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Zmienne kulturowe warunkujące dobrostan populacji powyżej sześćdziesiątego roku życia

Cultural variables determining well-being of the population above the age of sixty

Streszczenie

Wstęp. Postępujący proces starzenia się organizmu, a w konsekwencji pogarszający się stan zdrowia powodują, że zmienia się również stosunek człowieka do własnego życia we wszystkich jego aspektach: zdrowia, życia rodzinnego, zawodowego i społecznego. Dlatego też w ocenie stanu zdrowia, oprócz wskaźników biomedycznych uwzględnia się subiektywne poczucie zdrowia opierające się na przeżyciach osobistych i refleksji nad tym, co odczuwamy i jakimi jesteśmy ludźmi.

Cel. Głównym celem badania była próba stwierdzenia, czy i w jakim stopniu status społeczno-ekonomiczny oraz styl życia różnicują subiektywną ocenę zdrowia populacji powyżej 60 roku.

Materiał i metody. W badaniu uczestniczyło 176 osób w wieku od 60 do 90 lat korzystających ze świadczeń medycznych w poz. Narzędziem badawczym był kwestionariusz ankiety opracowany przez autorów badania. Ankieta została rozprawdzona wśród osób zgłaszających się do lekarza rodzinnego w okresie od stycznia do grudnia 2007 r. Uzyskane wyniki poddano analizie statystycznej.

Wnioski. W wyniku przeprowadzonego badania sformułowano następujące wnioski: samoocena stanu zdrowia jest sumarycznym osądem wpływu wielu subiektywnych i obiektywnych wskaźników zdrowia odbieranych przez jednostkę; samoocena i poczucie zadowolenia z własnego stanu zdrowia w wypadku osób starszych zależą w większym stopniu od poziomu ich sprawności funkcjonalnej niż od współwystępowania chorób przewlekłych.

Abstract

Introduction. The progressing ageing process and consequently deteriorating health status change the attitudes of man towards life in all its aspects: health, family, professional and social life. Therefore, health status is assessed not only with biomedical indices but also with subjective feelings concerning health based on personal experiences and reflections about what we feel and who we are.

Aim. The key objective of the present study was to determine whether and to what extent the socio-economic status and lifestyle affected the subjective assessment of health in the population above the age of 60.

Material and methods. The study population included 176 individuals aged 60-90 years getting primary health care services. The questionnaire designed by the authors was distributed amongst patients having appointments with their family doctor between January and December 2007.

Conclusion. The questionnaire results were statistically analysed and the following conclusions were arrived at: self-assessment of health is a total judgment of effects of many subjective and objective health indices perceived by an individual. Self-assessment and satisfaction with health status of the elderly are more dependent on their functional efficiency than the presence of chronic diseases

Słowa kluczowe: zmienne kulturowe: stan zdrowia, osoby starsze

Key words: cultural variables, health status, elderly people

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INTRODUCTION

Well-being of people is mainly determined by the quality of their social relations. In the definition of the World Health Organization of 1948, the term “well-being” was used in an extremely broad sense, as an idealized state of complete health. According to this definition, health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity [1]. The cultural modifiers of health include living conditions determined by socio-economical status and lifestyle as the factors which most significantly diversify the health status at various life stages. According to Welon et al. [2], their relevance markedly decreases after the age of 50. Due to the progressing ageing process and the resultant deterioration of health state, the attitudes of individuals towards life change in all its aspects: health as well as family, professional and social life. Therefore, the health state is assessed not only by biomedical indices but also subjective feeling of health based on personal experiences and reflections on what we feel and who we are [3-5].

The aim of the study was to determine whether and if so to what extent, the socio-economic status and lifestyle diversify the subjective assessment of health in the population above the age of 60.

MATERIAL AND METHODS

The study encompassed 176 individuals aged 60-90 years making use of primary health care services. The research tool used was the questionnaire prepared by the authors, which was distributed amongst patients having appointments with the family doctor between January and December 2007. To obtain the information about the issues in question from patients with health problems that cannot make use of medical services in primary care institutions, the questionnaire was delivered to them by district nurses during their visits and collected during next visits. The study analysed subjective assessment of health and effects of gender, age, education, place of residence, financial conditions, chronic diseases, physical activity, leisure activities, and contacts with relatives on subjective assessment of health. The results were statistically analysed. The values of parameters measured in the nominal scale were characterized by number and percentage whereas relations between features were evaluated using the χ^2 test of independence. The correlations between variables were described using logistic regression. Applying the logistic model, the odds ratio (OR) was calculated, i.e. probability of better self-assessment of health state versus independent variables. The 5% error of deduction was assumed; statistical significance was set at $p < 0.05$. The database was prepared and statistical analyses were performed by using the Statistica 8.0 software (StatSoft, Poland).

CHARACTERISTICS OF RESPONDENTS

The questionnaire study was conducted amongst 176 patients of primary health care institutions. The age range of respondents was 61-90 years. The mean age of the

population studied was 71.3 ± 8.8 years. The population consisted of 100 women aged 61-90 years and 76 men aged 63-78 years. The differences were not statistically significant ($t=8.74$; $p=0.00000$). The majority of respondents – 82.4% (145 individuals) were from villages. (Fig.1). Thirty-one respondents lived in towns (17.6%).

Analysis of education of respondents showed that 30.7% had elementary and vocational education, 24.4% – secondary education and the remaining (14.2%) – higher education (Fig.2).

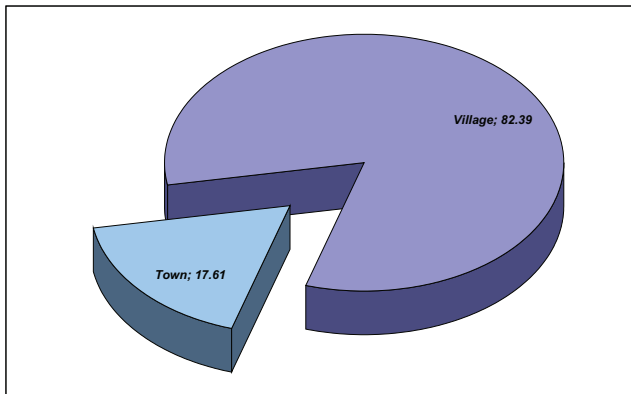


FIGURE 1. Place of residence of respondents.

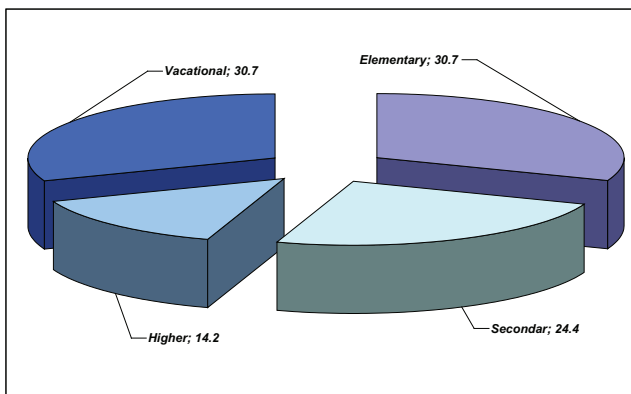


FIGURE 2. The level of education of respondents.

Furthermore, the study assessed the material conditions of respondents, which are likely to have substantial impact on subjective opinions about health [3-5]. The elderly often spend a high proportion of their income on treatment [6, 7]. The majority of respondents assessed their material conditions as average – similar to those of other people their age (55.1%); 7.4% considered them as very good and good. Noteworthy, a high percentage of respondents – 30.1%, found their material conditions bad (Fig. 3). Many authors emphasize that the present economic situation in Poland

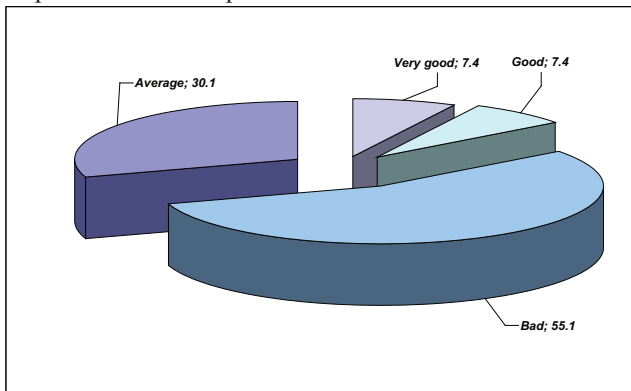


FIGURE 3. Material conditions according to respondents.

is the source of dissatisfaction with material conditions, especially amongst the elderly [5,6,8,9].

The opinions about material conditions were related to gender ($\chi^2=35.428$; $df=3$; $p=0.00000$). Worse assessments of material conditions were significantly more common amongst men compared to women. According to authors of numerous publications, men feel responsible for material sphere and thus are more often dissatisfied with the material conditions of their families [4,5,6,9]. When asked about children, the majority of respondents answered they had children – 122 (69.3%); 54 respondents had no children. In the group with children, the highest proportion had two children - 59 respondents (33.5%); 29 had one child (16.5%), 22 (12.5%) – three children and 12 (6.8%) – four children. The analysis of the marital status showed the largest group consisted of widowers and widows (68- 38.6%), followed by married - 64 (36.4%), divorced – 32 (18.2%) and single respondents - 12 (6.8%).

RESULTS

In the questionnaire the respondents were asked to assess their health. Self-assessment of health is one of the most relevant elements building the subjective sense of quality of life and a measurable index of health state of the population [6,10]. The health state was assessed according to the 5-degree scale – from very good to very bad. The largest group assessed their health as bad (68 individuals) – 38.6%; a similar percentage considered their health state good (64 respondents) – 36.4%. The lowest percentage found their health very good (6.8% – 12); the remaining respondents believed their health was similar to that of other people their age – „neither good nor bad” – 32 individuals, i.e. 18.2%. Subjective assessment of health was related to gender ($\chi^2=114.746$; $df=3$; $p=0.00000$) (Fig. 4). Assessments of health presented by women were significantly worse compared to men. The male respondents chose „good health state” and “similar to that of other people that age”; amongst women, a high percentage assessed their health as “bad” – 68%. This is in agreement with the results presented in numerous publications demonstrating that subjective assessment of health is related to gender and that women have worse opinions about their health compared to men although the incidence of health-promoting behaviour patterns amongst women is significantly higher [6,9].

To determine the structure of variables affecting self-assessment of health of respondents above the age of 60,

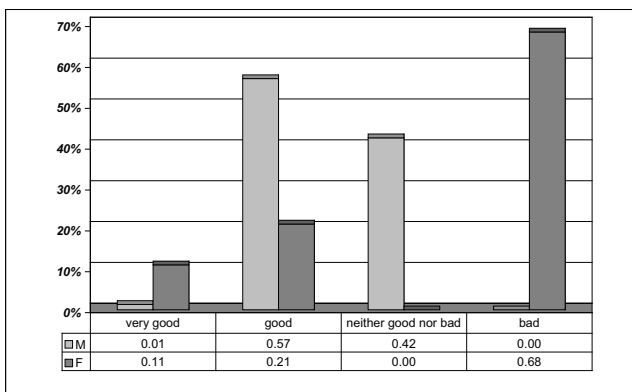


FIGURE 4. Subjective assessment of health according to male and female respondents.

logistic regression analysis was used. The categories of subjective assessment of health were converted in such a way as to obtain dichotomous distribution of this variable. Two categories were formed: “good” (earlier - very good and good) and “bad” (earlier - neither good nor bad and bad). The main objective was to determine whether and if so to what extent the socio-economic status diversified subjective assessment of health of the population.

Effects of the selected variables on subjective assessment of health were analysed. Using the logistic model, the odds ratio (OR) was calculated, i.e. the probability of better self-assessment versus independent variables. Thee logistic analysis demonstrated that:

- **age** is a variable that should be considered in the model. It was shown that with age the probability of better self-assessment increased almost 6 times ($OR=5.6$; $p=0.0000$).
- **education** – higher level ensured almost twofold higher self-assessment of health ($OR=1.998$; $p=0.0005$).
- **place of residence** – living in a town increased over 5 times better self-assessment of health ($OR=10.582$; $p=0.0014$). According to respondents, medical services are more accessible in towns, which is particularly important for the elderly.
- **material conditions** – the income sufficient to fulfil the existential needs of respondents increased the probability of better self-assessment over 6 times ($OR=6.16$). The respondents have stressed that a substantial proportion of their income is spent on medicines which they have to take regularly.
- **chronic diseases** – the respondents suffer from arterial hypertension, cardiovascular diseases. However, the presence and number of chronic diseases only slightly influenced subjective assessment of health ($OR=0.31$; $p=0.000$).
- **good family relations** – good contacts with the family and relatives and their support was essential for the elderly. **Family support almost tripled the probability of better assessment of health ($OR=2.689$; $p=0.02$).**
- **gender** – subjective assessment of health was related to gender. Men assessed their health almost 4 times better compared to women ($OR=3.654$; $p=0.003$).
- **home medical care** – the elderly paid great attention to home medical care. Better assessments of health were almost three times more frequent amongst those who could be provided with home visits of physicians and district nurses ($OR=2.96$; $p=0.003$).
- **physical activity** – is another variable analysed. The elderly who carried out household duties unaided (shopping, cleaning, preparing meals) more often assessed positively their health emphasizing that in older age it is important not to be a burden to the family, to feel needed and help the family members (taking care of grandchildren, meals for the family) ($OR=1.76$; $p=0.0005$).
- **leisure activities** – watching television was most popular, the respondents have their favourite programs (65%); they also go to church (56.2%) or spend their time gardening (34%). Moreover, they go for long walks with friends or grandchildren (26.3%) and help neighbours with shopping (8.7%). The collected data were divided in to active and passive leisure activities. The respondents with active leisure activities almost three times more often assessed their health positively ($OR=2.986$; $p=0.0007$).

CONCLUSIONS

Self-assessment of health is a total judgement about effects of numerous subjective and objective health indices perceived by an individual.

In the elderly, self-assessment of health and satisfaction with its state depend more on their functional efficiency than the presence of chronic diseases.

REFERENCES

1. Zalewska-Meller AA. Edukacja zdrowotna - nowa jakość w życiu człowieka. *Edukacja*. 2001;4:85-91
2. Welon Z, Bielicki T, Rogucka E, Malina R. Effects of education and marital status of premature mortality among urban adults in Poland, 1988-1989. *Am J Hum Biol*. 1999;11:397-403.
3. Kaczmarek M, Skrzypczak M, Maćkowiak K. Status społeczno-ekonomiczny oraz styl życia jako czynniki różnicujące subiektywne poczucie zdrowia wśród starzejących się mężczyzn. *Gerontolog Pol*. 2006;14(2):84-90.
4. Centrum Badań Opinii Społecznej: Poziom satysfakcji życiowej Polaków latach 1994 -2004. Komunikat z badań. Warszawa 2005.
5. Halicka M, Pędach W. Obiektywne i subiektywne korelaty satysfakcji życiowej w starości – subiektywne wyznaczniki jakości życia. *Gerontolog Pol*. 1999;7:69-74.
6. Kowalik S, Janecka Z. Użyteczność koncepcji jakości życia dla procesu rehabilitacji osób niepełnosprawnych. Materiały Stowarzyszenia Przyjaciół i Sympatyków Domu Pomocy Społecznej w Jarogniewicach i Katedry Kultury Fizycznej Osób Niepełnosprawnych AWF w Poznaniu. 1998;3:9-29.
7. Meyer K. Aging successfully. *J Public Health*. 2005;13:177-8.
8. Fox KR, Stathi A, McKenna J, Davis MG. Physical activity and dimensions of subjective well-being in older adults. *J Aging Phys Activ*. 2002;10:76-92.
9. Wojszel B. Uwarunkowania zdrowotne jakości życia oraz ocena stanu zdrowia ludzi starych. *Gerontolog Pol*. 1996;4:28-33.

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