ORIGINAL ARTICLE

QUALITY OF LIFE OF OLDER ADULTS WITH SELF-REPORTED SYSTEMIC ARTERIAL HYPERTENSION

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Highlights: (1) Hypertension impacts the Quality of Life of older adults. (2) Analysis of the quality of life of older adults with hypertension enables health promotion. (3) Women presented a lower quality of life compared to men.

PRE-PROOF
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ABSTRACT

Objective: To analyze the quality of life of older adults with self-reported hypertension. correlating it with sociodemographic and clinical aspects. **Method:** Cross-sectional and analytical study. Data were collected between June and November 2021 through interviews using instruments containing sociodemographic and clinical profile data, the World Health Organization Quality of Life Brief (WHOQOL-BREF) and Whoqol-old. The Mann-Whitney test was used to compare the domains of the Whoqol-Bref and Whoqol-old between sexes. The chi-square and Fisher's exact tests were applied to verify equality in the sociodemographic and clinical characteristics of the sexes. The relationship between the QoL scores of the Whoqol-Bref and Whoqol-old was verified by Spearman's correlation. A significance level of 5% was considered for all statistical tests. **Results:** The Whoqol-Bref showed that female participants had lower quality of life scores, ranging from 3.3 to 3.7, compared to males (3.7 to 4.0). In the physical aspect, a lower score was observed in females (median=3.3), with a statistically significant difference compared to males (median=3.7; $p<0.001$). In the overall quality of life score, men obtained a higher score (median=3.8) compared to women (median=3.5), a statistically significant difference between the sexes ($p=0.003$). **Conclusion:** The quality of life of older women is significantly worse compared to that of older men, and this constitutes an important element for planning interventions in the field of health.

Keywords: Quality of Life; Older adult; Hypertension; Nursing.

QUALITY OF LIFE OF OLDER ADULTS WITH SELF-REPORTED SYSTEMIC ARTERIAL HYPERTENSION

INTRODUCTION

Demographic and epidemiological changes related to population aging have motivated numerous studies addressing different perspectives and topics, especially due to the continuous and dynamic growth of the older population on a global scale[1]. In Brazil, the increase in the older population is clearly noticeable. According to information from the Brazilian Institute of Geography and Statistics (IBGE), projections indicate that, in 2031, the number of older adults will be double that of children[2]. According to the Statute of the Older adult, updated by Law 14.423 of 2022, an older adult is considered to be someone aged 60 or older, guaranteeing them access to the rights provided for in the law[3].

Alongside the increase in the older population, there is a rise in the number of Non-Communicable Chronic Diseases (NCDs), especially Hypertension (HTN). Therefore, it is necessary to promote intervention and communication strategies between managers of public health services, Primary Health Care (PHC) and the general population, in order to meet the needs of the target audience, made up of older adults[4].

The development of HTN is associated with multifactorial causes, involving genetic and environmental factors. This condition can be asymptomatic, silent, and its prevalence and vulnerability increase with age, leading to a greater risk of developing cardiovascular diseases. Systemic blood pressures within the tissues must be maintained within parameters in order to prevent undesirable consequences, such as hypotension or hypertension[5].

Blood pressure can change at different times in a person's life. Therefore, it is classified into stages (1, 2 and 3), monitored by the colors red (140/90mmHg), yellow (121/139 systolic by 81/89 mmHg diastolic) and green (less than or equal to 120/80 mmHg), meaning, respectively, hypertension, pre-hypertension and normotension[4].

Globally, the data reveal a significant increase in the number of hypertension cases, reaching 1.28 billion people in 2021. This increase confirms the presence of more than one billion hypertensive individuals in low- and middle-income communities, representing 82% of the total number of hypertensive individuals worldwide. Furthermore, it is estimated that, for the Brazilian older population, it will exceed 30 million people and most of them, around 85%, will be affected by at least one stage of

the disease. Among these conditions, cardiovascular problems are predominant, especially hypertension, which becomes more frequent as age advances[6].

There is evidence that older Brazilians who have hypertension or other non-communicable diseases view their Quality of Life (QoL) negatively, considering their unhealthy lifestyle (smoking, sedentary lifestyle, excessive consumption of sodium, ultra-processed foods and alcoholic beverages), and non-adherence to the treatment of these comorbidities. Socioeconomic aspects also corroborate this perception, as older adults experience insecurity related to public health, lack of assistance, leisure, violence, marital status, the value of remuneration (retirements and pensions), pain, discomfort and loneliness[7].

In 1994, the World Health Organization (WHO) defined QoL as a person's understanding of their life situation, within the cultural and value context in which they live, in relation to their goals, expectations, values, and interests. And in 1995, it created a multicultural group of experts in quality of life, the World Health Organization Quality of Life – WHOQOL, which established a series of consensuses and points regarding QoL that are widely accepted by researchers[8].

In the context of patient care for those with hypertension, primary health care is considered the gateway to the Unified Health System (SUS) and plays an important role in promoting and preventing health problems, providing centralized, comprehensive, and individualized care as a strategy to treat chronic diseases in the older population, focusing on improving their QoL. Also, Primary Health Care (PHC), through the Family Health Strategy (FHS), has the capacity to develop and expand the management of NCDs, based on existing protocols and ease of communication with public administrations, in order to articulate continuing education for older adults[9].

In this sense, it becomes relevant to investigate the QoL of older adults assigned to FHS, from the perspective of promoting healthy aging, a fact that partly justified the execution of this research. It is noteworthy that investigations related to the health of older adults are necessary, being considered a priority line by the National Agenda of Research Priorities in Brazil, in Axis 12 – Health of the Older adults[10].

Considering the significant data of people who have hypertension and also the impact that this disease has on the health of the older population, their QoL and the general public, this study aimed to analyze the quality of life of older adults who have self-reported hypertension, correlating it with sociodemographic and clinical aspects.

METHOD

This is an excerpt from a parent study entitled "Prevalence of dizziness and its impact on quality of life in community-dwelling older adults". This study has a cross-sectional, quantitative, and analytical design and was conducted in a municipality in the northwest region of the state of Rio Grande do Sul, Brazil. At the time of the research, the municipality had a total population of 33.131 inhabitants, of whom 4.507 were older adults; 3.932 lived in urban areas and 575 in rural areas. During the data collection period, the municipality had 10 Family Health Strategy (FHS) units, nine in urban areas and one in a rural area, with 100% coverage[11].

In the parent study, 380 older adults participated, of whom 239 with self-reported hypertension were selected to compose this study. The inclusion criteria were: being 60 years of age or older; being registered with one of the urban FHS units in the municipality; and having the ability to communicate verbally and understand the interviewers' questions. Individuals who were not found at home after three visits by the interviewers were excluded.

Data were collected between June and November 2021. Three instruments were used: one consisted of a questionnaire developed by the researchers regarding the participants' sociodemographic and clinical profile. The sociodemographic instrument included questions on age, sex, education, religion, marital status, children, health conditions and self-reported diseases, falls, medication use, and hospitalizations.

Two additional validated instruments were used to measure quality of life (QoL): the World Health Organization Quality of Life Bref (Whoqol-Bref) and the World Health Organization Quality of Life Old (Whoqol-old). The Whoqol-Bref contains 26 questions: two general questions related to overall QoL and general health, and 24 questions grouped into four domains: physical, psychological, social relationships, and environment. It uses

five Likert-type response scales: “very poor to very good” (evaluation scale)[12], “very dissatisfied to very satisfied” (evaluation scale),“not at all to extremely” (intensity scale), “not at all to completely” (capacity scale), and “never to always” (frequency scale). Each domain consists of questions scored from 1 to 5. Scores from 1.0 to 2.9 indicate a need to improve QoL; 3.0 to 3.9 indicate a regular level; 4.0 to 4.9 indicate good QoL; and 5.0 indicates very good QoL. The mean score in each domain reflects the individuals’ perception of their satisfaction in each aspect of life—the higher the score, the better the perception[13].

The Whoqol-old, a complementary instrument to the Whoqol-Bref validated for the Brazilian older population, contains 24 items divided into six facets: sensory functioning, autonomy, past, present and future activities, death and dying, and intimacy[14]. All items are answered on a five-point Likert scale ranging from 1 to 5[14].

The collected data were stored in a LibreOffice Calc spreadsheet and then exported to R software for statistical analysis. Results are presented as absolute and relative frequencies for qualitative variables and as median and interquartile range for quantitative variables. The median was used as a measure of central tendency and the interquartile range as a measure of variability, since the data did not follow a normal distribution. The analysis was stratified by sex.

The Shapiro–Wilk test was used to assess adherence to normal distribution for quantitative variables. For comparisons of Whoqol-Bref and Whoqol-old domain scores between sexes, the Mann–Whitney test was used for non-normally distributed data, and Student’s t-test for normally distributed data. The chi-square test and Fisher’s exact test were applied to assess equality in sociodemographic and clinical characteristics between sexes. The relationship between QoL scores from Whoqol-Bref and Whoqol-old was evaluated using Spearman’s correlation. A significance level of 5% was adopted for all statistical tests.

Throughout the study, the guidelines and legal standards of Brazilian National Health Council Resolution number 466/2012, which regulates research involving human subjects, were followed. The research project was approved by the Research Ethics

Committee of the Federal University of Santa Maria under Opinion number 4.594.497, issued on March 16, 2021.

RESULTS

The sociodemographic profile data of the participants showed a predominance of females (69.03%), under 80 years of age (83.03%). Regarding educational qualifications, it was found that among women with no schooling, the rate was higher than that of men, 22.42% and 17.56% respectively. Women who completed their studies, such as complete primary education, are in greater proportion (12.12%) than men (2.70%), similarly to complete higher education 1.81% and 1.35%. Meanwhile, men surpassed women in the level referring to incomplete primary education 63.51% and 53.33%, and in complete secondary education 12.16% and 6.66%, respectively. However, there was no statistically significant difference in the level of education between the sexes (p=0.099).

The number of children, for both sexes, was similar among the older adults, with a mean of 3 children, and the variation in the interquartile range oscillated from 3 for women to 2 for men, with no significant difference (p=0.083). Regarding marital status, it was observed that women remained single (7.27%) and divorced more often (7.27%) than men, 4.05% and 6.75%, respectively. Similarly, regarding widowhood, there was a percentage of 32.12% of widowed women, while among men it was 17.56%, with no significant difference (p=0.051) between the sexes. These data can be seen in Table 1.

Sociodemographic Variables	Female- n (%) 165 (69.03%)	Male - n (%) 74 (30.96%)	p
Age			
< 80 years	137 (83.03)	61 (82.43)	1.000[#]
≥ 80 years	28 (16.96)	13 (17.56)	
Education			
No schooling	37 (22.42)	13 (17.56)	0.099[$]
Incomplete elementary education	88 (53.33)	47 (63.51)	
Complete elementary education	20 (12.12)	2 (2.70)	
Incomplete high school education	6 (3.63)	2 (2.70)	
Complete high school education	11 (6.66)	9 (12.16)	
Incomplete higher education	0 (0)	0 (0)	
Complete higher education	3 (1.81)	1 (1.35)	
Children			
Median (IIQ)	3 (3)	3 (2)	0.083[&]
Marital status			
Married	88 (53.33)	53 (71.62)	0.051[$]
Single	12 (7.27)	3 (4.05)	
Divorced	12 (7.27)	5 (6.75)	
Widowed	53 (32.12)	13 (17.56)	

Table 1. Distribution of sociodemographic variables of older adults, according to sex. RS, 2021.
Note: IQR = interquartile range; [#]p refers to the chi-square test; [$]p refers to Fisher's exact test; [&]p refers to the Mann-Whitney test. Source: Authors, 2021.

It was found that 11.46% of the older adults interviewed who self-reported having hypertension did not use antihypertensive medication continuously. Furthermore, hypertension was present concomitantly with other chronic health conditions, such as Diabetes Mellitus (53.21%) and Depression (7.52%).

Regarding self-assessment of health, 12.12% of women considered their health to be excellent, while among men the percentage was 20.27%. However, in the perception of poor health, 33.93% of women and 16.21% of men answered yes, with a significant difference between the sexes (p=0.032). Also, among older women, 36.96% used diuretics as medication to treat hypertension, with no significant difference between the sexes (p=0.462), as can be seen in Table 2. For the other clinical variables, there was no significant difference between the sexes.

Clinical Variables	Female - n (%)	Male - n (%)	p
Self-Assessment of Health			
Excellent	20 (12.12)	15 (20.27)	0.032[#]
Good	75 (45.45)	40 (54.05)	
Bad	56 (33.93)	12 (16.21)	
Very bad	14 (8.48)	7 (9.45)	
Antihypertensive Medications			
Yes			
No	155 (93.93)	70 (94.59)	1.000[$]
Diuretics	10 (6.06)	4 (5.4)	
yes			
No	61 (36.96)	23 (31.08)	0.462[#]
	104 (63.03)	51 (68.91)	
Associated Chronic Diseases			
Diabetes	41 (24.84)	21 (28.37)	0.677[#]
Yes	124 (75.15)	53 (71.62)	
No			
Depression			
Yes	16 (9.7)	2 (2.7)	0.103
No	149 (90.3)	72 (97.3)	

Table 2. Distribution of participants' clinical variables according to sex. RS, 2021.
Note: [#]p refers to the chi-square test; [$]p refers to Fisher's exact test; Source: Authors, 2021.

Regarding the QoL assessment, verified through the Whoqol-Bref, it was identified that in all domains female participants presented lower values (median between 3.3 and 3.7) compared to male participants (median between 3.7 and 4.0). Furthermore, in the physical domain, which deals with issues related to pain, locomotion, and personal satisfaction, the lowest score was observed for older women, at 3.3. In the Whoqol-old assessment, the scores remained similar, with the median between 3.0 and 4.2 for females and between 3.5 and 4.5 for males. Significant differences were observed between the sexes in two domains: the intimacy domain ($p<0.001$) and the autonomy domain ($p=0.003$), with the score being higher for males. In the overall QoL score, the score for older men was 3.8 higher than that of older women, 3.5 ($p=0.003$).

Domains	Female Median (IIQ)	Male Median (IIQ)	p
Whoqol-Bref			
Physical Domain	3.3 (1.0)	3.7 (1.1)	<0.001
Psychological Domain	3.7 (0.8)	3.8 (0.7)	0.040
Social Relationships Domain	3.6 (0.6)	4.0 (1.0)	0.020
Environmental Domain	3.5 (0.8)	3.7 (0.7)	0.030
Overall QoL Score	3.5 (0.8)	3.7 (0.7)	0.003
Whoqol-Old			
Sensory Functioning	4.2 (1.5)	4.5 (1.0)	0.130
Autonomy	3.5 (1.2)	3.7 (0.9)	0.003
Past. Present. and Future Activities	3.7 (0.7)	4 .0 (1.0)	0.050
Social Participation	3.2 (1.0)	3.5 (1.1)	0.090
Death and Dying	4.0 (1.8)	4.0 (2.0)	0.220
Intimacy	3.0 (1.5)	3.7 (1.0)	<0.001
Overall QoL Score	3.5 (0.9)	3.8 (0.7)	0.004

Table 3. Correlation of domains in the Whoqol-Bref and Whoqol-Old instruments, according to sex. RS, 2021. IQR: interquartile range; p relative to the Mann-Whitney test. Source: Authors, 2021.

The correlation between the QoL scores of the Whoqol-Bref and Whoqol-Old is strong and significant (r=0.76. p<0.001), demonstrating consistency between the two instruments in assessing the quality of life of older adults, for both females (r=0.73) and males (r=0.80). (Figure 1).

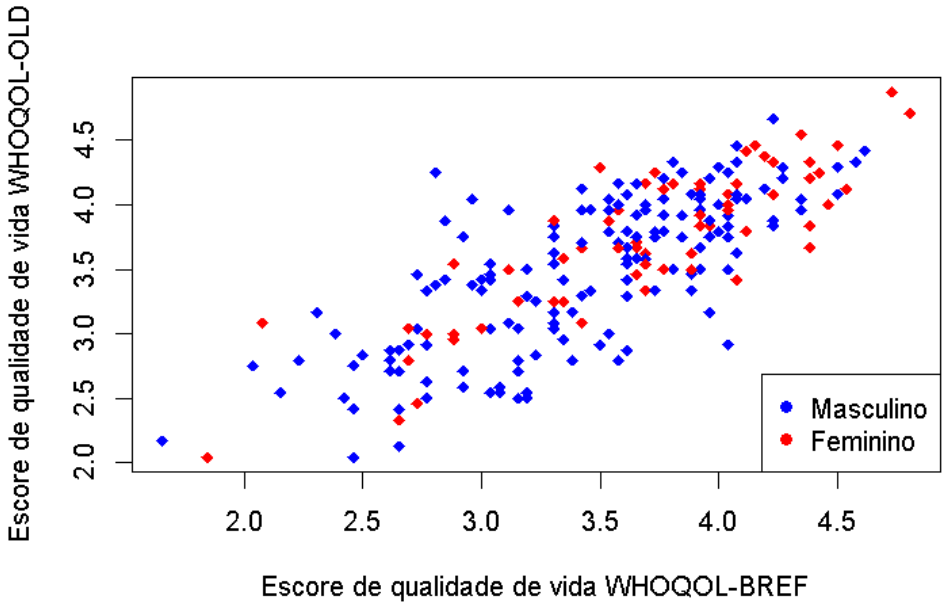

Figure 1. Correlation between overall QoL scores from the Whoqol-Old and Whoqol-Bref instruments, considering scores by sex. RS, 2021. Source: Authors, 2021.
WHOQOL-BREF Quality of Life Score
WHOQOL-OLD Quality of Life Score
Legend:
Male (blue dots)
Female (red dots)

DISCUSSION

The relevance of this study is centered on the objective, which was to evaluate the QoL of older adults who have self-reported hypertension and who are linked to primary health care through the Family Health Strategy (FHS). Furthermore, because the mean number of chronic diseases increases with age and is higher among women compared to men. Study[16] showed that, in the specific case of hypertension, about 50% of men and 60% of women reported experiencing it in 2019. In addition, in the same year, older women reported twice as many diseases as men.

Similarly, study[17] conducted in China showed that there is greater participation of women, due to the phenomenon of feminization, as well as that they are the ones who more frequently seek health services. It also pointed out that women had a reasonable

quality of life, especially when they had at least one NCD, did not have social ties, and did not perform physical activities.

The sociodemographic data from this research, such as the predominant female sex, age, education level, and mean number of children, are similar to those of other studies that also evaluated the health of older adults with hypertension. Specifically, data related to the education level variable are relevant because people with higher education levels have a greater capacity to understand the aspects involved in a pathology, from the disease itself to adherence to treatment. Factors such as advanced age and reduced or absent education contribute to making it difficult to understand the disease, as well as its complications, and to correctly follow the prescribed treatment[18].

In the marital situation, there was a predominance of married people, a condition that can constitute a protective factor for the recovery and/or maintenance of health and QoL. A study carried out with older women diagnosed with hypertension showed that those who have family support, especially when it comes from their spouses, are able to improve their quality of life. This is because partners are great influencers in changing lifestyle[19].

Furthermore, most participants rated their own health as either good or bad, in terms of "each individual's perception of their health". Research[20] showed that a chronic pathology such as hypertension in older adults directly affects their perception of their QoL, because this disease generates limitations and some dietary restrictions, requires physical activity to improve blood pressure control, and demands the correct use of medication as an effective form of treatment. Thus, this new adaptation in the lifestyle of the older adults with hypertension negatively influences their perception of their health, with a possible worsening over the years[20].

According to WHO recommendations in the 2021 Hypertension Guidelines, the treatment of hypertension should be determined by controlling systolic blood pressure (SBP) over 14 days, laboratory tests, assessment of cardiovascular disease (CVD) risk, and, through these, choosing the best antihypertensive drug, as well as drug combinations with other classes such as diuretics[21.22]. In this study, it was found that most older adults used only one class of medication, that of antihypertensive drugs.

Drug combinations are commonly used to ensure SBP control, and studies show that combinations of medications are used in patients who are at risk of developing heart disease or who already have a diagnosis for such pathologies. Typically, combination therapy with diuretics is the second or third choice, depending on the patients and the benefits they will receive from treatment. This is because drug interactions are a risk factor, not only due to age, sex, race, weight, or comorbidities, but also due to the possibility of errors in pre-therapeutic prescriptions. Therefore, when drug therapy is not properly evaluated and re-evaluated, it can become harmful and contribute to increased hospitalizations, putting the person's life at greater risk[23]. It is noteworthy that this research found a small number of older adults using drug combinations for the treatment of hypertension.

Regarding the presence of associated chronic diseases, it was identified that approximately one-quarter of the participants concomitantly presented with hypertension (HTN) and diabetes mellitus (DM). Depression was present in about 7.00% of the participants, showing that comorbidities coexist with HTN, a prevalent disease in the population. Attention should be paid to the percentage of people who present with comorbidities, especially DM, since this pathology can lead to impairment of functional capacity and cardiovascular, renal, and neurological functions. Studies[24] mention that, by 2030, there will be a 69% increase in DM cases in developing countries and 20% in developed countries. In turn, in the Brazilian older population, this comorbidity has increased by 25.9% in recent years.

Regarding depression, it constitutes a risk factor for the development of CVD, in addition to being associated with increased mortality, and the more severe the depression, the more significant the risk. The association of depression with cardiovascular diseases, including hypertension, imposes limitations on the individual, such as reduced self-care and adherence to clinical treatment[25].

The mean score in each domain, verified through the Whoqol-Bref, which expresses the individuals' perception of their satisfaction in each aspect of their life, relating to their QoL, showed a predominance of values between 3.3 and 3.7 in the group formed by women, values lower than those of men, who obtained values from 3.7 to 4.0,

evidencing regular QoL. The physical domain, which deals with issues related to pain, locomotion and personal satisfaction, had the lowest score, 3.3, in older women. Values similar to those found in another study[26].

Furthermore, in the environmental domain, which involves issues of physical safety and protection, home environment, financial resources, general health care, recreation, leisure, transportation, and others, the score was 3.5, with an interquartile range of 0.8, lower values among older women participants compared to those obtained by men. From this perspective, the study shows that, in general, older women have worse health indicators than men. The prevalence of depression and NCDs is higher among women for all age groups. The prevalence of NCDs among women aged 60 to 64 years (68%) is similar to the prevalence among men aged 80 or older (70%). The proportional difference between men and women in the prevalence of functional limitations increases with age. The results show that, for almost all dimensions studied, there is a persistent gradient indicating that older adults with lower incomes have worse health and a higher probability of requiring emergency care than older adults with higher incomes. Furthermore, the prevalence of depression and NCDs is higher among women for all age groups[27].

In the overall scenario, a study[28] comparing the quality of life of Brazilian older adults with those residing in Portugal showed that the Portuguese group had a better score in the “environment” domain, while the Brazilian group had the best scores in the “psychological” and “social relationships” domains. In Portugal, the domain with the lowest mean score was the “physical” domain, and in the Brazilian group it was the “environment” domain.

Furthermore, one of the components that contributes to achieving good QoL is financial condition. When it comes to older adults, the main sources of income are retirement pensions and benefits, which, in Brazil, reflect the low purchasing power and insufficient income of this population[29]. This component constitutes an element that can negatively affect QoL, since it compromises the acquisition of goods and services necessary for a good quality of life.

As with the QoL data verified by the Whoqol-Bref, the data obtained by the Whoqol-Old showed that women have a worse quality of life than men. The results of the Whoqol-old showed that the scores remained similar, the median was between 3.0 and 4.2 for females and between 3.5 and 4.5 for males. In two domains, a significant difference was observed between the sexes: intimacy domain ($p<0.001$) and autonomy domain ($p=0.003$). with the score being higher for males.

Furthermore, it was identified that the intimacy domain was the one that presented the lowest values, 3.0 and 3.7, respectively for women and men, with statistical significance $p<0.001$. Study[30] points out that aging does not imply giving up an active and pleasurable sexual activity. For this, life history counts for a lot: those who have always been able to create intimate and pleasurable relationships will continue to do so in old age. Sexuality corresponds to fundamental factors for the development of marital satisfaction, essential for the quality of life and well-being of individuals living as a couple.

The Whoqol-Bref instrument can be considered a support for management during research and/or study, since it collects data on QoL, but it includes items that can be modified and consequently improved with the help of public policies. The Whoqol-Old instrument, used to measure the quality of life of the individuals and understand their difficulties and positive points in their life, can contribute to proposals for specific interventions. focusing on the person.

The two instruments, when applied together, enhance the understanding of the QoL of a given population, in this case, older adults from a municipality located in the northwest region of Rio Grande do Sul/Brazil. The results highlighted the difference in social relationships, shown in the Whoqol-Bref, between men and women. Apparently, men are more involved in activities and in the community in general, thus improving their QoL. Consequently, in the domains of the Whoqol-Old instrument, men scored higher in social participation and intimacy, values that were noteworthy because the increase was significant. Between the instruments, it was found that in the psychological and death and dying domains, the scores were equal for both sexes.

CONCLUSION

It was evident that the QoL of older women is significantly worse compared to that of older men. There was a predominance of older women, aged between 60 and 79 years, in which women had lower literacy levels than men, 22.42% and 17.56% respectively.

In the self-assessment of health, women who considered their health optimal totaled 12.12%, and among men the percentage was 20.27%. However, in the classification as poor health, the percentage of women was higher at 33.93%, while men reached 16.21%.

The analysis of the mean score of the Whoqol-Bref and Whoqol-Old, in relation to the perception that older adults have regarding their satisfaction in each aspect of their lives, relating to their QoL, showed lower mean values among older women compared to older men, evidencing regular QoL. Similar data were also found across all domains of the instruments. In the facets of the Whoqol-Old instrument, the lowest values were found in intimacy, social participation, and autonomy, respectively.

Assessing QoL from the perspective of older adults is an important element in planning health interventions, since good quality of life is linked to better income conditions, social life, family relationships, education, and physical activities, categories understood differently from one individual to another. It is important to highlight that health professionals, including nurses, should be attentive to these aspects, since health, as an indicator of good QoL, may be insufficient to demonstrate active aging, that is, with functional, autonomous, and independent capacity.

The limitations of this study are associated with the data collection period, which occurred during the Covid-19 pandemic, and because it addressed the population of a single medium-sized municipality. In addition, it is considered relevant to develop studies that address aspects of the functional capacity of this population, since quality of life is influenced by people's ability to perform basic and instrumental activities of daily living.

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