Nationwide Survey of the Health Status and Quality of Life of Elderly Thais Attending Clubs for the Elderly

PRASERT ASSANTACHAI, MD, FRCP*,
NANTA MARANETRA, MD, FRCP**

Abstract

Thailand is seen as a developing Southeast Asian country with a fast-growing number of senior citizens. Meanwhile, they are also encouraged to attend a local club for the elderly for the sake of health promotion and disease prevention. Knowledge of the quality of life as well as the health status of elderly people in this setting would be invaluable for further planning. 1811 individuals from 66 provinces, who attended clubs for the elderly were recruited. Structured questionnaires with detailed instructions were distributed to clubs for the elderly nationwide. 61.4 per cent had a good quality of life. The independent factors determining poor quality of life were as follows: not living with a spouse, poor financial status, no regular exercise, sleeping or hearing difficulty, not taking milk regularly, suffering from joint pain or diabetes mellitus, history of a fall within the last 6 months and a poor mobility score and score of instrumental activities of daily living. No regular exercise had the highest adjusted odds ratio (2.38: 95% CI: 1.61-3.51). The main factors determining a poor quality of life in any region of the country were socioeconomic background in the northern region, having less exercise and joint pain in the eastern part and diabetes mellitus in the western region.

Conclusion : All these factors should be part of the geriatric assessment among elderly Thais. Socioeconomic factors could be employed to screen for those who are at risk while the other reversible factors should be highlighted and treated properly in order to reduce the outcomes of poor quality of life in those attending clubs for the elderly.

Key word : Health Status, Quality of Life, Club for the Elderly

ASSANTACHAI P & MARANETRA N
J Med Assoc Thai 2003; 86: 938-946

* Department of Preventive and Social Medicine,
** Department of Medicine, Faculty of Medicine Siriraj Hospital, Mahidol University, Bangkok 10700, Thailand.

According to the18th ASEAN Inter-Parliamentary Organization (AIPO) General Assembly in Bali, Indonesia in 1997, one of the recommendations concerning the human resources of the population between 60-80 years of age was to have a greater role in social development. An ad-hoc subcommittee was, therefore, set up by the Thai AIPO National Group to initiate a study of the health of elderly Thais. The main objectives were to determine the prevalence of various health problems, including physical, mental, social and environmental aspects. In addition, common risk factors for a poor quality of life were also highlighted. The ultimate objective of strategic and practical interventions in health promotion and disease prevention was to maintain the autonomy of elderly people. Knowledge of the benefits or otherwise of these interventions should be useful for health care providers who organize activities in the community.

POPULATION AND METHOD

The structured questionnaires including detailed instructions were distributed to the provincial health authorities nationwide under the co-operation of The Secretariat of the House of Representatives and the Ministry of Public Health from June 1999 to August 1999. The sample population included elderly people who attended clubs for the elderly organized by the local community hospitals. Local health personnel interviewed the elderly people and filled in the questionnaires which were later posted back to the author at Siriraj Hospital. The elderly people were recruited at random. The activities of daily living questionnaire designed by the Survey in Europe on Nutrition and the Elderly, A Concerted Action (SENECA) was used(1). Each item was measured on a 4-point scale namely: being unable to do the activity completely (4 points); can do it only with help (3 points); can do it with difficulty but without help (2 points); and, can do it without difficulty (1 point). This structured test is divided into three aspects of activities of daily living namely, mobility index (MI), self-care index (SI) and instrumental activities of daily living (iADL). When the walking ability (MI, range 4-16) was considered, the sum of the following 4 items namely, going outdoors, using stairs, walking at least 400 metres and carrying a heavy object for at least 100 metres was used. The SI index (range 7-28) was calculated by adding the following items together: walking between rooms, toilet use, grooming and bathing, dressing, getting in and out of bed, cutting toe-nails, and eating. The other five items of the test (i.e. ability to use the telephone, take own medication, manage finances, do light housework, and do heavy housework) could be summed up as iADL (range 5-20).

Quality of life was surveyed by an instrument based on the international study carried out by the World Health Organization in 11 countries in 1979 (2). The two questions were "Are you happy and content with your everyday life?" and "Do you feel well enough to do what you want to do ?". The choices of answer consist of "no hardly ever" (1 point), "yes now and then" (2 points), "yes most of the time" (3 points), and "don't know" (being excluded from the study). Those who obtained a score of 2-4 points would be rated as having a poor quality of life while those who had 5-6 points would be rated as having a good quality of life.

The SPSS statistical package was used to analyze the data. The level of statistical significance was set at a p-value of less than 0.05.

RESULTS

The sample population was taken from the northern region (14.0%), northeastern region (29.7%), central region (21.9%), eastern region (10.0%), western region (6.4%) and southern region (18.1%). The total sample population amounted to1811 cases from 66 provinces. The male to female ratio was 919 to 892 with an average age 69.3 $\pm$ 6.2 years. Around sixty five per cent were married while 30.7 per cent were widowed. Among the widowed group, more than three-quarters (76.4%) were elderly females. The actual number of the family members living in the same house was 3.6 $\pm$ 2.1 people and only 0.8 per cent lived alone. The majority (76.1%) stayed with their children followed by staying with grandchildren (65.5%) and staying with their spouse (59.3%). As far as education was concerned, the majority (59.1%) achieved only primary school or lower and up to 11 per cent had never attended a formal class in school. The majority of past occupations were related to agriculture 50.4 per cent, 19.3 per cent were retired government officials. 65.1 per cent revealed their financial status to be fair, 13.8 per cent had some savings while 20.4 per cent were not able to make ends meet.

Up to 19 per cent of the sample population suffered from at least one health problem. The most common chronic diseases listed in order were joint pain 30.8 per cent, hypertension 23.4 per cent, diabetes mellitus 12.8 per cent, dyspnea on exertion 13.9 per cent, sleeping difficulty 13.9 per cent, memory

impairment 11.6 per cent, constipation 8.8 per cent and heart disease 7.3 per cent. Regarding near vision ability, 47.9 per cent could see without spectacles, 46.1 per cent could see with spectacles and only 6 per cent could not see properly even with spectacles. On the other hand, 8.1 per cent could not see a distant object even with spectacles, 25.3 per cent could see distant objects only with spectacles and 66.6 per cent could see distant objects without difficulty. Concerning the regularity of exercise, 47.7 per cent had daily exercise, 38.8 per cent had occasional exercise and 13.6 per cent had not had any exercise over the past year. Walking was practiced in nearly 70 per cent, followed by body exercise in 18 per cent. The most frequent daily activities were house watch 42.6 per cent, doing housework 30.4 per cent, enjoying a light hobby 17.9 per cent and looking after their grandchildren 13.6 per cent. Interestingly, 12.3 per cent volunteered to do community work as the most frequent activity followed by 11.4 per cent attending the elderly club. Falling, another important nonspecific symptom of many silent diseases, was found in up to 17.1 per cent during the previous 6 months and mostly occurred during the daytime 62.5 per cent, and outside the residential area 61.4 per cent, whereas the common sites of fall occuring within the residential area were the toilet (46.7%) and stairs (42.9%). Nearly two-thirds neither smoked (64.4%) nor drank alcohol (62.6%) and more than 1 in 5 had quit smoking (22.3%) and drinking (23.5%). Interestingly, 13.4 per cent still enjoyed smoking and 13.9 per cent had not yet quit alcoholic drinking. Most of the drinking (81.9%) occurred during festivals or at a party while 15.1 per cent had an alcoholic binge everyday. Up to ninety per cent preferred spicy salad and other vegetable-containing food rather than fatty food. Two-thirds did not have milk on a regular basis.

As far as the quality of life was concerned, 61.4 per cent had a good quality of life. The socioeconomic factors significantly associated with a poor quality of life identified by univariate analysis were as follows (Table 1.) : female gender, widowed or single or divorced marital status, not living with a spouse, having grandchildren in the same house, primary school or no formal education, manual worker, poor financial status, still smoking, not taking milk regularly and no or occasional exercise. However, those who had a history of alcoholic drinking had a better quality of life than who had neither drank nor quit alcoholic drinking. Regarding the medical factors significantly associated with a poor quality of life (Table 2), diabetes mellitus, chronic joint pain, lung disease, poor memory, constipation, sleeping difficulty, dyspnea, chronic drug use, taking heart or psychiatric drugs, history of fall within 6 months, poor near or distant vision and hearing difficulty were all found more frequently among the poor quality of life group. Among these factors, not having regular exercise had the highest odds ratio of 3.31 (95% confidence interval : 2.43-4.51). In addition, some other quantitative variables were also different between the two groups of quality of life (Table 3). Those who had a poor quality of life were significantly lighter in weight, shorter in height, had smaller body mass index, poorer mobility index, poorer self care index, poorer instrumental activity of daily living score and more doctor visits both to private clinics and to the hospital over the past year.

After multiple logistic regression analysis, the independent factors determining a poor quality of life were (Table 1 and 2) : not living with a spouse, poor financial status, not taking milk regularly, no exercise, diabetes mellitus, chronic joint pain, insomnia, history of a fall over the past 6 months and hearing difficulty. In addition, the independent quantitative factors determining a poor quality of life were a poor mobility index (adjusted OR 1.24, 95% CI: 1.13-1.36) and poor instrumental activity of daily living score (adjusted OR 1.12, 95% CI: 1.02-1.23).

DISCUSSION

Among the widowed group, three quarters of them were elderly females reflecting the longer life expectancy of the female population. There are several reasons e.g. biological, behavioural and environmental aspects why women live longer than men[3]. However, the number of elderly men in the present sample population was slightly higher than women. This indicates that older men tend to participate in community activity to a greater degree than older women, therefore, any health promotion activity implemented in the elderly club may not get through to older women. Furthermore, female gender was found more frequently among the poor quality of life group let alone the older women who did not attend the local elderly club. Those who did not live with their spouse (women who out lived men) was the significant independent risk factor of a poor quality of life with an adjusted odds ratio of 1.41 (95% CI: 1.09-1.82). There is no doubt that experiencing loneliness has a negative effect upon the state of mood and quality of life even in the cognitively intact elderly[4]. Even though background

Table 1. Univariate and multivariate analysis of socioeconomic background between elderly people with a good and poor quality of life (QOL).

	Good QOL		Poor QOL		Univariate analysis		Multivariate analysis	
	Cases	%	Cases	%	Odds ratio	95% confidence interval	Adjusted odds ratio	95% confidence interval
Gender								
Male	618	67.2	301	32.8	1			
Female	494	55.4	398	44.6	1.65	1.36-2.01	n.a.	n.a.
Marital status								
Married	772	65.5	407	34.5	1			
Single, widowed, divorced	331	53.6	287	46.4	1.64	1.34-2.02	n.a.	n.a.
Living with a spouse								
Yes	693	67.0	342	33.0	1			
No	380	53.6	329	46.4	2.48	2.00-3.07	1.41	1.09-1.82
Grand children								
No	392	65.2	209	34.8	1			
Yes	680	59.5	462	40.5	1.27	1.03-1.57	n.a.	n.a.
Education								
Secondary school or higher	288	74.2	100	25.8	1			
Primary school	728	59.4	497	40.6	1.97	1.51-2.56	n.a.	n.a.
No formal class	94	48.2	101	51.8	3.09	2.12-4.52	n.a.	n.a.
Job								
Office worker	414	72.1	160	27.9	1			
Manual worker	584	56.4	451	43.6	2.0	1.59-2.51	n.a.	n.a.
Financial status								
Good	930	64.8	506	35.2	1			
Poor	176	47.8	192	52.2	2.01	1.59-2.53	1.51	1.11-2.04
Smoking								
Quit	267	68.5	123	31.5	1			
Yes	140	59.8	94	40.2	1.46	1.03-2.07	n.a.	n.a.
Alcohol consumption								
Yes	171	70.7	71	29.3	1			
Never or quit	890	59.4	608	40.6	1.65	1.21-2.24	n.a.	n.a.
Regular milk in take								
Yes	407	68.9	184	31.1	1			
No	649	56.5	499	43.5	1.70	1.38-2.10	1.40	1.06-1.85
Exercise								
Regular	611	73.0	226	27.0	1			
Occasional	357	52.4	324	47.6	2.45	1.97-3.06	2.20	1.68-2.88
None	107	45.0	131	55.0	3.31	2.43-4.51	2.38	1.61-3.51

education and previous occupation were related to a poor quality of life, the current financial status was the only significant independent risk factor for a poor quality of life with an adjusted odds ratio of 1.51 (95% CI: 1.11-2.04). However, no formal education was found more frequently among the poor quality of life group with a greater odds ratio than those who achieved only primary school. This emphasizes that the level of education has a significant unique contribution to health-related quality of life[5]. In conclusion, the elderly women who did not live with their spouse and were financially poor were inclined to have a poor quality of life.

Regarding the health risk behaviour (Table 1), those who still smoked had a poorer quality of life than those who had already stopped smoking, reflecting the adverse outcome of cigarette smoking[6]. Conversely, those who drank alcohol had a better quality of life than those who did not. It means that drinking alcohol either improves the quality of life or is often practiced by those who already have a good quality of life. Drinking alcohol is associated with a significantly better physical and role functioning, and better global health-related quality of life in some patients[7]. Traditional Thai food hardly contains any milk in its ingredients and from the present study up

Table 2. Univariate and multivariate analysis of medical problems between elderly people with a good and poor quality of life (QOL).

	Good QOL		Poor QOL		Univariate analysis		Multivariate analysis	
	Cases	%	Cases	%	Odds ratio	95% confidence interval	Adjusted odds ratio	95% confidence interval
Diabetes mellitus								
No	999	63.3	580	36.7	1			
Yes	112	48.5	119	51.5	1.83	1.39-2.42	1.59	1.10-2.29
Joint pain								
No	805	64.2	448	35.8	1			
Yes	306	54.9	251	45.1	1.47	1.20-1.81	1.37	1.03-1.81
Lung disease								
No	1,082	61.9	667	38.1	1			
Yes	29	47.5	32	52.5	1.79	1.04-3.08	n.a.	n.a.
Poor memory								
No	1,009	63.1	591	36.9	1			
Yes	102	48.6	108	51.4	1.81	1.34-2.44	n.a.	n.a.
Constipation								
No	1,037	62.8	613	37.2	1			
Yes	74	46.3	86	53.8	1.97	1.40-2.76	n.a.	n.a.
Insomnia								
No	994	63.8	565	36.2	1			
Yes	117	46.6	134	53.4	2.02	1.54-2.64	1.55	1.08-2.23
Dyspnea								
No	996	63.9	562	36.1	1			
Yes	115	45.6	137	54.4	2.11	1.60-2.79	n.a.	n.a.
Fall in the past								
No	938	64.1	525	35.9	1			
6 months								
Yes	138	45.8	163	54.2	2.11	1.64-2.71	1.75	1.26-2.43
Regular medication use								
No	463	67.0	228	33.0	1			
Yes	611	57.4	454	42.6	1.51	1.23-1.85	n.a.	n.a.
Heart medication								
No	886	62.8	524	37.2	1			
Yes	187	54.5	156	45.5	1.41	1.10-1.80	n.a.	n.a.
Psychiatric drug								
No	908	62.6	543	37.4	1			
Yes	165	54.6	137	45.4	1.39	1.07-1.80	n.a.	n.a.
Poor near vision								
No	1,047	63.1	611	36.9	1			
Yes	37	34.9	69	65.1	3.2	2.08-4.92	n.a.	n.a.
Poor distant vision								
No	1,031	62.9	607	37.1	1			
Yes	63	43.8	81	56.3	2.18	1.53-3.13	n.a.	n.a.
Hearing difficulty								
No	1,050	63.2	612	36.8	1			
Yes	44	40.7	64	59.3	2.50	1.68-3.71	1.85	1.10-3.12
Clinic visit								
No	222	70.5	93	29.5	1			
Yes	852	58.6	601	41.4	1.68	1.28-2.21	n.a.	n.a.

to ninety per cent of the sample population preferred spicy salad rather than fatty foods. Regular milk drinking, one of the independent factors related to a better quality of life with an adjusted odds ratio of 1.40 (95% CI: 1.06-1.85), would supplement calcium, essential fatty acids and protein. Traditional Thai food may not be able to achieve the recommended daily requirement. As nutritional state is one of the major deter-

Table 3. Comparison of various quantitative variables between the good and poor quality of life groups by Student *t*-test analysis.

	Good quality of life		Poor quality of life		P-value
	Mean	SD	Mean	SD	
Body weight (kg)	57.42	11.83	54.81	11.07	< 0.001
Height (centimeters)	158.37	8.36	156.83	8.71	< 0.001
Body mass index (kg/m^2)	22.81	4.04	22.27	4.10	0.008
Mobility index	4.72	1.54	6.25	2.68	< 0.001
Self care index	7.31	1.30	8.39	2.69	< 0.001
Instrumental activity of daily living	5.65	1.41	7.04	2.73	< 0.001
Number of private clinic visit last year	0.39	2.08	0.66	2.22	0.008
Number of hospital visit last year	2.58	4.26	3.24	4.35	0.002

minants of quality of life in the elderly[8,9], a history of regular milk drinking should be part of the geriatric assessment among the Thai elderly. Even though one of the major activities often practiced in clubs for the elderly is exercise, nearly 14 per cent had not had any exercise over the past year. Those who had not exercised over the past year were most likely to have a poorer quality of life with an adjusted odds ratio of 2.38 (95% CI: 1.61-3.51) than those who took occasional exercise with an adjusted odds ratio of 2.20 (95% CI: 1.68-2.88). The correlation between the regularity of exercise and the quality of life has been found even in frail elderly people[10]. In summary, an appropriate life style leading to good quality of life includes no smoking, regularly drinking milk and having exercise.

As far as chronic disease is concerned, those diseases which significantly determined a poor quality of life included poor hearing, a history of falls, diabetes mellitus, insomnia and joint pain. Therefore, every effort should target these remediable conditions e.g. hearing aids for those with poor hearing ability can protect against cognitive impairment and disability, improving quality of life of elderly people both in the community and in insitutions[11,12]. A repeated campaign to alert the elderly to the risk of falling, a cost-effective way of fall prevention among the healthy elderly in the community could be implemented[13]. Concerning insomnia, early recognition and treatment with both behavioural and pharmacological therapies may prevent a poor quality of life[14]. Agreeing with the present result, Hiltunen et al found that elderly subjects with previously diagnosed diabetes had a poorer quality of life compared to those with undiagnosed diabetes, impaired glucose tolerance or normal glucose tolerance[15]. As diabetes mellitus and chronic joint pain are the result of an earlier insult, life style modification e.g. avoiding obesity would be effective in preventing both pathologic conditions. Functional assessment, one of the necessary assessment tools for the elderly, proved to be effective in clinical evaluation as both mobility index and the score for instrumental activities of daily living determined a poor quality of life. Elderly people who lost their ability to move around or their ability to care for themselves showed a greater decrease in the number of relatives, friends and neighbours having frequent contacts and a larger decline in life satisfaction[16].

When comparing the prevalence of various risk factors affecting the quality of life found by the present results, some risk factors were found more frequently in different parts of Thailand (Table 4). Interestingly, elderly people in the northern part of the country had more socioeconomic risk factors e.g. the smallest proportion of elderly women attending clubs for the elderly (40.4%), second smallest proportion of those who lived with their spouse (32.4%), the highest proportion of those who had never attended formal education (17.4%), second largest proportion of those who had been manual workers (65.6%), the highest proportion of those who were financially poor (28.3%). However, elderly people in the eastern part were less likely to exercise, had the highest percentage of those who had not exercised over the last year (17.6%) and the smallest percentage of those who drank milk regularly (26.0%). The prevalence of chronic joint pain (35.4%), history of heart medication (28.7%) and history of psychiatric drug (26.0%) was highest in the eastern region. On the other hand, elderly people in the western region had the highest percentage of diabetes mellitus (17.8%) and this may

Table 4. Distribution of factors affecting poor quality of life of the elderly in each region of Thailand.

	North (%)	Northeast (%)	Central (%)	East (%)	West (%)	South (%)	P-value
Female gender	40.4	51.5	48.3	55.6	43.2	54.6	0.003
Marital status							
Single	1.9	2.2	3.7	1.6	1.7	2.7	0.005
Widowed	11.1	36	19.5	11.9	5.1	27.9	
Divorced	0.8	1.6	1.0	2.2	0.9	0.9	
Living without spouse	32.4	49.4	39.4	50.8	34.5	31.0	< 0.001
Education							
Primary school	58.7	64.4	52.4	68.3	44.4	59.2	< 0.001
No formal class	17.4	5.8	12.4	7.9	17.1	11.9	
Manual worker	65.6	58.2	50.2	65.9	44.9	58.1	< 0.001
Poor financial	28.3	22.7	19.2	22.2	16.2	14.0	< 0.001
Still smoking	15.1	15.4	12.2	12.6	12.4	9.1	< 0.001
Not taking milk	68.3	70.0	67.9	74.0	64.9	51.9	< 0.001
Exercise							
None	14.5	14.9	12.7	17.6	10.7	11.5	< 0.001
Occasional	38.7	42.1	37.1	45.5	44.6	30.2	
Diabetes mellitus	8.9	15.6	14.3	9.0	17.8	11.6	0.021
Joint pain	32.6	31.9	30.1	35.4	28.0	26.7	0.327
Lung disease	5.4	4.0	1.7	3.7	3.4	2.4	0.121
Poor memory	12.8	14.1	9.5	11.6	9.3	10.1	0.223
Constipation	7.8	10.1	8.3	10.1	11.0	7.4	0.618
Insomnia	14.0	11.6	17.0	15.9	12.7	13.1	0.244
Dyspnea	13.2	12.3	17.5	16.4	13.6	12.8	0.233
Fall within 6 months	13.5	18.9	18.3	15.1	19.1	16.8	0.455
Regular medication use	58.4	56.0	69.0	56.9	60.0	63.6	0.002
Heart medication	22.7	18.4	14.1	28.7	11.3	24.6	< 0.001
Psychiatric drug	20.3	18.8	11.1	26.0	3.5	21.5	< 0.001
Poor near vision	5.9	8.1	4.0	3.8	9.8	6.6	< 0.001
Poor distant vision	3.5	8.8	7.4	7.5	12.8	9.8	0.005
Hearing difficulty	5.9	6.9	5.0	6.5	3.5	7.6	0.536

lead to poor near vision (9.8%), poor distant vision (12.8%) and history of fall within the past 6 months (19.1%) which were also found most in this region. Concerning the prevalence of chronic medical problems, there was no significant difference between each region of the country except for diabetes mellitus ($p = 0.021$). The only medical problem found in the highest proportion in the northeastern part was poor memory (14.1%). Elderly people in the southern part tended to enjoy a good quality of life most frequently as the percentage of those who were financially poor (14.0%), still smoked cigarettes (9.1%) and had not had any exercise over the last year (11.5%) were lowest while those who took milk regularly (48.1%) were found most frequently compared to other regions of the country. In conclusion, the main factors determining a poor quality of life of the elderly in any region of the country were socioeconomic background in the northern region, having less exercise and joint pain in the eastern part and diabetes mellitus in the western region.

ACKNOWLEDGEMENT

This study was fully supported by ASEAN Inter-Parliamentary Organization (AIPO) Ad-hoc Committee on Human Resources Development. The authors wish to thank Professor Dr. Prasop Ratanakorn for his excellent advice and support of the study.

(Received for publication on May 26, 2003)

REFERENCES

1. Euronut SENECA investigators. Life-style: Physical activities and activities of daily living. Eur J Clin Nutr 1991; 45 (Suppl 3): 139-51.
2. Euronut SENECA investigators. Self-perceived health, chronic diseases, use of medicine. Eur J Clin Nutr 1991; 45 (Suppl 3): 169-82.
3. WHO expert committee on health of the elderly. Health of the elderly. Geneva: World Health Organization Technical Report Series 779; 1989: 28.
4. Holmen K, Ericsson K, Winblad B. Quality of life among the elderly. State of mood and loneliness in two selected groups. Scand J Caring Sci 1999; 13: 91-5.
5. Kempen GI, Brilman EI, Ranchor AV, Ormel J. Morbidity and quality of life and the moderating effectts of level of education in the elderly. Soc Sci Med 1999; 49: 143-9.
6. Bratzler DW, Oehlert WH, Austelle A. Smoking in the elderly-it's never too late to quit. J Okla State Med Assoc 2002; 95: 185-91.
7. Allison PJ. Alcohol consumption is associated with improved health-related quality of life in head and neck cancer patients. Oral Oncol 2002; 38: 81-6.
8. Maaravi Y, Berry EM, Ginsberg G, Cohen A, Stessman J. Nutrition and quality of life in the aged: The Jerusalem 70-year olds longitudinal study. Aging (Milano) 2000; 12: 173-9.
9. Vetta F, Ronzoni S, Taglieri G, Bollea MR. The impact of malnutrition on the quality of life in the elderly. Clin Nutr 1999; 18: 259-67.
10. Schechtman KB, Ory MG; Frailty and Injuries: Co-operative study of intervention techniques. The effects of exercise on the quality of life of frail older adults: A preplanned meta-analysis of the FICSIT trials. Ann Behav Med 2001; 23: 186-97.
11. Tsuruoka H, Masuda S, Ukai K, Sakakura Y, Harada T, Majima Y. Hearing impairment and quality of life for the elderly in nursing homes. Auris Nasus Larynx 2001; 28: 45-54.
12. Cacciatore F, Napoli C, Abete P, Marciano E, Triassi M, Rengo F. Quality of life determinants and hearing function in an elderly population: Osservatorio Geriatrico Campano Study Group. Gerontology 1999; 45: 323-8.
13. Assantachai P, Praditsuwan R, Chatthanawaree W, Pisalsarakij D, Thamlikitkul V. Strategy of prevent falls in the Thai elderly : A controlled study integrated health research program for the Thai elderly. J Med Assoc Thai 2002; 85: 215-22.
14. Ring D. Management of chronic insomnia in the elderly. Clin Excell Nurse Pract 2001; 5: 13-6.
15. Hiltunen L, Keinanen-Kiukaanniemi S. Does glucose tolerance affect quality of life in an elderly population ? Diabetes Res Clin Pract 1999; 46: 161-7.
16. Asakawa T, Koyano W, Ando T, Shibata H. Effects of functional decline on quality of life among the Japanese elderly. Int J Aging Hum Dev 2000; 50: 319-28.

การสำรวจภาวะสุขภาพและคุณภาพชีวิตของผู้สูงอายุในชมรมผู้สูงอายุทั่วประเทศ

ประเสริฐ อัสสันตชัย, พบ, FRCP, นันทา มาระเนตร์, พบ, FRCP***

ผลจากการเพิ่มสัดส่วนของประชากรผู้สูงอายุในสังคมไทยอย่างรวดเร็ว ขณะเดียวกันผู้สูงอายุได้รับการส่งเสริมให้เข้าร่วมกิจกรรมชมรมผู้สูงอายุในท้องถิ่นเพื่อการส่งเสริมสุขภาพและป้องกันโรค การศึกษานี้จึงมุ่งสำรวจภาวะสุขภาพและคุณภาพชีวิตของสมาชิกในชมรมทั่วประเทศ เพื่อประโยชน์ในการส่งเสริมและปรับปรุงรูปแบบของกิจกรรมในชมรมต่อไป มีผู้สูงอายุจำนวน 1,811 รายจาก 66 จังหวัดตอบแบบสอบถามซึ่งมีรายละเอียดการตอบแนบท้ายด้วย ผลการศึกษาพบว่า ร้อยละ 61.4 จัดอยู่ในกลุ่มที่มีคุณภาพชีวิตที่ดี ปัจจัยเสี่ยงอิสระที่สามารถทำนายสภาวะคุณภาพชีวิตที่ไม่ดีได้แก่ การที่ไม่ได้อยู่กับคู่สมรส ฐานะยากจน ไม่ได้ออกกำลังกายอย่างสม่ำเสมอ มีปัญหาการนอนหลับ การได้ยินลดลง ไม่ได้ดื่มนมสม่ำเสมอ มีโรคเรื้อรังได้แก่ เบาหวาน อาการปวดข้อ มีประวัติหกล้มภายในหกเดือนที่ผ่านมา ความสามารถในการเดินและการดำเนินชีวิตประจำวันแบบอุปกรณ์ที่ลดลง โดยที่การไม่ได้ออกกำลังกายเลยในช่วงปีที่ผ่านมามีค่า adjusted odds ratio สูงที่สุด เท่ากับ 2.38 (ช่วงความเชื่อมั่นร้อยละ 95 เท่ากับ 1.61–3.51) ปัจจัยเสี่ยงที่พบบ่อยในแต่ละภาคของประเทศแตกต่างกัน ได้แก่ปัญหาเศรษฐฐานะในภาคเหนือ การไม่ได้ออกกำลังกายและอาการปวดข้อในภาคตะวันออก และโรคเบาหวานในภาคตะวันตก กล่าวโดยสรุป ปัจจัยต่าง ๆ เหล่านี้สมควรเป็นส่วนหนึ่งในการประเมินผู้สูงอายุในชมรมผู้สูงอายุ โดยปัจจัยด้านสังคมเศรษฐกิจทำให้เจ้าหน้าที่ที่บริหารชมรมทราบผู้สูงอายุผู้ที่มีความเสี่ยง ขณะที่ปัจจัยที่แก้ไขได้ สมควรได้รับการสนใจ การดูแลและการป้องกันเพื่อนำมาสู่ภาวะที่มีคุณภาพชีวิตที่ดีของผู้สูงอายุในชมรมผู้สูงอายุ

คำสำคัญ : ภาวะสุขภาพ, คุณภาพชีวิต, ชมรมผู้สูงอายุ

ประเสริฐ อัสสันตชัย, นันทา มาระเนตร์
จดหมายเหตุทางแพทย์ ฯ 2546; 86: 938–946

* ภาควิชาเวชศาสตร์ป้องกันและสังคม,

** ภาควิชาอายุรศาสตร์, คณะแพทยศาสตร์ศิริราชพยาบาล, มหาวิทยาลัยมหิดล, กรุงเทพ ฯ 10700