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ORIGINAL ARTICLE

QUALITY OF LIFE OF USERS WITH CHRONIC NON-COMMUNICABLE DISEASES ASSISTED IN PRIMARY HEALTH CARE

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ABSTRACT

Objective: to evaluate the Quality of Life and its association with demographic and clinical characteristics of users with Chronic Noncommunicable Diseases, assisted in Primary Health Care. Method: cross-sectional study with individuals diagnosed with chronic non-communicable disease, developed with sociodemographic/clinical questionnaire and WHOQOL-Bref, in Primary Health Care in a municipality in the northwest of Rio Grande do Sul - Brazil, between July 2018 and June 2019. Results: quality of life with lower mean in the Physical domain (59.71) and higher in the psychological domain (73.30). Results with statistical difference for age group in the Physical ($p<0.048$), Psychological ($p=0.041$) and Environment ($p=0.003$) domains, and with the variables color and profession in the Environment domain ($p=0.002$). Conclusion: the study contributes to direct and strengthen health education actions developed by primary care teams, aiming at quality of life.

DESCRIPTORS: Chronic Disease; Primary Health Care; Quality of Life; Noncommunicable Diseases; Community Health Nursing.

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INTRODUCTION

In contemporary times, Chronic Noncommunicable Diseases (NCDs) are a public health problem due to their gradual increase in recent decades. They represent the greatest burden of morbidity and mortality in Brazil, which drives rapid and frequent changes regarding the sociodemographic and clinical aspects of users who seek care in Primary Health Care (PHC)(1-2).

Among the main causes of death are cardiovascular diseases, chronic respiratory diseases, cancer and diabetes. Factors that favor its development are genetic, gender, age, habits and risk behaviors such as physical inactivity, inadequate diet, obesity, smoking and alcohol abuse(1).

Such conditions overload the health services and influence the demands for care, since, according to the Ministry of Health (MH), approximately 57.4 million Brazilians have at least one NCD, implying an increased demand of users for health services(2). From this perspective, it is up to PHC professionals to identify users with NCDs in their territory and intervene early, given the negative impact on their lives. The MH emphasizes that the PHC should be the first contact of users and the community with the public health service, and that it has the responsibility to meet the health demands of those attached to a defined territory(3).

The development of NCDs, in most cases, has a slow progression, with periods of remission and exacerbation, and sometimes no cure(4). From this perspective, it is known that individuals with NCDs may have impaired physical and emotional health, with the potential to reflect on their Quality of Life (QoL). For users with these diseases to maintain an adequate QoL, it is important to evaluate the specificities of each subject in its context(5), as well as the ways of coping and how these influence the individual's routine, because they enable the expansion of health actions to improve QoL.

The Quality-of-Life Group of the World Health Organization (WHO) defines QoL as the individual's perception of his position in life, in the context of the value system in which he lives and in relation to his goals, expectations and concerns(6). Authors point out that this concept encompasses aspects related to physical health, psychological state, level of functionality, sociability, and relationships with environmental characteristics(7). Thus, when recognizing that individuals with NCDs have their QoL modified, measuring these aspects becomes important, since chronic patients encompass a range of physical, social, psychological and spiritual symptoms related to the natural progression of the disease and the adverse effects that permeate it(8).

In this interim, the present study is justified by the growing number of users diagnosed with NCDs who daily access health services with different demands. Assessing their QoL is important for care planning from a multi-professional perspective since it allows the weaving and implementation of comprehensive and personalized care throughout the life cycle. In this context, this study aims to assess QoL and its relationship with demographic and clinical characteristics of users with NCDs, assisted in PHC.

METHOD

Cross-sectional study, quantitative in nature and analytical in nature. This is a section of the institutional project called "Primary Health Care as a scenario for Health Care and Quality of Life of service users". It was developed in the PHC of a city in the northwest of the state of Rio Grande do Sul (RS).

The participants were selected by convenience, between July 2018 and June 2019. To verify the statistical representativeness, a sample calculation was performed based on the average number of users enrolled in the PHC of that municipality (60,000), multiplying this total by the number of Health Units. Based on an estimated percentage of 0.5%, a sampling error of 0.05, and a confidence interval of 95%, the minimum participation of 383 users was necessary to ensure statistical representativeness. Of this total, 216 individuals were diagnosed with NCDs.

We included individuals over 18 years old, with a medical diagnosis of NCD, assisted in the municipality's PHC, and excluded those who had difficulties answering the questionnaires, evaluated by the scholars and volunteers. Data collection was carried out by previously trained scholars and volunteers of the project; initially, the students/collectors were asked to read about the theme in order to acquire a theoretical foundation.

First, the users were invited to participate in the study. Those who agreed were explained about the objective, that the participation was voluntary and could be interrupted at any time. Next, they were presented with the Informed Consent Form. To ensure the participant's privacy, after delivery of the instruments, they were taken to a reserved room in the physical structure of the unit and/or residence, as preferred by the interviewee. As a collection instrument, we used a questionnaire of sociodemographic and clinical characterization, developed by researchers and fellows involved in the research project, which addressed issues such as age group, gender, color/race, profession status, family income, type of disease, time of diagnosis and frequency of consultations.

The WHOQOL-Bref abbreviated instrument was used, the Portuguese version proposed by WHO, developed by The WHOQOL Group and validated for Brazil(9). The instrument is composed of 26 questions, two of which are general, and the others represent each of the 24 facets that make up the original instrument, divided into four domains: "physical" (physical pain and discomfort, dependence on medication/treatment, energy and fatigue, mobility, sleep and rest, activities of daily living, ability to work), "psychological" (positive and negative feelings, spirituality/personal beliefs, learning/memory/concentration, acceptance of body image and appearance, self-esteem), "social relationships" (personal relationships, sexual activity, social support/support) and "environment" (physical safety, physical environment, financial resources, new information/skills, recreation and leisure, home environment, health care, transportation)(9).

The questions are formulated for responses on Likert-type scales and include intensity ("not at all" to "extremely"), capacity ("not at all" to "completely"), frequency ("never" to "always") and evaluation ("very dissatisfied" to "very satisfied"; "very bad" to "very good"). The scores of each domain were transformed into a scale from zero to 100 and expressed in terms of averages, where higher averages suggest better perception of QoL(9).

Data were typed and tabulated in SPSS® (Statistic Package for the Social Sciences, version 25) software for Windows®. In descriptive statistics, absolute (n) and relative (%) distributions were used, as well as measures of central tendency and variability, with study of normality of data distribution by the Kolmorogov-Smirnov test. Continuous data were compared between two independent groups using the parametric Student's t-test, and when the comparison involved three or more groups, the Analysis of Variance technique was used - Post Hoc Sheffé, employed in situations where rejection of the homogeneity of variance hypothesis between the compared groups was evident. For the decision about the hypothesis tests being significant, a 5% significance level was adopted.

The research was approved by the Research Ethics Committee of the institution under Opinion No. 2.758.802.

RESULTS

A total of 216 users participated in the study. Of these, 68 (31.5%) were between 61 and 70 years old, with a predominance of women, 141 (65.3%). Regarding self-reported color/race, 160 (74.1%) were white. Regarding professional status, 125 (57.9.7%) were inactive and 83 (38.4%) were retired. The highest percentage of respondents had family income between one and two minimum wages 155 (71.8%). The most prevalent diseases were cardiovascular 68 (31.5%), followed by neoplasms 40 (18.5%). As for the time of disease, 79 (36.6%) had been diagnosed for one to three years. Regarding the frequency of consultations, 87 (40.3%) sought care monthly, as shown in Table 1.

Table 1 - Sociodemographic and clinical profile of users diagnosed with Chronic Noncommunicable Diseases seen in Primary Health Care. Ijuí, RS, Brazil, 2019 (continues)

Variable	**N**	**%**
Age Group		
18 to 40	23	10.7
41 to 50	36	16.7
51 to 60	52	24.1
61 to 70	68	31.5
71 to 80	26	12
81 or more		5.1
Gender		
Female	141	65.3
Male	75	34.7
Color/race		
White	160	74.1
Brown	45	20.8
Yellow / Black	11	5.1
Profession Status		
Active	84	38.9
Inactive	125	57.9
Inactive status		
Length of service retiree	83	38.4
Disability retiree	26	12
Illness assistance	12	56
Family income		
Less than 1 salary	17	7.9
1 to 2 salaries	155	71.8
3 to 5 salaries	39	18.1
3 to 5 salaries	3	1.4
Disease Type		
Cardiovascular	68	31.5

Neoplasms	40	18.5
Diabetes	38	17.6
Chronic Kidney Diseases	29	13.4
Time of diagnosis		
Less than 1 year	30	13.9
1 to 3 years	79	36.6
3 to 5 years	32	14.4
5 years or more	74	34.3
Frequency of consultations		
Weekly	12	5.6
Fortnightly	18	8.3
Monthly	87	40.3
Semiannually	62	28.7
Annually	33	15.3

Source: Authors (2019)

When assessing the reliability of the instrument, the overall Cronbach's alpha = 0.898 was obtained. The QL with the highest mean was in the psychological domain (73.3±13.7), while the lowest mean was detected in the Physical domain (59.7±17.6) (Table 2).

Table 2 - Distribution of mean scores of Qualities of Life overall and by domain of the WHOQOL-bref. Ijuí, RS, Brazil, 2019

Domains	**Average**	**SD**	**Min**	**Max**	**25°**	**50°**	**75°**
Psychological	73,3	13,7	29,1	100	66,6	75	79,1
Environment	68,1	13,9	31,2	100	59,3	65,6	56,2
Social Relationships	71,7	15,1	16,6	100	66,6	75	83,3
Physical	59,7	17,6	10,7	100	46,2	60,7	71,4

SD- Standard Deviation
Source: Authors (2019)

As for the age group, significant results were obtained in the Physical ($p<0.048$), Psychological ($p=0.041$) and Environment ($p=0.003$) domains. Regarding the variable color/race and occupation status, there was a statistically significant difference in the Environment domain ($p=0.002$). In the inactive status, the domains Social Relationships ($p=0.021$) and Environment ($p=0.042$) were significant.

Family income was the variable that most impacted QoL, as it differed significantly in all domains: Physical ($p=0.006$), Psychological ($p=0.001$), Social Relationships ($p=0.000$), Environment (p=0.001) and Global QoL (p=0.005). Regarding the time of diagnosis, there was representation in the domains Social Relationships (p=0.042) and Environment (p=0.031). Regarding the frequency of consultations, significant differences were present in the Psychological (p=0.012), Social Relations (p=0.038), Environment (p=0.000) and Global QoL (p=0.002) domains (Table 3).

Table 3 - Mean and standard deviation of overall Quality of Life and domains, according to demographic and clinical characteristics. Ijuí, RS, Brazil, 2019 (continues)

Variable	**Domains Quality of life WHOQOL-Bref**									
	Physical		**Psychological**		**Social Relationships**		**Environment**		**Global QoL**	
	Average	**SD**	**Average**	**SD**	**Average**	**SD**	**Average**	**SD**	**Average**	**SD**
Age group										
18 to 40	55	17,3	66,3	16,1	69,7	18,5	62	13,4	69,2	12
41 a 50	58,3	20	70,6	17,2	70,6	15,6	63	15,4	69,4	11,7
51 a 60	61,9	18,8	74,5	13,7	73,9	15,5	68,9	13,3	70,8	13,6
61 a 70	61,4	16,1	74,6	11,9	71,8	13,4	69,6	13,2	74,1	13
71 a 80	63	13,8	78	10,5	73,4	12,5	75,4	11,6	73,1	13,5
Over 81	45,8	16,4	72	8,6	65,9	20,9	69,6	13,6	69,1	17
p-value	0,048		0,041		0,615		0,003		0,394	
Color/race										
White	60,3	18,4	74,4	13,5	72,6	15,3	70,1	14,3	72,6	12,9
Brown	57,5	14,7	69,3	14,6	68,9	14,1	63,8	11,2	68	13,9
Yellow / Black	60,1	17,9	73,9	11,8	71,2	17,6	58,8	11,8	72,7	10,1
p-value	0,629		0,086		0,344		0,002		0,113	
Profession Status										
Active	61,2	16,3	71,4	14	71,8	13,9	65,7	13,4	70	12,5
Inactive	58,5	18,6	74,9	13,1	71,5	16	70	14,3	72,9	13,4
p-value	0,274		0,67		0,89		0,033		0,121	
Inactive status										
Time retired	61,4	16,9	75,7	10,9	73,7	14,6	71,3	13,4	74,3	13,5
Disability retired	54,3	18	73,4	14,2	69,2	17,4	68,1	13,9	70,8	13,5
Illness benefit	50,1	26,3	73,3	20,9	60,4	20,1	70,8	16,8	64,2	13,1
p-value	0,054		0,651		0,021		0,593		0,042	
Family income										
Less than 1 salary	57	15,5	67,6	15	64,7	19,7	64,2	12,9	64,7	14,6
1 to 2 salaries	58,1	17,6	72,4	13,5	70,2	14,3	66,8	13	71,1	13,2
3 to 5 wages	67,5	15,7	80,1	10,8	81,2	12,4	74,9	14,8	76,4	10,8
p-value	0,006		0,001		0		0,001		0,005	
How long the illness lasts										
Less than 1 year	64,3	21,3	74,3	17,1	73,6	14,2	73,2	15,6	70	12,9

1 to 3 years	60,8	18,1	75,2	13,3	74,8	14,2	69,1	13,3	73,3	12,4
3 to 5 years	59,7	13,7	68,9	12,7	66,1	19,4	64,1	13,8	68,4	15,3
5 years or more	54,1	16,5	70,6	14,5	68,5	13,9	64,4	12,9	70,3	12
5	59,3	17,1	75,2	11	72,1	13,8	69,9	13,7	73,4	13,9
p-value	0,179		0,134		0,042		0,031		0,323	
Periodicity/consultations										
Weekly	50,3	19,5	71,5	11,4	61,1	17,5	65,1	14,1	65	11,7
Fortnightly	54,6	18	68,1	16,3	65,7	17,6	62,1	11,8	64,4	17,6
Monthly	59,6	17,4	72,7	13	72,1	15,8	69,1	13,4	70,7	13,2
Half-yearly	60,8	17,2	71,8	14,1	72,8	10,9	64	11,9	72,1	9,9
Annually	63,1	17,1	80,6	13	74,2	16,1	77	15,1	77,9	12,9
p-value	0,164		0,012		0,038		0		0,002	

¥One Way Analysis of Variance - Post Hoc Sheffé. SD = Standard Deviation

Source: Authors (2019)

DISCUSSION

The sociodemographic profile of users diagnosed with NCDs is consistent with studies that obtained similar results(10-11). Regarding the clinical profile, the literature is correlated with the results found, which indicate that among the most recurrent NCDs are cardiovascular diseases, chronic respiratory diseases, chronic kidney disease, cancer and diabetes(1).

QL has a broad concept that covers the complexity of interrelating with objective and subjective aspects of physical and personal well-being, being the objective evaluation focused on physical health indicators and their limitations and subjective in the evaluation of the individual in the physical, psychological, social, and environmental dimensions(9).

Authors point out that people with NCDs classify their QoL as bad, especially in the physical domain, showing that QoL is impaired by physical abilities and has important repercussions during treatment(8). This fact can be correlated with a study conducted with diabetics, since the lowest mean presented was in this domain, justified by the visual changes that DM can cause (besides skin lesions and amputations)(12).

Thus, these aspects can interfere directly or indirectly in QoL, since authors state that the circumstances imposed by these diseases promote changes in physiological processes and influence limitations in daily life, corroborating to the weakness of the health status and functional dependence and facilitating the simultaneity of other pathologies(13).

The findings of this study show that the respondents have a good QoL, as in a research conducted in Belo Horizonte-MG whose findings reveal a positive relationship of QoL in the Physical and Psychological domains in individuals with advanced age(14). However, in relation to the Environment domain, the results differ from the present study, because it was found that this domain had a low score, which negatively influenced the QoL of the respondents.

It is inferred that the results related to the statistical difference to color/race prevailed, since in contemporary times white individuals have more opportunities to act, access information and security in daily life, when compared to those of yellow/black. In contrast, due to a cultural factor, yellow/black people are more vulnerable due to social determinants and therefore often have more difficulty entering the labor market, which influences the financial resources in order to meet their needs, negatively influencing the perception of QoL(15).

Research has identified that, with the development of NCDs, individuals start to present lower productivity rates, and consequently, worse perceived QoL(16). On the other hand, in this study, data show that users have good QoL. It is understood that this may be associated with the personal relationships that permeate them, acceptance of the disease and security in health care and daily life.

The development of work activity can be compromised because changes negatively influence the daily life of the patient with NCD, due to the difficulty of reconciling work with the health-disease process. A study with patients with chronic kidney disease showed that most of them cannot stay in the labor market, being necessary to receive sick pay (sometimes lower than their income before the disease); financial problems affect not only the patient with NCD, but also have family repercussions and influence other aspects of life such as food, leisure, transportation, among others(17).

Regarding the inactive status, the significant differences oversaw the Social Relationships and Global QoL domains, in which the investigated individuals in the group of sick pay presented a mean for QoL significantly lower, when compared to the cases that reported retirement for length of service. This may be related to the early work leave and, consequently, the decrease in contact with people/friends, which reflects on QoL, since the interaction with other people, dialogue, expression of emotions and sharing of fears and anxieties is essential for individuals with chronic situations(18).

It was found that family income was the variable that most impacted on QoL, as it differed significantly in all domains. This is consistent with a study developed in the city of Goiânia-GO, which revealed significant statistical representation in the item family income, showing that the population that has more financial conditions has better QoL, since it has more resources to meet their needs, which provides better and greater satisfaction about the physical and psychological health(19).

Regarding the time of diagnosis of the disease, the significant differences were in the domains of Social Relationships and Environment. In the former, the means for QoL of the times less than one and one to three years were higher than the cases with time of disease from three to five years. For the Environment domain, the mean for QoL was significantly higher in the group with times less than one year compared to those with times three to five and five or more. Therefore, it is possible to state that the presence of a NCD causes an impact on the individual's/population's health, and the longer the time of diagnosis, the more influence the disease has. In this interim, when addressing issues related to QoL, it is inherent that the social, environmental and economic conditions influence the health conditions of the population(20).

As for the frequency of consultations, significant differences were present in most domains, except the Physical. In general, the means for QoL in the treatment with monthly frequency was significantly higher when compared to the means for the weekly and biweekly frequencies. It is noteworthy that having a NCD and the health problems resulting from it are contributors to the population's greater access to health services. It is also noteworthy that the continuous use of medications, especially polypharmacy and in the elderly, side effects from drug interactions and injuries resulting from NCDs can negatively influence the QoL of users(21).

From this context, the PHC health team has an important role, because through the reception of the user in the unit and continued health education activities, it can disseminate concepts and care in order to prevent NCDs and their complications. It is also important the role of nurses, who have been the daily reference in health services and, through the bond and their attention to patients, can contribute to prevention, as well as in the care of families attached to the health unit and consequently improve QoL(22).

Another study conducted with ostomy patients points out that anxiety and depression contribute to greater impairment of QoL, therefore, these aspects should be observed and identified by the teams that assist them(23).

In this sense, the findings of this study can collaborate to the planning of health actions by PHC teams, especially nursing, with a view to planning care for people with NCDs and empowering them to face the challenges imposed by the disease.

As a limitation of the study, we highlight the fact that the data was collected in only one municipality in the South of Brazil, which prevents its results from being generalized.

CONCLUSION

The overall QoL was considered satisfactory. The domains presented the scores respectively psychological, social relations, environment and physical (73.3; 71.7; 68.1; and 59.7). QoL was statistically related to age, color, professional status, income, duration of disease, and frequency of consultations.

The study allowed us to know the profile of patients with NCDs, the quality of life and its relationship with the sociodemographic and clinical characteristics of patients assisted in primary care, as well as the most common diseases in the study site, a fact that can direct and strengthen health education actions developed by primary care teams, aiming at quality of life, especially in the physical domain, which had the lowest score.

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