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ORIGINAL ARTICLE

OLDER ADULTS' PERCEPTIONS OF HOW HEALTH PROFESSIONALS COMMUNICATE INFORMATION

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Highlights:
(1) Most of the older adults interviewed reported no difficulty understanding the information provided by health professionals
(2) The guidance provided during consultations is often quite generic
(3) The appointments focused on disease control and monitoring.

ABSTRACT

Objective: To identify the perception of older adults with limited or inadequate Functional Health Literacy regarding how primary healthcare professionals communicate information. *Method*: This is a qualitative, exploratory, and descriptive study. Twenty-seven older adults participated. Data were collected from seven Family Health Units in a city in the southern region of Rio Grande do Sul, Brazil. *Results*: The participants' average Functional Health Literacy score was 36.21 points, indicating inadequate literacy. They reported difficulties that compromised their understanding, including the excessive amount of information provided during medical appointments and the need to bring a family member to help interpret the information. *Final considerations:* Identifying the difficulties reported by older adults in understanding health information supports the development of strategies to improve health outcomes in this population's care.

Keywords: health communication; health literacy; primary health care; elderly; nursing.

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INTRODUCTION

The number of people aged 60 and over has increased significantly in Brazil. According to the Brazilian Institute of Geography and Statistics (IBGE), the country's population continues to follow an aging trend. Data from the IBGE's National Household Sample Survey show that the proportion of individuals aged 60 or older rose from 11.3% to 14.7% of the total population over ten years, indicating a substantial shift in the country's age structure[1].

Although aging does not necessarily lead to illness, there has been an increase in chronic conditions within this population. Chronic non-communicable diseases, such as diabetes mellitus and hypertension, have functional consequences that can result in reduced quality of life, limitations, and disabilities. These conditions are also responsible for 71% of deaths worldwide[2-3].

Older people often live with complex health conditions and face great difficulty understanding and following instructions and guidance regarding their clinical conditions, treatments, and medications provided by professionals during health education, which affects their independence and self-care, leading to poor health outcomes and dissatisfaction with health services[4-5].

Functional Health Literacy (FHL) is a concept used to assess an individual's ability to understand health-related information and apply it in routine healthcare situations. It refers to the capacity to comprehend and interpret health information presented in written, spoken, or digital formats. This ability – or the lack thereof – can significantly influence a person's health status[6].

The Test of Functional Health Literacy in Adults (TOFHLA) is one of the most widely used instruments to assess FHL[7]. Based on the TOFHLA score, older adults are classified into three literacy levels: inadequate (0–53), marginal (54–66), and adequate (67-100)[7]. FHL levels tend to be lower among older adults than the general population. A study conducted in Recife, PE, Brazil with 213 individuals aged 60 or older with chronic kidney disease, found that approximately 71.7% had inadequate FHL[8]. Similarly, a study involving 529 older adults in the United States reported that 48.2% had limited or inadequate FHL[9].

Assessing a patient's understanding of health information is as important as using communication strategies to promote such understanding. Therefore, recognizing communication as a fundamental component of care and the basis of interpersonal relationships is essential. Effective professional-patient communication requires deliberate effort, given its crucial role in encouraging patients' active engagement in their care, promoting well-being, and mitigating the effects of limited health literacy[10]. In light of this, this study explores how older adults with limited or inadequate FHL perceive the way primary healthcare professionals communicate information.

METHOD

This is a qualitative, exploratory, and descriptive study. Data were collected from seven Family Health Units (FHUs) in a municipality in the southern region of Rio Grande do Sul, Brazil. The study was conducted between April and July 2022 and is part of the dissertation *Comunicação entre profissionais da saúde e pessoas idosas na atenção básica: estratégias para o Letramento Funcional em Saúde* [Communication between health professionals and older people in primary care: strategies for Functional Health Literacy].

The Family Health Units in this municipality were selected due to the town's low literacy rate – approximately 68% of the population is either illiterate or has not completed primary education – and its low average monthly income (2.7 times the minimum wage)[11]. Both factors are associated with lower levels of Functional Health Literacy.

Four older adults from each Family Health Unit (FHU) in São José do Norte, RS, Brazil, were invited to participate in the study, which was conducted across all FHUs in the municipality (Bujuru, Carlos Santos, Cidade Baixa, Veneza, Tamandaré, Hélio Rossano, and Estreito). Participants were selected based on the following inclusion criteria: being 60 years of age or older; residing in the area covered by the FHU; having at least one year of self-reported schooling; being able to read the Jaeger card at a level of 20/40 – considered normal for peripheral vision with or without corrective lenses; passing the Whisper Test in both ears; and achieving a minimum score on the Mini-Mental State Examination (MMSE)[12]. The MMSE cutoff scores were as follows: illiterate = 19 points; 1 to 3 years of schooling = 23 points; 4 to 7 years = 24 points; and more than 7 years = 28 points[12]. These criteria are required by the S-TOFHLA[13], the instrument used to assess functional health literacy. The S-TOFHLA has a total score of 100 points: scores from 0 to 53 indicate inadequate FHL; 54 to 66, marginal FHL; and 67 to 100, adequate FHL. Only older adults with marginal or inadequate FHL were included in the study[13].

Twenty-nine older adults were interviewed; one was excluded for having adequate FHL, and another was excluded for not attending the health unit. The primary researcher, a registered nurse, and a master's student in nursing conducted all interviews individually. The interviews were scheduled in advance by telephone and took place in the participants' homes. The interviews were audio-recorded and later transcribed verbatim. Convenience sampling was used, and data collection was concluded upon reaching data saturation.

A semi-structured form based on the instrument created by Schwartzberg et al. I[14] (American Medical Association Communication Techniques Survey – AMA Survey) was developed for this study and used to collect data to characterize the participants. Open-ended questions were also included to explore health communication strategies. A pilot interview was conducted with one older adult to assess the clarity and appropriateness of the questions. The interviews lasted an average of 7.27 minutes.

Data were analyzed using the discursive textual analysis method, a self-organized process aimed at producing new understandings of the phenomena under study[15]. This analytical approach is structured around four foci. The first three form a cycle: (1) **disassembly of the texts**, also known as unitarization, in which the material is closely examined and fragmented into meaning units related to the phenomenon; (2) **establishment of relationships, or categorization**, where similar meaning units are grouped to generate various levels of analytical categories; and (3) **capturing the emergent new**, in which deep engagement with the material – fostered by the previous steps – enables a renewed understanding of the whole, thereby completing the cycle. The fourth focus is the **self-organized process**, in which the fragmentation and disorganization of earlier phases give way to a reconstruction marked by the emergence of new insights[15].

Participants received clarification about the study's objectives through a free and informed consent form, which they signed in two copies. The participants' statements are identified using a code composed of an Arabic numeral preceded by an abbreviation – for example, OP1 (Older Patient 1) to preserve confidentiality. This study complied with all ethical guidelines and was approved by the Institutional Review Board at Furg (CEP-Furg) under opinion number 5,248,648. The Consolidated Criteria for Reporting Qualitative Research (Coreq) was used to guide the reporting of results.

DISCUSSION

The FHL scores of the 27 older participants ranged from 6 to 65, with an average score of 36.21 points, indicating inadequate FHL. The participants had a mean age of 69.8 years; 40.7% (n=11) lived in rural areas, and 77.7% (n=21) had completed up to the 5th grade. Regarding self-reported race/ethnicity, 62.9% (n=17) identified as White, 25.9% (n=7) as multiracial, and 11.1% (n=3) as Black.

Other studies have also shown that a significant proportion of older adults with fewer than eight years of schooling have low FHL[16]. Lower educational attainment is associated with limited FHL, as reduced reading and comprehension skills may hinder the ability to understand information provided by health professionals. This limitation is directly linked to lower levels of health-related knowledge and greater dependence on family members in decision-making[17].

Older adults tend to have lower FHL[18-19], and individuals with limited FHL often face difficulties managing their healthcare and treatments. This can lead to increased use of health services, poorer self-management of chronic conditions, and higher mortality rates. Low FHL among older adults is particularly concerning, as this group typically has greater information needs related to managing their health and age-associated chronic conditions[20].

Two categories emerged from the identified meaning units: "Understanding Information" and "Main Topics Covered," as presented in Table 1.

Table 1 – Units of meaning and categories (n=27). Rio Grande, RS, Brazil, 2023

	Unit of meaning	Category
PERCEPTIONS OF OLDER ADULTS WITH LIMITED OR INADEQUATE FHL REGARDING HOW PRIMARY CARE PROFESSIONALS COMMUNICATE INFORMATION	To answer To ask To explain To understand Paper Written	**Understanding Information**
	Blood pressure Renewal of prescriptions Medications Diet	**Main Topics Covered**

Source: Developed by the authors (2023).

Understanding Information

Most of the older adults interviewed reported no difficulty understanding the information provided by health professionals (OP2, OP3, OP4, OP5, OP6, OP7, OP9, OP10, OP11, OP12, OP13, OP15, OP16, OP17, OP18, OP19, OP20, OP21, OP22, OP23). When asked whether the professional at the health unit had ever noticed they did not understand the information, participants generally

responded that this had never occurred (OP2, OP3, OP4, OP5, OP6, OP7, OP8, OP9, OP10, OP11, OP12, OP15, OP16, OP17, OP18, OP19, OP20, OP21, OP22, OP23). Additionally, several participants noted that when they did not understand something, they would ask questions, and the professional would explain the information again (OP1, OP5, OP13, OP14).

> I have no problems understanding information; everything is very clear (OP17).
>
> I don't remember a situation when I didn't understand, but if I had not, I'd ask. I believe that's how they explain things (OP16).
>
> I asked them to explain to me what I had to do, what I didn't have to do, and they explained. (…) They didn't repeat information much (OP15).
>
> I have no difficulty. (…) When I don't understand, I ask again, and he answers properly. If I have any doubts, I ask, and he helps me. Sometimes there's something he says that I don't understand, and I ask, and he answers (OP12).
>
> I don't have this problem of not understanding the doctor – although that doctor didn't speak our language. She was Cuban and didn't speak Portuguese, but I understood her (OP18).

This finding is consistent with previous studies, which indicate that most patients do not understand health information and often do not recognize this lack of understanding[21]. Moreover, individuals with limited FHL may encounter additional challenges, as they are generally less familiar with medical concepts and tend to ask fewer questions during consultations due to feelings of embarrassment. This reluctance can hinder their active participation in the decision-making process[22].

However, some participants reported difficulties understanding the information (OP1, OP8). One older adult noted that certain professionals did not limit the amount of information shared during consultations, which compromised their ability to understand it fully.

> It's like I told you – now things seem to have calmed down, but before, everything was very hectic. We'd ask something, and they would explain a bunch of things that you just can't wrap your mind around. I think the first thing a professional needs to do when working in healthcare is to be calm (OP1).

Complex information is more likely to be understood, retained, and followed when the information provided during each appointment is limited. Therefore, the knowledge conveyed should be simplified and delivered in stages – across multiple medical appointments – to enhance understanding among patients with low levels of FHL[23].

Furthermore, one older adult reported bringing a companion or family member to consultations to help interpret health information, as they could not fully understand the information provided during the consultation.

> It's hard for me to understand. I never go to the doctor alone – it's very hard for me. My daughter goes with me; she's the one who understands the most. I don't understand much of what they say. My daughter goes with me and understands most of it. I have a lot of trouble understanding these things. (OP8)

Studies show that having a social support network, such as family and friends, is essential and is associated with better health outcomes[24-25]. Individuals living with a spouse or partner tend to adhere more to medical recommendations[26]. As a result of aging, older adults often become more dependent on their social support network, and having a family member accompany them to medical appointments can promote the adoption of self-care practices and assist family members in navigating the therapeutic process. Thus, having a companion facilitates treatment adherence among those with chronic conditions[27]. However, not all older adults have the support of family members, which highlights the crucial role of community health agents. These professionals are well positioned to

identify the need for additional support and alert other healthcare team members to implement more specific interventions[28].

Main Topics Covered

The topics addressed during medical appointments are known to contribute to disease prevention[29] by raising awareness among the target population about the importance of adopting healthy behaviors. However, the reports from older participants indicate that the guidance provided during consultations is often quite generic. The main topics discussed included blood pressure (OP5, OP6, OP7, OP12, OP17, OP18), prescription renewal (OP1, OP4, OP11), medications (OP5, OP10, OP20), and diet (OP5, OP18, OP21).

> I go there more often when there's a problem with the prescription. When the medication expires, I have to go so they can give me a new one (OP4).
>
> They talk about high blood pressure, salt, fat, and fried foods (OP7).
>
> About medication – taking it correctly (OP10).
>
> I went to check my blood pressure. I have high blood pressure (OP12).

A lack of empathetic and active listening in patient care becomes evident. Active listening is essential for building a trusting relationship between the patient and the professional, as it enables a deeper understanding of the individual's physical, social, cultural, and emotional dimensions and helps identify issues that require attention and discussion[30-31]. The Individualized Care Plan places singularity at the center of care, aiming to address each person's specific needs. This approach requires recognizing each individual's unique characteristics rather than relying on pre-established therapeutic guidelines[31].

The participants' accounts also indicate that the appointments focused on disease control and monitoring. A study conducted in João Pessoa, PB, Brazil, involving higher education professionals working in FHUs found that these professionals dedicate little time to prevention, health promotion, and educational activities[32]. When the transmission-based approach is used, educational actions tend to concentrate on chronic conditions[33], thereby distancing themselves from the broader goal of transforming health behaviors and instead emphasizing curative or medicalized approaches.

When asked whether they had received printed materials with health guidelines, only one older adult reported receiving written information following a medical appointment (OP14). A few participants mentioned receiving written instructions from a nutritionist (OP7, OP18, OP21), which included dietary and nutritional guidance. The remaining participants stated that they had never received any written guidelines (OP2, OP3, OP4, OP5, OP6, OP8, OP9, OP10, OP11, OP12, OP13, OP15, OP16, OP19, OP20, OP22).

> Just the prescription for the medicine (OP12).
>
> In writing? Sometimes, when we have to go on a diet (OP21).
>
> Once, I had a consultation (…), it was with a nutritionist (OP7).
>
> They provide a service that I think is very appropriate, especially since I already have trouble remembering information. Usually, they give me written instructions about how I should proceed (OP14).

Several factors can interfere with a patient's ability to understand and recall information that health professionals provide. Hence, written materials provided alongside verbal instructions are recommended to reduce misunderstandings and enhance information retention. Such materials are critical, as they are considered essential to the success of any health intervention[34].

FINAL CONSIDERATIONS

The older participants had an average FHL score of 36.21 points, indicating inadequate functional health literacy. Despite this, most reported no difficulty understanding the information provided by health professionals. However, some participants pointed to factors that compromised their comprehension, including the excessive amount of information shared during a single consultation and the need to bring a family member to accompany them, as they could not fully understand the information independently.

Understanding the difficulties reported by older participants in comprehending health information contributes to developing strategies to improve health outcomes in this population. One limitation of this study is the exclusion of illiterate older adults, as existing instruments for assessing FHL require participants to have at least one year of schooling and basic reading skills. Therefore, FHL assessment tools should be adapted to reflect better the context and needs of older adults in Brazil.

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Jamila Geri Tomaschewski Barlem: Project administration; Supervision; Writing – review & editing.

Daiane Porto Gautério Abreu: Supervision; Writing – review & editing.

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