



SELF-PERCEPTION OF THE HEALTH STATE OF HYPERTENSIVE PEOPLE

AUTO PERCEPÇÃO DO ESTADO DE SAÚDE DE HIPERTENSOS

AUTO PERCEPCIÓN DEL ESTADO DE SALUD DE HIPERTENSOS

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ABSTRACT

Objective: to evaluate the determinants of the self-assessment of hypertensive health status. **Method:** this is a quantitative and qualitative, observational field study with hypertensive patients over 40 years old and stratified cardiovascular risk. The data were collected with consultation to the medical records, questionnaire, and semi-structured interview. The Content Analysis technique was used in the category Categorical Analysis modality. **Results:** there were 19 (54%) participants rated their health as poor, 13 (54%) women and 6 (55%) men were not satisfied with their health status. Among the aspects mentioned in the interview to determine health self-assessment, 39% were from the physical domain, 35% were from the behavioral domain, 22% from the functional domain and the domain of well-being, which was the least mentioned, was cited by 2 %. **Conclusion:** the results demonstrate the multidimensional nature of the self-perception of the health state the high incidence of negative self-perception is due to the methodological characteristics of this study. The aspects of the physical domain were the most prevalent, evidencing the predominance of the biomedical vision in the studied group. **Keywords:** Self-Concept; Health Status; Hypertension; Primary Health Care; Qualitative Research; Quality of Life.

RESUMO

Objetivo: avaliar os determinantes da autoavaliação do estado de saúde de hipertensos. **Método:** estudo quantiquantitativo, de campo observacional, com hipertensos com idade superior aos 40 anos e risco cardiovascular estratificado. Os dados foram coletados com consulta aos prontuários, questionário e entrevista semiestruturada. Foi utilizada a técnica de Análise de conteúdo na modalidade Análise Categorical temática. **Resultados:** 19 (54%) participantes avaliaram sua saúde como ruim, sendo que 13 (54%) mulheres e 6 (55%) homens não estavam satisfeitos com o seu estado de saúde. Dentre os aspectos mencionados na entrevista para determinar a autoavaliação de saúde, 39% eram do domínio físico, 35% eram do domínio comportamental, 22% do domínio funcional e o domínio do bem-estar, que foi o menos mencionado, foi citado por 2%. **Conclusão:** os resultados demonstram o caráter multidimensional da auto percepção do estado de saúde a alta incidência de auto percepção negativa se deve às características metodológicas deste estudo. Os aspectos do domínio físico foram os mais prevalentes, evidenciando o predomínio da visão biomédica no grupo estudado. **Descritores:** Auto percepção; Nível de Saúde; Hipertensão Arterial; Atenção Primária à Saúde; Pesquisa Qualitativa; Qualidade de Vida.

RESUMEN

Objetivo: evaluar los determinantes da auto-evaluación del estado de salud de hipertensos. **Método:** estudio cuantitativo y cualitativo, de campo observacional, con hipertensos con edad superior a los 40 años y riesgo cardiovascular estratificado. Los datos fueron recogidos con consulta a los prontuarios, cuestionario y entrevista semi-estructurada. Fue utilizada la técnica de Análisis de contenido en la modalidad Análisis Categorical temático. **Resultados:** 19 (54%) participantes evaluaron su salud como mala, siendo que 13 (54%) mujeres y 6 (55%) hombres no estaban satisfechos con su estado de salud. Dentro los aspectos mencionados en la entrevista para determinar la auto-evaluación de salud, 39% eran del dominio físico, 35% eran del dominio comportamental, 22% del dominio funcional y el dominio del bienestar, que fue el menos mencionado, fue citado por 2%. **Conclusión:** los resultados demuestran el carácter multidimensional de la auto percepción del estado de salud la alta incidencia de auto-percepción negativa se debe a las características metodológicas de este estudio. Los aspectos del dominio físico fueron los más prevalentes, evidenciando el predominio de la visión biomédica en el grupo estudiado. **Palabras clave:** Auto-percepción; Estado de Salud; Hipertensión; Atención Primaria de Salud; Investigación Cualitativa; Calidad de Vida.

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INTRODUCTION

Health self-assessment has been widely used as a reliable method for measuring and monitoring health status and well-being of individuals, as well as being a practical and low-cost means for use in health services.¹ This is a quality of life, morbidity, functional decline and, above all, a solid predictor of mortality, which is fundamental in the evaluation of people's health conditions. This general self-classification of health status encompasses several aspects of the individual's life such as physical, functional, cognitive and emotional, as well as well-being.²

The factors considered by the individual to self-classified their health status are not yet fully understood but seem to reflect the comprehensive health perception that includes biological, psychological, and social aspects as well as demographic, cultural, and environment of life.³

Besides capturing the exposure to diseases (diagnosed or not by health professionals), the health self-assessment captures the impact that these diseases generate on the physical, mental and social well-being of individuals.⁴ Self-assessment of health status is one of the indicators recommended by the World Health Organization to assess the health of the population. It is a reliable and valid indicator of people's real and objective health conditions.⁵

High blood pressure (HP) is the main risk factor for cardiovascular diseases, being a clinical condition associated with high mortality and may result in serious consequences for some organs (heart, brain, kidneys and blood vessels), as well as being considered a serious public health problem due to its chronicity, high hospitalization costs, incapacity due to disability and early retirements.⁶⁻⁷

Risk factors for HP include modifiable lifestyle-related habits such as smoking, dyslipidemia, obesity, sedentary lifestyle, alcohol abuse, poor diet, and non-modifiable characteristics such as age, gender, and family history. Thus, because of its close correlation with lifestyle, HP can be avoided, minimized or dealt by adopting healthy habits.⁸

Despite difficulties in adherence to treatment, the advances in knowledge and the evolution obtained in the therapeutics have increased the life expectancy of the population. With longevity, it is important for individuals to maintain autonomy and health, as aging increases the risk of chronic diseases,

especially cardiovascular diseases. Also, with increased survival of patients with chronic and/or severe diseases, quality of life became more valued and the importance of its evaluation was recognized and incorporated into clinical trials.⁶

Given the close relationship between health self-assessment and mortality and morbidity, a better understanding of the factors related to this indicator can be a basis for the development of preventive actions to maintain or improve the health of the population.

OBJECTIVE

- To evaluate the determinants of self-assessment of the health status of a group of hypertensive patients.

METHOD

This is a quantitative and qualitative, observational field study carried out in a basic health unit with four family health strategy teams, serving an area of residential neighborhoods in the city of Janaúba, a city in the North of Minas Gerais, Brazil. It was selecting a team of the unit for convenience, having, 3050 people its attached area and 322 of them are hypertensive.

This study is a continuation of a research carried out in 2015 that stratified 50 of them according to cardiovascular risk and socioeconomic and demographic variables, after analyzing the records of all the hypertensive people enrolled in the team.

Hypertensive patients of both genders enrolled in the team, who had the cardiovascular risk stratified previously were included. As this study worked with participants from an earlier study, it is worth mentioning the inclusion criteria of this initial study that were age over 40 years old (age at which the risk classification is most sensitive), duly completed medical record containing information on total cholesterol, High Density Lipoproteins (HDL), triglycerides, and fasting glycemia, dosed less than 12 months, and who agreed to participate in the study. Hypertensive patients who had a previous cardiovascular event record (acute myocardial infarction, angina pectoris, stroke, peripheral arterial disease or heart failure) were excluded.

This study was developed in the second half of 2016, through semi-structured interviews, recorded and transcribed in full for later analysis.

The interviews were carried out in the hypertensive residences with an average

duration of 10 minutes, conducted by the researcher accompanied by the health agent responsible for each patient. The interviews were guided by the following research questions: How do you describe your current health status? In general, compared to people of your age, how do you consider your own state of health?

The answers of the question of self-perception of health status were considered as dichotomic, yes or no, for the analysis of the incidence of self-perception of positive and negative health status.

The interviews were analyzed according to the content analysis proposal, in the categorical thematic analysis modality. This approach consists of a set of communication analysis techniques aiming to obtain, by systematic and objective procedures for describing the content of the messages, indicators that allow the inference of knowledge regarding the conditions of production and reception of these messages.⁹ For the analysis, the clipping of the speeches was made considering the frequency of the themes extracted from the speeches to find the main nuclei of meaning, whose presence gives meaning to the proposed objective.

For the analysis of the data the following steps were accomplished: a) transcription and typing of the recordings of the interviews; b) assigning codes to interviewees; c) comprehensive reading of texts; d) elaboration of analysis structures, grouping excerpts of more illustrative statements in the thematic axes; e) identification of core ideas; f) identification of the meanings attributed to ideas; and g) elaboration of comprehensive, interpretive and contextual syntheses.

In this study, it was opted to analyze all the health aspects mentioned by the participants, characterizing them as a multiple reference, for demonstrating a broader view of the factors considered by the individuals in their self-assessment.

The final categorization scheme consists of 12 health aspects, categorized into four health domains: physical, functional, behavioral and well-being domains.

Characteristics observed for the characterization were as follows: a) Physical references, any reference to the disease, medical treatments or other “body” theme were considered; b) Any reference to general functional abilities or limitations was considered as aspect of the functional domain; c) it was considered that any reference to a positive attitude towards a current illness or that has adapted to its

limitations and any subject referring to the health behavior to be an aspect of the behavioral domain d) any reference to feel fit or energetic (“not feeling tired”) or feelings without additional justification (simply “feeling good”) were considered an aspect of the wellness domain.

The ethical criteria were observed, following all the recommendations of Resolution 466/2012 of the National Health Council and this work was submitted to the Research Ethics Committee of the United Colleges of Minas de Montes Claros - MG and approved under the opinion 1,897.679 with Certificate of presentation for ethical evaluation: 60540716.4.0000.5141. All the participants signed the Free and Informed Consent Form, and the health unit coordinator agreed to the research. To ensure anonymity, the speeches were identified with the letters “P”, in reference to the word patient, followed by the number, according to the sequence of its performance.

RESULTS

At the end of the methodological process, there were 35 individuals evaluated, 11 (31.4%) were male and 24 (68.6%) were female, the age group was between 45 and 85 years old, with a mean age of 64 ± 10.0 (men) and 65 ± 10.8 (women) so 24 (68.5%) of the individuals are elderly. Most of the interviewees were self-declared as “non-white”, 22 (63%) and 13 declared as “white” (37%). Concerning the socioeconomic situation, 97% of the sample had a monthly income between R\$ 622.00 and R\$ 1,866.00 (1-3 minimum salaries), 43% had no education level and 46% had completed elementary education. As for marital status, 26 (76%) were married.

Regarding self-perception of health status, 19 (54%) of the participants rated their health as bad, and 13 (54%) of the women and 6 (55%) of the men were not satisfied with their health status.

The aspects mentioned during the interviews to determine the self-perception of the health status of hypertensive patients in this study were categorized into four domains according to Table 1:

Table 1. Frequency of health domains in the discourse of a group of hypertensive people enrolled in a Basic Health Unit. Janaúba (MG), Brazil, 2016.

Health Domains	n (% do total)
Physical Domain	37 (39.3%)
Presence of the disease/complaints (25)	
Limitations (6)	
Age (6)	
Behavioral Domain	33 (35.1%)
Social relationships (18)	
Medicine picture (12)	
Fear (2)	
Maintaining Healthy Habits (1)	
Functional Domain	22 (23.4%)
Ability to perform daily activities (12)	
Be useful/active (9)	
Dependency (1)	
Well-being Domain	2 (2.1%)
Be alive (1)	
Know how to live with the disease (1)	

The number of domains reported by the participants varied from 1 to 4. Almost half of the participants (48.6%) mentioned aspects of two domains, 25.7% of the participants mentioned aspects of three domains and 2.6% of the participants mentioned aspects of four areas of health. In total, 35 participants made 94 references to health determinants, of which 54 were negative and 40 were positive, so the participants mentioned 3.6 aspects of health on average.

Depending on the context and the experience of each individual, the same aspect may exert a positive or negative influence in the formation of judgment on the state of health. The frequency with which aspects have been reported as determinants of good health and poor

health is shown in Table 2:

Table 2. The positive and negative determinants of health aspects in the health self-assessment of a group of hypertensive people enrolled in a Basic Health Unit. Janaúba (MG), Brazil, 2016.

Negative Determinants	n	Positive Determinants	n
Presence of illness/frequent complaints	19	Social relationships	12
Having to take medicine	09	Ability to perform daily activities	08
Age	06	Absence of complaint/illness	06
Limitations	06	Be active	06
Social relationships	06	Have medicine	03
Inability to perform daily activities	04	Be useful	02
Fear	02	Be alive	01
Dependency	01	Maintaining Healthy Habits	01
Not being active	01	Know how to live with the disease	01

Most of the individuals referred to the physical domain, which corresponded to 39.3% of the aforementioned aspects, and it was mentioned by 81% of the men and 67% of the women, prevailing in the youngest sample of the studied sample, aged between 40 and 59

years old, with 82%. The physical domain was predominantly associated with the negative perception of health status, as shown in the following statements:

The only thing I have there are the restrictions that the weather even favors, I

am healthy, I just have the difficulties of time. (P. 16)

I am full of problems, if I go to count here... Asthmatic, knees with problems, I cannot walk, I have restless legs syndrome [...], I am hypertensive too. (P.18)

The behavioral domain, which was the second most mentioned, 35.1% of the aspects, referred by most men, 81%, and women, 58%, prevailing in the males as more commonly referred by the older extracts of the sample, being reported by 69% of individuals aged 60 to 39 years old, 73% of those aged 70 years old or older compared to 54.5% of individuals aged 40 to 59 years old.

The behavioral aspects were frequently mentioned as determinant as good health, being the social relationship and more mentioned. In many interviews, it was emphasized that being surrounded by people, having company, having a good marriage, not being alone, helping others, being a member of an organization and having relationships with others are important aspects of being healthy.

I have neighbors so good, they are my best friends... and I could not wish for a better neighbor next. He sweeps the sidewalk for me, and if I need help with anything, I can trust him. (P.28)

Significant social roles are an important aspect of a good life at any age. The ability to maintain a meaningful social life and to continue social activities, when absent, was also important in the negative perception of health.

I'm not, I'm just sick, I'm not going anywhere, to a friend's house, a neighbor's house, nobody... And the fear of me falling? (P.32)

This work allowed identifying feelings of dissatisfaction manifested by the patients in face of the disease situation and the treatment in which they are. The patient's knowledge is about the possibility of suffering an HP complication and the exhaustion due to living in the patient's condition.

There is a time that I'm up to good, but these pressure business is dangerous right, it can give cardiac arrest to infarct because of age and fat in the blood. (P.7)

My bones are weak if I fall and break something... You have to be careful. (P.32)

Although the figure of the medicine was the second most mentioned aspect as a negative determinant of health, there were some patients who associated it positively, evidencing the subjectivity of this theme.

Because I live in peace, mainly, my health is controlled, I only take the medicine right and I am in peace. (P. 21)

The functional domain was more frequent in the discourse of older individuals, 64% of those 70 years old or older, and 85% of individuals aged 60 to 69 years old mentioned aspects of this domain, while 27% of individuals aged between 40 and 59 years old. Men also mentioned this area more frequently, 72% versus 24% of women. This domain showed a greater association with good health status in individuals' discourse.

The most present idea in the speeches that contemplated the functional domain links the understanding of health to remain active within the physical and mobility capacities and to perform simple daily tasks.

I am (healthy) because I do everything, I wash, I pass and nobody does anything to me, just like my sister, she wakes up there for nine hours and she cannot do anything. (P. 15)

Dependence was present in the self-perception of health of the older individuals as the fragment below shows:

I think so that the healthy person has every moment that we need him, he is able to help, because he has health, he has experience in the mind and heart to help. (P. 6)

Finally, the domain of well-being was the least mentioned in the self-perception of health status in this study. Feeling good and knowing how to live with the disease were aspects that the older extract, an individual over 70, did not mention.

Just reaching the age of 70 already, I have to thank God. (P. 4)

I have health, I have no difficulty, I take controlled medicine, but I feel healthy, I do the right treatment. (P. 12)

DISCUSSION

In a systematic review of the literature on the self-assessment of health status in the Brazilian elderly population,¹⁰ the prevalence of poor self-assessed health in the studies ranged from 12 to 51%. Although there are no reference values in the literature defining what would be acceptable in terms of self-assessed health alone, it is necessary to compare the results of different articles and to analyze the associated similar and divergent factors. Nevertheless, the authors suggest 25% for prevalence of poor health self-assessment among the elderly.

Self-perception has an intrinsic subjective nature and therefore the qualitative approach is better suited to unveil the multidimensional aspects of this indicator and can broaden the understanding of its effects on health.³

The qualitative analysis of self-assessed health shows that different aspects of health may seem incommensurable and even contradictory to the individual, it is often only through a complex process of reasoning and negotiation that this genuinely multidimensional phenomenon of their own health can be expressed.¹¹

In a qualitative study,¹² it was shown that men and women from higher social groups used more multidimensional information in their health assessment, including being fit, active, and disease free, while those from lower classes tended to be more limited in physical and functional aspects. As this study shows a population almost homogeneous in terms of income, this association was not observed.

The presence of diseases is a variable whose association with negative health self-assessment is expected and maybe a result of the health referential of the elderly as absence of disease, approaching the biomedical model. It is known that comorbidities, common with the advancing age, can present limitations and difficulties of self-care, which can influence the perception of health.¹³

More complex issues such as functional capacity and quality of life are more related to the perception of being sick than to having a chronic illness and its consequences.¹³

A qualitative study conducted among elderly women living in the city of Bambuí showed that assessing the severity and relevance of a health problem was determined by the possibility of facing it rather than by the problem. This possibility was associated with family support and access to medical care.¹⁴

Individuals who evaluate their health as negative often have physical health problems, while more positive evaluations reveal a broader concern for health in general well-being.¹⁴

Different from the physical domain, in which the aspects are mainly focused on the presence of health problems, in the behavioral domain, the focus is on the extent to which individuals are able to deal with these problems that determines their eventual health assessment. In this way, physical aspects were frequently mentioned as a determinant of poor health and behavioral aspects as good health.

The social relationship was the most mentioned aspect as a determinant of good health. The explanation for such results may

be based on the protective effect on health that social support favors.³

The reports reveal that this positive self-assessment of health covers some individuals' efforts to remain active, to preserve their intersubjective identity and their role in the group.¹⁵ The most present idea in the interviews links the understanding of health to remain active within the physical and mobility and perform simple daily tasks.

In a qualitative study on successful aging, independence, the ability to make decisions, and the freedom to act according to their interest was identified as an important determinant of good aging.¹⁶

A sense of autonomy can often result in well-being and a positive attitude toward people.¹⁶ Because dependence is linked to fragility, defined as a vulnerability that the individual presents to the challenges of their environment, reducing their adaptability and sense to be useful to it, tends to be present in the self-perception of health of older individuals as in this study.¹⁷

As in this study, another study¹⁷ showed that men refer to functional aspects more often than women. This result was associated with the fact that, in Western societies, men are usually the head of the household and responsible for the main source of income. Thus, this may be the reason why men, rather than women, with incorporated the functional definition of health as "being able to perform the necessary duties".¹⁷

The proportion of reference to well-being in this study was much lower than another study¹⁷ in Dutch individuals, where half of the participants less than 40 years old mentioned aspects of well-being, while only one elderly participant mentions that he based his "feel fit" health assessment. Therefore, this difference may have been influenced by the participants' age.

The narratives show that the people who mentioned this theme perceived health as a complex and multidimensional concept. People may think they are healthy, despite the health problems they are aware of and that they voluntarily report. Being healthy and have health are not seen as synonymous in the individuals' reports.

In general, people notice the presence or absence of disease or symptoms, but this is only one of the main aspects of health, the remaining aspects include their ability to do what they need and want to do (functioning) as they have adapted or their attitude towards an existing disease (behavior) and a general sense of well-being, vitality, strength,

and endurance (well-being). Thus, in health assessment, individuals include disease and disability indicators as well as indicators of positive health and functioning, and these conceptions are not mutually exclusive.

CONCLUSION

The incidence of self-perceived negative health status among hypertensive patients in this study was 54%, almost twice the average found in other national studies, which may be associated with the methodological characteristics of this study, including predominantly elderly hypertensive individuals with few income, besides being patients who have updated records, which shows frequent use of the health service.

Several studies have used self-assessment of health status to assess the health of populations based on a number of demographic and socioeconomic characteristics. However, almost none of them sought to know what aspects of health were being considered for self-assessment of health status and how these aspects were considered in this self-assessment. In this regard, this study contributed significantly. The factors influencing the perception of health status of these individuals were investigated and four domains were reached: physical, behavioral, functional and well-being.

The physical domain, with emphasis on the presence of disease, was the most mentioned as determinant of negative perception and the behavioral domain, especially the aspect of social relationship was decisive to determine good health. Other important findings are the fact that mention of physical appearance was more frequent among the younger patients, behavioral and functional domains were more mentioned by men and older people and the domain of well-being was the least mentioned and was not present in the report of older individuals in the sample.

Individuals who incorporated the physical domain in the evaluation presented a biomedical vision of the health-disease process, those that incorporated the behavioral domain value the coping mechanisms. As for the functional domain, the focus of individuals who mentioned their aspects is focused on the consequences of health problems and age and those who mentioned the field of well-being privileged adaptation to adverse circumstances.

In the midst of this complex relationship, two analyses arise: self-perception of health status reflects the level of consciousness of individuals in relation to their health status,

so those who evaluate their health in a favorable way, despite objective health indicators precarious, they should have their self-perception of health-adjusted through education and the adoption of appropriate behavior changes.

Another possible inference is that self-perception of health status is motivated by a particular sociocultural context and not just an act of ignorance, although inconsistent with objective health measures, some positive ratings may be indicative of resilience.

Knowledge of the differences in characteristics associated with good or poor health related to socioeconomic variables and risk factors is important to guide appropriate interventions, considering that health status is a complex construction, so the health implications of a single factor risk or exposure may not be universally identical, that is health status would depend on interaction with coexisting variables, so different combinations of risk and protective factors produce different results. The use of self-perception of health status to guide the practice requires the adoption of a holistic view of the patient, who perceives it in his entirety given the complexity of this indicator.

The results of this study can subsidize the service of basic care by broadening the view on the subjectivity of each patient, considering it as a complex whole, not limited to care of the illness or the patient, but of the individual. Self-perception of health status refers to the individual's self-image, which is determined by considering cultural values, expectations and experiences. Therefore, its use as an indicator of health, which must be analyzed in conjunction with the behaviors and risk factors, is capable of directing the actions of health education that tends to be more decisive when considering the subjectivity of individuals.

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