INSTRUCTION, SOCIAL ECONOMIC STATUS AND EVALUATION OF SOME DIMENSIONS OF OCTOGENARIANS' QUALITY OF LIFE[1]

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Objectives: To describe the profile of a sample of octogenarians (n=80) attended at the municipal health network of a city in the interior of São Paulo, Brazil; evaluate their perception regarding quality of life dimensions (QoL); identify correlations between socio economic status, education level and QoL. It is an exploratory descriptive study with a quantitative analysis of data. The results revealed that this population is predominantly female, widowed, illiterate, sedentary and poor, who need health services and leisure opportunities, and whose main support is religion. The socio economic status did not interfere in the QoL perception, though, higher education and participation in physical activities result in higher satisfaction.

DESCRIPTORS: aged; aging; health of the elderly; quality of life; poverty

NÍVEL DE INSTRUCCIÓN, SOCIOECONÓMICO Y EVALUACIÓN DE ALGUNAS DIMENSIONES DE LA CALIDAD DE VIDA DE OCTOGENARIOS

Objetivos: describir el perfil de una muestra de octogenarios (n=80) atendidos en la red municipal de salud de una ciudad del interior del Estado de São Paulo, Brasil; evaluar su percepción sobre las dimensiones de la calidad de vida (CV); e identificar correlaciones entre el status socioeconómico, nivel de instrucción y CV. Se trata de un estudio exploratorio descriptivo de aproximación cualitativa de los datos. Los resultados revelaron que esta población es predominantemente femenina, viuda, analfabeta, sedentaria y pobre, que le faltan servicios de salud y oportunidades de ocio, admitiendo la religión como el mayor apoyo. El status socioeconómico no interfirió en la percepción de la CV. Sin embargo, observamos tendencia de que mayores niveles de instrucción y participación en actividades físicas resultan en mayor satisfacción.

DESCRIPTORES: anciano; envejecimiento; salud del anciano; calidad de vida; pobreza

NÍVEL DE INSTRUÇÃO, STATUS SOCIOECONÔMICO E AVALIAÇÃO DE ALGUMAS DIMENSÕES DA QUALIDADE DE VIDA DE OCTOGENÁRIOS

Os objetivos deste trabalho foram: descrever o perfil de uma amostra de octogenários (n=80), atendidos na rede municipal de saúde de uma cidade do interior do Estado de São Paulo, Brasil; avaliar a percepção desses acerca das dimensões da qualidade de vida (QV) e identificar correlações entre o status socioeconômico, nível de instrução e QV. Trata-se de estudo exploratório descritivo, de abordagem qualitativa dos dados. Os resultados revelaram que essa população é predominantemente feminina, viúva, analfabeta, sedentária e pobre que carece de serviços de saúde e oportunidades de lazer, admitindo a religião como o maior apoio. O status socioeconômico não interferiu na percepção da QV, contudo, observa-se que há tendência de que maiores níveis de instrução e participação em atividades físicas resultem em maior satisfação.

DESCRITORES: idoso; envelhecimento; saúde do idoso; qualidade de vida; pobreza

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INTRODUCTION

The World Health Organization estimates a 223% increase, between 1970 and 2025, in the number of people aged sixty or more[1]. Considering that older people do not comprise a homogeneous group, the diversity among individuals tends to increase. From this perspective, the concern with the development of actions that share values, despite the differences, involves an inclusive, flexible and dynamic signification that values people[2]. This process should support the optimization of knowledge and talents that encourage under-skilled people, satisfying their individual needs, so that they all feel welcomed, understood and respected regarding their different forms of being, learning and living[3,4].

We are currently undergoing a demographic revolution, in which adults aged over 80 comprise the group with the (proportionally) highest growth in the world. Today, the total number of octogenarians is approximately sixty-nine million; that is, 1% of the planet population, and 3% of developed countries' population[1]. In this context, governments, international organizations and civil society are called upon to promote health in its broadest perspective, surpassing the simplistic remediation view, and assure access to medical appointments, hospitalizations and medications[5]. Healthy aging should have a broader character. It should be recognized that health care and physical integrality are as important as an active participation in social, economic, cultural, spiritual and civil relationships that aim at elders' autonomy and independence. These activities should take place through a continuous process of education, growth, updating and personal fulfillment; and should include elders as effective members in the construction of society.

Broad, well founded knowledge about aging should be incorporated in curricula and training programs, so that students and workers from the social, health, recreation, urban planning and architecture areas work in collaboration and have the conditions needed to perform functions in agreement with the new demographic demands[1].

In this perspective, public policies are challenged to open new horizons to the elderly age group, which is expected to reach 1.2 billion people in 2025[1]. There is an urgent need for circumstances favorable to increasing situations of sharing, living together, as well as the possibilities of choice. Indispensable adjustments to accessibility are mandatory as well. The integration between preservation and improvement in every community's wellbeing should be the focus of reflections, questionings, discussions and action plans in every dimension, so that aging can be a positive experience followed by infinite possibilities, resources and opportunities. Otherwise, we reach a merely quantitative advantage, adding years to lives without a qualitative concern to also add "life" to the years[6].

Quality of life depends on several determining factors that derive from a history of interpersonal and environmental interactions in a continuous interplay of past and present external and internal influences[7]. Bronfenbrenner's *biologic approach* appoints that a developing person's characteristics are strongly entwined with the social tissue. According to this systemic conception, the proposals will only make sense if the exchange processes that take place in as well as among the systems comprised by individuals, their caregivers, families and other contexts are taken into consideration[8].

Different from what happens in international literature, there are still few studies in our environment that specifically address elderly's quality of life. The lack of information regarding their perceptions, objectives, expectations, concerns and main difficulties need further investigation so as to better understand the tracks we must follow in terms of public policies and implementing services that meet the true needs and expectations of old age[9].

Therefore, we elected people aged 80 or more as the target population of our study, which aimed to: (a) describe their socioeconomic profile; (b) assess their perception regarding quality of life dimensions; and (c) identify correlations between their socioeconomic *status*, education level and total score obtained on the Alzheimer's quality of life scale (QOL-AD)[10]. At this moment, it should be clarified that we adopted the following quality of life dimensions to be investigated: physical health, eagerness, mood, housing, memory, family, marriage, friends, the overall you, ability to accomplish tasks, ability to carry out leisure activities, money, and life in general*.

METHODS

We performed an exploratory, descriptive study, with a quantitative approach. Data were

* These three magnitudes are components of the Quality of Life Scale

collected from August 2006 to March 2007, at a medium-sized municipality in Central Sao Paulo State, Brazil, with a population of 210,000, 12% of which is aged 60 years or more[11].

Study subjects were 80 elderly people, users of the municipal health system in 2006, who met the inclusion criterion: being at least eighty years old. The eligible participants were selected through a draw. The first 80 subjects who agreed to participate comprised the study sample.

Data collection instruments were:

(a) characterization form and semistructured interview script: elaborated by the researcher to collect personal information and data about social living, recent life events, family composition, hobbies and physical activities;

(b) Brazil Criterion Questionnaire[12]: a scale that divides the population into seven social classes (A1, A2, B1, B2, C, D, and E) by means of an evaluation of the family purchase power, based on the number of durable consumer goods, instruction level of family head and some other factors, such as having a house maid. People with the highest purchase power were categorized as "A1", and those with lowest as "E";

(c) The quality of life with Alzheimer's Disease assessment scale (QOL-AD)[10]: a translated and cross-culturally adjusted instrument validated for Brazil to assess the quality of life of caregivers and elderly with Alzheimer's. The thirteen scale aspects evaluated by the participant are: physical health, eagerness, mood, housing, memory, family, marriage, friend, the overall you, ability to accomplish tasks, ability to carry out leisure activities, money, and life in general.

The following scores were used: 1 for "bad"; 2 for "regular"; 3 for "good"; and 4 for "excellent". The overall minimum score was 13 and the maximum 52. This instrument was chosen since it was elaborated for elderly with cognitive alterations and probable Alzheimer's Disease, but also for their caregivers, who do not necessarily present any health problems nor are aged over 60. Therefore, it is appropriate for any person. Moreover, since the average prevalence of Alzheimer's Disease in the world population is 16.22% among people aged between 80 and 84 years, reaching 54.83% for individuals over 95[13], we sought an instrument that would not exclude any person who met the research inclusion criteria, so that the results would show an overall profile of octogenarians.

After being approved by the Institutional Review Board at Sao Carlos Federal University, elderly who met the inclusion criteria, along with their lawfully responsible caregivers, were informed about the research and its objectives. Those who agreed to participate provided written consent and answered the instruments mentioned in the previous paragraph. A single meeting with each participant was enough to collect and record the data.

The collected data were inserted in a database, using the *Statistical Program for Social Sciences* (SPSS-PC) *for Windows*, version 10.0, for statistical calculations and analyses.

RESULTS

Of all the participants (n=80), 58 were women (72.5%) and 22 men (27.5%). Average age was 83.56 (±3.47, x_{min}=80, x_{max}=95) and 83.00 years (±2.91, x_{min}=80, x_{max}=90), respectively.

In terms of education, 60 (75%) were illiterate or had not concluded elementary education; 10 (12.5%) had complete elementary or incomplete primary education; 2 (2.5%) had complete primary or incomplete secondary education; 5 (6.3%) had complete secondary or incomplete higher education; and 3 (3.8%) had complete higher education.

Data concerning average family income in Brazilian Reais, obtained through the Brazil Criterion socioeconomic questionnaire[12], revealed that 8 (10%) participants received R$2804; 10 (12.5%) received R$ 1669; 24 (23%) received R$ 927; 37 (46.25%) received R$ 424; and 1 (1.25%) received R$ 207.

Regarding family composition, we verified that 7 (8.8%) were single and without children, 33 (41.3%) were married with children, and 40 (50%) were widowed. No subjects reported being separated or divorced. As to the relation between the variables gender and marital status, 15 men and 18 women had a companion; widows were the majority, at a ratio of 33:7, and single subjects were all women.

In terms of their participation in activities they considered enhancing to their health or quality of life, 41 octogenarians (48.8%) reported having no access; 29 (36.6%) reported religion as a source of happiness, pleasure, or comfort; 3 (3.8%) practiced physical therapy; 2 (2.5%) followed psychological treatment; 2 (2.5%) did craft work; 1 (1.25%) was an elderly club member; 1 (1.25%) took part in a university program for elderly; and 1 (1.25%) followed occupational therapy treatment.

As to sports activities, only women (1.3%) reported being a health club member, 21 (26.3%) went walking at least once a week, and most (n=58; 72.5%) did not do any physical activity at all.

In terms of the total scores obtained on the QOL-AD[10], on a scale from 13 to 52 possible points, the lowest score was 19 and the highest was 48 (Figure 1).

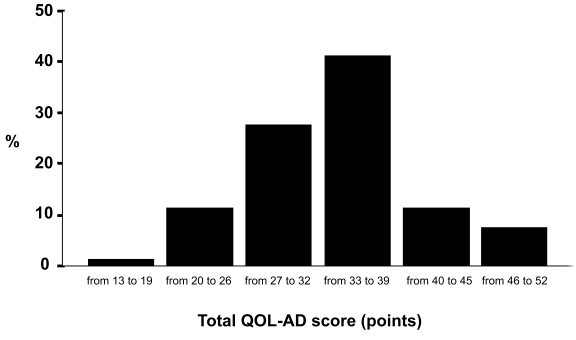

Figure 1 - Distribution of scores obtained by QOL-AD

The evaluation frequencies participants reported about their quality of life dimensions are shown in Table 1.

Table 1 - Octogenarians' self-perception about quality of life dimensions

Dimensions	Self-perception								Total	
	Good		Regular		Good		Excellent			
	n	%	n	%	n	%	n	%	n	%
Physical Health	11	13.8	34	42.5	30	37.5	5	6.3	80	100
Eagerness	17	21.3	22	27.5	30	37.5	11	13.8	80	100
Mood	7	8.8	15	18.8	45	56.3	13	16.3	80	100
Housing	-	-	7	8.8	68	85	5	6.3	80	100
Memory	16	20	16	20	28	35	20	25	80	100
Family	-	-	1	1.3	64	80	15	18.8	80	100
Marriage (relationship)	-	-	3	3.8	52	65	25	31.3	80	100
Friends	5	6.3	7	8.8	47	58.8	21	26.3	80	100
The overall you	2	2.5	24	30	43	53.8	11	13.8	80	100
Ability to accomplish tasks	24	30	13	16.3	30	37.5	13	16.3	80	100
Ability to perform physical activities	23	28.8	20	25	27	33.8	10	12.5	80	100
Money	22	27.5	50	62.5	8	10	-	-	80	100
Life in general	8	10	40	50	29	36.3	3	3.8	80	100
Total	**135**	**12.97**	**252**	**24.22**	**501**	**48.19**	**152**	**14.62**	**1040**	

When octogenarians' information regarding the socioeconomic *status* is crossed with education level and total QOL-AD[10] score, there is no statistically significant correlation regarding education level and quality of life. However, it can be stated that there is a tendency towards higher scores among people with higher education levels (Figure 2). Participants who were used to walking were more fulfilled (m=38.2381, sd=5.27) compared to sedentary participants (m=32.9138, sd=6.2836), t(77)=3.463, p<0.001 (Figure 3). It appears that the average monthly income is not affected by subjects' quality of life. (Figure 4).

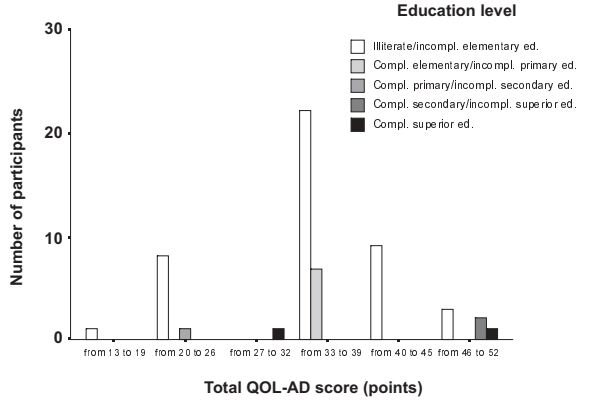

Figure 2 - Distribution of octogenarians per education level and total quality of life score obtained through the QOL-AD

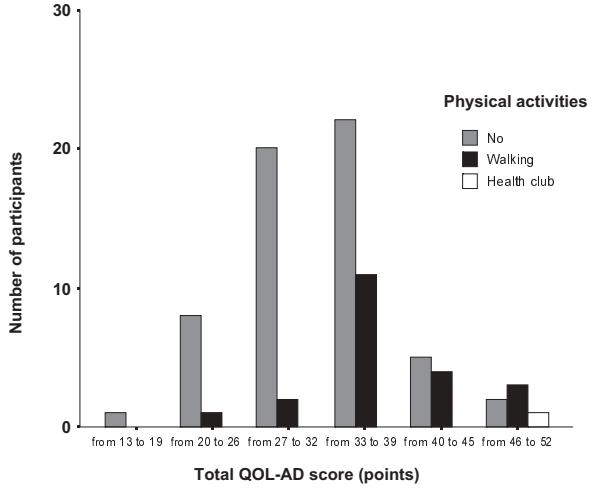

Figure 3 - Distribution of octogenarians per physical activity performance and total quality of life score obtained through the QOL-AD

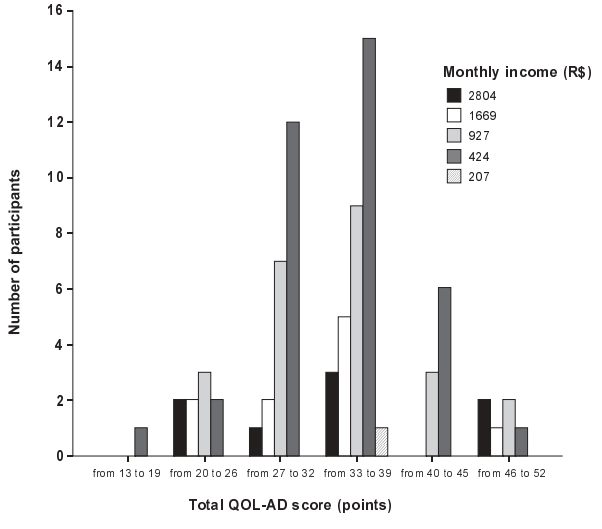

Figure 4 - Distribution of octogenarians per average monthly income and total quality of life score obtained through the QOL-AD

DISCUSSION

Our research is in agreement with numerous studies that point at the prevalence of females in the elderly population. This information is important for planning and implementing intervention programs and preventive health actions.

In terms of education, it is worth observing that high illiteracy rates are due to difficult access to school. Men had higher education levels compared to women, and all participants with complete higher education were men. That was expected since, in the past, culture did not value women's school education. In fact, women were often raised to be good wives, mothers and housewives. Today, it is better understood why many public incentives and non-governmental actions focus on literacy and continuous education programs for adults and elderly.

Regarding socioeconomic *status*, according to pre-existing data about the Sao Paulo population[12], we expected to find a greater concentration of individuals with an average family income of R$927.00; however, the majority of the sample (n=37, 46.25%) received an income lower than approximately R$ 424.00. This data is important, since inferior incomes could limit people's access to nutritional and social care, especially for health and education, significantly compromising people's quality of life.

The subjectivity of the quality of life construct was confirmed in our study, evidencing that welfare is influenced by multiple factors, which are not limited by time, as well as socioeconomic, cultural and health conditions.

CONCLUSIONS

The study population's profile mainly consists of female widows, illiterate or with incomplete primary education, from classes "C" or "D". In addition, they do not practice any kind of physical activity, complain about the lack of leisure opportunities for their age groups, and their greatest encouragement for quality of life is religion. They lack access to health services like occupational therapy, physical therapy and psychological treatments.

Old age is a moment in the life cycle in which biopsychosocial interactions are very narrow[14,15] and most of the study subjects were fulfilled with their family, marriage, close relationships and their place of residence. Nevertheless, it is important to stress that none of them were staying in shelters, nursing homes, hospitals or institutions. This may have caused a positive bias in the evaluation of these variables.

The average monthly income was the highest point of the octogenarians' dissatisfaction. However, we did not find any relationship between the individuals' self-perception and their real socioeconomic level; that is, many of those with higher income reported being just as dissatisfied as those with lower incomes. The most frequent complaints regarded health, readiness and lack of leisure options for the elderly.

It appears that the researchers' socioeconomic level did not have any positive effect on the perception of overall quality of life. However, the obtained data suggest a tendency of higher educational levels and involvement in physical activities, resulting in higher QOL-AD scores. This directs us to the concern that public policies should encourage the organization of physically appropriate and safe areas for walking or doing adapted exercises. Moreover, education and learning resources should be permanently promoted with a view to minimizing the cultural distance between generations, which could cause loneliness and social isolation. In addition, just as important as the availability is the diffusion of these resources in the community, so that people have the right to choose between participating or not in what is offered in their area, in terms of resources and activities.

We recognize that this study does not permit us to make generalizations due to some methodological limitations; for example, it is a specific experience, in one city, with a relatively small number of participants (n=80). It would also be interesting to compare the sample with a group of elderly younger than 80, since it would permit a better assessment on the impact of age on people's quality of life. However, the importance of studying populations aged over 80 years can be argued, due to the scarcity of studies on these subjects and the accelerated demographic increment of elderly around the world.

Despite these limitations, and based on the obtained results, it can be affirmed that people with advanced age have lived in adverse conditions regarding their access to empowerment opportunities and resources. It should be emphasized that aging-elated issues should consider the entire diversity the universe of people aged over sixty represents.

FINAL CONSIDERATIONS

With health advancements, the tendency that people will live longer is incontestable. Therefore, it should be seen to that this track be pursued in the most satisfactory way possible, by means of planning processes that optimize access to resources and opportunities of maintaining and improving social participation, welfare, independence and dignity.

It is indispensable that information be collected among the elderly population, investigating economic, cultural and emotional aspects, so that governmental strategies favor the implementation of programs that promote the improvement of elders' quality of live, based not only on their constitutional rights, but also an their real needs. By identifying the target population's profile, as well as their specificities, it is possible to make personalized interventions that contribute to improve quality of life and reduce public expenses on health care.

The professionals involved, especially those in health and social services, require continuous training and empowerment so they can offer services compatible with the new demographic demands. Modules about healthy aging, as well as instruction concerning self-care, health maintenance and enhancement should be incorporated into training courses, as the basis for the consensual construction of new approaches that respect generation differences, without discrimination.

Since the family environment can be the source of support for dealing with adversities, the encouragement and strength for partnerships between family and professional caregivers could minimize the difficulties both experience. Through mutual effort, we can think of all the preventive measures and interventions that would ensure that aging is seen as a conquest, by means of the resignification of negative values and stereotypes associated with old age.

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