
FUNCTIONAL CAPACITY, MORBIDITIES AND QUALITY OF LIFE OF THE ELDERLY¹

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ABSTRACT: This study was performed with the objective to describe the sociodemographic profile, functional capacity and morbidities of the elderly, and verify the association between quality of life and the number of functional incapacities and of morbidities. This analytical and cross-sectional study was performed with 2,142 elderly individuals. The data were collected at the subjects' homes using a structured instrument. The analysis consisted of frequency distribution, ANOVA-F and the *Bonferroni* test ($p < 0.05$). Most subjects were female, between 60-70 years old, married, with 4-8 years of education, and income of one minimum salary. Most subjects had between 1-3 functional incapacities, related to mobility, and 4-7 associated morbidities, with the most prevalent being those affecting their sight and back, and hypertension. The highest quality of life scores were for social relationships and sensory functioning, and the lowest for the physical domain and autonomy. It was found that the higher numbers of functional incapacities and morbidities were associated with lower quality of life scores.

DESCRIPTORS: Aging. Elderly. Geriatric nursing. Quality of life.

CAPACIDADE FUNCIONAL, MORBIDADES E QUALIDADE DE VIDA DE IDOSOS

RESUMO: Pesquisa que objetivou descrever o perfil sociodemográfico, capacidade funcional e morbidades de idosos, e verificar a associação da qualidade de vida com o número de incapacidade funcional e de morbidades. Estudo analítico e transversal realizado com 2.142 idosos. Os dados foram coletados no domicílio com instrumento estruturado. A análise foi por meio da distribuição de frequência, teste ANOVA-F e *Bonferroni* ($p < 0,05$). A maioria era do sexo feminino, com 60-70 anos, casados, 4-8 anos de estudo e renda de um salário mínimo. Houve predomínio entre os idosos de 1-3 incapacidades funcionais, relacionadas à mobilidades e 4-7 morbidades associadas, sendo as mais prevalentes problemas de visão e de coluna e hipertensão arterial. Os maiores escores de qualidade de vida foram para relações sociais e funcionamento dos sentidos e os menores para o físico e a autonomia. O maior número de incapacidade funcional e de morbidades associou-se aos menores escores de qualidade de vida.

DESCRIPTORIOS: Envelhecimento. Idoso. Enfermagem geriátrica. Qualidade de vida

LA CAPACIDAD FUNCIONAL, LA MORBILIDAD Y LA CALIDAD DE VIDA DE LAS PERSONAS DE EDAD AVANZADA

RESUMEN: La investigación tiene como objetivo describir el perfil demográfico, la capacidad funcional y la morbilidad de los ancianos, y verificar la calidad de vida relacionado con el número de incapacidad funcional y la morbilidad. Estudio transversal analítico llevado a cabo con 2.142 personas mayores. Los datos fueron recolectados en el hogar con un instrumento estructurado. El análisis se realizó distribución de frecuencias, F-test de ANOVA y *Bonferroni* ($p < 0,05$). La mayoría eran mujeres, 60-70 años, casado, 4-8 años de escolaridad y los ingresos de un salario mínimo. Predominaron los adultos mayores 1-3 discapacidades funcionales relacionadas con la movilidad y 4-7 morbilidad, los problemas de visión más frecuente y la columna vertebral y la hipertensión. Las puntuaciones más altas de calidad de vida para las relaciones sociales y el funcionamiento de los sentidos y el más bajo para su desarrollo físico y la autonomía. El mayor número de incapacidad funcional y la morbilidad asociadas con bajas puntuaciones en la calidad de vida.

DESCRIPTORIOS: Envejecimiento. Anciano. Enfermería geriátrica. Calidad de vida.

INTRODUÇÃO

Population aging is a global phenomenon. In Brazil, the number of elderly individuals has increased from 8.8% to 11.1%, between 1998 and 2008. Currently, it is estimated that there are 21 million individuals with 60 years of age or older.¹

With the increase in the elderly population, there has also been a rise in the incidence of chronic-degenerative diseases, which can be followed by complications that affect one's functional performance and cause dependence.²⁻³

Approximately 80% of the subjects with more than 65 years of age have at least one chronic health problem, and 10% have at least five. The presence of multiple diseases with different levels of severity can affect one's performance in the Activities of Daily Living (ADLs).⁴

There is evidence that 26.8% of the elderly have some level of dependence to perform ADLs, with bathing and getting dressed ranked as the most prevalent. It is highlighted that functional capacity is an important indicator of one's level of independence, as well as the need to implement preventive measures and treatment interventions. Such measures aim at reducing the mechanisms that affect the decline in the subject's ability to perform several everyday physical and mental functions.⁵

Considering that diseases and functional incapacities affect the family, health system, and the everyday lives of the elderly, efforts must be made to delay their evolution in order to guarantee longevity with autonomy, independence and better quality of life.²⁻⁶

The concept of quality of life adopted herein is that of the World Health Organization (WHO), considering its characteristics of subjectivity, multidimensionality, and bipolarity: "individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns".^{7,1405}

In Brazil, it is observed there is a scarcity of studies focusing on functional incapacity and its relation to quality of life, a relationship that remains unclear.⁸⁻⁹ Studies with dependent elderly subjects did not find any association

between compromised functional capacity and quality of life.⁸ Another study evidenced that functional incapacity was related to lower quality of life scores.⁹

Regarding the morbidities, it is evidenced that elderly individuals with more diseases have a worse quality of life.¹⁰ However, it is outlined that quality of life has been measured using generic instruments with limitations in terms of identifying relevant items for this age group.

In this sense, the objectives of the present study are to describe the socioeconomic profile, functional capacity, and morbidities of the elderly, and verify the association between quality of life and the number of functional incapacities and morbidities, using an instrument specifically designed for the elderly, thus supporting interventions aimed at groups that need more attention.

METHODS

This analytical, cross-sectional, qualitative study was performed in the urban area of Uberaba-Minas Gerais (MG).

The study population was determined using the population sample calculation, performed in a prior study developed by the Collective Health Research Center (*Núcleo de Pesquisa em Saúde Coletiva*), which considered 95% confidence, 80% power of the test, 4.0% error margin for the interval estimates and an estimated ratio of $\pi=0.5$ for the ratios of interest. Therefore, the estimated sample was 2,892 elderly individuals.

The elderly individuals were included in this study if they met the following criteria: age of 60 years or more; having a minimum score of 13 on the cognitive test*; either genders, living in the urban area of Uberaba-MG, and agreeing to participate in the study. Thus, the present study counted with the participation of 2,142 individuals.

The data were collected at the subjects' homes, using a semi-structured instrument to characterize the population, whereas the quality of life was assessed using the WHOQOL-BREF and WHOQOL-OLD. Data collection was performed between August and December 2008.

The WHOQOL-BREF is an abbreviated version of the WHOQOL 100, comprised by 26 ques-

* The cognitive evaluation, comprised by six questions, aims at identifying the preservation of recent memory. The total sum of the questions range between zero and 19, with 13 being the cut-off score. Therefore, the elderly individual was considered without cognitive decline, and capable of answering the questions proposed in the present study.

tions, with the first two being generic. This version was validated in Brazil and has four domains.¹¹⁻¹² The WHOQOL-OLD module, aimed specifically for the elderly, validated in Brazil, has 24 Likert scale items attributed in a total score and six facets.¹³⁻¹⁴ The quality of life scores range between zero and 100, considering that the higher the score, the better the quality of life.

The studied variables were: sociodemographic (gender, age group, marital status, education level, and income); functional capacity (ADLs, basic and instrumental); morbidities (specification of the disease and number of associated diseases); quality of life according to the WHOQOL-BREF (domains: physical, psychological, social relationships, and environment) and the WHOQOL-OLD (facets: sensory functioning; autonomy; past, present and future activities; social participation; death and dying, and; intimacy).

Functional incapacity was considered when the individual reported being incapable of performing a certain ADLs without the help of another person.

An electronic worksheet was constructed using Excel® and the collected data were processed on a microcomputer, by two people, using double entry. It was verified there were duplicated registers of individuals, and different names between the two databases. Therefore, the typing was reviewed to verify the consistency of the data. In case there was inconsistent data, the original interview was reviewed to confirm and/or correct the information.

The statistical analysis was performed using the Statistical Package for Social Sciences (SPSS) version 17.0. Each WHOQOL-BREF domain and WHOQOL-OLD facet was analyzed separately and consolidated with their respective syntaxes.

The categorical variables were analyzed using simple frequency distribution. The groups were compared using ANOVA-F and the Bonferroni test due to the normality of the data and the homogeneity of the variances. The tests were considered significant if $p < 0.05$.

This study was approved by the Human Research Ethics Committee at Universidade Federal do Triângulo Mineiro, protocol number 897. The elderly were contacted at their homes, and presented the study objectives, the Free and Informed Consent Form, and given any pertinent information. The interview was conducted after obtaining the subject's agreement and signature of the referred Form.

RESULTS AND DISCUSSION

Table 1, below, lists the socioeconomic and health characteristics of the studied population.

Table 1 - Distribution of the frequency of the socioeconomic and health variables of the elderly. Uberaba, 2010

Variables	n	%
Gender	Male	804 37.5
	Female	1338 62.5
Age group	60 70	994 46.4
	70 80	822 38.4
	80 or older	326 15.2
Marital status	Never married/lived with a partner	110 5.1
	Lives with spouse or partner	1046 48.9
	Widowed	796 37.2
	Separated/divorced	188 8.8
Education (in years)	No education	426 19.9
	1 4	683 31.9
	4 8	705 32.9
	8 years	95 4.4
	9 or more	215 10
	None	224 10.5
Personal income (in minimum salaries)	< 1	24 1.1
	1	1179 55
	1 3	577 26.9
	3 5	84 3.9
	6 or more	40 1.9
Functional incapacities	0	1571 73.3
	1 3	475 22.2
	3 5	41 1.9
	> 5	55 2.6
	0	38 1.8
Morbidities	1 4	402 18.8
	4 7	704 32.9
	7 10	613 28.6
	≥10	385 18

Most were female (62.5%) (Table 1). This finding is consistent with other studies, evidencing a longer longevity of the female gender.¹⁵⁻¹⁶ It is estimated that women live, approximately, seven years more than men.¹⁷

The predominant age group was 60 |70 years (46.4%) (Table 1). A higher percentage was obtained in a study performed with the elderly living in the city's outskirts (56.6%).¹⁵

Regarding the marital status, 48.9% were married or lived with their partner (Table 1). A similar result was found in a study with the elderly¹⁷, however, other studies highlight a higher percentage.¹⁵⁻¹⁸

Regarding education, the prevalence was 4 | 8 years of study (32.9%) (Table 1). A higher percentage was found in a survey performed with elderly subjects enrolled in the Family Health Program, which found that 71.1% had less than four years of education.¹⁸

It was observed that most subjects received one minimum salary (55%) (Table 1). This finding is lower than that obtained for elderly subjects living in the outskirts of a Brazilian capital city (62.8%)¹⁵ and higher to that found among the elderly living in a city in the interior of São Paulo state (30.7%)¹⁶.

It is outlined that 26.7% of the elderly showed functional incapacity to perform ADLs, with a predominance of 1 | 3 (22.2%) (Table 1). A survey observed a prevalence of three or more functional incapacities among the elderly, different from the present study finding.⁴

The ADLs that the elderly were incapable of performing were, predominantly, cutting their toenails (25.1%), ascending and descending stairs (6.7%) and walking close to home (4.8%). A study performed with the elderly found that 11% had dependency to perform ADLs including urinating and/or evacuating (21.3%), getting dressed (9.9%) and bathing (8.9%), different from the present study findings, in which the greatest difficulties were related to their locomotion.⁵

Health care professionals must promote preventive activities aimed at maintaining functionality, and delaying incapacities that impose limitation to the independence of the elderly. These individuals must be the target population of educational interventions and individual care, in such a way that nurses can encourage self-care.

On the other hand, the functional incapacities in activities related to mobility evidenced the need for architectonic adjustments of urban facilities considering that the proportion of older and dependent individuals tends to increase. The political environment as well as the community should be encouraged to engage in discussions to address the restructuring of urban areas and residences that make everyday life easier for the elderly.¹⁹

We outline that 98.3% of the elderly presented morbidities with a predominance of 4 | 7

(32.9%) (Table 1). It is crucial that health care professionals promote interventions aimed at helping the elderly cope with the difficulties caused by multiple morbidities. During the nursing consultation, it is possible to identify the health needs reported by the elderly and, based on this information, it is possible to systemize the care. The diversification of the health care spaces, as well as health actions will permit a broader view of the care to be developed. Home care permits to unveil certain everyday situations and family relationships that would not be identified in the healthcare service. Group education favors the exchange of experiences, promoting a sensation that other people face similar challenges, besides allowing nurses to establish a stronger attachment with the elderly and perform a better follow up about their self-care.

Among the referred morbidities, most subjects presented sight (78.1%) and back problems (63.3%), hypertension (60.9%) and varicose veins (53.1%). These have been the prevalent morbidities among the elderly.⁴⁻¹⁹ In this view, nurses must, while providing care, seek evidence related to the disease that are the most prevalent in this age group, aiming at referring the patient for an early diagnosis and intervention, with the purpose to delay possible complications.

The prevalent health problems that interfere in their daily life include: back problems (54.9%), constipation (38.7%), varicose veins (38%) and hypertension (35.6%). A similar result, though with lower percentages compared to this study, was found in a study with the elderly that observed that back problems (18.6%) and hypertension (16.3%) were the most prevalent interferences in their daily lives.¹⁹

Concerning the self-evaluated quality of life, most considered their life as good (67.3%), followed by neither good nor bad (22%). A similar result was found in another study, in which most elderly subjects rated their quality of life as good (46%) and neither good nor bad (32%).²⁰

Self-satisfaction towards health evidenced that most of the elderly subjects were satisfied (64.4%) and neither satisfied nor dissatisfied (16.4%). Considering that satisfaction towards health can be related to several factors such as independence, autonomy, the behavior of seeking and living life to the fullest,²¹ the factors that have a negative effect on their self-evaluation must be identified, and interventions must be implemented to improve this.

Quality of life, measured by the WHOQOL-BREF, obtained a higher score for the social relationships domain (68.82), which agrees with another study¹⁸ and disagrees with a survey performed among elderly clients of a Family Health Team, which obtained a higher score in the psychological domain (63.01).²²

The physical domain (59.52) presented the lowest quality of life score. This result is different from that found in studies performed with elderly patients enrolled in the Family Health Program¹⁸ and clients of a Family Health Team²², who obtained lower scores in the environment domain.

Quality of life measured by the WHOQOL-OLD evidenced higher scores in the sensory functioning facet (79.95). A result different from that found among the participants of a group for

the elderly (72) and non-institutionalized elderly individuals (76.2), who had higher scores in the social participation facet.²³⁻²⁴

The autonomy facet obtained the lowest score (60.44). This result is similar to that found in other studies.²³⁻²⁴ There are many ways to guarantee the autonomy of the elderly, such as providing them with the opportunity to decide the clothes they wish to wear, which food they prefer, the places they want to visit, and many other items. The most important thing is to recognize their capacities and potentialities, and encourage them to life enjoying their rights, and maintaining their physical and existential space.²³

Table 2, below, lists the distribution of the quality of life scores, WHOQOL-BREF and WHOQOL-OLD, according to the number of functional incapacities of the studied population.

Table 2 - Distribution of the quality of life scores, WHOQOL-BREF and WHOQOL-OLD, according to the number of functional incapacities. Uberaba-MG, 2010

Quality of life scores	Number of functional incapacities				P*
	None	1 3	3 5	5 or more	
WHOQOL-BREF					
Physical	63.69	50.9	40.51	29.16	<0.001
Psychological	68.38	62.71	59.65	54.17	<0.001
Social relationships	69.68	66.93	66.26	62.88	<0.001
Environment	63.57	59.43	60.82	61.14	<0.001
WHOQOL-OLD					
Sensory functioning	82.85	72.52	75.91	65	<0.001
Autonomy	62.36	56.07	53.81	49.2	<0.001
Past. present and future activities	66.67	62.97	63.57	59.09	<0.001
Social participation	67.07	59.2	54.11	44.77	<0.001
Death and dying	76.3	73.87	72.1	83.18	0.023
Intimacy	69.04	66.78	68.75	70.57	0.056

* ANOVA-F.

In the physical domain, it was verified that as the number of functional incapacities increase the quality of life score decreased (F=184.436; $p < 0.001$) (Table 2). A study performed with elderly individuals with functional incapacity evidenced a risk 36.1 times higher for a worse quality of life in the physical domain compared to those without incapacities.⁹ The aspects evaluated by this domain include mobility and the capacity to perform activities of daily living.¹¹

Regarding the psychological domain, greater numbers of functional incapacities was associated with the lower quality of life scores (F=53.450; $p < 0.001$) (Table 2). A study evidenced that the elderly who referred having functional incapacities had a risk 16.9 times higher of presenting a lower score in the psychological domain.⁹ Therefore, it is evidenced that a greater number of functional incapacities affects self-esteem, body image and positive feelings. The elderly individual can feel discouraged towards health care, because of the

limitations imposed by the functional incapacities, thus favoring negative feelings.

The elderly individuals with a greater number of functional incapacities presented lower quality of life scores compared to those without incapacities ($F=11.644$; $p<0.001$) (Table 2). A different result was obtained in a study performed with elderly subjects enrolled in the Family Health Program, in which no relationships was found between functional incapacity and this domain.⁹ The elderly with functional incapacity needs more social support to perform their daily activities. It is possible that a greater number of functional incapacities, particularly those related to mobility, are compromising the personal relationships of the elderly. Within this context, nurses can offer support to the elderly and their relatives and/or caregivers, in terms of discussing about strategies to adjust their functionalities, aiming at maintenance. Furthermore, nurses can identify, within their covered area, the institutions and organization that offer activities for the elderly, with the purpose to increase social support.

In the environment domain, the elderly with 1-3 functional incapacities present a lower quality of life score, compared to the others ($F=15.108$; $p<0.001$) (Table 2). A different result was found in a study conducted with elderly enrolled in the Family Health Program, which found no relationships between functional incapacity and this domain.⁹ This fact evidences that the elderly with a lower number of functional incapacities are facing difficulties to adapt to the family and community environments, besides having few opportunities to acquire new information and leisure.

In the sensory functioning facet, the elderly with five or more and 1-3 functional incapacities presented significantly lower quality of life scores compared to the others ($F=48.146$; $p<0.001$) (Table 2). A study performed with dependent elderly subjects did not find any significant difference between compromised functional capacity and the sensory functioning facet, different from the present study finding.⁸

An association was observed between greater numbers of incapacities and lower quality of life scores ($F=46.024$; $p<0.001$) (Table 2). A different result was obtained among dependent elderly subjects, with no significant difference between compromised functional capacity and this facet.⁸ A greater dependence on other people to perform ADLs has led the elderly to lose their capacity of making decisions about their life. This topic re-

quires further work by health care professionals with the elderly and their relatives, considering that dependency is not related to the loss of autonomy. If the cognitive capacity is preserved, the elderly, despite being dependent, can and should make decisions about their life.

Elderly subjects with five or more and 1-3 functional incapacities presented lower quality of life scores in the past, present and future activities facet, compared to the others ($F=14.838$; $p<0.001$) (Table 2). A study performed with dependent elderly subjects did not find a significant difference between compromised functional capacity and quality of life measured by this facet, which disagrees with the present study finding.⁸ A lower satisfaction towards life and further perspectives can be related to hopelessness towards achieving their needs and aspirations due to the functional limitations.

Regarding the social participation facet, it was verified that as the number of incapacities increased, the elderly presented lower quality of life scores ($F=77.525$; $p<0.001$) (Table 2). This result agrees with the study with dependent elderly subjects, which found lower scored in the social participation facet (32.3) although no significant difference was found between the level of commitment of the functional capacity and quality of life.⁸ These findings evidence that the elderly individuals with a greater number of functional incapacities present limitations to participate in community activities. This fact reinforced the need for health care professionals, in a partnership with the community, to discuss and implement strategies to maintain the social insertion of the elderly.

Different from the findings related to the other facets, in death and dying the elderly subjects with five or more functional incapacities presented a higher quality of life score, compared to the others ($F=3.199$; $p=0.024$) (Table 2). This result disagrees with that found in a study conducted with dependent elderly subjects, in which no relationships was found between functional incapacity and this facet.⁸ This fact suggests a reflection regarding the aspects related to the questions and fear about death that are more frequently experienced by the elderly with a greater number of functional incapacities.

Table 3, below, lists the distribution of quality of life scores, WHOQOL-BREF and WHOQOL-OLD, according to the number or morbidities of the studied population.

Table 3 - Distribution of quality of life scores, WHOQOL-BREF and WHOQOL-OLD, according to the number or morbidities. Uberaba-MG, 2010.

Quality of life score	Number of morbidities					P*
	None	1 4	4 7	7 10	10 or more	
WHOQOL-BREF						
Physical	78.63	71.42	62.58	54.81	47.11	<0.001
Psychological	72.59	71.22	67.4	65.13	61.98	<0.001
Social relationships	67	70.22	69.74	68.84	65.88	<0.001
Environment	63.3	63.31	62.73	61.89	62.36	0.422
WHOQOL-OLD						
Sensory functioning	87.33	83.97	80.89	77.84	76.75	<0.001
Autonomy	66.61	63.28	61.59	58.47	57.98	<0.001
Past, present and future activities	69.08	67.78	66.27	63.88	64.46	<0.001
Social participation	69.41	66.03	65.71	63.56	61.72	<0.001
Death and dying	83.55	75.92	74.46	75.71	77.82	0.073
Intimacy	66.78	67.83	67.92	68.82	70.35	0.145

* ANOVA-F.

In the physical domain, it was verified that as the number of morbidities increased, there was a significant reduction in the quality of life score of the elderly ($F=184.436$; $p<0.001$) (Table 3). A study obtained a lower quality of life score in the physical domain among elderly subjects with more than one chronic disease (37.59) compared to those without diseases (48.72).¹⁰ A greater number of morbidities can be related to pain, discomfort, dependence on medications, and the need to follow treatment for diseases at health services, which are factors evaluated in this domain.¹¹ The reorganization and restructuring of services that comprise the health care network can help the elderly cope with these situations. These aspects, if dealt with considering the perspective of progressive health care and the stratification of risk, will favor the accessibility, solvability and the availability of resources.

A greater number of morbidities among the elderly was associated with a lower quality of life score in the psychological domain ($F=34.737$; $p<0.001$) (Table 3). A greater number of morbidities can contribute to the emergence of negative feelings. It is necessary to provide the elderly with support so they can feel prepared to deal with the adversities related to their disease. In this sense, nurses must promote educational interventions that effectively generate opportunities for learning, as they help the subjects to develop the necessary skills and confidence to adapt and deal with the disease.²⁵

In the social relationships domain, the elderly subjects with 10 or more morbidities, and those without diseases, presented lower quality of life scores compared to the others ($F=8.418$; $p<0.001$) (Table 3). Both the greater number of morbidities and the absence of disease had a negative effect on the quality of life. In this domain, an evaluation is performed of the issues related to social support, sexual activity and personal relationships. These data suggest the need for further studies to better understand the phenomenon that have a negative effect on the quality of life of the elderly with and without morbidities.

As the number of morbidities increased among the elderly, there was a significant reduction in the quality of life score in the sensory functioning facet, ($F=10.520$; $p<0.001$) (Table 3). The comorbidities associated with the alterations resulting from the process of aging can increase the impact of sensory loss, with a negative effect on quality of life. Nurses must investigate this aspect during the nursing consultation, with the purpose of helping in the treatment, when necessary, and preserving the sociability of the elderly.

The elderly subjects with a greater number of morbidities presented a lower quality of life score in the autonomy facet, compared to the others ($F=14.651$; $p<0.001$) (Table 3). These results evidence that maintaining the autonomy becomes more difficult due to the greater number of diseases.

es. However, this fact does not impede the elderly to decide about their interests in life.

In the past, present and future activities facet, the elderly subject with 7-10 morbidities presented significantly lower quality of life scores compared to the others ($F=7.111$; $p<0.001$) (Table 3). The restrictions imposed by the disease and/or treatment can contribute with the impact of this facet on the quality of life of the elderly with multiple morbidities. Health services can help improve these aspects by identifying the factors that have contributed to minimize the hope of the elderly. In addition, activities can be performed to follow the health of the elderly, helping them to understand the aspects related to their disease. Nurses can develop strategies that aim at encouraging the elderly to recognize new plans and aspirations according to their strengths.

An association was found between a greater number of morbidities among the elderly and a lower quality of life score in the social participation facet ($F=7.011$; $p<0.001$) (Table 3). The comorbidities can affect quality of life as the elderly face restrictions in their daily activities and in the community. Therefore, it is necessary to include the elderly in family and community activities according to their interests and possibilities.

CONCLUSIONS

The present study results evidence the need to focus attention in maintaining the functionality and on the morbidities affecting this population.

Functional incapacities related to self-care and mobility suggest the need to develop interventions to encourage functionality, aiming at improving the independence of the elderly. It is possible to conduct group activities at the health services, in addition to individual interventions during home visits.

In terms of the number of morbidities, it is necessary that health services monitor and follow up with the elderly patients in order to avoid complications.

These interventions can help minimize the impact that incapacities and morbidities have on the quality of life of the elderly. It is crucial that health services prioritize interventions that aim to reduce the effects on the everyday life and autonomy of the elderly. Furthermore, the family and community can provide resources to improve the further expectations of the elderly subjects, as well as the implementation of community activities that meet their needs.

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