



## Elders' perception of quality of life\*

*Percepção de pessoas idosas sobre qualidade de vida*

*Percepción de personas ancianas sobre calidad de vida*

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### ABSTRACT

**Objectives:** To explore the perception of quality of life of elders from a health care district in Porto Alegre, RS, and to identify the most common dimensions of voice by the elders. **Methods:** This was a cross-sectional descriptive study using the following open question: What quality of life means to you? Participants consisted of 260 elders who were residents of Porto Alegre, RS. N-Vivo 2.0 was used to conduct content analysis by observing the dimensions of the Brazilian Portuguese version of the WHOQOL-100 and the module WHOQOL-OLD. **Results:** The majority of participants reported that quality of life was synonym of good health. The most common dimensions of quality of life were positive feelings, personal relationships, and access to food. **Conclusion:** The study's findings support that quality of life is a multidimensional construct that can be used to evaluated objectives and subjective parameters.

**Key Words:** Quality of life; Aged; Health of the Elderly.

### RESUMO

**Objetivos:** Conhecer a percepção de idosos de um distrito de saúde de Porto Alegre/RS sobre o significado de qualidade de vida e identificar quais as facetas de qualidade de vida foram mais referidas pelos idosos. **Métodos:** Estudo descritivo e transversal a partir de uma questão aberta: "O que significa QV para você?". Responderam a essa pergunta 260 idosos, moradores de Porto Alegre-RS. Foi realizada análise de conteúdo, com apoio do *software NVivo 2.0*, utilizando como categorias as facetas de QV propostas pela versão brasileira do instrumento WHOQOL-100 e módulo WHOQOL-OLD. **Resultados:** Para a maioria, QV significava ter Saúde. Em seguida, as categorias mais representativas foram: sentimentos positivos, relações pessoais e alimentação. **Conclusões:** Os achados reforçam a idéia de que QV é um conceito multidimensional, podendo ser analisada tanto por parâmetros objetivos como subjetivos.

**Descritores:** Qualidade de Vida; Idoso; Saúde do idoso.

### RESUMEN

**Objetivos:** Conocer la percepción de ancianos de un distrito de salud de Porto Alegre/RS sobre el significado de calidad de vida y identificar cuáles son las facetas de calidad de vida que fueron más referidas por los ancianos. **Métodos:** Estudio descriptivo y transversal a partir de una pregunta abierta: "¿Que significa CV para usted?". Respondieron a esa pregunta 260 ancianos, residentes en Porto Alegre/RS. Fue realizado el análisis de contenido, con apoyo del *software NVivo 2.0*, utilizando como categorías las facetas de CV propuestas por la versión brasileña del instrumento WHOQOL-100 y módulo WHOQOL-OLD. **Resultados:** Para la mayoría, CV significaba tener Salud. En seguida, las categorías más representativas fueron: sentimientos positivos, relaciones personales y alimentación. **Conclusiones:** Los hallazgos refuerzan la idea de que CV es un concepto multidimensional, pudiendo ser analizado tanto por parámetros objetivos como subjetivos.

**Palabras clave:** Calidad de Vida; Anciano; Salud del anciano.

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## INTRODUCTION

Changes in the world demographic profile have incited discussions and investigations from different perspectives in the most varied fields of knowledge. One of the fields that has been studied in the national and international contexts is related to Quality of Life (QoL) in old age. This is a subject much investigated in the international context by nurses and multidisciplinary teams as an important parameter in evaluating health policies and interventions, and, more specifically in nursing, to evaluate the quality of care delivery<sup>(1)</sup>.

Issues concerning the concept of QoL have been focus of discussions since the first philosophers<sup>(1)</sup>. Even today it is considered a complex construct and is differently interpreted and employed in several fields. One author<sup>(2)</sup> understands that the multidisciplinary use of this construct is exactly one of the factors determining the lack of consensus to define it. QoL is difficult to define and measure because cultural, ethical, religious and personal values influence its consequences and how it is perceived<sup>(3)</sup>.

Several terms have been used in the literature to define QoL: satisfaction with life<sup>(4)</sup>, well-being<sup>(3)</sup>, and the difference between one's real situation and the situation to which one aspires<sup>(5)</sup>.

Despite the different definitions of this concept, the majority of authors agree that one has to use a multidimensional approach<sup>(3-4)</sup> to evaluate QoL. Even though there is no consensus about the dimensions that constitute this construct, the most frequently reported are the physical, psychological, social and spiritual dimensions<sup>(6)</sup>.

QoL is also established on both objective and subjective parameters<sup>(7)</sup>. The subjective parameters would be well-being, happiness and self-realization among others, and the objective ones would be related to meeting basic needs and those created in a given social structure. The objective parameters are not subject to the observers' bias while subjective parameters allow people to make judgments about issues that involve their lives<sup>(8)</sup>.

In addition to issues related to the context, the multidimensionality and objective and subjective parameters, another aspect that the literature seems to have reached a consensus concerning the interpretation of QoL is that it should be based on personal perception<sup>(3-5)</sup>.

The concept of QoL emerged in the health field after a movement of humanization and valorization of other evaluation parameters beyond symptoms or epidemiological data such as incidence and prevalence of diseases<sup>(9)</sup>.

The *World Health Organization Quality of Life Assessment*<sup>(10)</sup> defined QoL based on the individuals' perception of their position in life. The concept adopted by the World Health Organization (WHO), in addition to showing concern with

the subjective aspect of QoL, also relates individual aspects to cultural, social and environmental contexts in which people are inserted. This concept was adopted in this study.

With the collaboration of research centers in 15 different countries, WHO developed and tested, from a cross-cultural perspective<sup>(11)</sup>, the WHOQOL-100. Recently, WHO developed the WHOQOL-OLD module, which was based on WHOQOL-100 and followed the same methodological approach, but permits a specific evaluation of older persons<sup>(12)</sup>. In general, studies that address the QoL of the older persons in international and national contexts investigate the perceptions of elderly people of the meaning of QoL<sup>(8,13-14)</sup> and the potential determinants of QoL for older persons<sup>(1,15)</sup>. There are also other studies that measure the QoL of older persons in the community<sup>(16-17)</sup>. There are also clinical trials that mainly focus on evaluating diseases in this age range.

The objectives of this study were: to explore the older adults perceptions about the significance of the QoL in a health district in Porto Alegre, RS, Brazil and identify, as well, the most referred QoL categories. This study was carried out based on a larger investigation addressing factors associated with QoL of elderly people in a health district of Porto Alegre<sup>(18)</sup>, in one of the regions in the city with the largest proportion of older persons. A population study using probabilistic sampling was carried out with 292 subjects through a household survey. The participants answered a questionnaire about social and economic characteristics and aspects related to health and disease in addition to the WHOQOL-BREF.

There is a scarcity of studies addressing the Brazilian context that can support actions and assessments of the health care delivered to older persons. Thus, in addition to demographic and morbidity data, understanding the perspective of these individuals concerning their QoL based on the local context is important in supporting interventions developed by the services responsible to provide health care to these individuals and to adjust educational programs for professionals in the field. As presented by some authors<sup>(14)</sup>, we believe that this study contributes empirical data that permit evaluating the validity of the construction of theoretical models and measures of QoL related to the aging process.

## METHODS

The study was a descriptive exploratory cross-sectional study developed with data collected in the second semester of 2004 for the larger investigation.

The Northwest district was chosen from among the 16 districts in the city because it has the second largest proportion of elderly people in the city: 20,302 inhabitants 60 years old and older according to the 2000 Census of the Brazilian Institute of Geography and Statistics,

amounting to 15.63% of the district's population<sup>(19)</sup>.

After completing the demographic and socioeconomic data form, 260 older persons, from the 292 selected at random in the larger study, responded to the open-ended question "What does QoL mean to you?". This open-ended question was asked before the WHOQOL-BREF was administered. When the participants were unable to write their answers, the interviewers transcribed their responses verbatim.

Qualitative Solutions Research NVivo® 2.0 was used to support the content analysis<sup>(20)</sup>. Coding notes were created using as pre-established categories the facets from the Brazilian versions of the WHOQOL-100 questionnaire and WHOQOL-OLD module. The WHOQOL-100 measure contains six domains: Physical, Psychological, Level of Independence, Social Relationships, Environment and Spirituality. These domains include 24 facets: *Physical Domain* – pain and discomfort, energy and fatigue, sleep and rest; *Psychological Domain* – self-esteem, body image and appearance, positive feelings, negative feelings, thinking, learning, memory and concentration; *Level of Independence Domain* – mobility, activities of daily living, dependence on medication or treatments and working capacity; *Social Relationships Domain* – personal relationships, social support, sexual activity; *Environment Domain* – physical safety and security, home environment; financial resources, health and social care, opportunities for acquiring new information and skills, physical environment, leisure opportunities, physical environment, transport; and the *Spirituality Domain* – spirituality, religious and personal beliefs. Each facet includes 4 items, giving a total of 96 items (96 questions). One additional facet (with 4 questions) is about global QoL and health. The WHOQOL-OLD module is comprised of 24 questions divided in to 6 facets: sensory abilities; autonomy; past, present and future activities; death and dying; social participation and intimacy<sup>(11-12)</sup>.

Analysis of data was conducted by two researchers independently with the purpose of achieving a further confirmability. Findings were compared and after discussion, final agreed upon version was identified.

The software used consists of a program that performs qualitative and quantitative data analysis and can be used in several research fields, permitting one to work with data originating from different data collection instruments<sup>(21)</sup>. The main function of the NVivo is to code text and store it in specific categories, managed in three spheres such as documents (where interviews are stored); nodes (where code-categorization is stored) and attributes (where individuals' characteristics are kept, e.g. age, gender, occupation). The program also permits identifying the frequency of citations present in each category.

Socioeconomic and demographic data were obtained from the original project SPSS data base. Descriptive

statistics analysis (mean and frequency) were calculated.

The larger investigation was approved by the Research Ethics Committee of the Federal University of São Paulo (Process number 0423/04). All participants were asked to sign a written informed consent form, ensuring them of confidentiality.

## FINDINGS

Among the elderly included in the study, 33.1% were male and 66.9% were female ranging from 60 to 94 years and mean age 71.3 years (DP 7,4). In relation to marital status, 54.5% of the respondents were not married or partnered and 21.1% reported living alone. Among the respondents, 23.2% had no education or less than 4 years of elementary education, 43.2% reported 4 to 8 years of study and 33.6% had 8 or more years of study.

As noted previously, pre-existing categories were used to code the answers of the 260 participants, based on the facets from the Brazilian versions of the WHOQOL-100 questionnaire and WHOQOL-OLD module. *In order to determine which category was most appropriate, it was sought consensus between the researchers. It was evident that there were connections among the categories.*

### Health

One *living with health*: theme cited by 109 older persons was *Health*, affirming that quality of life is

*"Not living with a serious health problem and having good health conditions"* [E.141].

*"Health is priority in quality of life"* [E.235].

However, *health* seems not only to be associated with absence of disease or not being in need of medical care or medication, but also related to having leisure activities and to the ability to work:

*"Being healthy is to have all these leisure resources I have"* [E.431].

*"Health you know... so we can work"* [E.408].

### Positive feelings

For 78 older persons, quality of life represents having positive feelings such as living and feeling well, being happy and living in peace:

*"Live in peace, with tranquillity and everything organised"* [E.242].

*"It is the state of emotionally and physically living well, feeling helpful and having peace. Disease belongs to everybody. By having*

*peace and harmony we will achieve happiness*" [E.245].

Living well is also related to positive circumstances in life:

*"Have everything we need to live well"* [E.101].

*"Have access to life pleasures"* [E.107].

### Personal Relationships

In relation to Personal Relationships, 71 older persons highlighted the social and family living as quality of life:

*"Living with family"* [E.102].

*"Having lots of friends, going to parties, and getting along with the neighbors"* [E.111].

*"Being with your own family...if they are ok and I am ok, everything is ok. They care about me and give me love"* [E.713].

But this living is also associated with an idea of not bother anybody, not being disturbed, having the family nearby and not feeling alone:

*"A united family without financial conflicts"* [E.232].

*"Have kids and family nearby"* [E.217].

The respondents' definitions seem to be also related to Social Participation category, concerning the satisfaction with the level and living opportunities.

### Financial resources

Quality of life, for 64 participants, was considered having the resources to acquire what they need, do what they like and not be dependent on others; it was also about being able to have an anxiety-free old-age considering their financial situation:

*"A good pension to assist me to get my necessities"* [E.105].

*"Not needing to ask people for charity"* [E.107].

*"Being able to live during the old age with the same conditions that I had when I was working"* [E.124].

*"Having the means to go out and exercise"* [E.256].

*"Have money to buy medicine and food"* [E.251].

### Recreation and Leisure opportunities

Furthermore, 54 older persons pointed out that having leisure activities (what also allowed them to live with other persons) was also viewed as quality of life:

*"Being able to go for a walk sometimes"* [E.109]

*"Living, going out, having fun, having somebody to talk"* [E.132].

*"Leisure and safety are essential for quality of life"* [E.234].

*"Participating in groups and having leisure, above all"* [E.406].

*The idea of having leisure associated with independence is also reported by the elderly:*

*"Walking, being able to do everything I want, cooking, sewing, painting."* [E.128].

Also highlighted, but with less frequency, were statements related to the following categories: "Health and social care"; "Home environment"; "Working capacity"; "Activities of daily living"; "Autonomy"; "Spirituality/religious/personal beliefs"; and "Social support". The responses addressed almost all the facets from the WHOQOL-100 six domains and all the WHOQOL-OLD facets. Only two WHOQOL-100 facets were not identified by participants: sexual activity and physical appearance.

There were also data related to diet and this category was not included in any WHOQOL-BREF or WHOQOL-OLD facets. Nevertheless, it was retained by researchers because it was frequently mentioned and considering that this facet could be to be related to other categories as financial resources and autonomy.

### Diet: having what to eat and having a healthy diet

Diet as an aspect of quality of life was highlighted by 66 older persons. For them, diet is associated with circumstances needed to buy food, have a healthy diet and eat what is most pleasant:

*"Have what to eat"* [E.148].

*"Adequate food in quality. I do no sugar. I eat, but moderately. I do no salt and carbohydrates (flour, sugar, salt)"* [E.446].

*"Considering the age we are, desire eating something and eat it."* [E.438].

## DISCUSSION

The data obtained suggest that when older persons define QoL they relate it to health. Data also suggest that health is not understood by participants as the absence of a disease but "...there is more to quality of life than health"<sup>(2)</sup>. Being healthy denotes the importance of being



away from the biological model, because, for older persons, having a controlled disease or taking medication do not make them feel sick. The responses related to health, capacity to work and leisure activities are also linked with autonomy and their experiences in life.

Social and psychological tension might speed up deterioration that is associated with the aging process<sup>(22)</sup>, thus, we understand that elderly people identify positive feelings, such as living well and in peace, as quality of life.

Personal relationships were emphasized by the respondents, considering the importance of family and friends giving support. Other studies point to the importance of personal relationships to maintain older adults' autonomy and maintain their health; this category does not relate only to receiving help, but also to feeling helpful, and supporting other people<sup>(22)</sup>.

QoL was also described in relation to having financial resources. This finding could be related to the fact that in Brazil many older persons live with reduced resources, work to complement their wages and support multigenerational residences<sup>(23)</sup>. On the other hand, economic security could be represented in terms of maintaining autonomy.

Although the opportunities for leisure activities are reduced for older persons, the participants highlight it as an important aspect of QoL. On the one hand, it demonstrates the importance that leisure activities have, and, on the other hand, shows that older people are looking for leisure alternatives in their homes and/or in the community.

In relation to the category, *diet*, added to the other WHOQOL categories, it is important to note that during the WHOQOL-OLD development in Brazil, during the focus groups, good appetite and eating well was an area considered to be relevant to QoL assessment<sup>(24)</sup>, although this item was not retained in the final module.

As already mentioned, the association of QoL with more than one category was identified in the individuals' reports, which seems to reinforce the concept's multidimensionality. Similarities were found in the comparison between the categories most reported in this study and definitions identified in other Brazilian and international studies, as described in the following.

The WHOQOL-OLD<sup>(24)</sup> project carried out with elderly people in Porto Alegre investigated the QoL concept and its determinants and obtained results fairly close to those found in this study. QoL was defined among the studied elderly individuals as: feeling well; health; sociability; social support; physical activity; possibility of giving support; feeling of usefulness; stable financial condition and good life conditions. The authors of the article addressing the development of the WHOQOL-OLD<sup>(25)</sup> module also report that in a re-analysis of the data obtained with the WHOQOL-100, elderly people

also related great satisfaction with aspects concerning social support, social relationships, finance and aspects concerning the home environment.

The authors<sup>(26)</sup> of another study analyzed the prevalence of positive evaluations of QoL and aspects considered determinant for this evaluation in a community of octogenarians in RS, Brazil. A little more than 77 interviewed individuals positively evaluated their current QoL and related it with multiple categories such as activity, income, social life and family relationship. For the study participants, the main factor determining a poor QoL, was not being healthy. Despite the different questions presented by both studies, issues related to personal relationships, financial resources and health present similar results.

Studies<sup>(2,8,14,27)</sup> in which researchers analyze the definitions of QoL based on the individuals' perspectives are highlighted in the international context. In two studies<sup>(2,8)</sup> that evaluated the dimensions of QoL, the ones most mentioned by the elderly people were: family, social contact, health, mobility, material circumstances, activities, happiness, youth and home environment.

Aiming to inform development of health related quality of life scales, a study was developed in Great Britain<sup>(27)</sup> with 2000 adult members of the population about the five most important aspects of their lives. The most cited were: their relationship with their family and relatives, followed with their own health, the health of a close person and finances/standard of living/housing.

In another study with 999 British older adults<sup>(14)</sup> on QoL definitions, the constituents of a good QoL most frequently cited were: having good social relationships (81%), followed by social roles and activities (60%), health (44%), psychological well-being (38%), and neighbourhood leading to social integration and safety (37%), having no financial worries, and independence (33% and 27%, respectively).

Despite the fact that these studies cited above were completed in developed countries with diverse cultures, it is nevertheless possible to note that the aspects of QoL were similar to those found in the present study. However, good social relationships were cited more frequently in the afore mentioned studies, while health was most frequently identified in the present investigation.

Other investigation<sup>(13)</sup> with older Canadian adults' perceptions about constituents of QoL utilising both qualitative and quantitative, identified that for them, QoL, essentially meant personal control and autonomy in decision making. The author pointed out that the findings challenge traditional beliefs related to frailty, vulnerability and the desire for personal controlling. Some similarities exist with the findings of this study too, although the respondents' perspectives go beyond the individual autonomy and independence noted by Brazilian older

adults. Considering that in Brazil many people are worried about their basic necessities; hence, perhaps personal control and autonomy in decision making at the collective level were not mentioned.

In relation to the two WHOQOL-100 facets that were not identified by the respondents (sexual activity and physical appearance), the researchers noted similar observations at the Brazilian WHOQOL-OLD module development paper<sup>(24)</sup>. They mentioned that the respondents considered all facets from the WHOQOL-100 to be relevant, including the two cited facets. They argue that perhaps sexual activity per se is less important for this age group than intimacy and, physical appearance is not as important to elderly people as for young people.

## CONCLUSIONS

According to the perceptions of the individuals

participating in this study, QoL means being healthy, living well, getting along with family and friends, having food and healthy eating habits, being able to have leisure activities and having resources to meet their needs. These people also reinforced that QoL is a multidimensional construct and that perceptions of individuals concerning QoL have specific meanings for this age range.

Understanding how older persons perceive the aging process coupled with the notion of QoL allows nurses and other health professionals to devise strategies for actions focusing beyond the disease. Understanding what elderly people value and how they experience their health issues, social relationships, family life, leisure, work and also the means of meeting their basic needs, permits us to find a strategy to work in the mode of health promotion, helping current and future older persons to navigate this stage of life and to implement plans and undertake actions that contribute to change the Brazilian health care model.

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