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Research Article

Quality of life, sociodemographic profile, and self-perceived health among older adults assisted in primary health care

Qualidade de vida, perfil sociodemográfico e autopercepção de saúde em idosos assistidos na atenção primária à saúde

Calidad de vida, perfil sociodemográfico y autopercepción de salud en adultos mayores que reciben atención primaria de salud

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Abstract

Introduction: As individuals age, quality of life (QoL) is closely related to personal characteristics, the environment in which they live, the ability to maintain relationships, housing, financial security, and a positive self-perception of health. **Objective**: **To** analyze the association between sociodemographic profile, self-perceived health, and QoL among older adults receiving care in primary health care. **Methods:** This is a household survey conducted in 2024 with a sample of 306 older adults who were users of a Primary Health Care Unit (Unidade Básica de Saúde — UBS) in the Paraná, Brazil. Sociodemographic variables (sex, marital status, income, and occupation) were assessed using a structured questionnaire, in addition to the World Health Organization Quality of Life — brief (WHOQOL-BREF) and World Health Organization Quality of Life — Older Adults Module (WHOQOL-OLD) scales. Data analysis was performed using Statistical Package for the Social Sciences (SPSS®) software, version 25.0. For inferential analysis, Student's t-test (for two groups) and one-way Analysis of Variance (ANOVA) followed by Tukey's Post Hoc test (for more than two groups) were used. A significance level of $p<0.05$ was adopted. **Results:** Among the 306 participants, 53.6% reported having regular health. Women showed poorer health perception, while men had higher average scores in the sensory functioning facet. Regarding marital status, those with a partner had better scores in the psychological domain. A good self-perception of health was positively associated with all facets and domains of quality of life. **Conclusions:** Older men, who were married or had a partner, had an income above two minimum wages, were active in the labor market, independent, and had a good self-perception of health, showed better QoL.

Keywords: Quality of life; Aged; Health of the elderly; Socioeconomic factors.

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Resumo

Introdução: À medida que o indivíduo envelhece, a qualidade de vida (QV) está intimamente relacionada às características pessoais, ao meio em que está inserido, à capacidade de manter relacionamentos, à habitação, à segurança financeira e a uma autopercepção positiva de saúde. **Objetivo:** Analisar a associação entre o perfil sociodemográfico, a autopercepção de saúde e a QV entre idosos atendidos na atenção primária à saúde. **Metódos:** Trata-se de um inquérito domiciliar conduzido em 2024 com uma amostra de 306 idosos usuários de uma unidade básica de saúde (UBS), no estado do Paraná, Brasil. Variáveis sociodemográficas (sexo, estado civil, renda e ocupação) foram avaliadas por meio de questionário estruturado, além das escalas WHOQOL-BREF e WHOQOL-OLD. A análise dos dados foi realizada por meio do *software* Statistical Package for the Social Sciences, versão 25.0. Para a análise inferencial, utilizaram-se os testes t de Student (para dois grupos) e *one-way analysis of variance* (ANOVA), seguidos do teste *post hoc* de Tukey (para mais de dois grupos). Adotou-se nível de significância de p<0,05. **Resultados:** Dos 306 idosos participantes, 53,6% relataram ter saúde regular. As mulheres apresentaram pior percepção de saúde, enquanto os homens obtiveram maior média na faceta de funcionamento sensorial. Em relação ao estado civil, aqueles com companheiros apresentaram melhores escores no domínio psicológico. A boa autopercepção de saúde esteve positivamente associada a todas as facetas e domínios da qualidade de vida. **Conclusões:** Idosos do sexo masculino, casados ou com companheiro, com renda superior a dois salários mínimos, ativos no mercado de trabalho, independentes e com boa autopercepção de saúde apresentaram melhor QV.

Palavras-chave: Qualidade de vida; Idoso; Saúde do idoso; Fatores socioeconômicos.

Resumen

Introducción: A medida que los individuos envejecen, la calidad de vida (CV) se relaciona con las características personales, el entorno en el que viven, la capacidad de mantener relaciones, la vivienda, la seguridad financiera y una autopercepción positiva de la salud. **Objetivo:** Analizar la asociación entre el perfil sociodemográfico, la autopercepción de salud y la CV en adultos mayores que reciben atención primaria de salud. **Métodos:** Se trata de una encuesta domiciliaria realizada en 2024 con una muestra de 306 adultos mayores usuarios de una Unidad Básica de Salud (UBS) en Paraná, Brasil. Las variables sociodemográficas (sexo, estado civil, ingresos y ocupación) se evaluaron mediante un cuestionario estructurado, además de las escalas WHOQOL-BREF y WHOQOL-OLD. El análisis de datos se realizó con el software SPSS®, versión 25.0. Para el análisis inferencial se utilizaron la prueba t de Student (para dos grupos) y ANOVA de una vía, seguido de la prueba post hoc de Tukey (para más de dos grupos). Se adoptó un nivel de significancia de p<0,05. **Resultados:** Entre los 306 participantes, el 53,6% reportó tener una salud regular. Las mujeres tuvieron una peor percepción de salud, mientras que los hombres obtuvieron puntajes promedio más altos en la faceta de funcionamiento sensorial. En cuanto al estado civil, aquellos con pareja obtuvieron mejores puntajes en el dominio psicológico. Una buena autopercepción de la salud se asoció positivamente con todas las facetas y dominios de la calidad de vida. **Conclusiones:** Los hombres mayores, casados o con pareja, con ingresos superiores a dos salarios mínimos, activos en el mercado laboral, independientes y con buena autopercepción de salud, tuvieron mejor CV.

Palabras clave: Calidad de vida; Anciano; Salud del anciano; Factores socioeconómicos.

INTRODUCTION

With the increase in life expectancy, population aging is considered a global phenomenon, combined with the senescence process, which is natural, irreversible, continuous, and non-pathological, influenced by biological, environmental, and psychological aspects.[1,2] The aging of the population leads to reflections not only on the importance of longevity but also on ensuring it is based on the maintenance of functional capacities, general well-being, quality of life (QoL), and personal satisfaction. Thus, it is understood that having positive expectations, good self-perception of health, and access to the necessary resources to meet social and health demands are fundamental factors for aging with QoL.[1,3]

Quality of life is a process resulting from satisfaction with physical, psychological, emotional, self-esteem, social, environmental, family, and existential aspects. It is an eminently human notion, relative and dependent on individual aspects regarding what is considered a standard of comfort and well-being.[4] As the individual ages, QoL is linked to the ability to maintain autonomy and independence, relationships, housing, financial security, and a positive self-perception of health.[5-7] Thus, among the aspects responsible for the perception of QoL in the elderly is the way they perceive their health and their ability to care for it.[8]

Therefore, self-perception of health (SPH) is an important indicator of QoL that encompasses physical, cognitive, and emotional aspects,[9] referring to the correlation between health condition and functionality, capable of reflecting individuals' perception and actual health status.[8] It is also associated with sociodemographic aspects such as gender, race, marital status, and income, where lower prevalence of positive SPH is found among women and Black or Brown men, with low education levels and widowed status; while higher prevalence occurs in older adults with a partner, higher income, and who are physically active.[10,11]

Likewise, the QoL of the elderly population is influenced by social determinants that can be considered predictors of this variable.[8] Supporting this statement, studies[5,7] show that among the oldest with better QoL averages are those with younger age groups, male gender, married status, sufficient income and home ownership, and those who still perform work-related activities. Thus, it can be inferred that the QoL of older individuals is influenced by biopsychosocial factors, and social characteristics are predictors of QoL and contribute to active and healthy aging.[7,12]

Among demographic characteristics, age is one of the determining variables of QoL in aging. The increase in age makes the elderly more susceptible to the onset of diseases that may negatively impact their QoL.[12,13] A similar phenomenon occurs in the gender context, since this variable is a determinant in the aging process, directly impacting health conditions, well-being, and QoL of the elderly.[14,15] Regarding marital status, studies state that older adults who are married or have partners show better QoL than those who are single.[15,16]

Moreover, labor market participation and access to resources also appear as important determining factors for QoL. Studies[16,17] point out that having sufficient financial income to meet basic life needs provides older adults with security and consequently an improvement in QoL. Likewise, work is considered a mediator of biological health, psychological state, and social competence.[13] Furthermore, the influence of work on the QoL of the elderly goes beyond income-related needs, showing the maintenance of health in older adults.[18]

Although the theme of QoL in the elderly population has gained importance due to its impact on the physical, mental, and social health of older individuals, few studies analyze the impact of sociodemographic profile and health self-perception on the QoL of this group, which highlights the relevance of the present construct. Beyond identifying the influence of these predictors on QoL, the study also aims to foster new discussions regarding more assertive health actions based on these determinants. Thus, the objective of the study was to analyze the association between sociodemographic profile, self-perception of health, and QoL of older individuals assisted in primary care.

METHODS

This is a cross-sectional household survey conducted with elderly individuals registered at a Primary Health Care Unit (UBS) in a municipality in the southern region of Brazil. It is worth noting that the presented data is part of a larger study titled «Analysis of the Living and Health Conditions of Elderly People Attended in Primary Health Care in Maringá: A Look at the Completeness of Care for Health Promotion,» conducted from June to August 2024.

At the time of data collection, the municipality had 33 Primary Health Care Units and 71 Family Health Strategy (ESF) teams. The UBS in question had three ESF teams with 1,660 elderly individuals registered: 562 in team 1, 664 in team 2, and 434 in team 3. The UBS was chosen for convenience by

the researchers, considering its proximity and ease of access to data about the local elderly population. Moreover, the area has a high concentration of elderly individuals, indicating intensive use of the services provided by the UBS.

The study's target population consisted of elderly individuals registered in the three ESF teams of the UBS, who had been attending for at least six months, a criterion adopted to align with the larger study. Exclusion criteria included those with cognitive impairments that compromised the understanding of questions, as assessed using the Mini-Mental State Examination (MMSE),[19] which aims to evaluate cognitive functions through 12 questions. It should be noted that no individual was excluded for this reason. Also excluded were elderly individuals who were absent from their homes for at least two attempts on different days and times.

During the study, national and international ethical guidelines for research with human beings were followed, and the project was approved by the Ethics Research Committee of University Cesumar, under opinion number 6.841.861. All participants, after being informed about the study's objectives and participation criteria, signed the Informed Consent Form (ICF) in two copies.

For the sample size calculation, a 50% prevalence was assumed to ensure higher variability in the studied event, with an estimation error of 5%, and a sample confidence and precision of 95%. An additional 10% (32 individuals) was added for potential losses, resulting in a sample of 344 individuals. Once the number of individuals eligible for inclusion in the study was determined, lists with names and addresses of elderly individuals were requested, and a proportional random selection of participants was conducted. After refusals (20) and changes/absence at the addresses (18), 306 elderly individuals were effectively interviewed.

Data collection occurred from June to August 2024, in the elderly individuals' homes, with their consent to participate during weekdays and Saturdays, in both morning and afternoon periods. If an individual was not at home, two additional visits were made at different times. If the interview could not be conducted, the next individual on the list was contacted, with only one substitution allowed.

The dependent variable defined for the study was QoL, measured using the WHOQOL-BREF and WHOQOL-OLD scales. The WHOQOL-BREF[20] consists of 26 questions assessing QoL across four domains: physical, social, social relationships, and environment. Each item is scored on a scale from 1 to 5, where 1 represents a negative assessment and 5 represents a positive assessment. The WHOQOL-OLD[21], a validated tool for assessing QoL in elderly individuals, contains 24 questions divided into six domains: sensory functioning, autonomy, past, present, and future activities, social participation, death and dying, and intimacy. Each domain includes four questions, and responses follow a Likert scale (1 to 5), with higher percentages (closer to 100%) indicating better QoL.

Independent variables were the socioeconomic characteristics (sex, education, occupation, and income) and self-perception of health, measured by the question: «How do you evaluate your health compared to others of the same age?» with response options: good, fair, and poor.

The completed instruments were checked for errors before being compiled into a database using Microsoft Office Excel 2010. Data analysis was performed using SPSS Software 25.0, with both descriptive and inferential statistical approaches. Frequency and percentage were used as descriptive measures for categorical variables. For numerical variables, data normality was assessed using the Kolmogorov-Smirnov test and skewness and kurtosis coefficients.

For the analysis of sociodemographic characteristics, some variables were categorized. Age was grouped into 60–69, 70–79, and 80 or older; marital status was grouped into «no companion» and «with

companion.» Occupation was separated into «yes,» «no,» and «retired.» Monthly income was grouped into «up to 1 minimum wage,» «1-2 minimum wages,» and «more than 2 minimum wages.»

Bootstrapping procedures (1,000 re-samplings; 95% BCa Confidence Interval) were also performed to increase the reliability of the results, correct potential deviations from normality in the data distribution, and account for differences between group sizes, as well as to provide a 95% confidence interval for the means. To compare the QoL domains and facets based on sociodemographic variables, dependent Student's t-test (two groups) and One-Way ANOVA followed by Tukey's Post Hoc test (more than two groups) were used. A significance level of $p<0.05$ was adopted.

The used research data are publicly available, in website URL: https://osf.io/zk9ue/.

RESULTS

Among the 306 elderly participants in the study, ages ranged from 60 to 89 years (M=70.12; SD=6.62). A predominance of women (62.4%) and elderly individuals in the 60–69 age group (50.3%) was observed. Furthermore, the majority of participants were retired (73.2%), had a companion (61.4%), and received a monthly income above the minimum wage (76.1%). Regarding self-perception of health, 53.6% of the elderly individuals rated their health as fair (Table 1).

Table 1. Description of the profile of elderly participants in the research. Maringá, Paraná, 2024.

Variables	*f*	%
Sex		
Female	191	62.4
Male	115	37.6
Age group (years old)		
60 to 69	154	50.33
70 to 79	118	38.56
80 or more	34	11.11
Marital status		
With partner	188	61.4
Whithout partner	118	38.6
Occupation		
Yes	54	17.6
No	28	9.2
Retired	224	73.2
Monthly Income[a]		
Up 1 (MW)	73	23.9
1 to 2 (MW)	141	46.2
More than 2 (MW)	91	29.9
Health perception		
Poor	73	23.9
Fair	164	53.6
Good	69	22.5

[a]Variable with missing cases; MW: minimum wage.

In the domains of QoL, the highest mean was found in the psychological domain (M=3.96; SD=0.57), followed by the physical domain (M=3.90; SD=0.66), environment (M=3.85; SD=0,52), and social relationships (M=3.83; SD=0.59). Regarding the facets, the highest mean was observed in sensory functioning (M=4.37; SD=0.74), death and dying (M=4.11; SD=0.97), intimacy (M=3.97; SD=0.83), past, present, and future activities (M=3.85; SD=0.65), social participation (M=3.84; SD=0.65), and autonomy (M=3.82; SD=0.62).

Regarding the comparison between QoL domains and facets and the tested variables, a significant difference was found between males and females only in the sensory functioning facet (p=0.033), indicating that men presented a higher mean (M=4.47; SD=0.62) compared to women (M=4.32; SD=0.80). As for age groups, a significant difference was observed only in the sensory functioning facet (p=0.002), with older adults aged 60–69 years presenting a higher mean in this facet of QoL compared to those aged 80 years or older.

When comparing the QoL domains and facets according to marital status (Table 2), a significant difference was found between the groups in the psychological domain (p=0.012) and in the facets of past, present, and future activities (p=0.013) and intimacy (p<0.001).

When analyzing the QoL domains and facets of older adults according to occupational status, a significant difference was found between groups in the physical domain (p<0.001), social relationships (p=0.029), and environment (p=0.007), as well as in the facets of sensory functioning (p=0.015), autonomy (p=0.015), past, present, and future activities (p=0.004), social participation (p=0.002), and intimacy (p=0.046). It is noteworthy that older adults with active occupational status had higher mean scores in all QoL domains compared to retired older adults who were not working.

Table 2. Comparison of quality of life domains and facets among older adults attending a Primary Health Care Unit in the city of Maringá -PR, according to sex, age group, and marital status. Maringá, Paraná, 2024.

Variables	*Sex*		*P*	*Age Group*			*p*	*Marital Status*		p-value
	Female (n=191)	Male (n=115)		60–69 (n=154)	70–79 (n=118)	≥80 (n=34)		With Partner (n=188)	Without Partner (n=118)	
	M (SD)	M (SD)		M (SD)	M (SD)	M (SD)		M (SD)	M (SD)	
Quality of Life Domains										
Physical	3.8 (0.7)	3.9 (0.6)	0.074	3.9 (0.7)	3.9 (0.6)	3.7 (0.7)	0.211	3.9 (0.6)	3.8 (0.7)	0.084
Psychological	3.9 (0.6)	4.0 (0.6)	0.145	3.9 (0.6)	4.0 (0.6)	3.8 (0.5)	0.310	4.0 (0.6)	3.9 (0.6)	**0.012***
Social Relationships	3.8 (0.9)	3.4 (0.6)	0.381	3.8 (0.6)	3.9 (0.5)	3.7 (0.5)	0.458	3.9 (0.6)	3.8 (0.5)	0.145
Environment	3.8 (05)	3.9 (0.5)	0.105	3.8 (0.5)	3.9 (0.5)	3.8 (0.5)	0.752	3.9 (0.5)	3.8 (0.5)	0.089
QoL Facets										
Sensory Functioning	4.3 (0.8)	4.5 (0.6)	**0.033***	4.5 (0.6)[a]	4.3 (0.8)	4.0 (0.8)	**0.002****	4.4 (0.7)	4.3 (0.8)	0.067
Autonomy	3.8 (0.6)	3.9 (0.6)	0.141	3.8 (0.5)	3.82 (0.6)	3.7 (0.72)	0.314	3.85 (0.57)	3.8 (0.7)	0.152
Activities	3.8 (0.7)	3.9 (0.6)	0.254	3.7 (0.6)	3.9 (0.7)	3.7 (0.6)	0.445	3.9 (0.6)	3.7 (0.6)	**0.013***
Social Participation	38 (0.6)	3.9 (0.6)	0.177	3.8 (0.7)	3.93 (0.6)	3.7 (0.7)	0.182	3.8 (0.7)	3.8 (0.6)	0.384
Death and Dying	4.0 (1.0)	4.2 (0.9)	0.080	4.0 (1.0)	4.1 (1.0)	4.0 (0.9)	0.519	4.1 (1.0)	4.0 (0.9)	0.208
Intimacy	3.9 (0.9)	4.0 (0.7)	0.367	4.0 (0.8)	3.93 (0.9)	4.0 (0.6)	0.732	4.1 (0.7)	3.7 (0.9)	**<0.001***

*Significant difference: p<0.05 — Independent Student's t-test; **significant difference: p<0.05 — One-Way ANOVA between:
a) 60–69 years with 80 years or older.

A significant difference was also observed in the psychological (p=0.011) and environment (p<0.001) domains, and in the intimacy facet (p=0.002), according to monthly income. These findings indicate that older adults with an income above two minimum wages had a higher mean in the psychological domain compared to those with an income of up to one minimum wage, as well as higher scores in the environment domain compared to all older adults with lower monthly income. Finally, older adults with an income of up to one minimum wage had lower mean scores in the intimacy facet when compared to all older adults with higher income (Table 3).

When comparing the QoL domains and facets of older adults according to their health perception, a significant difference was observed in almost all of them (p<0.05), except for the "death and dying" facet (p=0.750). These findings indicate that older adults with a good perception of their health presented higher mean scores across all QoL domains and in the social participation facet when compared to those with regular or poor health perception. Moreover, older adults with a poor perception of their health showed lower mean scores in the facets of sensory functioning, autonomy, past, present, and future activities, and intimacy when compared to those with regular and good health perception (Table 4).

DISCUSSION

In the analysis of the sociodemographic profile of the elderly participants in the study, a predominance of women (62.4%), retirees (73.2%), and those with a partner (61.4%) was observed, data that aligns with Brazilian literature on aging.[22] It was also observed that most elderly individuals reported regular health perception, as well as high QoL scores, with emphasis on the psychological and physical domains, and the facets of maintaining the senses, death and dying, and intimacy, reinforcing the importance of maintaining functionality, cognition, and social relationships for and well-being.

Table 3. Comparison of quality of life domains and facets among older adults attending a Primary Health Care Unit in the city of Maringá-PR, according to occupational status and monthly income. Maringá, Paraná, 2024.

Variables	Occupational Status*			p-value	Monthly Income**			p-value
	Yes (n=54)	No (n=28)	Retired (n=224)		≤1 MW (n=73)	1 a 2 MW (n=141)	>2 MW (n=91)	
	M (SD)	M (SD)	M (SD)		M (SD)	M (SD)	M (SD)	
QoL Domains								
Physical	4.2 (0.5)[a]	3.9 (0.6)	3.8 (0.7)	**<0.001***	3.8 (0.6)	3.9 (0.7)	3.9 (0.7)	0.242
Psychological	4.0 (0.6)	3.9 (0.7)	3.9 (0.6)	0.37	3.8 (0.6)	3.9 (0.6)	4.1 (0.5)[a]	**0.011***
Social Rel.	4.0 (0.6)[a]	3.7 (0.7)	3.8 (0.5)	**0.029***	3.7 (0.6)	3.9 (0.60)	3.9 (0.56)	0.098
Enverinoment	4.0 (0.5)[b]	3.6 (0.6)	3.8 (0.5)	**0.007***	3.7 (0.6)	3.8 (0.5)	4.0 (0.4)[b]	**<0.001***
QoL Facets								
Sensory Func.	4.6 (0.6)[a]	4.5 (0.7)	4.3 (0.8)	**0.015***	4.2 (0.8)	4.4 (0.7)	4.4 (0.7)	0.078
Autonomy	4.0 (0.5)[a]	3.7 (0.7)	3.8 (0.6)	**0.015***	3.7 (0.7)	3.8 (0.6)	3.8 (0.6)	0.462
Activities	4.1 (0.6)[c]	3.7 (0.8)	3.8 (0.6)	**0.004***	3.7 (0.7)	3.9 (0.7)	3.9 (0.5)	0.172
Social Participation	4.0 (0.6)[a]	3.6 (0.9)	3.8 (0.6)	**0.002***	3.8 (0.6)	3.8 (0.7)	3.9 (0.6)	0.629
Death and Dying	4.1 (0.9)	3.9 (1.0)	4.1 (1.0)	0.485	4.1 (0.9)	4.1 (0.93)	4.1 (1.05)	0.936
Intimacy	4.2 (0.6)[a]	3.8 (1.1)	3.9 (0.8)	**0.046***	3.6 (1.0)[c]	4.0 (0.8)	4.1 (0.7)	**0.002***

*Significant difference: p<0.05 — One-Way ANOVA between: a) Yes and Retired; b) Yes and No; c) Yes with No and Retired;
**Significant difference: p < 0.05 — One-Way ANOVA between: a) more than 2 MW with Up to 1 MW; more than 2 MW with Up to 1 MW and 1 to 2 SM; c) Up to 1 MW with 1 to 2 MW and More than 2 MW.

Table 4. Comparison of quality of life domains and facets among older adults attending a Primary Health Care Unit in the city of Maringá, Paraná, according to health perception. Maringá, Paraná, 2024.

Variables	Health perception			p-value
	Poor (n=73)	Fair (n=64)	Good (n=69)	
	M (SD)	M (SD)	M (SD)	
QoL Domains				
Physical	3.5 (0.7)	3.9 (0.6)	4.2 (0.5)[a]	**<0.001***
Psychological	3.7 (0.9)	3.9 (0.5)	4.3 (0.4)[a]	**<0.001***
Social Rel.	3.6 (0.6)	3.8 (0.6)	4.0 (0.5)[a]	**<0.001***
Environment	3.6 (0.6)	3.9 (0.4)	4.1 (0.5)[a]	**<0.001***
QoL Facets				
Sensory Func.	4.0 (0.8)[b]	4.4 (0.7)	4.6 (0.6)	**<0.001***
Autonomy	3.6 (0.7)[b]	3.8 (0.6)	3.9 (0.6)	**0.003***
Activities	3.5 (0.8)[b]	3.9 (0.5)	4.0 (0.5)	**<0.001***
Social Participation	3.6 (0.8)	3.8 (0.5)	4.1 (0.5)[a]	**<0.001***
Death and Dying	4.1 (1.0)	4.1 (1.0)	4.2 (0.9)	0.750
Intimacy	3.7 (1.0)[b]	4.0 (0.7)	4.1 (0.9)	**0.004***

*Significant difference: p<0.05 — One-Way ANOVA between: a) Good and Regular/Poor; b) Poor and Regular/Good.

When comparing QoL domains and facets, it is observed that although there was a predominance of women in the study, men had higher scores in the facet of sensory functioning, a finding that can be related to biological and social differences in aging.[23] The higher male scores in sensory functioning align with a study[24] showing that men tend to report fewer sensory impairments at older ages compared to women. Biological differences and the fact that women live longer increase chronic diseases, which may explain the lower female scores in non-sensory domains and reflect poorer health perception.[25]

Similarly, sensory functioning showed differences among the oldest elderly participants, with lower scores reported, while younger participants had higher scores. These findings corroborate with literature,[24] as aging can bring natural changes to the body, including sensory loss and its association with multiple comorbidities, contributing to elderly dependence. These results highlight how influential the maintenance of communication, based on the preservation of the senses, is for QoL and how the elderly perceive their interaction with their surroundings.

Regarding marital status, elderly individuals with a partner had better scores in the psychological and intimacy domains. These findings are consistent with the literature,[26] which indicates that emotional and social support provided by a partner contributes to better psychological QoL. This finding reinforces the need to promote health interventions that include social support as a central factor, as well as highlight the importance of emotional and social bonds in maintaining well-being.[25,26]

In old age, living with a partner is a protective factor for mental health, providing emotional support that can reduce depression incidence and promote greater social engagement, reflecting on the QoL of elderly individuals.[26] Marriage can also contribute to greater family support and influence the adoption of health-promoting behaviors in the elderly.[4]

The average score in the facet of past, present, and future activities was also higher among those with a partner, indicating that companionship may favor participation in physical and social activities.[27] Having a partner not only provides emotional support but also encourages joint participation in activities

such as walking and social events, reinforcing physical health, mental well-being, and self-care. It is widely accepted that having a partner can serve as an important facilitator in the routine of activities, seeking preventive care, improving mental health, and satisfaction with life in this population, preventing functional decline.[28,29]

The analysis of economic aspects revealed the prevalence of higher QoL scores among elderly individuals with an active occupational status, as opposed to those who were retired, particularly in the physical, social relationships, and environment domains. This result supports the premise that entering the job market has a strong potential to maintain functionality, cognition, and QoL, and that continuing some form of occupational activity in old age, whether formal or voluntary, is associated with a more positive perception of QoL, especially in the physical domain.[30] Consistent with this, individuals aged 60 or older who remain in the workforce have an increased life expectancy, enhancing self-esteem, identity, and sense of purpose.[31]

Additionally, elderly individuals with higher income reported better QoL scores, particularly in the environmental domain. This pattern was similarly found in studies in Germany[6] and Japan,[32] where financial security was associated with better QoL perception and greater access to health services. In Brazil, a study[33] showed that lower income is directly related to worse health and well-being indicators in the elderly. These findings converge with the extensive epidemiological literature discussing the relationship between income and health perception, showing that individuals with lower purchasing power tend to report worse health perceptions compared to those with higher income.[34]

Moreover, income stands out as a significant factor for QoL, particularly in the environmental domain, which involves access to resources, transportation, and safety. Elderly individuals with income above two minimum wages reported better perception in this aspect, aligning with studies that show that higher income offers greater access to health services and cultural activities, improving QoL.[35] On the other hand, elderly individuals with lower income tend to face limitations in accessing essential services and increased social vulnerability, which can harm mental and physical health.[25]

Therefore, it is understood that the health perception of the elderly is influenced not only by objective factors, such as disease diagnoses but also by subjective factors, such as living conditions and psychological well-being. These aspects are closely related to QoL. Social support, in addition to being a mediator for mental well-being, directly impacts QoL. Emotional elements, such as gratitude and optimism, and socioeconomic factors, such as income, play a crucial role in the intersection between self-perception of health and QoL.[36]

The findings highlighted in this study demonstrate the importance of providing care actions for the elderly with a focus on the individual, considering their specificities. Considering the social inequalities in the country, it is crucial that the formulation of public policies promotes measures to ensure the right to age with dignity and health, with QoL.

CONCLUSION

Given the study results, it was possible to observe the probability that the socioeconomic profile and self-perception of health have a significant impact on the QoL of the elderly participants. Thus, we observed the probable influence of variables such as sex, marital status, income, and occupational activity on various domains of QoL, with men, those married or with a partner, those earning more than two minimum wages, and those active in the labor market appearing to have a higher QoL.

This discussion reinforces the need for public policies that encourage active aging, both through the stimulation of occupational participation and by promoting social and cultural activities. Additionally, it is essential to develop strategies focused on equity in access to resources for low-income elderly individuals, ensuring their inclusion and well-being. Interventions that integrate social support, participation in activities, and health promotion may be more effective in maintaining QoL in old age.

However, it is necessary to point out that there were some limitations in this study, such as being conducted in a single center, which may hinder the comparison of the results with other populations and regions in the country, as well as the sample size, which does not allow generalization of these results to the broader elderly population. There is also the possibility of reverse causality caused by the cross-sectional design, which can significantly affect the temporality of the factors. Nevertheless, this is a highly relevant result, as it provides greater visibility to sociodemographic aspects and self-perception of health, which can be more valued in the formulation and implementation of health promotion actions for this group. It is suggested that new studies be conducted with a similar method, including other sociodemographic data, aiming to expand research on the factors influencing the QoL of elderly people.

CONFLICT OF INTERESTS

Nothing to declare.

AUTHORS' CONTRIBUTIONS

ABGG: Conceptualization, Data curation, Formal analysis, Writing — first draft, Writing — review and editing; MESM: Conceptualization, Data curation, Formal analysis, Writing — first draft, Writing — review and editing; VRJO: Conceptualization, Data curation, Formal analysis, Writing — first draft, Writing — review and editing; FSN: Writing — first draft, Writing — review and editing; ABS: Data curation, Formal analysis, Writing — first draft, Writing — review and editing; PPFM: Data curation, Formal analysis, Writing — first draft, Writing — review and editing; NQS: Conceptualization, Data curation, Formal analysis, Writing — review and editing; ALS: Conceptualization, Data curation, Formal analysis, Writing — first draft, Writing — review and editing.

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