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Socioeconomic characteristics, self-evaluation of health, and quality of life in women

Características socioeconômicas, autoavaliação de saúde e qualidade de vida em mulheres

Características socioeconómicas, autoevaluación de salud y calidad de vida en mujeres

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The objective of this research was investigation the relations between the socioeconomic features, health evaluation and quality of life in women. This is a cross-sectional study with a population bases and a sample of 1489 women living in Uberaba, Minas Gerais, Brazil, in 2014. The youngest women (18-40) were frequent in the group "dissatisfied with health" ($p<0.001$), as were those with higher educational levels (9 years or more) ($p=0.002$) and those dissatisfied with their income ($p<0.001$). Women from 41-59 ($p<0.001$), with higher educational levels ($p<0.001$) and insufficient income ($p<0.001$) evaluated their quality of life as bad more frequently than women in other groups ($p<0.001$). A bad quality of life and dissatisfaction with health were more frequent among younger women, those with lower educational levels, and those dissatisfied with their family income.
Descriptors: Women's health; Socioeconomics factors; Public Health.

O objetivo foi investigar as relações entre características socioeconômicas, autoavaliação de saúde e qualidade de vida em mulheres. Trata-se de estudo transversal de base populacional com amostra de 1489 mulheres residentes em Uberaba, Minas Gerais, em 2014. As mulheres mais jovens (18-40 anos) foram frequentes no grupo "insatisfeitas com a saúde" ($p<0,001$), assim como aquelas com mais anos de escolaridade (9 anos ou mais) ($p=0,002$) e as insatisfeitas com a renda ($p<0,001$). As mulheres entre 41-59 anos ($p<0,001$), com maior escolaridade ($p<0,001$) e com renda insuficiente ($p<0,001$) avaliaram a qualidade de vida como ruim com mais frequência do que as mulheres em outros grupos ($p<0,001$). Qualidade de vida ruim e insatisfação com a saúde foram mais frequentes entre mulheres mais jovens, naquelas com maior escolaridade e insatisfeitas com a renda familiar.
Descritores: Saúde da mulher; Fatores socioeconômicos; Saúde Pública.

El objetivo fue investigar las relaciones entre características socioeconómicas, autoevaluación de salud y calidad de vida en mujeres. Se trata de un estudio transversal de base poblacional con muestra de 1489 mujeres residentes en Uberaba, Minas Gerais, Brasil, en 2014. Las mujeres más jóvenes (18-40 años) fueron comunes en el grupo "insatisfechas con la salud" ($p<0,001$), así como aquellas con más años de escolaridad (9 años o más) ($p=0,002$) y las insatisfechas con los ingresos ($p<0,001$). Las mujeres entre 41-59 años ($p<0,001$), con mayor escolaridad ($p<0,001$) y con ingresos insuficientes ($p<0,001$) evaluaron la calidad de vida como mala con más frecuencia que las mujeres en otros grupos ($p<0,001$). Mala calidad de vida e insatisfacción con la salud fueron más comunes entre mujeres más jóvenes, en aquellas con mayor escolaridad e insatisfechas con los ingresos familiares.
Descriptores: Salud de la mujer; Factores socioeconómicos; Salud Pública.

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INTRODUCTION

Brazilians tend to have many different trajectories in health and wellbeing, depending on economic, demographic, and social features, which determine positive or negative conditions throughout life[1,2]. These aspects influence their load of diseases and disabilities, their use and access to health services, and their adherence to treatments and programs of health promotion and prevention[3,4].

The female population is different than the male one with regards to health and wellbeing conditions, and these differences tend to increase with age[5–7]. Women live longer, are more affected by chronic diseases and disabilities due to being less exposed to accidents, violence, and other external causes of death when compared to men[8]. They health self-perception is also more negative[9]. This setting highlights the importance of understanding phenomena related to women's health and the specificities of their processes of health, disease, and disability, so that healthcare to this population can be increased

Recently, there has been an increase in the incidence and prevalence of non-transmissible chronic diseases (NTCD), women have been more present in the work market, and there have been changes in family structures and social roles. Considering this epidemiological and demographic context, subjective health and wellbeing indexes lead to more effective assessments, since they give more relevant information on how much health and live events affect the individual[1,5,10]. This type of evaluation has been standing out in collective health in the last years, and is recognized as the current health paradigm[11]. Among these indexes, are the health self-evaluation, and the quality of life self-evaluation.

Quality of life is an evaluation made by subjects about their own lives, considering personal expectancies and realizations, as well as demands and standards of their sociocultural contexts[12]. This concept has been widely investigated since the beginning of the transition from a biomedical health model to bio-psycho-social, ecological, and holistic models. These models reiterate the importance and the possibility of maintaining quality of life despite the diseases and adversities of life cycles[13]. From then on, promoting a better quality of life for the populations has been one of the main challenges of current society, its administrators, and health services.

The health self-evaluation is the evaluation of a subject about their own health. It is a global evaluation, in which the subject generally considers the health state of their pears — social comparison and comparisons with oneself. This was, until recently, known as personal comparison[10,14]. This evaluation reflects the impact of diseases, health problems, symptoms, and disabilities in the life of an individual, especially considering their independence and autonomy. This concept has been strongly related to worst functional health prognostics and an increased mortality[15].

Many conditions or events can take place through one's life to make them more likely to have a lower quality of life and a worse health self-evaluation. Diseases, disabilities, loss of autonomy, advancing age, accidents, financial problems, stressful family relations, and lack of social support are the most common[16,17].

Some conditions worsen one's quality of life and changing them is impossible or has little effect. That means that individuals affected have a disadvantage with regards to their pears. These inequalities can be present among women, determining different outcomes in health and quality of life. Such conditions include age, educational level, income, and living with a partner in a stable union.

Knowing the socioeconomic differences related to quality of life and health self-evaluation among women contribute to understand how broad these phenomena are, considering the inequality and disadvantages to which the female population is submitted. As a result, this work aimed to investigate the association between socioeconomic characteristics, self-evaluation of health, and quality of life in women.

METHOD

Data from this research resulted from the Inquiry of Women's Health (ISA Woman), carried out in the city of Uberaba - MG, in 2014. This is a cross-sectional population-based study, with a probabilistic sample of 1556 18-year-old or older women who live in Uberaba. The research was approved by the Research Ethics Committee of the Universidade Federal do Triângulo Mineiro, under CAAE nº 1826/2010. It was funded by FAPEMIG (the Minas Gerais Foundation for Research Support), under register APQ-01825-12.

Sampling was random and stratified in two stages, taking into account the census sectors and the households, according to the 2010 Census of the Brazilian Institute of Geography and Statistics (IBGE). Were eligible 18-year-old or older women who lived in Uberaba-MG, understood the objective of the research and agreed to answer the protocol by signing the Free and Informed Consent Form (FICF).

Interviews were carried out in the house of the participants by trained and adequately identified female interviewers, who were coordinated by professors, researchers, and students with scholarships. The training of the researchers involved the application of the questionnaires, lectures on technical aspects of interviews, and the performance of a pilot study with a convenience sample.

The content of the research protocol was especially elaborated for the study, considering the selection of instruments and validated measures for the Brazilian population. Sample calculation considered the absence of previous knowledge on the estimates of the prevalence of the events of interest. As a result, they were considered 50%. A confidence level of 95% was also considered, with a margin of error of, at most, 2.5%, and 20% of losses.

Quality of Life (QoL) was evaluated by a question extracted from the World Health Organization Questionnaire of Quality of Life (WHOQOL Bref): "How would you rate your quality of life?". The response options were "very poor", "poor", "neither poor nor good", "good", or "very good". Due to the low prevalence of "very poor" quality of life, the categories were grouped to make statistical analysis possible. As a result, women whose quality of life was "very poor"or "poor" were categorized as "bad", and those whose quality of life was "good", or "very good" were categorized as with a "good" quality of life. The intermediary category, "neither poor nor good", was kept as it is in the original instrument.

The health self-evaluation was also found through a question from the WHOQOL Bref: "How satisfied are you with your health?" The response options were: "very dissatisfied", "dissatisfied", "neither satisfied nor dissatisfied", "satisfied", and "very satisfied". Once again, the categories were grouped to classify women as "satisfied with health" or "dissatisfied with health".

The socioeconomic conditions investigated were age group (18 to 40 years; 41 to 59 years; 60 years or older), satisfaction with income, years of formal education (none; 1 to 4; 5 to 8; and 9 or more), and whether the patient lives with a partner in a stable union. All information was self-reported.

The prevalence was described in frequency and percentage. Later, the association of socioeconomic variables and health self-evaluation and quality of life were verified using Pearson's Chi-square and Fisher's Exact test, with a significance of 5%. The differences between the groups were found using the analysis of adjusted standardized residues <1.96. The analyses were carried out using the software SPSS, version 24.

RESULTS

The estimated number of women in the research was 1530. 1556 were interviewed, but this study only considered the 1489 ones that presented all data necessary to carry out this study.

The distribution of women in the age groups 18-40, 41-59 and 60+ was, respectively 32.9%, 35.9%, and 31.2%. The percentage of women who report having less than four years formal education was 25.7%; 48.2% live with no partner, and 72.4% declared that their income is not enough to satisfy their daily needs (Table 1).

Comparisons between satisfied and dissatisfied women show that the youngest ones (18-49 years old) are the most likely to be dissatisfied (P<0.001). They are also the ones with the most years of education (9 or more) (P=0.002) and those who declared being dissatisfied with their income (p<0.001). No association could be found between health self-evaluation and stable unions (p=0.541) (Table 1).

Table 1. Characterization of the sample and association between socioeconomic variables and health self-evaluation (n=1489). Uberaba, MG. 2014.

		How satisfied are you with your health?		
Variables	**F (%)**	**Satisfied (n=263)**	**Dissatisfied (n=1226)**	**p***
Age group				
18-40	490 (32.9)	63 (12.9) [24]	427 (87.1) [34.8]	
41-59	534 (35.9)	119 (22.3) [22.3]	415 (77.7) [33.8]	<0.001
60+	465 (31.2)	81 (17.4) [17.4]	384 (82.6) [31.3]	
Years of study				
Zero	55 (3.9)	13 (23.6) [5.1]	42 (76.4) [3.6]	
1-4	309 (21.8)	67 (21.7) [26.3]	242 (78.3) [20.8]	0.002
5-8	347 (24.5)	76 (21.9) [29.8]	271 (78.1) [23.3]	
9+	706 (49.8)	99 (14) [38.8]	607 (86) [52.2]	
Stable union				
No	717 (48.2)	122 (17) [46.4]	595 (83) [48.6]	0.541
Yes	771 (51.8)	141 (18.3) [53.6]	630 (81.7) [51.4]	
Satisfaction with income				
No	1077 (72.4)	299 (21.3) [87.4]	848 (78.7) [69.2]	<0.001
Yes	411 (27.6)	33 (8) [12.6]	378 (92) [30.8]	

* Chi-squared test; () % on the line; []% on the column.

Regarding quality of life, women in their midlife, that is, from 41-59 (p<0.001), with higher educational levels (p<0.001), and insufficient income (p<0.001) evaluated their quality of life as bad more frequently than women in other groups (p<0.001). No association could be found between quality of life and stable unions (p=0.716) (Table 2).

Table 2. Associations between socioeconomic variables and quality of life. Uberaba, MG. 2014.

	How do you rate your quality of life?			
Variables F (%)	**Poor/very poor (n=76)**	**Neither poor nor good (n=362)**	**Good/very good (n=1051)**	**p**
Age group[a]				
18-40	15 (3.1) [19.7]	111 (22.7) [30.7]	364 (74.3) [34.6]	
41-59	38 (7.1) [50]	132 (24.7) [36.5]	364 (68.2) [34.6]	<0.001
60+	23 (4.9) [30.3]	119 (25.6) [32.9]	323 (69.5) [30.7]	
Years of study				
Zero	4 (7.3) [5.4]	20 (36.4) [5.8]	31 (56.4) [3.1]	
1-4	20 (6.5) [27]	107 (34.6) [31]	182 (58.9) [18.2]	<0.001
5-8	22 (6.3) [29.7]	89 (25.6) [25.8]	236 (68) [23.6]	
9+	28 (4) [37.8]	129 (18.3) [37.4]	549 (77.8) [55]	
Stable union[a]				
No	37 (5.2) [51.3]	181 (25.2) [50]	499 (69.6) [52.5]	0.716
Yes	39 (5.1) [48.7]	181 (23.5) [50]	551 (71.5) [47.5]	
Satisfaction with income[a]				
No	65 (6) [85.5]	301 (27.9) [83.1]	711 (66) [67.7]	<0.001
Yes	11 (2.7) [14.5]	61 (14.8) [16.9]	339 2.5) [32.3]	

[a] Chi-squared test; b. Fisher's Exact Test; () % on the line; [] % on the column.

DISCUSSION

Results show that there are inequalities, especially concerning age, educational level, and satisfaction with the income, showing that the groups with the worst perceptions of health and quality of life are young women, with higher educational levels and dissatisfied with their income.

With the exception of the income, these results are opposed to the initial hypotheses of this study. These were created taking into consideration the increasing incidence of chronic diseases that accompany the aging process, and the negative effects that these conditions have on the functioning of a person, and consequently, on their wellbeing[10]. The premise was that people who live in negative social and economic conditions - in this case, older women[18,19]- and those with lower educational levels[20,21] tend to present a worst health state of health and functioning. As a result, their subjective assessment of their own health and quality of life would be worse. That was not corroborated by this study.

Regarding age, a study [10]stated that, as age increases, health problems become more closely linked to psychological problems. Depression, for example, increases the chance of a worst health self-evaluation. However, the same study found that the relations between worse physical health and negative health self-evaluation is stronger between younger people, when they are compared to older age groups, probably due to the higher prevalence of depression among the younger[10]. The findings of this research, similarly, suggest that there might me mediating variables that would explain the worse health self-perception among younger people.

Studies have shown that people with lower income and lower educational levels present lower subjective health self-evaluations[14,22]. That could be because these conditions lead to more physical limitations, which restrict the participation in community activities, the access to health services, and increase the risk of depression, disabilities, and death[21,23,24]. On the other hand, personal and social resources can be recruited to face adversity, allowing individuals to deal with their problems and experience positive experiences despite negative conditions[25,26]. These resources include resilience, spirituality, social and family support, feelings of self-sufficiency and autonomy, social-emotional selectivity, among others[27,28].]

The availability and use of these resources can partially explain empirical observations that found people who reported a good quality of life and health, despite adverse situations[19]. Additionally, age and educational level might have influenced in the perception of real life conditions, leading younger and more educated people to have more access to and understand better the information surrounding them, being, as a result, more critical and demanding with regards to their expectations and to the potential of their own existence and conditions of life. That would explain the lower satisfaction with health hand quality of life among women with lower educational levels.

Researches also suggested that elders may know better how to deal with and overcome stressful events in life, due to their accumulated experience[29,30]. During old age, people also show selective behavior when confronted with adversities to guarantee the preservation of their emotional state and wellbeing[26]. These explanations seem to be the most adequate for the results found by this study, showing aging as a process of life in which health and quality of life are determined by social and economic inequalities.

CONCLUSION

A poor quality of life and dissatisfaction with health were more frequent among younger women as opposed to the older ones, among those with higher educational levels and not among those with a lower one, and among those dissatisfied with their family income.

There was no association with living with or without a partner. Relations between socioeconomic characteristics, health self-evaluation, and quality of life are complex, and can

be mediated and moderated by other variables that denote the availability of psychosocial resources that would, as a matter of fact, determine how people will experience and deal with adversities and their consequences to their wellbeing.

The results of this study were achieved using recognized epidemiological methods that guarantee the quality of the findings for the population of women who live in Uberaba-MG. However, generalizations or extrapolations to other populations should be done carefully.

Despite the utility of the self-reported and subjective measures in the fields of Gerontology and Collective Health, limitations inherent to population inquiries, such as the absence of specific objective measures, can lead relevant information, which could help understand the phenomena investigated, to be neglected. Therefore, further studies, using other variables, are encouraged.

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Isabel Aparecida Porcatti de Walsh acted in the conception of this article, as well as in its analysis, data interpretation, writing, and revision. **Adriana Cristina de Araújo Figueiredo, Juliana Martins Pinto, Ana Paula Gomes Fernandes, Mariana Thays Carvalho** and **Cristiane Vitaliano Graminha** took part in data analysis and interpretation, writing, and revision.

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