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Quality of Life in Older Adults in Tijuana

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Abstract

Background: A person older than 60 years of age is considered a senior or an elderly person. Older adults undergo numerous biopsychosocial changes that depend on the lifestyle, social and family system, these factors continuously influence the areas of functioning, favor the loss of autonomy and result in family and social impact. Quality of life is a broad and complex concept about physical health, psychological state, level of independence, social relationships, as well as its relationship with the essential elements of its environment.

Aim: The purpose of this study is to determine the quality of life in older adults in Tijuana, Mexico.

Design and Setting: Comparative cross-sectional study.

Methods: In 380 patients in the Family Medicine Unit #27, Tijuana, Baja California, quality of life, age and sex were measured to make an association between them. The following variables were collected: age, sex and quality of life. For statistical analysis, association was established with chi-squared test with 95% interval confidence ($p<0.05$).

Results: 71.5% of the patients reported a poor quality of life in the functional role and 21.3% in the mental role according to the SF-12 questionnaire. The association between quality of life, age and sex showed the following results: in functional role, age and QOL (functional) [X2=0.17, p=0.99], sex and QOL (functional) [X2=0.008, p=0.51]; in mental role, age and QOL (mental) [X2=1.8, p=0.77], sex and QOL (mental) [X2=0.39, p=0.31].

Conclusion: This result shows that the great majority of older adults have physical problems that diminish their ability to be independent; however, their mental capacity perceive it as good, which is a tool to face the daily difficulties to which they are exposed.

Keywords: Older adults; SF-12 questionnaire; Quality of life

Introduction

According to World Health Organization (WHO), a person older than 60 years of age is considered a senior or an elderly person, and is divided into the following categories: senior between 60-74 years, fourth age between 75-89 years, long-lived between 90-99 years and centenarians with more than 100 years; in Mexico, it is considered a senior from 60 years of age [1-2]. During the present century, more and more people overcome chronological barriers of age so that population aging has become a challenge for modern societies. To this demographic fact called "aging of aging", we can add the percentage and absolute increase of the most advanced age groups [3]. Older adults undergo numerous biopsychosocial changes that depend on the lifestyle, social and family system, these factors continuously influence the areas of functioning, favor the loss of autonomy and result in family and social impact [4]. Quality of life is a broad and complex concept about physical health, psychological state, level of independence, social relationships, as well as its relationship with the essential elements of its environment. The concept is used to assess the living conditions of a person or a community estimating the degree of progress achieved, the achievement of a dignified, healthy, free, equitable and happy existence" [5].

Quality of life is monitored with several indicators, divided into 3 categories: a) individual capacities: economy, employment, education, health, culture, recreation, poverty, inequality and interpersonal relationships; b) urban environment: urban development, housing, mobility, environment and public space; c) institutional context: government, public services, security, justice and citizenship [6]. The aging model proposed by Rowe and Kahn determined the difference between normal and healthy aging, establishing that healthy aging is the one with the lowest probability of presenting diseases and disability [7]. Many elderly people, as a consequence of their illnesses, present difficulties to carry out their daily activities and progressive loss of autonomy, which leads to a worsening of the quality of life. In certain situations, the elderly attach more importance to the quality of life than to duration of life itself, also limited by the evolution of their illnesses. In any health activity, the quality of life related to health is as important an objective as the decrease in hospital admissions or even in mortality, and at the same time, the decrease in quality of life is associated with a greater frequency of hospitalizations and mortality [8].

The vulnerability of the elderly is caused by the deterioration of the intrinsic capacity generally associated with aging and the greater dependence on the characteristics of the environment to maintain functional capacity. Consequently, the slight deficiencies of intrinsic capacity that had been compensated in various ways in the normal

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Table 1: Association between age, sex and quality of life (functional role).

		Poor QOL (n=272)		Good QOL (n=108)			
Variable		N	%	N	%	X^2	p
	65-69 years	100	36.7	42	38.9		
	70-74 years	103	37.9	40	37		
Age	75-79 years	35	12.9	13	12	0.17	0.99
	80-84 years	23	8.5	9	8.3		
	85-89 years	11	4	4	3.8		
Sex	Men	157	41.3	112	41.2	0.008	0.51
	Women	223	58.7	160	58.8		

%: Percentage; n=Frequency; QOL: Quality of Life; p: Ji-Square

Table 2: Association between age, sex and quality of life (mental role).

		Poor QOL (n=272)		Good QOL (n=108)			
Variable		N	%	N	%	X^2	p
	65-69 years	31	38	111	37		
	70-74 years	28	35	115	39		
Age	75-79 years	11	14	37	12	1.8	0.8
	80-84 years	9	11	23	7.7		
	85-89 years	2	2.5	13	4.3		
Sex	Men	31	38	126	42	0.4	0.3
	Women	50	62	173	58		

%: Percentage; n: Frequency; QOL: Quality of Life; p: Ji-Square

environment of the older person quickly become a significant burden [9]. Based on the above, the main objective of this research is to determine the quality of life in older adults in Tijuana, Mexico.

Materials and Methods

A comparative cross-sectional study was carried out in the Family Medicine Unit #27 (FMU-27), of the Instituto Mexicano del Seguro Social (IMSS), located in Tijuana, Baja California, Mexico, in adults that met the following inclusion criteria: age greater than 65 years, any sex, that accepted and signed the informed consent; adults with psychiatric illness were not included and eliminated those who did not complete the survey. The following data were obtained directly from the participants or medical records: age, sex, occupation, marital status, schooling and quality of life. The procedure for the data collection was as follows: age was calculated in years according to the year of birth; sex was determined according to phenotypic characteristics of each patient; occupation, marital status and schooling was determined asking directly to patients and Quality of Life (QOL) was evaluated with the SF-12 health questionnaire, which has 12 questions on a Likert scale, which guides us to the patient's health status, the score ranges from 0-100, the cut-off point is 50, a score higher than 50 is considered good quality of life and a value less than 50 points is considered as poor quality of life, a value close to 100 indicates better quality of life. The SF-12 questionnaire divide the QOL in two categories, functional and mental.

The recollected data was integrated into data collection sheets and analyzed using the SPSS program version 20 in Spanish, where we applied descriptive statistics; for qualitative variables, frequencies and percentages were used and for quantitative variables, mean and standard deviation were used. For the bivariate analysis, Ji-Square test was used to determinate association and statistically significant differences between the groups. The Kolmogorov-Smirnoff test was used to establish the normality of the data. It was considered a $p<0.05$ as statistically significant, with a 95% confidence interval. The Protocol was authorized by the Local Committee of Research and Ethics in Health Research from the Family Medicine Unit #27, where this study took place.

Results

We analyzed a sample of 380 patients, 71.5% of the patients reported a poor quality of life in the functional role and 21.3% in the mental role according to the SF-12 questionnaire. Within the functional role (Table 1) we found that the majority of patients were in the group of 70-74 years of age (37.6%, n=143), 37.4% (n=142) in the group 65-69, 12.6% (n=48) in 75-79 years, 8.4% (n=15) in the group 80-84 years and 3.9% (n=15) in the group 85-89 years. In the functional group, most patients had poor quality of life (71.5% *vs*. 28.5%) and in this group the majority of patients were women (58.5%). In the mental role, according to the results of quality of life, we observed data contrary to those presented in the functional role; the majority of patients had a good quality of life (78.7% *vs*. 21.3%). We found that the majority of patients were in the group of 70-74 years of age (38.5%, n=115), 37.1% (n=111) in 65-69 years, 12.4% (n=37) in 75-79 years, 7.7% (n=23) in 80-84 years and 4.3% (n=13) in 85-89 years. In this group, the majority of patients were women (57.9%).

For bivariate analysis we make an association between quality of life, age and sex (Tables 1,2); the association between quality of life, age and sex showed the following results: in functional role, age and QOL (functional) [X2=0.17, p=0.99], sex and QOL (functional) [X2=0.008, p=0.51]; in mental role, age and QOL (mental) [X2=1.8, p=0.77], sex and QOL (mental) [X2=0.39, p=0.31]; no statistically significant association was observed between quality of life and age or sex.

Discussion and Conclusion

According to research, our population had a higher prevalence of poor quality of life in the functional role; in the mental role, a high level of quality of life was observed. This result shows that the great majority of older adults have physical problems that diminish their ability to be independent; however, their mental capacity perceive it as good, which is a tool to face the daily difficulties to which they are exposed. We did not find an association between age and sex with the quality of life, which tells us that there are other variables that may be associated with the loss of quality of life; for this reason, we recommend opening new lines of research on quality of life in older adults and provide support mainly focused on their physical problems.

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