ORIGINAL ARTICLE

OLDER ADULTS' PERCEPTIONS OF HOW HEALTH PROFESSIONALS COMMUNICATE INFORMATION

Juliana Piveta de Lima[1]; Jamila Geri Tomaschewski Barlem[2]
Daiane Porto Gautério Abreu[3]

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.

http://dx.doi.org/10.21527/2176-7114.2025.50.15304

How to cite:
de Lima JP, Barlem JGT, Abreu DPG. Older adults' perceptions of how health professionals communicate information. Rev. Contexto & Saúde, 2025;25(50): e15304

[1] Universidade Federal do Rio Grande – FURG. Rio Grande/RS, Brasil.
https://orcid.org/0000-0002-2703-9189
[2] Universidade Federal do Rio Grande – FURG. Rio Grande/RS, Brasil.
https://orcid.org/0000-0001-9125-9103
[3] Universidade Federal do Rio Grande – FURG. Rio Grande/RS, Brasil.
https://orcid.org/0000-0002-1125-4693

OLDER ADULTS' PERCEPTIONS OF HOW HEALTH PROFESSIONALS COMMUNICATE INFORMATION

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.

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. l[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.

REFERENCES

1 Instituto Brasileiro de Geografia e Estatística (IBGE). Pesquisa Nacional por Amostra de Domicílios Contínua. Características gerais dos moradores 2020-2021. 2022. Disponível em: https://biblioteca.ibge.gov.br/visualizacao/livros/liv101957_informativo.pdf

2 World Health Organization (WHO). Noncommunicable diseases country profiles 2018. Genebra: WHO; 2018.

3 Francisco PMSB, Assumpção D, Bacurau AGM, Neri AL, Malta DC, Borim FSA. Prevalência de doenças crônicas em octogenários: dados da Pesquisa Nacional de Saúde 2019. Ciência & Saúde Coletiva, 2022, 27(7):2655-2665.

4 Belim C, Almeida CV. Communication Competences are the Key! A Model of Communication for the Health Professional to Optimize the Health Literacy – Assertiveness, Clear Language and Positivity. J Healthc Commun, 2018.

5 Kim MY, Oh S. Nurses' Perspectives on Health Education and Health Literacy of Older Patients. Int J Environ Res Public Health. 2020 Sep 4;17(18):6455.

6 Adams RJ, Stocks NP, Wilson DH, Hill CL, Gravier S, Kickbusch I, Beilby JJ. Health literacy a new concept for general practice? Aust Fam Physician. 2009 Mar;38(3):144-7.

7 Passamai MPB, Sampaio HAC, Lima JWO. Letramento Funcional em Saúde de Adultos no contexto do Sistema Único de Saúde. Fortaleza. 255p. 2013.

8 Lima MF, Vasconcelos EMR, Borba AKOT, Carvalho JC, Santos CR. Letramento funcional em saúde e conhecimento do idoso sobre a doença renal crônica. Enferm. foco (Brasília) 2021; 12(2): 372-378.

9 Smith SG, O'Conor R, Curtis LM, Waite K, Deary IJ, Paasche-Orlow M, Wolf MS. Low health literacy predicts decline in physical function among older adults: findings from the LitCog cohort study. J Epidemiol Community Health. 2015 May;69(5):474-80.

10 Warde F, Papadakos J, Papadakos T, Rodin D, Salhia M, Giuliani M. Plain language communication as a priority competency for medical professionals in a globalized world. Can Med Educ J. 2018 May 31;9(2):e52-e59.

11 Instituto Brasileiro de Geografia e Estatística (IBGE). Censo Amostra Educação São José do Norte-RS. 2010. Disponível em: https://cidades.ibge.gov.br/brasil/rs/sao-jose-do-norte/pesquisa/23/22469?detalhes=true

12 Brasil. Ministério da Saúde. Secretaria de Atenção à saúde. Departamento de Atenção Básica. Envelhecimento e saúde da pessoa idosa. Brasília-DF: 2006. 192p.

13 Carthery-Goulart MT, Anghinah R, Areza-Fegyveres R, Bahia VS, Brucki SMD, Damin A, et al. Performance of a Brazilian population on the test of functional health literacy in adults. Rev. saúde pública [Internet]. 2009Aug.1 [cited 2023Oct.30];43(4):631-8.

14 Schwartzberg JG, Cowett A, VanGeest J, Wolf MS. Communication techniques for patients with low health literacy: a survey of physicians, nurses, and pharmacists. Am J Health Behav. 2007 Sep-Oct;31 Suppl 1:S96-104.

15 Moraes R, Galiazzi MC. Análise textual discursiva. Ijuí, Brasil: Editora Unijuí. 2011.

16 Scortegagna HM, Santos PCS, Santos MIPO, Portella MR. Letramento funcional em saúde de idosos hipertensos e diabéticos atendidos na Estratégia Saúde da Família. Esc Anna Nery, 2021; 25(4) :e20200199.

17 Lima AS, Lima BJS, Oliveira AT, Farias MGN, Passos MKA, Sandes MF, et al. Letramento funcional em saúde em pacientes portadores de doenças crônicas. Research, Society and Development. 2022; 11(9).

18 Mahmoodi R, Hassanzadeh A, Rahimi M. Health literacy and its dimensions in elderly people in Farsan city, Iran. J Educ Health Promot. 2021 Sep 30;10:362.

19 Wells TS, Rush SR, Nickels LD, Wu L, Bhattarai GR, Yeh CS. Limited Health Literacy and Hearing Loss Among Older Adults. Health Lit Res Pract. 2020 Jun 4;4(2):e129-e137.

20 Uemura K, Yamada M, Okamoto H. The Effectiveness of an Active Learning Program in Promoting a Healthy Lifestyle among Older Adults with Low Health Literacy: A Randomized Controlled Trial. Gerontology. 2021;67(1):25-35.

21 Yen PH, Leasure AR. Use and Effectiveness of the Teach-Back Method in Patient Education and Health Outcomes. Fed Pract. 2019 Jun;36(6):284-289.

22 Otte R, Roodbeen R, Boland G, Noordman J, van Dulmen S. Affective communication with patients with limited health literacy in the palliative phase of COPD or lung cancer: Analysis of video-recorded consultations in outpatient care. PLoS One. 2022 Feb 10;17(2):e0263433.

23 Hersh L, Salzman B, Snyderman D. Health Literacy in Primary Care Practice. Am Fam Physician. 2015 Jul 15;92(2):118-24.

24 Knight L, Schatz E. Social Support for Improved ART Adherence and Retention in Care among Older People Living with HIV in Urban South Africa: A Complex Balance between Disclosure and Stigma. Int J Environ Res Public Health. 2022 Sep 12;19(18):11473.

25 Hudani ZK, Rojas-Fernandez CH. A scoping review on medication adherence in older patients with cognitive impairment or dementia. Res Social Adm Pharm, 2016, 12(16):815-29.

26 Uchmanowicz B, Chudiak A, Uchmanowicz I, Rosińczuk J, Froelicher ES. Factors influencing adherence to treatment in older adults with hypertension. Clin Interv Aging. 2018 Nov 28;13:2425-2441.

27 Barreto MS, Marcon SS. Participação familiar no tratamento da hipertensão arterial na perspectiva do doente. Texto Contexto Enferm, Florianópolis, 2014 Jan-Mar; 23(1): 38-46.

28 Schenker M, Costa DH. Avanços e desafios da atenção à saúde da população idosa com doenças crônicas na Atenção Primária à Saúde. Ciência & Saúde Coletiva, 2019; 24(4):1369-1380.

29 Machado-Becker R, Heidemann ITSB, Kuntz Durand M. Health promotion and primary care for people with chronic non-transmissible diseases. Rev. Salud Pública, 2020; 22(1): 41-47.

30 Baptista JA, Camatta MW, Filippon PG, Schneider JF. Singular therapeutic project in mental health: an integrative review. Rev Bras Enferm. 2020;73(2): e20180508.

31 Viana AVDG, Rodrigues CDS, Quadros JD, Santos LF, Soares PHM, Canto RBB et al. Secretaria Estadual da Saúde. Projeto terapêutico singular na atenção primária à saúde. Divisão de atenção primária à saúde – Porto Alegre: Secretaria da Saúde do Rio Grande do Sul, 2022.

32 Brito GEG, Mendes ACG, Neto PMS. O trabalho na estratégia saúde da família e a persistência das práticas curativistas. Trab. educ. saúde, 2018, 16(3).

33 Azevedo PRA, Sousa MM, Sousa NF, et al. Ações de educação em saúde no contexto das doenças crônicas: revisão integrativa. Rev Fund Care Online. 2018 jan./mar.; 10(1):260-267.

34 Nakamura MY, Almeida K. Desenvolvimento de material educacional para orientação de idosos candidatos ao uso de próteses auditivas. Audiol Commun Res. 2018;23: e1938.

Submitted: October 30, 2023

Accepted: November 1, 2024

Published: April 11, 2025

Author contributions:

Juliana Piveta de Lima: Conceptualization; Data curation; Formal analysis; Investigation; Funding acquisition Methodology; Validation; Visualization; Writing – original draft.

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

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

All authors approved the final version of the text.

Conflict of interest: No conflict of interest.

Funding: Fundação Coordenação de Aperfeiçoamento de Pessoal de Nível Superior - CAPES

OLDER ADULTS' PERCEPTIONS OF HOW HEALTH PROFESSIONALS COMMUNICATE INFORMATION

Corresponding author:
Juliana Piveta de Lima
Universidade Federal do Rio Grande – FURG
Km 8 Avenida Itália Carreiros, Rio Grande/RS, Brazil. CEP 96203-900
julianapivettal@hotmail.com

Editor-in-Chief: Adriane Cristina Bernat Kolankiewicz. PhD