk before I'd want to go for a walk (P9) ; "People also have to seize the opportunities that are offered to them (P1)"; "Me and those two, on Wednesdays we get together in the cafe all afternoon (P17) ; "On Sundays we go to mass first (P17) ; "At the end of mass we all go for breakfast. (P12) ; "That little bit at the end of mass feels so good (P12) ; "The socializing, going to the cafe, I leave here, I'm in the cafe with them, we're there for a while, we talk (P17)"; "I go to the swimming pool, it's all part of being healthy, walking (P12) ; "Now during the day, if I can come, I take advantage of everything. It's only good for me. (P15) ; "Look at the days I don't have time, I have a big yard, so much grass to weed, so many things to look after, planting potatoes, sowing potatoes, scrubbing corn when it comes. (P14) ; "We watch TV and fall asleep (P17) ; "Oh no, I go to my sister's on Sunday, I always have to do things, I have the house to tidy (...) have to clean (P25) ; "Me and that lady do pilates, but we pay for it, we go twice a week (P29) ; "But I have my dog who I talk to a lot (P1) ; "My sister has a parrot, as soon as she gets up he calls her name and says good morning (P3)". The literature states that with age the number of social relationships decreases and can exacerbate feelings of social isolation and loneliness, with an increased risk of mental health decline and affirm the benefits that pets can have on mental health,*

especially for older people, as pets can provide a source of social connection (Stanley et al., 2014) subsequently facilitating interaction in the community (Hui Gan et al., 2020; Stanley et al., 2014). Owning a pet conveys comfort, security, inclusion and social participation, reduces feelings of social isolation and loneliness and positively influences mental health (Hui Gan et al., 2020; Lu et al., 2023).

Subtheme- Community factors

In this subtheme, it is important to reflect essentially on the existing responses in the community that contribute to combating social isolation and loneliness. In general, the participants mentioned various activities and were relatively satisfied, as can be seen in the following quotes *"We go for a walk now and then, it's very good (P8)."; "All the centers should be like this one (P1)."; "We have walks, we have a music teacher, we have gymnastics (P6)."; "But it's run by the council, it's all run by the council, but anyone can come here, they accept everyone (P8)."; "You have to be registered, you have to be retired and you have to belong to Póvoa... (P6)."; "We come whenever we want (P8)."; "We're going to have a concert here in a while with our music teacher (P6)."; "And now the St. Peter's festivities are coming up, we're going dancing (P1)."; "For our happiness. It's our wellbeing (P6)."; "That's why this building here was well designed for us to come together and talk, chat and we're all happy (P6)."; "There are centers like this one, it's excellent (P1)."; "Look, we have a math teacher here too, once a week, this is where I took my fourth grade exam, so it's like this, we're opening up our mentality and pulling our heads together so we don't age so badly (P6)."; "Before the pandemic, we used to go to Fátima almost every year, and we even went to Santiago de Compostela, also on excursions, but then the pandemic hit, in those years we didn't go, and there hasn't been anything else yet. (P14)."; "No. The Town Hall already helps us, it gives us snacks every day. We go for a walk. There are outings. (P26)."; "Yes, of course. There's a car for us to go for a walk. (P25)."; "It's like this here, some days on Monday we have a music teacher, on Tuesday we have gymnastics, on Wednesday we have gymnastics, on Thursday we have a music teacher, on Friday we have bingo and the week is over and next week it's repeated again (...) that's our life here. When there's a walk, the girls arrange it, sometimes the council just gives us the bus and we have to pay for lunch (P25)."; "Throughout the week we only have that, when there isn't, we go to bingo, sometimes there*

isn't bingo, we talk to each other and that's it (P25)"; "We have gymnastics, we have everything. (P32)"; "Our only activities are the gymnastics we have, which is offered by the parish council. (P34)"; "Yes, but if we want to go for a walk, we have to pay for it (P33)"; "I wanted to say something that I forgot, we have the old people's walk in September. We only go from Aguçadoura (...) so we only pay for lunch. (P36)"; "The bus is free, nothing else is free. (P33) ".

International ageing policies have been emphasizing the importance of social connection for health and wellbeing, with special emphasis on community participation as well (Bantry-White et al., 2018; Gardiner et al., 2018; Lee et al., 2022) and their activities that enable productive involvement (Gardiner et al., 2018). Other studies have tried to show that creating new social connections is one of the most rewarding and beneficial components for older people, since people can have similar life journeys, contributing to a greater sense of belonging (Noone & Yang, 2022). However, it should be noted that sometimes these community events are not always free, as we have seen, and that older people in poorer economic circumstances are often deprived of these activities (Eronen et al., 2016) which has an impact on social participation (Y. Zhang et al., 2022) and can consequently lead to a greater risk of social isolation (Lai et al., 2023) (Figure 2).

In this regard, the importance of disseminating information stands out, not only so that older people in general feel informed, but also so that they are aware of the activities/events that are taking place and which they can take advantage of. However, the participants are not very satisfied with this issue, as can be seen in the following quotes *"No, nothing. But before there were still messages in the church, this and that, now there's absolutely nothing. (P34)"; "And every two months the newspaper comes out and goes to all the houses and nothing has been announced, not even senior gymnastics. (P32)"; "I don't know, I've never heard of it. (P34)"; "It hasn't been published anywhere. (P34)"; "Nothing, zero. It doesn't matter. Little information. (P32)"; "Nobody knows (P2)"; "There's no information (P7) ".*

Therefore, it is now essential to understand the elderly people's perspective on what they think is important to implement in the community to help combat social isolation and loneliness. In this way, the participants conveyed their opinions by suggesting new activities of personal and collective interest, as can be seen in the following passages *"And that's something I'm tired of saying. I think it's a big mistake, everyone, every municipality*

should have houses like this (P10)"; "I mean home visits, which in many places do this, that the person feels alone, sometimes it's raining or something, they can't go shopping, that's what we need (P6)."; "What we wanted was, for example, people who are ill have no one to turn to. Look, we phoned, I can't go to Porto, I don't even know, and the truth is that I can't get to Porto on my own. That would be a help. Look, you can help, that's it (P6)."; "It was precisely these get-togethers (P18)"; "But for example, I'm going to send this, I don't know if it's going to go, crochet stuff, sewing stuff. (P14)"; "I'm not good at drawing (laughs), handicrafts like that. (P14)"; "I'd like to do a little crochet, I know how to do it, but I've lost my way a bit (P35)"; "We needed a swimming pool, we already have gymnastics, if they don't go it's because they don't want to, for example people learning how to use computers, that's what we needed, because most of them don't know, our age, they don't know how to use them. (P33)"; "A swimming pool would come in handy (P28)"; "That's it, a few English lessons would come in handy, a few English lessons would come in handy. (P33)"; "People learning to sew, embroider, make lace, all those things that old people can do and maneuver their arms and legs (P34)"; "Music, ballroom. (P32)". Concerning the dissemination of information, the participants also suggested adopting new strategies, as can be seen from the following quotes "Look, first the church is one of the main ones and then they put it on posters (P33)"; "The parish newspaper, which we've had for many years, so why doesn't it come out every few days there's this, every few days there's that, everything's clear. (P33)"; "It's the main thing, because all the houses receive it. All the houses receive it. It's free. The newspaper is free. (P33)"; "The Parish Council pays for it. (P34)".

Subtheme- Sociodemographic factors

This subtheme aims to identify sociodemographic aspects that can have implications for the social participation of older people and consequently contribute to social isolation and loneliness.

Social participation is not just a personal choice, but one that is influenced by the elderly person's environment (Jones et al., 2023). Numerous studies have tried to show that there is a strong correlation between social participation and health. However, individuals aging in rural areas face challenges in terms of health and wellbeing (Hussain et al., 2023) as they are subject to geographical isolation, limited public transportation and restricted

community services and are therefore unable to participate and socialize in the community, which negatively influences social activity (Hughes et al., 2019; Jones et al., 2023). Additionally, the rural environment offers less support and fewer opportunities to interact with family and friends, leading to a lack of social life and consequently feelings of social isolation and loneliness (Hussain et al., 2023; Moskalewicz et al., 2019) (Figure 2). The area of residence of the participants was the most important factor in this case, as the focus groups were held in four different parishes in *Póvoa de Varzim*. Most of the participants from Occupational Center of *Lapa* live in the center of *Póvoa de Varzim*, while those from Occupational Center of *Aver-o-Mar* live in *Aver-o-Mar*, which is one of the parishes closest to the center. On the other hand, the participants from *Rates* and *Aguçadoura* are further away from the center of *Póvoa de Varzim* (Figure 1).



Figure 1- Map of the municipality of *Póvoa de Varzim* (Câmara Municipal da Póvoa de Varzim, 2023)

Thus, the area of residence can influence this issue of social isolation and loneliness, to the extent that the participants from the more distant parishes feel unequal access to various opportunities, as can be seen in the following quotes *"I'm already more distant from them and I don't have the social interaction that they have, because I'm distant if I was closer to them (...) and I used to socialize with them more.) and I'd socialize more with them, we're all acquaintances (P15)"; "not to take us to Póvoa, we have to go to a certain place and we have to walk for a quarter of an hour to catch the bus to Póvoa. (P15)"; "But in the center of Póvoa de Varzim, there's no room for so many people, not even anyone can get in there, because it's always full, not even for the locals, what will it do for outsiders (P14)"; "even Póvoa doesn't have any, there's only this one and Lapa, there's nothing else (P10)"; "Of course there should be more, why do they have to come here from Beiriz? It's no good. Why doesn't Aguçadoura have one? Why doesn't Navais have it? Why doesn't Estela have one? I don't think it's right (P10)"; "Yes, yes, everyone has the right (P6)"; "In Aver-o-Mar there's much more support and activities than we have. (P35)"; "There's a walk, the seniors sit there, they have a little snack in the afternoon. (P35)"; "There's even a center, a pole. (P32)"; "And there's also a swimming pool and everything for free, or they used to, now I don't know. And the bus would come to pick them up from home and take them there, I know that. (P34)"; "They make lace, they draw pictures (P35)"; "I don't think it's fair for people from another parish to take their place there. Each parish. (P37)"; "That there were people here in our Parish Council. (P34)". This shows the need for the development of community interventions. (Rodríguez-Romero et al., 2021; Sen & Lei, 2023) such as cultural, sporting and recreational activities, which contribute to the social participation of older people and promote wellbeing and health (Jones et al., 2023; Lee et al., 2022; Y. Zhang et al., 2022).*

In summary, after interpreting the data obtained, it can be seen that the topics covered in this study become a helical process, in that they directly or indirectly contribute to the vulnerability of older people, as can be seen in the following image:

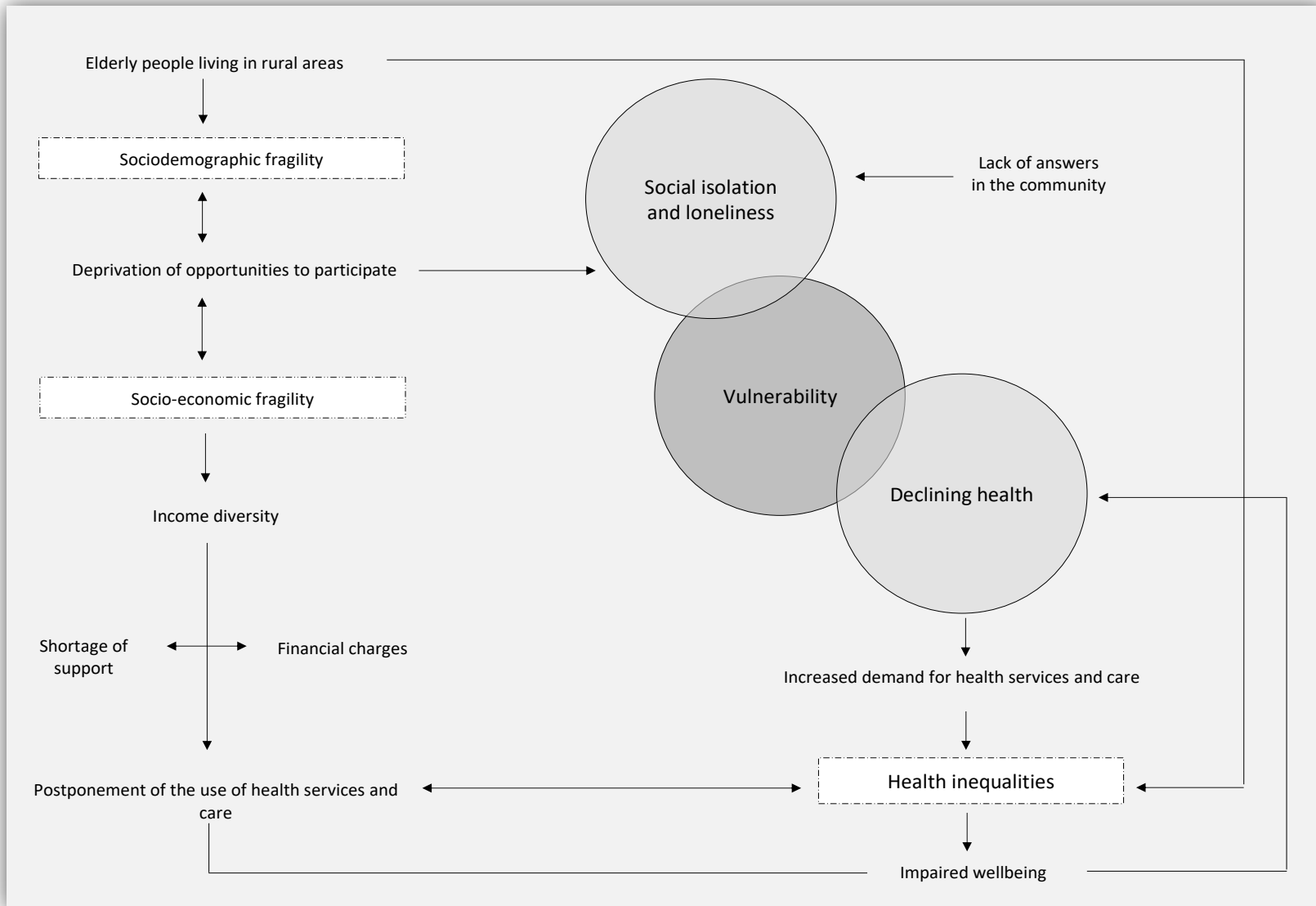


Figure 2- Summary diagram of data interpretation

4. Conclusion

The main objective of this research was to understand the perspective of elderly people in *Póvoa de Varzim* regarding to health (dis)equalities and social isolation and loneliness, and the extent to which these concepts are interrelated. This study has shown that the elderly is a vulnerable population in terms of the risks of developing physical, mental, and social health problems, due to extrinsic factors.

Considering the analysis of the participants' statements, in general individuals experience health inequalities, and it was possible to perceive the main aspects that contribute to older people feeling this discrepancy. The inefficient functioning of health services and their consultations, socioeconomic factors and a lack of support are the aspects that contribute to this sense of injustice described by the participants, and which can have a negative influence on their health. Regarding social isolation and loneliness, the majority of elderly people do not have a correct and accurate perception of what social isolation and loneliness correspond to, and this may probably explain the low number of participants with feelings of social isolation and loneliness according to the UCLA Loneliness Scale. Furthermore, this number corresponds mainly to participants who attend the Occupational Center, i.e. who are at an advantage in their occupational performance, which is surprising. However, it should be noted that there is an inconsistency between the UCLA Loneliness Scale score and the participants quotes. From this perspective, it can be seen that community factors, i.e. the lack of responses in the community, and socio-demographic factors, i.e. the deprivation of opportunities for participation, can support a risk of social isolation and loneliness, with the effect of a decline in the wellbeing and general health of older people, which leads to greater concern for the health system.

Considering the need and requirement to protect the mental health of older people, given the vulnerability to which they are subject, it is essential to take measures to guarantee an equitable response for this population, paying special attention to those who age in rural areas. Thus, also according to the information obtained throughout the study, it is considered pertinent to develop actions and/or strategies at the level of policies and the organization of health services, the availability of social and economic support for older people, their training and qualification for health and the implementation of community

interventions. Thus, in an attempt to break the helical connection between health inequalities and social isolation and loneliness (Figure 2).

So, when thinking about occupation in conjunction with ageing and everything that goes with it, it is essential to talk about the Occupational Therapist. This is the professional who plays a crucial role in changing the way we view ageing, a process that awaits everyone and which can really take its toll if it is marked by poor health, loneliness and social isolation. Occupational Therapists can play an active role through psycho-educational programs that promote health, by promoting the development of skills needed to use technology and through community interventions that facilitate involvement in meaningful activities would possibly be able to improve the wellbeing and mental health of older people, contributing to healthy ageing, which is much more than being healthy. There are still many steps to be taken in order to safeguard the equal rights of older people and ensure that they are treated with dignity.

It should be noted that this study has its limitations, namely the size of the sample, and there was also a scenario of agreement and/or affinity bias, given that the interviews took place with groups of people who were already familiar with each other, recall bias is also possible, given that the questions reflected on topics that were not very common, and social desirability bias should not be ruled out, given the delicacy of the topic of social isolation and loneliness.

5. Implications for research and practice

The results of this research contribute to a better understanding of the impact of health inequalities and social isolation and loneliness on elderly people in *Póvoa de Varzim*, and the factors that influence this.

This study can be a starting point in identifying the adversities that exist in health services in Portugal, with a view to developing future actions in this direction, as well as the needs experienced by the elderly population in Portugal in the face of social isolation and loneliness.

In view of the results obtained in this study, it would be essential to delve deeper into the perspective of older people living in more rural areas and older people who are more dependent or even institutionalized, and from another angle, to investigate the point of view

of other people, such as health professionals or significant members of a community/region, who also play an important role in this issue. Future studies should explore the role of the Occupational Therapists and others healthcare professionals to foster a healthier and a more fulfilling live to the elderly.

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7. Supplementary material

Appendix 1- Focus Group Script



Focus group script

First of all, before we start the interview, I would like to thank you for accepting the invitation to take part in this study and for being here today. This study aims to understand the relationship between health inequalities and levels of loneliness and social isolation in portuguese elderly people.

As such, this interview will take approximately one hour to one hour and thirty minutes without interruption, and several questions related to the topic will be asked throughout. Please feel free to express your thoughts and opinions. I would like to ask you to authorize me to record only the audio of the interview for the purposes of the study, and to guarantee your anonymity. We began with a brief introduction of the participants.

-How do you feel about living in *Póvoa de Varzim*?

Accessibility to health services:

-From your perspective, as elderly people, do you feel that you have easy access to health services?

-Are there Hospitals, Health Centers and Pharmacies? Are they easily accessible?

-How do you get to these places? How easy do you find it?

-Do they have a family physician?

-Do they have easy access to appointments and medication?

Do they have any kind of financial support for health-related issues?

-Do they have any kind of support other than financial for health-related issues (e.g. home help...)?

-Do you feel that the municipality or Parish Council supports you in managing your health?

-Do you feel that health difficulties have an impact on your wellbeing?

-Do you feel that there are responses that contribute to your wellbeing?

Social isolation and loneliness:

- What do you mean by social isolation and loneliness?
- Are there events/programs (e.g. leisure) in your area? Do they contribute to your wellbeing? Are they easily accessible?
- Do you feel you have a network of people you can turn to when you need help (for example, your family, friends or neighbors...)?
- What does healthy ageing mean to you? Do you feel that you have healthy ageing?
- What do you think is important to implement in order to have healthy ageing?
- Having said that, what strategies/solutions can be adopted to deal with these situations that have been addressed here (social isolation, loneliness, social and health inequalities...)?
- Is there anything else you would like to add that you think is relevant to the topic in question?

Appendix 2- Theme tree

