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ORIGINAL

Characterization of older adults from a family doctor's office in Palma Soriano

Caracterización de los adultos mayores pertenecientes a un consultorio médico de la familia, Palma Soriano

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ABSTRACT

Introduction: aging is an inherent biological phenomenon, defined by morphophysiological alterations stemming from cumulative deterioration. From a demographic perspective, it refers to a transformation in the age composition of the population. Globally, this phenomenon has acquired an accelerated growth rate, becoming a significant challenge that demands the design of specific strategies targeted at this population segment.
Objective: to characterize the older adult population belonging to Family Doctor's Office No. 1 of the "Carlos Montalván" South Polyclinic in Palma Soriano, during the period March - June 2025.
Method: an observational, descriptive, cross-sectional study was conducted with a population of 297 individuals over 60 years of age, of both sexes. The entire population was included. Data were collected in contingency tables.
Results: males predominated (51,52 %), with the highest concentration in the 70-80 age group (42,76 %). 58,92 % were classified as ill (Group III), with Hypertension (HTA) (86,20 %) and Smoking (79,46 %) standing out as the main comorbidities. High multimorbidity was evident. Extended/expanded families (69,11 %) and functional families (72,06 %) predominated. Normal weight (44,78 %) co-occurred with male obesity (13,13 %) and female underweight (9,76 %). 93,27 % received full family support, but 81,14 % presented a risk of home accidents.
Conclusions: the phenomenon of demographic aging is progressively intensifying. This reality makes it imperative to implement measures that enhance the well-being of older adults, while promoting preventive health initiatives and healthy habits specifically designed for this age group.

Keywords: Population Aging; Aging Population; Primary Health Care; Older Adult; Elderly.

RESUMEN

Introducción: el envejecimiento constituye un fenómeno biológico inherente, definido por alteraciones morfofisiológicas derivadas de un deterioro acumulativo. Desde la perspectiva demográfica, alude a una transformación en la composición etaria de la población. A nivel global, este fenómeno ha adquirido un ritmo acelerado de crecimiento, convirtiéndose en un desafío significativo que demanda el diseño de estrategias específicas dirigidas a este segmento poblacional.
Objetivo: caracterizar la población de adultos mayores pertenecientes al Consultorio Médico de la Familia No. 1 del Policlínico Sur "Carlos Montalván", de Palma Soriano, en el periodo de marzo - junio de 2025.
Método: se realizó un estudio observacional, descriptivo, transversal con un universo de 297 personas

mayores de 60 años, de ambos sexos. Se trabajó con la totalidad del universo. Los datos fueron recogidos en tablas de contingencia.
Resultados: predominó el sexo masculino (51,52 %), con mayor concentración en 70-80 años (42,76 %). El 58,92 % fue clasificado como enfermos (Grupo III), destacando HTA (86,20 %) y tabaquismo (79,46 %) como principales comorbilidades. Se evidenció alta multimorbilidad. Predominaron familias extensas/ampliadas (69,11 %), funcionales (72,06 %). El normopeso (44,78 %) coexistió con obesidad masculina (13,13 %) y bajo peso femenino (9,76 %). El 93,27 % recibió apoyo familiar total, pero 81,14 % presentó riesgo de accidentes domésticos.
Conclusiones: el fenómeno del envejecimiento demográfico se intensifica progresivamente. Esta realidad hace imperativo implementar medidas que eleven el bienestar de las personas mayores, al tiempo que se promuevan iniciativas de salud preventiva y hábitos saludables específicamente diseñados para este grupo etario.

Palabras clave: Envejecimiento Poblacional; Envejecimiento de la Población; Atención Primaria de Salud; Adulto Mayor; Ancianos.

INTRODUCTION

Aging, understood as an intrinsic biological phenomenon, is a natural process characterized by the progressive accumulation of molecular and cellular alterations over time. These underlying changes trigger a series of morphological and physiological transformations that gradually compromise the body's ability to adapt and respond effectively to harmful agents. This loss of functional resilience results in a gradual deterioration of physical and cognitive abilities, a substantial increase in susceptibility to disease, and, ultimately, the end of the life cycle.

At the same time, a demographic phenomenon with far-reaching implications is being observed on a global scale: population aging. This manifests itself as a structural reconfiguration of age pyramids, with the segments corresponding to older and long-lived adults experiencing sustained growth, while younger age groups tend to stabilize or decline. The data speaks for itself: while in the mid-20th century only 5,4 % of humanity was over 60 years old, by 2002 this proportion had risen to 8 %. Projections indicate a continued rise, with estimates reaching 12,8 % by 2025 and exceeding 20 % by 2050.[2]

Various prospective analyses agree that there will be a significant increase in the geriatric population in the coming decades, which will inevitably lead to higher morbidity rates and a growing demand for health services.[2]

In the regional context, Mexico, with a population of over 126 million, recorded 12,3 % of its citizens (15,4 million) aged 60 or over, according to the Demographic Dynamics Survey. Cuba, for its part, stands out as one of the most aged nations in the Americas. By 2022, provinces such as Villa Clara (22,8 %), Havana (20,8 %), and Sancti Spíritus (20,6 %) had the highest longevity rates.

By the end of 2023, 20,8 % of Cubans belonged to this age group, and this figure is projected to rise to 30 % by 2030. With a life expectancy of around 78,5 years, most older Cuban adults remain independent in their basic activities.

This accelerated aging in Cuba, a phenomenon with profound implications for the present and future, is mainly due to increased life expectancy, reduced mortality, a persistent decline in fertility, and negative net migration.[3]

This accelerated demographic aging represents one of the greatest challenges of the 21st century, inseparable from the increase in the burden of age-related disease. In this scenario, the concept of "healthy aging" takes on fundamental relevance. Defined by the World Health Organization (WHO) as "the process of promoting and maintaining functional capacity that enables well-being in old age," it emphasizes the importance of preserving the physical and mental attributes that allow people to continue doing what they value.[4]

The increasing longevity observed in recent decades, both in developed and developing nations, has profound implications for the socioeconomic planning of all countries, including Cuba. The high morbidity characteristic of this population segment generates significant demand for care, with an increase in mortality attributable to chronic noncommunicable diseases (CNCDs) directly related to increased life expectancy.[5]

Therefore, the objective of this study is to characterize the elderly population belonging to Family Medical Clinic No. 1 of the Carlos Montalván South Polyclinic in Palma Soriano during the period from March to June 2025.

METHOD

Type of study, period, and location

The study was descriptive and cross-sectional. The research was carried out at the Family Medical Clinic No. 1 of the Carlos Montalván Southern Polyclinic, located in Palma Soriano. The study was conducted between March and June 2025.

Sample and participants

The study population consisted of all adults aged 60 or over, of both sexes, registered at the clinic in question, representing a total of 297 people. Given the characteristics of the study population, no sample selection procedure was carried out, and all individuals who met the above criteria were included.

Variables, instruments, techniques, and procedures

To achieve the proposed objective, a set of variables was operationalized. Sociodemographic variables included age, sex, education, occupation, and socioeconomic status. Clinical variables consisted of dispensary group, personal medical history, number of noncommunicable diseases, nutritional assessment, major geriatric syndromes, and functional capacity. Family and social variables included family structure, life cycle stage, family functioning, overcrowding, and family support.

The literature review was conducted by consulting databases available through Infomed and using the Google Scholar search engine. Primary data were obtained by reviewing family health histories and individual medical records. In addition, interviews were conducted with older adults to obtain specific information on family functioning and support, using the FF-SIL family functioning perception test.

Data collection

The information gathered from documentary sources and interviews was entered into a data collection spreadsheet designed specifically for the purposes of this study. This tool allowed for the systematic organization of all information corresponding to the defined variables.

Data analysis

The data were processed using a database created in Microsoft Excel. Descriptive statistical techniques such as absolute frequency, percentage, arithmetic mean, and ratio were used to summarize the information. The results were presented in tables and graphs. The information was also analyzed and synthesized, comparing the results with the findings of other authors, and the conclusions of the study were reached using the inductive-deductive method.

Ethical aspects

During the research process, the statutes established in Cuban ethical standards for health science research were strictly complied with. Similarly, the bioethical principles enshrined in the Declaration of Helsinki were respected.

RESULTS

Males predominated (51,52 %), with the highest concentration in the 70-75 age group (21,21 %) and the 75-80 age group (21,55 %). The highest masculinity indices were recorded in adults aged 65-69 (189,47) and ≥85 (194,44) (table 1).

Table 1. Distribution of older adults studied according to age and sex

Age groups	Sex				Total		Masculinity index
	Male		Female				
	No	%	No	%	No	%	
60 to 64 years old	27	9,09	35	11,78	62	20,88	77,17
65 to 69 years old	36	12,12	19	6,40	55	18,52	189,47
70 to 75 years	14	4,71	49	16,50	63	21,21	28,57
75 to 80 years	41	13,80	23	7,74	64	21,55	178,26
85 and over	35	11,78	18	6,06	53	17,85	194,44
Total	153	51,52	144	48,48	297	100	106,25

58,92 % of older adults were classified as ill (Group III), followed by 22,90 % at risk (Group II). Only 5,39 % were identified as apparently healthy (Group I) (table 2).

Table 2. Distribution of older adults according to dispensary attendance		
Dispensary group	**No**	**%**
I. Apparently Healthy	16	5,39
II. At Risk	68	22,90
III. Sick	175	58,92
IV. Disabled and handicapped persons	38	12,79
Total	297	100

In the patient group, the most common conditions were high blood pressure (86,20 %), diabetes mellitus (67,68 %), and smoking (79,46 %). Heart disease (32,66 %) and psychiatric disorders (21,55 %) were the most relevant comorbidities after metabolic conditions (table 3).

Table 3. Distribution of older adults receiving outpatient care in group III according to personal medical history		
Personal medical history	**Population, n=297**	
	No	**%**
HTA	256	86,20
Diabetes Mellitus	201	67,68
Heart disease	97	32,66
Cancer	14	4,71
Glaucoma	37	12,46
Smoking	236	79,46
Motor disability	43	14,48
Kidney failure	21	7,07
Psychiatric disorders	64	21,55

A high prevalence of multimorbidity was observed, with most older adults presenting two or more simultaneous chronic diseases (figure 1).

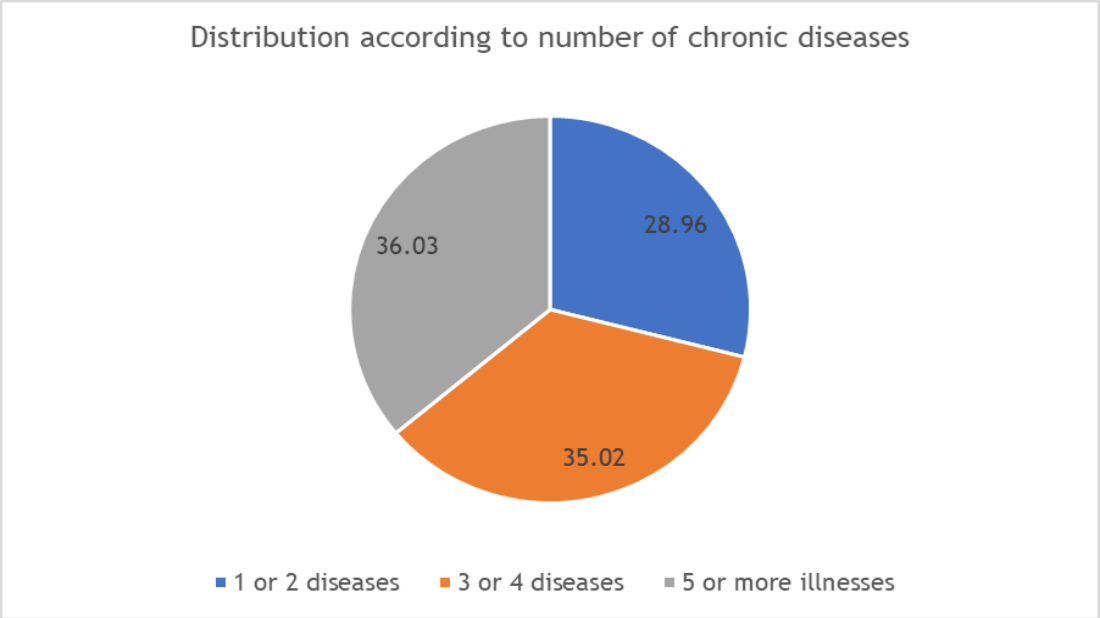

Figure 1. Distribution of older adults according to number of chronic diseases

Extended families (35,29 %) and enlarged families (33,82 %) predominated, with the majority being functional (72,06 %). Sixty-point-two-nine percent were in the “contraction” stage of the life cycle, and 20,59 % were overcrowded (table 4).

Table 4. Distribution of older adults according to different classification axes

Classification axes		Categories	No	%*
Structure	Ontogenesis	Nuclear	21	30,88
		Extensive	24	35,29
		Expanded	23	33,82
	Number of members	Small	19	27,94
		Medium	35	51,47
		Large	14	20,59
	Number of generations	Single generation	17	25
		Two-generation	14	20,59
		Three generations	21	30,88
		Multigenerational	16	23,53
	Functionality	Functional	49	72,06
		Moderately functional	10	14,71
		Dysfunctional	9	13,24
	Life cycle stage	Contraction	41	60,29
		Dissolution	27	39,71
	Overcrowding	No overcrowding	54	79,41
		Overcrowded	14	20,59

Note: *Calculated from the total number of families (n=68)

44,78 % were of normal weight, but obesity was observed in 13,13 % of men (vs. 5,72 % in women) and underweight in 9,76 % of women (vs. 4,71 % in men) (table 5).

Table 5. Distribution of older adults according to nutritional assessment and sex

Nutritional assessment	Sex				Total	
	Male		Female			
	No	%	No	%	No	%
Normal weight	59	19,87	74	24,92	133	44,78
Overtaking	41	13,80	24	8,08	65	21,89
Obese	39	13,13	17	5,72	56	18,86
Underweight	14	4,71	29	9,76	43	14,48
Total	153	51,52	144	48,48	297	100

93,27 % received full family support. The risk of domestic accidents (81,14 %) was the most common geriatric syndrome, and 92,93 % maintained full functional capacity. Urinary incontinence (22,56 %) was the main clinical complication reported (table 6).

Table 6. Distribution of older adults according to personal characteristics

Characteristics		No	%
Family support	Support for all needs	277	93,27
	Limited support	14	4,71
	Scarce support	6	2,02
	Total abandonment	0	0
Major geriatric syndromes	Risk of accidents in the home	241	81,14
	Urinary incontinence	67	22,56
	Immobility or confinement to bed	16	5,39
	Dementia	9	3,03
Disability	Fully capable	276	92,93
	Partial limitations	19	6,40
	Totally disabled	2	0,67

DISCUSSION

Population aging in Cuba, particularly in semi-urban contexts such as Palma Soriano, represents a multifactorial challenge for the health system. The comprehensive characterization of older adults receiving primary care reveals epidemiological, social, and functional dynamics that transcend demographic indicators, shaping a health profile with implications for geriatric policies.

The predominance of males in the total sample contrasts with studies such as those by Angulo et al.[6] in rural Cuban contexts, where a higher representation of females is reported. This discrepancy could be attributed to migratory or sociodemographic particularities of the locality studied, where there may be less labor mobility among older men compared to other regions. However, the higher masculinity in the 65-69 and 85+ age groups coincides with the findings of Diaz et al.[7] in Santiago de Cuba, suggesting regional patterns of male longevity potentially linked to lifestyles, genetic factors, or a lower prevalence of risk behaviors in these specific cohorts. The most numerous age group differs from the research by Espinosa et al.[8] in urban areas, which identified a higher concentration in the >80 age group, which could be explained by a younger demographic structure in the semi-urban area or by differential migratory flows of very old adults to urban centers.

With regard to morbidity, the high percentage of older adults in group III exceeds the 45 % reported by Bustamante et al.[9] This higher burden of chronic disease in our population could be a consequence of the accumulation of risk factors throughout life, combined with better access to diagnosis in primary care. However, it is consistent with the burden of morbidity described by PAHO in aging rural populations. The low proportion of "apparently healthy" individuals is consistent with studies such as that by Arévalo-Avecillas et al.[10], which report less than 7 % in this group, reflecting the high level of chronicity that characterizes aging populations.

Hypertension and diabetes exceed global prevalences but replicate trends in the Caribbean islands, as shown in the research by Félix López et al.[11], suggesting the influence of regional dietary factors and similar epidemiological transitions. Smoking doubles the Cuban national average, possibly reflecting historical cohorts as shown by Acosta Martínez et al.[12], indicating the persistence of habits acquired in past decades. The frequency of heart disease is in line with Briceño et al.[13], while renal failure is lower than reports from Mexico according to the study by Guerra et al.[14], a difference that could be due to variations in diagnostic criteria, access to nephrology services, or the prevalence of its main causal factors.

In the psychosocial sphere, the predominance of extended and enlarged families coincides with the support network model described by Cardozo et al.[15] in Cuban older adults, suggesting the persistence of supportive family structures as a coping strategy in the face of economic constraints. Family dysfunction is lower than in Brazilian studies such as that by Ferrony et al.[16], possibly due to cultural differences in the perception of family functionality, but overcrowding exceeds the 15 % observed in Havana by Gómez et al.[17], reflecting housing limitations typical of semi-urban areas. The "contraction" stage of the life cycle reflects the findings of Campos-Tapia et al.[18] on reduced family units in rural areas, a phenomenon associated with the emancipation of children and the aging of couples.

In terms of nutritional status, normal weight is lower than the 52 % recorded by Rodríguez et al.[19] in Camagüey, which could be related to differences in regional dietary patterns or access to varied foods. While male obesity is twice that of females, a pattern also documented by Corrales et al.[20], this could be explained by gender roles that keep men away from domestic food management. Underweight rates are higher among women than men, coinciding with Ekmeiro et al.[21] on nutritional risks in older women, perhaps associated with greater socioeconomic vulnerability or greater longevity with debilitating chronic diseases.

Total family support exceeds 85 % in Colombian studies such as that by Toneto et al.[22], supporting the Cuban model of multigenerational care and strong family ties as buffers against material deprivation. The high functional capacity contrasts with the 78 % in Spanish older adults reported by Chavarro-Carvajal et al.[23], which could be due to a selection effect or a more active aging pattern in this context, although the risk of domestic accidents is in line with WHO warnings about non-adapted environments, pointing to the need to implement home adaptation programs.

Study limitations

It is important to recognize the limitations of this research. The cross-sectional design does not allow causal relationships to be established between the variables analyzed, only associations. The focus on a single medical office limits the generalization of the results to other contexts, although it provides a detailed profile of this specific population. The reliance on secondary data from medical records may introduce information biases, as the quality and completeness of the records were not uniform. The assessment of family functioning, although using a validated instrument, is subject to the subjectivity of the participants. Likewise, the collection of data on socioeconomic status was based on declared income, which may not fully capture the actual economic situation of households. Future research should consider longitudinal designs that allow for tracking the evolution of this population and expand the sample to multiple clinics to obtain a more representative view of the region.

CONCLUSIONS

There is evidence of a geriatric population with a high burden of chronicity, where the extended/enlarged family structure acts as the predominant support despite moderate dysfunctions. The combination of nutritional risks, together with functional capacities preserved in most cases, coexists with environmental threats such as domestic accidents.

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CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

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