Identificación de niveles de calidad de vida en personas con un rango de edad entre 50 y 85 años

Identification of levels of quality of life in people with a range of between 50 and 85 years old

Identificação dos níveis de qualidade de vida em pessoas com idade entre 50 e 85 anos

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Resumen

La calidad de vida es la percepción que cada persona tiene sobre su salud, emociones y, en general, bienestar. Es importante diferenciar la calidad de vida del nivel de vida, ya que el primero está relacionado con la percepción de cada sujeto y el segundo se refiere al aspecto económico. El objetivo aquí es identificar el nivel de calidad de vida que presentan las personas mayores. Para ello se aplicó en un solo momento la escala de calidad de vida WHOQOL-BREF a veintinueve personas mayores en un rango de edad de 50 a 85 años que acuden a dos grupos de apoyo diferentes. En los ítems No. 1 y 2, 21 % (seis sujetos) obtuvieron valores menores a 3, calificando su calidad de vida como negativa y salud insatisfecha, en comparación con 79 % que califica esos dos rubros (calidad de vida y salud) como normales y muy buenos. En el ítem No. 26, 21 % de los sujetos de estudio muestra altos niveles de frecuencia de tristeza, sentimientos negativos y desesperanza, contrastando con el restante 79 %, que presenta satisfacción con su calidad de vida y salud, es decir, baja

frecuencia de sentimientos negativos. Sólo 7 % (dos personas) presenta una percepción negativa en los dos rubros. En conclusión, cerca del 80 % de los sujetos de estudio se muestra satisfecho con su calidad de vida y percibe una salud acorde a su edad. Se identifica en riesgo al 7 % de la población, al tener una autopercepción de su calidad de vida y salud como muy mala y muy insatisfecha. Se recomienda diseñar un programa de intervención gerontológica para evitar un riesgo mayor.

Palabras clave: Calidad de vida, salud, Personas Mayores.

Abstract

Quality of life is the perception that each person has your health, emotions and, in general, welfare. It is important to differentiate the quality of life of the standard of living, since the first is related to the perception of each subject and the second refers to the economic aspect. The objective is to identify the level of quality of life in older people. This was applied in a moment the quality of life, WHOQOL-BREF scale to twenty-nine elderly people in a range of 50 to 85 years old who attend two different support groups. In items no. 1 and 2, 21% (six subjects) values obtained less than 3, as their quality of life as negative and unmet health, compared with 79% qualifying these two products (quality of life and health) as normal and very good. Item No. 26, 21% of the subjects of study shows high levels of frequency of negative feelings, sadness and hopelessness, contrasting with the remaining 79%, that shows satisfaction with their quality of life and health, i.e., low frequency of negative feelings. Only 7% (two people) shows a negative perception in the two areas. In conclusion, about 80% of the subjects of study is satisfied with their quality of life and perceived health according to their age. Are identified at risk to 7% of the population, have a self-perception of their quality of life and health as a very bad and very dissatisfied. We recommend designing a gerontological intervention program to prevent one increased risk.

Key Words: quality of life, health, seniors.

Resumo

A qualidade de vida é a percepção de que cada pessoa tem sobre a sua saúde, emoções e bem-estar geral. É importante distinguir a qualidade de vida do nível de vida, uma vez que a primeira está relacionada com a percepção de cada sujeito e o segundo refere-se ao aspecto económico. O objetivo aqui é identificar o nível de qualidade de vida que apresentam os idosos. Para este foi aplicado em um único momento a escala de qualidade de vida WHOQOL-BREF a vinte idosos na faixa etária de 50-85 anos, alunos de dois grupos de apoio diferentes. Nos itens No. 1 e 2, 21% (seis

indivíduos) apresentaram valores inferiores 3, descrevendo a sua qualidade de vida como negativo e de saúde não atendidas, em comparação com 79% qualificando estes dois itens (qualidade de vida e saúde) como normal e muito bom. No item nº 26, 21% dos sujeitos do estudo mostram uma alta frequência de tristeza, sentimentos negativos e desespero, em contraste com os restantes 79%, que tem satisfação com a sua qualidade de vida e saúde, ou seja, de baixa frequência sentimentos negativos. Apenas 7% (duas pessoas) tem uma percepção negativa nas duas áreas. Em conclusão, cerca de 80% dos sujeitos do estudo foram satisfeitos com a sua qualidade de vida e percebe uma saúde de acordo com a sua idade. Ele está em risco de 7% da população, tendo um auto-percepção de sua qualidade de vida e saúde como muito ruim e muito insatisfeito. Recomenda-se a projetar um programa de intervenção gerontológica para evitar mais riscos.

Palavras-chave: Qualidade de vida, saúde, Idosos.

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Introduction

Frequently relates to the quality of life with economic perception. It is very easy to confuse the terms quality of life and standard of living, since both terms revolve around the person; however, there are substantial differences that are then explained: the standard of living is linked with the economic aspect and the monetary perception of the individual, i.e., external, material and surface aspects; on the other hand, the term quality of life refers to the perception that has the person on their health condition, an aspect more related to feelings, the internal.

Quality of life is:

> … individual perception of one's position in life within the context of the cultural system and values in which we live in relation to their goals, expectations, standards and concerns. Is a concept of broad-spectrum, including complex shape the physical health of the person, his psychological state, their level of independence, social relationships, personal beliefs and their relationship with the relevant characteristics of its environment (OMS, 1994, quoted by OMS 2002, p. 98).

Quality of life is related to what the person perceives the world, their relationships with people coming and the treatment received by all persons and the different situations in which it is immersed.

> Over time an attempt to give a definition covering all edges of the concept of quality of life, its subjective and objective components where the point in common is the individual WELFARE. Subjective aspects can be grouped into 5 main domains: physical well-being (such as health, physical security), material well-being (privacy, possessions, food, housing, transportation), social welfare (interpersonal relationships with family, friends, etc), development and activity (education, productivity and contribution), and emotional well-being (self-esteem, status with respect to others, religion). However, it is important to understand that the answer to each of these domains is subjective and highly variable due to the influence of social factors and materials, the same age of the person, their employment situation or health policies (National Institute of Medical and Nutrition Sciences Salvador Zubirán, 2013, p.1).

This perception that the person has about their quality of life depends a lot on external factors, such as the economy and their family relationships, to mention a few. And it is changing as financial independence is lost, especially in people who have worked for a great part of their lives, been productive and totally independent. What happens when the person no longer has the same rhythm of life, the same routine? What happens when the person reaches the age of retirement and now has more time but less resources? The picture changes considerably, since it is now perceived that the person is worth according to the economic contribution he makes in the family. When his contribution decreases, his value decreases within the family; In addition are the pathologies that are emerging by age and for which it requires economic resources to be attended to. Then his situation is transformed and he ceases to contribute an "income" to become an "egress", a burden for the family, in which if he is not prepared psychologically and economically to face this new stage, more conflicts arise. All this affects the health of the elderly person and the way they perceive their quality of life. Experts point out that it is important to prepare in advance for retirement, to reduce the negative impact that is experienced when retiring and for the family and the elderly to perceive that moment as an opportunity to carry out activities that they could not do because of lack of time.

The gerontologist is the health professional who has the skills to perform the previous work that allows to improve the scenario at the time of retirement, through the application of strategies in the family and the elderly person, and the creation of activities and networks support. In this sense, the family is the first and most important support network, which is the one that offers the first moral aid. The closest relatives can support the elderly person to feel always accompanied and avoid falling into depression. If the family fails or is disintegrated, then the State through different public instances must collaborate in the care of the elderly person.

The following table gives an overview of the aspects that define the concept of quality of life.

Table 1. Various definitions for the concept of quality of life.

REFERENCIA	DEFINICIÓN PROPUESTA
Ferrans (1990b)	Calidad de vida general definida como el bienestar personal derivado de la satisfacción o insatisfacción con áreas que son importantes para él o ella.
Hornquist (1982)	Define en términos de satisfacción de necesidades en las esferas física, psicológica, social, de actividades, material y estructural.
Shaw (1977)	Define la calidad de vida de manera objetiva y cuantitativa, diseñando una ecuación que determina la calidad de vida individual: QL=NE x (H+S), en donde NE representa la dotación natural del paciente, H la contribución hecha por su hogar y su familia a la persona y S la contribución hecha por la sociedad. Críticas: la persona no evalúa por sí misma, segundo, no puede haber cero calidad de vida.
Lawton (2001)	Evaluación multidimensional, de acuerdo a criterios intrapersonales y socio-normativos, del sistema personal y ambiental de un individuo.
Haas (1999)	Evaluación multidimensional de circunstancias individuales de vida en el contexto cultural y de valor al que se pertenece.
Bigelow et al., (1991)	Ecuación en donde se balancean la satisfacción de necesidades y la evaluación subjetiva de bienestar.
Calman (1987)	Satisfacción, alegría, realización y la habilidad de afrontar… medición de la diferencia, en un tiempo, entre la esperanza y expectativas de una persona con su experiencia individual presente.
Martin & Stockler (1998)	Tamaño de la brecha entre las expectativas individuales y la realidad a menor intervalo, mejor calidad de vida.
Opong et al., (1987)	Condiciones de vida o experiencia de vida.

Tomado de Urzúa, A. y Caqueo-Urizar, A. (2012). Calidad de vida, una revisión teórica al concepto. http://www.scielo.cl/pdf/terpsicol/v30n1/art06.pdf

OBJECTIVE

To identify the level of quality of life presented by the elderly.

MATERIALS AND METHODS

Selection criteria. Persons within the age range of 50-85 years, indistinct gender, who come to the support groups located in the following places: Community Development Center of Leovigildo Gómez and Association of Retired and Pensioners of the ISSSTE that meet in the facilities of The CNOP, in the City of San Francisco de Campeche, Campeche, Mexico.

Instrument. The Whoqol-Bref Quality of Life Measurement Instrument was used, which consists of three sections: the first part is identification data such as gender, date of birth, studies, marital status, health problems, labor aspect; The second part begins with the indications to solve the five categories or dimensions: I. Integrates two items: No. 1 and 2, related to their quality of life and satisfaction with their health; II. It integrates seven items: No. 3, 4, 5, 6, 7, 8 and 9 related to their perception of pain, enjoyment of life, concentration and physical environment, among other aspects; III. It integrates six items: No. 10, 11, 12, 13, 14 and 15, related to physical independence; IV. It integrates ten items: No. 16, 17, 18, 19, 20, 21, 22, 23, 24 and 25, related to satisfaction through activities of daily living (ADL), sexual life, S conditions of the place where he lives, among other aspects; V. Integrated by an item: No. 26, related to the frequency of negative feelings; A total of 26 multiple choice items. The person is asked to solve the last two weeks thinking about their way of life, expectations, pleasures and concerns; The categories that integrate this second part are divided into domains: physical, psychological, social relations and environment. All items have five response options, below are options:

Very Poor, Poor, Normal, Good and Very Good

Very satisfied, Unsatisfied, Neither satisfied nor unsatisfied, Satisfied, Very satisfied

None, A little, Moderate, Quite, Completely

The third part is made up of three open questions, which allow you to identify the following aspects: if you received help, the time to answer the instrument, ending with a space for the respondent, write your comments on the questionnaire.

The Whoqol-Bref quality of life scale is the original version of the World Health Organization, the Spanish version is by Lucas R. in 1998, and has been used in a variety of research. It is useful in the assessment of life in general and the satisfaction in health of the person who responds. At the end of the application all values are added and it is interpreted that the higher the score, the better the quality of life.

For the analysis of the results, four dimensions were considered: I, III, IV and V. For dimension I, the sum of the two items was taken as a criterion, considering a minimum of 6 points as acceptable, since the Values of 3 in each category corresponds to Normal and neither satisfied nor dissatisfied. For dimension III, it is observed that the more value is more positive its perception, taking into consideration that there are six items and that the minimum accepted option is "moderate" with a value of 3 points each; It is considered as minimum accepted 20 points in total in this dimension. For dimension IV, consisting of ten items with a value of 3 points each, a minimum of 35 points is considered acceptable. For dimension V, composed of one item, a maximum value of 3 points is considered acceptable, values smaller than three are good.

Results

Figure 1. Gender of the population.

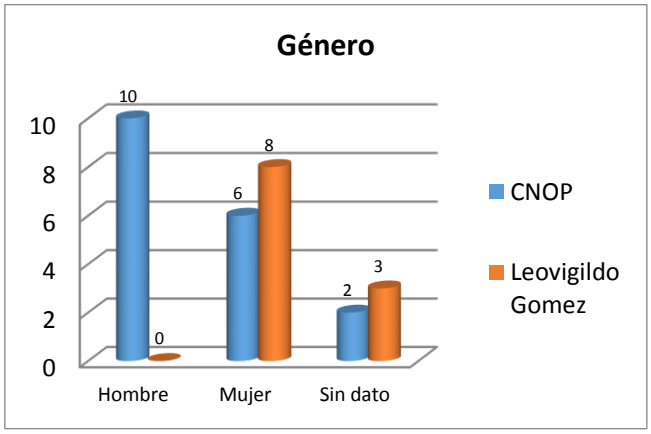

Figure 1 shows that of the twenty-nine study subjects, 17% (5) did not put the gender data, of the remaining twenty-four 35% (ten) are male and 48% (14) female . There was a slight prevalence of female gender.

Figure 2. Level of studies of the population.

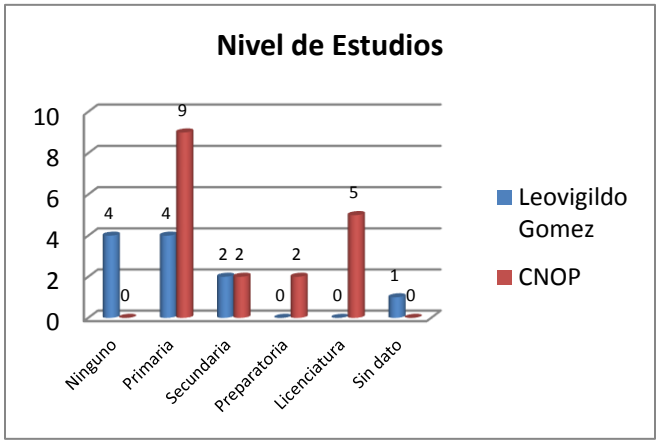

Figure 2 shows that, of the 29 study subjects, 3% (1) is without data, with 28 people being informed, of which: 14% (4) refers without studies, 45% (13) have primary education, 14% (4) secondary, 7% (2) upper secondary and 17% (5) higher education. It is observed that the people responded as a higher level to the fact of having studied the Normal of Teachers, since most of them in the Headquarters of the CNOP are of the magisterial scope, one of the few options of study within their reach.

Figure 3. Marital status of the population.

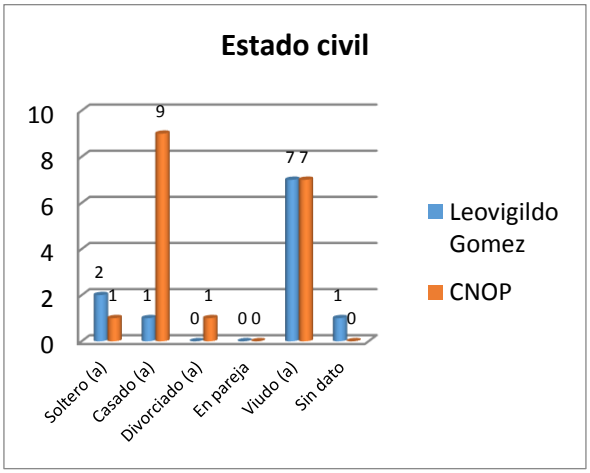

Figure 3 shows the marital status of the study subjects, of which 3% (1) did not provide data, 10% (3) are single, 34% (10) married, 3% (1) divorced , 48% (14) widow. A total of 18 people reported without a partner, ie 62% of the population.

Figure 4. Self-perception of disease.

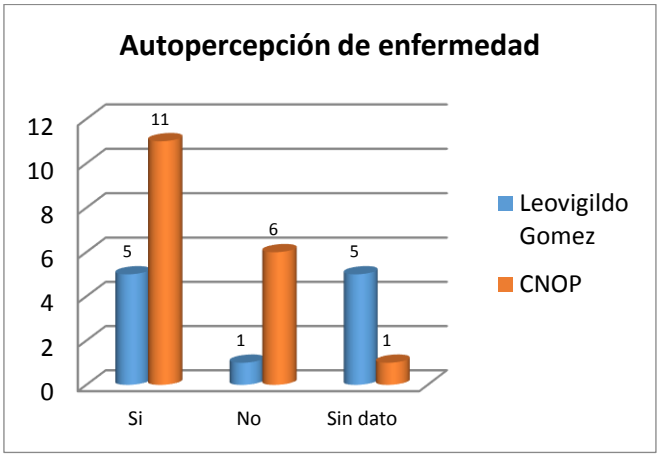

Figure 4 also corresponds to the previous part of the quality of life scale and refers to responding if you are currently sick. On the one hand, 55% (16) answered affirmatively and 24% (7) negatively, and the remaining 21% (6) did not give information.

Figure 5. Results by size at Leovigildo Gómez

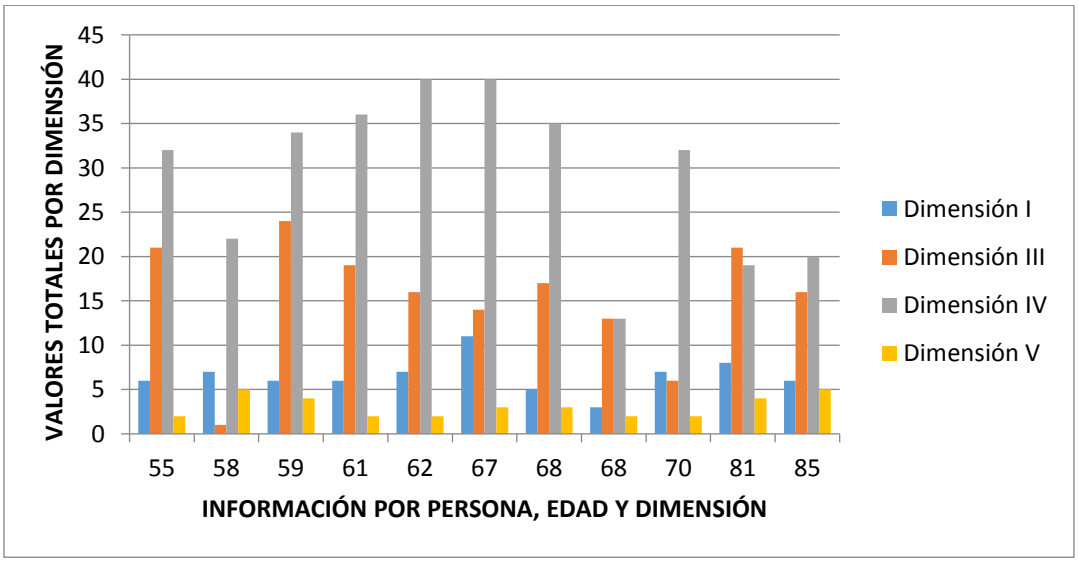

Figure 5 shows the results of the eleven study subjects attending the headquarters in the Leovigildo Gómez colony, according to their age and analyzed dimension.

Figure 6. Results by size at CNOP headquarters.

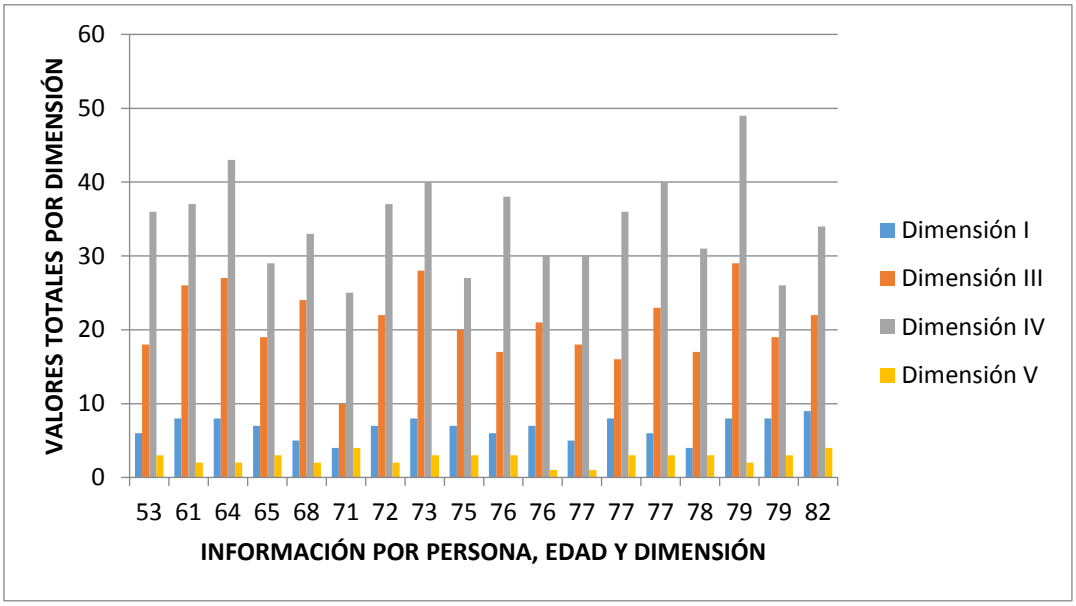

Figure 6 shows the results of the eighteen study subjects attending the CNOP headquarters, according to their age and analyzed dimension.

Dimensional Analysis

Dimension I, consisting of two items No. 1 and 2, 21% (six subjects: 4 from CNOP + 2 from Leovigildo) obtained values lower than 3, classifying their quality of life as negative and unsatisfied health, compared to 79% (Twenty-three subjects: 14 from CNOP + 9 from Leovigildo) who classified these two items (quality of life and health) as normal and very good. At least the value of six points is considered to be safe.

Dimension III, composed of six items from 10 to 15, to consider without risk, has been considered the minimum value of twenty points. On the other hand, 55% (sixteen subjects: 8 CNOP + 8 Leovigildo) obtained maximum values of nineteen, failing to reach the minimum of twenty. Likewise, 45% (thirteen people: 10 CNOP + 3 from Leovigildo) obtained values in a range of twenty to twenty-nine points.

Dimension IV, composed of ten items from 16 to 25, to consider without risk, has been considered the minimum value of thirty-five points. More than half, 55% (sixteen subjects: 8 CNOP + 8 Leovigildo) obtained maximum values of thirty-four, failing to reach the minimum of thirty-five. In

addition, 45% (thirteen people: 10 CNOP + 3 from Leovigildo) obtained values ranging from thirty-five to forty-nine points.

Dimension VI, integrated by an item, No. 26, to consider without risk has been considered the maximum value three points. Thus, 79% (twenty-three subjects: 16 from CNOP + 7 from Leovigildo) obtained maximum values of three; 21% (six people: 2 CNOP + 4 Leovigildo) reached values in a range of four to five points.

CONCLUSIONS

About 80% of the study subjects are satisfied with their quality of life and perceive health according to their age. However, 7% of the population is identified as at risk, since they express a self-perception of their quality of life and health as very poor and very unsatisfied. It is recommended to design a program of gerontological intervention to avoid a greater risk. Dimensions III and IV coincide in percentage values. At Leovigildo headquarters, only 27% (3 people) obtained values above 35, which is the minimum, which reflects that it is necessary to work with this branch in the health and self-esteem aspects. It is important to apply other scales that allow identifying the areas of opportunity of these elderly people, with the intention of improving their self-perception of quality of life.

Finally, researchers are advised to avoid applying the scales directly, because there is a risk of obtaining biased information. Older people need to see the usefulness of what they do and the time they spend, for this reason it is suggested to have an approach with them through an informal talk that is useful and sensitizes them, and thus guarantee a better result.

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