PANDEMIC AND PERCEIVED HEALTH STATUS: A CASE STUDY

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ABSTRACT

Each older person's perception of their health status is a fundamental factor in understanding quality of life and should be considered in social interventions. Health is one of the main concerns of the elderly, since at this stage of life there is a change in functional capacity and, consequently, a greater sense of fragility and dependence. The aim of this study was to analyze the perceived health of a group of elderly people attending the Day Care Centre (DC) and Home Support Service (HSS), as well as its comparison with the previous year, with the peer group and with the impact of the Pandemic. We conducted a questionnaire survey. We found that there is a relationship between gender and self-assessment of health status, with women being the ones who mostly make a negative assessment. Most of the older people had an "acceptable" value for self-assessment of health, followed by older people with a negative view of their health and only a very small number considered it to be positive. When health status was compared with the previous year the majority consider it to be "more or less the same" showing an adaptive process to ageing, followed by those who consider that their health status had worsened compared to the previous year. 38.1% of the elderly respondents considered that the pandemic had an impact on their health. All of them were female and belonged to the DC, a social response which suffered major impacts from the pandemic. Most of these elderly women consider that the greatest impact of this pandemic was at the psychological level.

Keywords: *aging, perceived health, quality of life, pandemic*

INTRODUCTION

The 21st century began with various challenges, some of which had never been experienced before. One of the challenges faced by developed countries refers to ageing, the way we want and should care for and face this phase of life which, in countries like Portugal, constitutes a substantial slice of the population. According to data from INE/PORDATA the resident population in Portugal aged over 65 years at the end of 2019 was 2,280,424 individuals, i.e., around 22.2% of the resident population in Portugal. We know that we are an ageing country where we have long since passed the balance point in the ratio between the young population (under 15 years of age) and the population over 65 years of age, with the ageing index in 2019 standing at 161.3. Obviously, the fact that we live more

years is a positive indicator, only possible due to the improvement in the quality of life of the Portuguese population in the recent decades. However, we know that many of these elderly people, for objective or subjective reasons, do not age with quality and present a set of diseases and in many cases dependency.

Ageing involves a set of biological, morphological, psychological and social changes, which occur in a continuous and, as a rule, irreversible way. These changes, according to Santos (2010, p. 1036) [1], are varied: "the biological modifications are the morphological, revealed by the appearance of wrinkles, white hair and others; the physiological, related to the alterations of the organic functions; the biochemical, which are directly linked to the transformations of the chemical reactions that are processed in the organism (...) the psychological [that] occur when, when aging, the human being needs to adapt to each new situation of his daily life (...) the social ones are verified when the social relations become altered".

All these changes cause, as a rule, a decline of organic functions in general. This decline does not occur in the same way in all people and varies from individual to individual with the influence of several factors, such as the environment in which one lives, the socio-economic situation, the habits and lifestyles, among others. Each particular context and life history influences lifestyles, the way of growing older, the way one views and the meaning attributed to this process. This complexity implies that old age should be understood in its globality, which includes the biological, social, cultural and, as Queiroz and Sousa (2010, p.408) [2] state, an "existential dimension, which modifies the person's relationship with time, generating changes in their relationships with the world and with their own history".

The subjectivity in the way of facing aging interferes with the way the subject faces his/her health condition. Several studies demonstrate the relationship between objective and subjective conditions in the quality of life of the elderly (Neri, 1993) [3]. As objective factors, we can refer to health conditions, level of education, economic situation, among others. Fundamental factors, but they do not clarify the subject's perception of his/her life and the impact of these factors on his/her life. Subjective factors seek to understand this understanding and may include factors such as life history, psychological state, affective reactions, life satisfaction, perceived health, among others.

Perceived health is one of the commonly used ways to understand the perceived quality of life of the elderly. The concept of perceived health refers to the subjective assessment that each person makes regarding the quality of their health and can be analysed considering the past, present and future. It is a concept that according to Ferreira, Izzo and Jacob (2007, p.155) [4] presents "an individual integration of many aspects of health, among them behavioural competence (social dimension) and the sense of self-efficacy (psychic dimension), i.e. with

the person's sense that he/she is able to perform the necessary behaviours to produce the results he/she desires".

It is, therefore, a subjective assessment that each subject makes about the quality of his/her physical and mental health and may include a comparative assessment of the current and past functional capacity and an assessment (individual and subjective) of aspects such as the ability to perform certain tasks, the functional status and the health status (Teixeira; Neri, 2008) [5]. As a rule, the most common ways in which each person integrates their "perceived health" is through factors such as the existence of illnesses, the volume of medicine taken, the presence of pain and discomfort, changes in cognitive state, a decrease in physical capacity. It should be noted that age does not imply homogeneity in the perception of health status, since the same age group may have different ways of perceiving it, which is related, as already mentioned, to the complexity and heterogeneity of the ageing process.

We may consider that the perceived health status of each elderly person may be a way to understand their functional capacity/ disability. According to Pitanga (2010) [6], there are two ways of looking at health: on the one hand, the positive one, which is related to each person's ability to develop the functions and respond to daily challenges, as well as the positive attitude towards life; on the other hand, the negative one, which, on the contrary, is associated with morbidity and, ultimately, mortality.

The aim of this study was to analyse the perceived health of a group of older people, to understand their self-assessment of their current health status, as well as its comparison with the previous year and with their peer group. In addition, we sought to understand how the concept of perceived health was modified with the current Pandemic scenario. The consequence, on the one hand of the imposed isolation and, on the other hand, of the cancellation of occupational activities (leisure, play, physical, motor, etc.) may have contributed to the deterioration of the functional status of many older people and, therefore, to the increase of their negative perception of their health.

METHODOLOGY

The results of the work presented here were developed from descriptive research. To this end, we opted for the questionnaire survey as a data collection tool. The survey was divided into three dimensions: the 1st dimension refers to the respondents' sociodemographic information; the 2nd dimension integrates the self-assessment of health status. For this purpose, an adapted version of the Self-assessment of Health questionnaire was used. The questionnaire on health self-assessment used was taken from "The European Survey on Aging Protocol - Portuguese version (Paúl et al., 1999) [7]. It aims to evaluate the indices of perceived health in groups of individuals with advanced age, with competence associated with the aging process; The 3rd dimension refers to the relationship

between health and the pandemic, where the respondent is asked to identify the influence of the pandemic on his/her health status and how this influence occurs.

The surveyed population was made up of Day Centre (DC) and Home Support Service (HSS) users from a Private Social Solidarity Institution in the centre region of the country. The total number of users of these social responses was 25 and 23, respectively, from which 30 were selected according to the following inclusion criteria: no diagnosis of dementia, ability to self-complete the questionnaire or support in completing it, and express willingness to participate (with a declaration of informed consent). Thus, 13 Day Care Centre users and 17 Home Support Service users were selected. The questionnaires were personally delivered to the participants.

Initially we performed a statistical analysis of the data to then interpret the results based on the existing literature review.

PRESENTATION AND DISCUSSION OF THE RESULTS

Of the 30 questionnaires sent out, 25 were completed, of which 4 were eliminated, leaving the sample with a final number of 21 participants. The main reasons for their elimination were their incomplete completion and failure to complete the informed consent. Thus, the sample includes 10 users of the DC and 11 of the HSS, for a total of 21 elderly people.

Regarding gender, 61.9% (13) of the sample are women and 38.1% (8) are men. Women were distributed in 8 in the DC and 5 in the HSS. The men were integrated 2 in DC and 6 in HSS. This may be related to the phenomenon of the feminisation of old age, explained by the differences in the physical and metabolic decline between men and women, which leads to greater longevity of women, which has also been related to other risk factors, such as occupational accidents, smoking and alcohol use, as well as differences in the way of facing diseases and disabilities.

In relation to gender, we highlight a difference between the two social responses, with men being more present in the HSS (6) and women in the DC (8). Although no data were collected to justify this difference, we can assume, based on the existing literature, that men have greater difficulty in participating in group activities (Ferreira; Izzo, Jacob, 2007) [4].

Most of the sample was widowed, of the 12 elderly people corresponding to 57.1%, 5 were married (23.8%) and 4 were single (19.1%). The distribution of the elderly by marital status and social response is very similar, since we have 2 singles in each social response, 3 married in DC and 2 in HSS and equal number (6) of widowers in DC and HSS.

Regarding cohabitation, a large proportion, 10 older people (47.6%), live alone. Of these, most (7 elderly people) are integrated in a HSS response which currently represents one of the alternatives for the elderly not having to leave their homes and their belongings, since this service can meet their basic needs at home. It presents itself, therefore, as an important response that, in many cases, is articulated with the informal solidarity that in our country emerges as an important support for the care of the elderly (Pimentel, 2005)[8].

The predominant schooling in the sample has complete primary education, with a percentage of 47.6%, which corresponds to 10 elderly people. Of the respondents, 5 (23.8%) had never attended school and the same number (5, 23.8%) had incomplete primary education. Only 1 elderly person (4.8%) has completed the 2nd cycle. The low level of education of our sample is visible, since approximately half of them (10 older people) do not have completed the 1st cycle and the same number only have primary education. This situation is related to the age of our sample, since compulsory education did not exist when they were young and the opportunity to attend school for several years was scarce, especially in rural areas, as is the case in the geographical context of our respondents.

About the question on self-assessment of health, we put 5 hypotheses of choice for the qualitative self-assessment of the state of health: very good, good, acceptable, weak and very weak. Most respondents (11 elderly, corresponding to 52.4%) consider their health to be "acceptable". According to the data, none of the elderly respondents considers their health to be "very good" and only two (9.5%) consider it to be "good" (both attending the CD). In the evaluation of health as "weak", there are 4 seniors (19.05%), divided equally between the DC and the HSS (with 2 seniors in each), and as "very weak", there are another 4 seniors (19.05%), 1 corresponding to the HSS and 3 to the DC. Thus - and considering the "acceptable" as an intermediate qualitative evaluation, the "very good" and "good" as a positive evaluation and the "weak" and "very weak" as a negative evaluation - we can say that only 9.5% of our sample (2 elderly people) has a positive evaluation of their own health status and 38.1% (8 elderly people) has a negative evaluation of their health status. Thus, in the HSS, the perception of the health condition by the elderly themselves was acceptable (8), weak (2) and very weak (1); in the DC, this gradation was good (2), acceptable (3), weak (2) and very weak (3).

We found a relationship between perceived health status and gender. Thus, the only respondents who made a positive assessment of their health status (as "good") were males. On the other hand, the answers "weak" and "very weak", corresponding to a negative self-assessment of their health, belonged mostly to female respondents (7 women and only 1 man).

When asked to compare with last year their current health situation, the items that presented the highest number of answers were: "More or less the same" answered by 12 participants (57.1%) and "A little worse than a year ago"

answered by 9 individuals (42.9%). The answers "much better than a year ago", "a little better than a year ago", and "much worse than a year ago" did not receive any answer from the respondents. It is thus visible that the feeling that all older people have about their state of health is in line with the known process of ageing, in which the functional deterioration and the state of health is progressive and occurs over time. A curious fact was that for the majority of HSS users (8 against 4 from the DC) their health is perceived as stable when compared to the previous year, but on the contrary most users who consider it to be worse belong to the DC response (6 elderly against 3 from the HSS).

When we asked the respondents to make a comparison with most people of their age and gender, we found that a large part of the elderly (10, corresponding to 47.6%) consider it to be "more or less the same", and that of these the majority who responded were from HSS (7 against 3 in DC). A high number of older people (7, corresponding to 33.3%) consider that their state of health is "a little worse" when compared to their peers, with the answers from HSS and DC being very close (with 3 and 4 older people, respectively). Two older adults (9.5%), both from DC, were more positively considering their health to be "much better" than their peers and, at the other extreme, one older person (4.8%) in a HSS was "much worse". One (4.8%) of the interviewees does not know/does not answer.

Following the same logic of the previous answer, most of the older people (10) assessed their health as stable when compared to their peers. The positive assessment of their health when compared to their peers only emerged in two older people, both attending the DC, which may indicate that they are autonomous older people. The negative evaluation of their health condition in comparison with their peers appears in 8 older adults (38.1%), with the one who makes the worst evaluation ("much worse") being integrated into HSS.

When questioned whether the pandemic had an influence on their health status, we found that the majority, 13 elderly people, consider it had not (61.9%) and 8 answered yes (38.1%), all females. This answer can be easily explained as most older people who answered no (10 out of 13) are integrated in a HSS response, which with the pandemic continued to operate in an identical way to what already existed (with the obvious introduction of personal protective equipment). Most of the older people who answered yes belong to the DC (7 out of 8), a response that was discontinued which led, despite all the effort of the institutions to maintain contact with these older people, to a change in the daily lives of these older people, with a substantial reduction in the activities they developed and, above all, the social contacts, and gatherings they had.

The way in which the 8 older women consider that the pandemic influenced their lives is mostly (7) at the psychological/ emotional level, namely with an increased feeling of isolation (2), feeling of immobility (2), sadness (1) anxiety (1) and fear (1). One of the elderly women mentioned the difficulty in accessing health care/treatment.

CONCLUSION

In this study, we verified a relationship between gender and self-assessment of health status, where most respondents who made a negative assessment of perceived health were women and only men made a positive assessment of it. These data contradict the study prepared by French, Gekoski and Knox (1995)[9] in which they found that there was a difference between genders in the evaluation of their physical and psychological well-being, where women appeared to have higher levels of perceived health which they related to differences in coping strategies between men and women. However, the data from the present study is in line with the studies where older women, due to having more comorbidities and a higher risk of disability and chronic pain, are the ones who assess their health status the worst. In the same vein, in a prospective study by Wilcox, Kasl and Idler [10] on the relationship between physical disabilities and perceived health with 254 hospitalised older people, the female gender recorded lower rates of perceived health.

We can also conclude that the majority of the older people in our sample (11 older people, 52.4%) have the value "acceptable" in the self-assessment of their health, which may be an indicator that they accept the inevitable biological, psychological and social changes that occur over time; whereas the 8 older people (38.1%) who consider their perceived health to be negative have a pathological view which, as a rule, is related to the onset of illness and the consequent functional decline and onset of discomfort and pain; only two older people (9.5%) have a positive view of their perceived health, which may correspond to a perspective of successful ageing (Baltes & Baltes, 1990, cited in Gonçalves et al, 2006)[11]. It should be noted that the only ones with a positive assessment belonged to the DC which may be explained, according to Almeida [12], by the existing relationship between functional capacity (and the respective reflection of autonomy and independence) and perceived (good) health.

When any comparison criterion was used, the data shows that women have a negative perception of their state of health when compared to the previous year and to men. These results are in line with the studies that show a greater existence of morbidities in women than in men with age. As Pinheiro et al. remind us (2002, p. 688)[13] "although they live longer than men, women report more morbidity and psychological problems and use more health services".

The fact that in the evaluation of health status in comparison with the previous year much of the elderly (12, 57.1%) consider it to be "more or less the same" may indicate an adaptive process, throughout the life course, in relation to physical and functional health. These results were in line with the study presented by Fernandes [14], where a large part of the elderly in the study considered their health to be the same as in the last year. The remaining older people (9, 42.9%) considered that their health status had worsened in relation to the previous year, which may be related, according to Ebly, Hogan and Fung [15], to the tendency

for health problems (visual, hearing, cardiac and musculoskeletal) to worsen and the consequent functional limitations for the performance of basic and instrumental activities of daily living.

Since the WHO defined the outbreak as a pandemic on March 11, everyone's life has changed, especially the lives of the elderly: those who were in the Residential Structures for the Elderly have stopped receiving visits and developing a set of activities, those in Day Centres have been forbidden to continue attending them, many no longer see their relatives at home, on the streets there are no daily meetings and gatherings and, in the moments of hardest confinement, they no longer have any social contact. If we consider that the functional capacity of the elderly is negatively impacted and consequently deteriorates when they stop walking, exercising, developing motor skills, playing games, talking and socialising, then it is easy to imagine that the impact that the current Pandemic is having on their lives will be enormous.

Of the elderly respondents, 8 (38.1%) considered that the pandemic had an impact on their health. All of them were female and integrated the DC, a social response that suffered major impacts with the pandemic, namely with its closure. The activities developed with the frequenters of the DCs were replaced by more individualised activities, the quantity of which was reduced and, obviously, the activities that implied social interaction no longer existed.

Most of these older women consider that the greatest impact of this pandemic was on a psychological/ emotional level, because of the decrease in social encounters and the increase in anxiety, fear and isolation. It is still too early to analyse the impact of the pandemic, but we know that it will certainly have impacts on the mental health of the Portuguese. In a study being developed, with adults over 50 years old, by a team of researchers from the University of Coimbra, to assess the "impact of social isolation imposed by the covid-19 pandemic on the physical and psychological well-being of adults and elderly people", after a first data analysis, the researcher Sandra Freitas states that "the period of mandatory confinement significantly favoured the development of higher levels of depressive symptoms and, consequently, worse quality of life in the Portuguese" [16]

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