

# Comparative study of quality of life of elderly living in condominiums versus community dwellers

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## Comparative study of quality of life of elderly living in condominiums versus community dwellers

**Objective.** To compare the quality of life of elderly living at a geriatric institution with that of elderly living in the community. **Methodology.** Quantitative study in which the quality of life of 50 elderly living in condominiums was compared with that of 173 community dwellers. To assess the quality of life, the instruments WHOQOL-BREF and WHOQOL-OLD were applied. The data were collected between November 2011 and February 2012. **Results.** The groups differed significantly with regard to the domains: physical, environment, functioning of the senses and participation, which were better in the condominium residents; while the community dwellers scored higher in the domain intimacy. **Conclusion.** Different factors can interfere in the elderly's quality of life, including the place of residence, which indicates the need for further monitoring by health professionals, especially nurses, with a view to outlining strategies to maintain the elderly's quality of life

**Key words:** quality of life; nursing; aged; housing for elderly.

## Estudio comparativo de la calidad de vida de ancianos residentes en condominios versus la de los residentes en la comunidad

**Objetivo.** Comparar la calidad de vida de ancianos residentes en una institución geriátrica –condominios- versus la de los que son residentes en su hogar –en la comunidad-. **Metodología.** Estudio cuantitativo en el que se comparó la calidad de vida de 50 ancianos que vivían en una institución geriátrica con la de 173 residentes en su hogar. Para evaluar la calidad de vida se aplicaron los instrumentos WHOQOL-BREF y WHOQOL-OLD. Los datos se recolectaron de noviembre de 2011 a febrero de 2012. **Resultados.** Los grupos difirieron significativamente en relación con los dominios: físico, medio ambiente, funcionamiento de los sentidos y participación, que fueron mejores en los residentes en el condominio; mientras que el dominio intimidad fue mayor en los ancianos residentes en la comunidad. **Conclusión.** Existen

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diversos factores que pueden interferir en la calidad de vida del anciano, incluso el lugar de residencia, lo que indica la necesidad de un mayor acompañamiento de los profesionales del área de la salud, en especial del enfermero, con el fin de trazar estrategias tendientes al mantenimiento de su calidad de vida.

**Palabras clave:** calidad de vida; enfermería; anciano; viviendas para ancianos.

### **Estudo comparativo da qualidade de vida dos idosos que vivem em condomínios contra moradores da comunidade**

**Objetivo.** Comparar a qualidade de vida de idosos residentes em uma instituição geriátrica contra aqueles que residem em sua casa. **Metodologia.** Estudo quantitativo sobre a qualidade de vida dos 50 idosos que vivem em condomínios com 173 residentes na comunidade foram comparados. Para avaliar a qualidade de vida das ferramentas WHOQOL-BREF e WHOQOL-OLD foram aplicados. Os dados foram coletados a partir de novembro de 2011 a fevereiro 2012. **Resultados.** Os grupos diferiram significativamente em relação aos domínios: físico, ambiental, funcionamento e participação dos sentidos, que foram melhores nos moradores do condomínio; enquanto domínio privacidade foi maior nos moradores mais antigos. **Conclusão.** Vários fatores podem interferir na qualidade de vida dos idosos, incluindo o local de residência, o que indica a necessidade de maior apoio dos profissionais de saúde, especialmente os enfermeiros, a fim de desenvolver estratégias que visem manutenção da qualidade de vida dos idosos.

**Palavras chave:** qualidade de vida; enfermagem; idoso; habitação para idosos.

## Introduction

As a phenomenon that initially marked developed countries, population aging is observed around the world, due to the dynamic interaction between mortality and fecundity rates.<sup>1</sup> In Brazil, elderly is considered as anyone aged 60 years or older<sup>2</sup>, corresponding to 11.3% of the population. In the State of Paraná, the proportion of elderly people corresponds to 11.6%.<sup>3</sup> These estimates evidence the need to develop research with a view to understanding the dynamics of population aging for the purpose of a better organization of health care for the elderly. A great challenge longevity imposes is to add quality to the extra years lived. Hence, public policies are needed that permit dignified and healthy aging to the population.<sup>4</sup> Among the fundamental rights established in the Statute of the Elderly, Chapter IX, focused on Housing, the priority of the elderly to purchase their own housing is determined, therefore reserving 3% of residential units. Nevertheless, 43.2% of the Brazilian elderly population gains a

monthly income of one minimum wage,<sup>3</sup> making it difficult for them to enjoy the right to their own house.

To minimize this problem, the Condominiums of the Elderly emerge as a new housing modality for low-income elderly, constituting a strategy to guarantee the right to housing, mainly for those living in precarious conditions. Differently from asylums and homes, people living in condominiums are independent, pay (symbolic) rent for their housing and have the autonomy to come and go whenever they want, besides collectively deciding on the organization of the condominium.<sup>5,6</sup> Condominiums have existed in North America, Australia and New Zealand for more than 60 years, where they have become a very popular housing option. It is estimated that 5% of the American elderly live in these condominiums.<sup>7</sup> Besides granting the right to dignified housing to the elderly, the condominium

maintains their quality of life (QoL), which depends on many mutually interacting elements across the lifetime.

The expression QoL has received different concepts over the years and, in this study, the concept elaborated by the expert group of the World Health Organization (WHO) was adopted, given its subjective characteristics, multiple dimensions and bipolar nature,<sup>8</sup> and because it comprises the physical and social conditions and the environment, that is: "an individual's 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".<sup>8:1405</sup> This research intends to answer the following question: Do elderly living in this new housing modality reveals some difference in QoL when compared to those living in the community? Regarding what aspects? From this perspective, this research intended to enhance the knowledge about this theme and favor the proposal of actions for the residents in these condominiums and in the community, aiming to promote improvements in the care they receive in the field of collective health and QoL. Thus, the study aimed to describe and compare the QoL in elderly living in condominiums and in the community.

## Methodology

This study is an excerpt from a larger research about the life and health conditions of elderly people living in a Condominium for the Elderly. An exploratory study with a quantitative approach was undertaken, involving residents from the first and only Condominium for the Elderly in the city of Maringá, Paraná. The proportion of elderly in that city corresponds to 12.2% of the population, with few services and support opportunities for the elderly population. In 2006, the policy was adopted to encourage the adoption of healthy habits, including the implementation of silver health clubs (SHC), 47 of which have been installed across different neighborhoods in the city. In addition,

there are 10 Long-Term Institutions for the Elderly, three Daycare Centers, 31 Community centers and one Condominium for the Elderly, active since August 2010, with 50 residents.<sup>9</sup>

The study population was divided in two groups: G1, including all residents of the Condominium for the Elderly (n=50) and G2, including a number of elderly thrice as high than in G1, plus another 20% for possible losses, resulting in a convenience sample of 180 elderly. The definition of a number thrice as high is due to the belief that that would be sufficient to represent the characteristics of the elderly community dwellers. To constitute G2, the neighborhood where the elderly lived before moving to the condominium was investigated, also identifying the Primary Health Care services (UBS) of reference, showing that these elderly came from neighborhoods attended by the 23 UBS located in the urban region of the city. Thus, considering each elderly's place of residence before moving to the condominium, the number of elderly was proportionately defined who lived in the coverage area of each of the UBS located in the urban region of the city. To define the elderly community dwellers who would be part of the study, a proportional random draw was used, by means of a list of the registered elderly, provided by the directors of the UBS.

The following inclusion criteria were adopted: being over 60 years of age, accepting to participate in the study and having reached the minimum score of 13 points on the cognitive assessment accomplished by means of the application of the Mini Mental State Examination (MMSE), short version, validated by the researchers of the SABE project.<sup>10</sup> Among the 180 elderly community dwellers drawn, 173 were included in the study, as five did not accept to participate and two did not reach the minimum score on the MMSE. Thus, 223 elderly (G1 and G2) were part of the study. The data were collected at the homes between November 2011 and February 2012, through an individual semistructured interview. The sociodemographic characteristics were obtained based on section I of the instrument BOAS (BRAZIL OLD AGE SCHEDULE), translated and validated in Brazil<sup>11</sup>, as this instrument had

been applied in the larger study. The QoL was measured by means of the WHOQOL-BREF<sup>12</sup> and the WHOQOL-OLD module<sup>13</sup> both validated in Brazil, which should be used at the same time and permit a more comprehensive data collection.<sup>14</sup>

The WHOQOL-BREF consists of 26 questions and assesses the following QoL domains: physical, psychological, social relations and environment. The answers to each question are displayed on a five-point Likert scale, with total scores ranging between 38 and 118 points. It should be reminded that, in the assessment of the results, questions 03, 04 and 26 should be interpreted inversely. This process is necessary to avoid problems in the interpretation of the scores, as the instrument assesses QoL and its variables in a positive and increasing manner.<sup>12</sup> The WHOQOL-OLD, in turn, has a range of 24 points and the facets it assesses are: functioning of the senses, autonomy, past, present and future activities; social participation; death and dying and intimacy. The answers to each question are also presented on a five-point Likert scale, and seven questions come with a negative interpretation: 1, 2, 6, 7, 8, 9, and 10.<sup>13,14</sup> The total scores range between 52 and 102. Both instruments do not recommend a cut-off point to classify the QoL as excellent, good or bad, simply defining that, the higher the QoL score, the better it is perceived.<sup>8</sup>

The QoL instruments are self-applied but, due to possible reading difficulties, visual problems and illiteracy among the elderly, the decision was made to interview all participants directly, who were instructed to answer the questions from the questionnaires based on the two weeks before the data of the data collection, according to the two instruments' instructions. After applying the instruments mentioned, the researchers formulated a question to discover the elderly's self-perceived QoL: How do you assess your general QoL: 1: Bad; 2: Good; 3: Excellent.

The results obtained were registered on an electronic worksheet in EXCEL 2007 through double entry, verifying the consistency between the fields. In case of inconsistency, the gross data were consulted. The sociodemographic data were described and analyzed through a contingency table (chi-square or Fisher's test). Each WHOQOL-

BREF domain and WHOQOL-OLD facet were consolidated separately in the software Statistical Package for the Social Sciences (SPSS 16), with the respective syntaxes. As the data do not follow a normal distribution, the median was used to represent them, and non-parametric statistics to compare the QoL between the two groups by means of the Mann-Whitney test. For all analyses, the percentiles 2.5% and 97.5% were considered for the inferior and superior limits of the data distribution, i.e. the lower and maximum scores of the 95% confidence interval.

The study was developed in compliance with the Ministry of Health recommendations established in Resolution 466/2012, and approval for the project was obtained from the Permanent Ethics Committee for Research Involving Human Beings at Universidade Estadual de Maringá (Opinion 709/2011). All participants signed two copies of the Free and Informed Consent Form.

## Results

As observed in Table 1, when comparing the sociodemographic characteristics between the elderly in group 1 and group 2, some are similar: predominance of women (62% and 69%, respectively), monthly income up to one minimum wage (90% and 78%) and Catholic religion (68% and 75%). As regards the age range, 44% of the elderly from group 1 are between 70 and 79 years old, while 42% of the elderly from group 2 are between 60 and 69 years old, but the age difference between the groups was not significant. The groups differed significantly with regard to the education variable. The strongest influence in this difference came from the levels primary education and high school or elementary school. The marital status married/living together was predominant in both groups, with 44% in G1 and 56% in G2. Nevertheless, a significant difference was observed between the groups and, after the residue analysis, it was verified that the answer never married was the most influential in the difference between the groups.

Among the 223 elderly interviewed, 79% reported some kind of illness, the most frequent of which

were arterial hypertension (70% in G1 and 57% in G2) and Diabetes Mellitus (16% in G1 and 22% in G2).

**Table 1.** Frequency of sociodemographic variables in the elderly participants, Maringá, 2012

| Variables                 | Group 1<br>(N=50) |      | Group 2<br>(N=173) |      | Total<br>(N=223) |      | P value* |
|---------------------------|-------------------|------|--------------------|------|------------------|------|----------|
|                           | n                 | %    | n                  | %    | n                | %    |          |
| Sex                       |                   |      |                    |      |                  |      | 0.332    |
| Female                    | 31                | 62.0 | 120                | 69.3 | 151              | 67.7 |          |
| Male                      | 19                | 38.0 | 53                 | 30.6 | 72               | 32.2 |          |
| Education                 |                   |      |                    |      |                  |      | 0.007    |
| None                      | 15                | 30.0 | 54                 | 31.2 | 69               | 30.9 |          |
| Primary                   | 18                | 36.0 | 93                 | 53.7 | 111              | 49.7 |          |
| High school or elementary | 14                | 28.0 | 14                 | 8.0  | 28               | 12.5 |          |
| Finished secondary        | 2                 | 4.0  | 7                  | 4.1  | 9                | 4.0  |          |
| Higher education          | 1                 | 2.0  | 5                  | 2.8  | 6                | 2.6  |          |
| Age range                 |                   |      |                    |      |                  |      | 0.774    |
| 60-69 years               | 21                | 42.0 | 73                 | 42.2 | 94               | 42.1 |          |
| 70-79 years               | 22                | 44.0 | 69                 | 39.8 | 91               | 40.9 |          |
| 80 or older               | 7                 | 14.0 | 31                 | 17.9 | 38               | 17.0 |          |
| Marital status            |                   |      |                    |      |                  |      | 0.022    |
| Married/Living together   | 22                | 44.0 | 97                 | 56.0 | 119              | 53.3 |          |
| Widowed                   | 16                | 32.0 | 52                 | 30.0 | 68               | 30.4 |          |
| Divorced/Separated        | 3                 | 6.0  | 16                 | 9.3  | 19               | 8.5  |          |
| Never married             | 9                 | 18.0 | 8                  | 4.6  | 17               | 7.6  |          |
| Income                    |                   |      |                    |      |                  |      | 0.191    |
| 0 to 1 minimum wage       | 45                | 90.0 | 135                | 78.0 | 180              | 80.7 |          |
| 2 to 3 minimum wages      | 5                 | 10.0 | 35                 | 20.2 | 40               | 17.9 |          |
| 4 or more minimum wages   | 0                 | 0.0  | 3                  | 1.7  | 3                | 1.3  |          |
| Religion                  |                   |      |                    |      |                  |      | 0.496    |
| Catholic                  | 34                | 68.0 | 122                | 70.5 | 156              | 70.0 |          |
| Evangelical               | 16                | 32.0 | 45                 | 26.0 | 61               | 27.3 |          |
| None                      | 0                 | 0.0  | 6                  | 3.5  | 6                | 2.7  |          |
| Types of health problems  |                   |      |                    |      |                  |      |          |
| Diabetes Mellitus         | 8                 | 16.0 | 39                 | 22.5 | 47               | 21.0 | 0.317    |
| Arterial Hypertension     | 35                | 70.0 | 100                | 57.0 | 135              | 60.5 | 0.120    |
| Arthritis/Arthrosis       | 2                 | 4.0  | 17                 | 9.8  | 19               | 8.5  | 0.193    |
| Heart disease             | 6                 | 12.0 | 27                 | 15.0 | 33               | 14.7 | 0.526    |
| Depression                | 4                 | 8.0  | 7                  | 4.0  | 11               | 4.9  | 0.255    |
| Dyslipidemia              | 4                 | 8.0  | 34                 | 19.6 | 38               | 17.0 | 0.053    |
| Cancer                    | 1                 | 2.0  | 3                  | 1.7  | 4                | 1.7  | 0.901    |
| Renal illnesses           | 2                 | 4.0  | 13                 | 7.5  | 15               | 6.7  | 0.382    |

(\*) Chi-square and Fisher's exact test. Five percent significance level ( $p < 0.05$ )

When asked specifically about their self-perceived QoL, most of the elderly (62% in G1 and 56% in G2) considered it good. The total QoL score assessed through the WHOQOL-BREF was the same for both groups and was not associated with any of the two housing places. Nevertheless, a statistically significant association is observed between the QoL scores in the physical and environmental domains and living in the Condominium for the Elderly (G1), which demonstrates the positive influence of these two variables on these elderly's QoL.

The total QoL score, assessed through the WHOQOL-OLD, was higher for the elderly living in the Condominium, but without a statistically significant difference with any of the two housing sites. It should be highlighted that the variables functioning of the senses and social participation demonstrated a positive influence of the QoL score of the elderly living in the Condominium, while the intimacy variable influenced that of the community dwellers.

**Table 2.** QoL scores of the elderly according to WHOQOL-BREF and WHOQOL-OLD, Maringá-Paraná, 2012

| Variables                           | Group 1 (n=50) |          |          | Group 2 (n=173) |          |          | P value* |
|-------------------------------------|----------------|----------|----------|-----------------|----------|----------|----------|
|                                     | Median         | 95%CI    |          | Median          | 95%CI    |          |          |
| WHOQOL-BREF                         |                | Inferior | Superior |                 | Inferior | Superior |          |
| Physical                            | 61             | 36       | 86       | 54              | 18       | 89       | 0.041    |
| Psychological                       | 71             | 46       | 92       | 71              | 38       | 92       | 0.334    |
| Social Relations                    | 67             | 25       | 92       | 67              | 17       | 92       | 0.631    |
| Environment                         | 66             | 50       | 84       | 63              | 41       | 88       | 0.008    |
| Total                               | 63             | 25       | 88       | 63              | 25       | 88       | 0.148    |
| <b>WHOQOL-OLD</b>                   |                |          |          |                 |          |          |          |
| Functioning of the senses           | 88             | 19       | 100      | 75              | 19       | 100      | 0.001    |
| Autonomy                            | 63             | 38       | 88       | 63              | 31       | 94       | 0.526    |
| Past, present and future activities | 63             | 38       | 94       | 69              | 25       | 94       | 0.842    |
| Social participation                | 75             | 44       | 88       | 63              | 19       | 88       | <0.01    |
| Death and dying                     | 75             | 6        | 100      | 75              | 19       | 100      | 0.343    |
| Intimacy                            | 69             | 31       | 100      | 75              | 25       | 100      | 0.029    |
| Total                               | 71             | 45       | 91       | 67              | 33       | 88       | 0.068    |

(\*) Mann Whitney test

## Discussion

A considerable part of the elderly living in the Condominium live with a partner (44%), but what is truly noteworthy in this group is the fact that 18% of them never constituted a family, while this condition is almost five times less frequent among community dwellers, based on which it is inferred

that not constituting a family is a condition that indicates greater social vulnerability in old age and the fact of living in a condominium confirms this hypothesis. This fact shows that these people need to be identified and monitored since the adult phase, involving different social sectors, in

the attempt to minimize the harmful effects of this condition in old age.

On the other hand, the proportion of elderly who live with a partner, identified in this and other studies,<sup>15,16</sup> indicates the need for health professionals to investigate and observe the factors that influence the maintenance of the elderly couple's QoL, with a view to granting them help when necessary. Also regarding the marital status, the second highest percentage found referred to widowed elderly, in line with the results of another study.<sup>4</sup> Concerning the elderly living in the Condominium, besides being widowed, most of them do not have family support, and the residue analysis indicates that the elderly who never got married are more prone to condominium life. Based on these findings, it is suggested that health professionals should become increasingly apt and prepared to stimulate self-care, so that these elderly can maintain, and as long as possible, a maximum level of independence and functional ability, as this is a condition to get a house and live in the condominium. In addition, strategies need to be elaborated that, in case they become dependent, the people currently living in the condominium will have a place of referral to be forwarded to, considering that one of the criteria to live in the condominium is independence.

Illiteracy among the elderly is a reality in developing countries, including Brazil. That is so because, in the past, schooling was not valued, especially for women. This fact justifies why many public initiatives and non-governmental actions are focused on literacy and permanent education for adults and elderly.<sup>17</sup> Data from the National Household Survey (PNAD) reveal that 9.4% of the people between 60 and 64 years of age in Brazil are illiterate and that, among the elderly, this percentage increases to 29.4%.<sup>18</sup> In this study, almost half of the elderly (49.7%), with a higher proportion among the community dwellers, studied four years at most. The low education level interferes in the illness process, as it can trigger difficulties with health service access, self-care and treatment compliance.<sup>19</sup> A study undertaken among elderly registered in the

Family Health Strategy (FHS) in a predetermined residential region in the District of Sousas, Campinas, São Paulo, showed that elderly with one or more years of education show a higher perception of health problems than people without formal education, making the authors conclude that, through partnerships, the health services need to offer learning and educational opportunities inside the Condominium, so as to grant these elderly improvements in aspects related to self-care, health and QoL too.<sup>20</sup>

Most of the elderly, with a higher proportion in G1, show a good self-perceived QoL, which may be related to the countless activities the Social Service Secretary offers direct or indirectly to the elderly at the condominium, including the possibility for excursions with assistance from the city and participation in cultural activities. In addition, the municipal government has hired a physical exercise professional for stretching activities one per week, and the Condominium is a training area for the physiotherapy program of a private higher education institution. Therefore, after an individual assessment, the elderly can take part in physiotherapy sessions and practice physical exercise in group and with assistance. What the QoL is concerned, assessed through the WHOQOL-BREF, the physical domain showed the strongest influence on the QoL of the elderly in G1, which may be related to one of the basic requirements to live in the condominium: independence to maintain one's daily life. This is also the variable with the lowest score in both groups though. This result may be related to the number of morbidities among the elderly in this research, which influence the daily life, due to the pain or discomfort and reduced capacity for work.<sup>10</sup> In addition, the limitations that come with age should also be considered.

The variable environment shows the greatest influence on the QoL of the elderly in G1, which may also be related to the supply of countless activities and the physical structure of the condominium, which serves to attend to the elderly's specific needs.<sup>5</sup> An international study indicated that the condominiums for the elderly have a planned

and appropriate physical space for the elderly, contributing to maintain their autonomy and QoL, besides providing for a positive lifestyle by permitting, at the same time, opportunities for companionship, privacy and independence.<sup>21</sup> Also regarding the QoL, greater influence of the variable functioning of the senses was found on the QoL of the elderly living in the condominium, which may be associated with one the requirements to live in the condominium – the independence for activities of daily living. In an international study<sup>21</sup> that investigated the inhabitants' perception of the Condominiums' mission, it was identified that, according to them, one of the objectives is to maintain their autonomy. Despite the association found, it should be highlighted that the elderly from both groups showed a higher QoL score on the variable functioning of the senses, which may be related with the large percentage of elderly in the age range between 60 and 69 years, when the alterations in sensory skills are less perceived than in the more advanced age range, considering that they are cumulative.

The SSC promotes the engagement of the elderly living in the Condominium by offering countless activities. This fact contributes to the greater statistically significant influence of the variable social participation in the QoL of elderly from G1. In addition, the mere fact of living in a condominium specifically for the elderly has been associated with the greater possibility of social interaction and wellbeing in terms of reducing solitude and anxiety.<sup>22</sup> Therefore, condominiums favor the establishment of a social network – a strategy that facilitates the maintenance of QoL. A study undertaken among dependent elderly in the city of Jequié (BA) indicated that the QoL of the elderly is less compromised regarding the facet intimacy, which considers aspects related to companionship, ability to love and be loved.<sup>23</sup> In this study, greater influence of the intimacy variable was found in the QoL of elderly belonging to G2, which may be related to the larger number of elderly in this group who live with a partner.

Social life is fundamental for people to live well at any time, which has been associated with an

increased sense of wellbeing and better physical functioning.<sup>17</sup> In this study, the second highest QoL score found in both groups (G1 and G2) was in the social relations domain, which indicates the existence of satisfactory relations built among the elderly. Hence, social life positively influences the health and mortality conditions.<sup>12</sup> Therefore, the need is reinforced to create engagement and involvement programs in activities that increasingly allow the elderly to maintain and stimulate social life.

Although no statistical association has been observed either with the place of housing, lower QoL scores were also found for the facet autonomy, which involves aspects associated with the ability to make one's own decisions, demonstrating that, in general, the elderly in this study are dissatisfied with their autonomy. This dissatisfaction was related with other people's lack of respect for the elderly's freedom, not allowing them to make decisions on what they would like to do or regarding future plans. This perception, however, may be associated with negative earlier experiences. As regards this aspect, during the nursing consultation or the home visit, the nurse can identify the reasons leading to the elderly's loss of autonomy and outline an individual care plan that focuses on preservation and support for the elderly's decisions<sup>22</sup>, in view of their current life conditions, particularities and desires.

**Conclusion.** The total QoL score, as assessed by both instruments, was not associated with the place of housing, but higher QoL scores appeared, assessed by the WHOQOL-OLD, for elderly living in the Condominium. The scores in the physical and environmental domains, assessed through the WHOQOL-BREF, and the facets functioning of the senses and social participation, found through the WHOQOL-OLD, showed a statistically significant association with the place of housing, demonstrating the positive influence of these two variables on the QoL of elderly living in the Condominium. The scores for the facet intimacy, then, were significantly higher among the community dwellers, probably in function of the greater proportion of elderly with partners in this



group. Therefore, when comparing the QoL of the elderly living in the Condominium with that of the community dwellers, it is observed that the variables with statistically significant associations are directly related with characteristics of this new housing modality, as well as with the activities promoted and the inclusion criteria to gain this housing.

These research results can contribute to expand the body of knowledge about this new housing modality in the Brazilian and international reality, and also evidence the aspects that influence these elderly's QoL, which supports planning actions with a view to promoting and maintaining the QoL of the long-lived. Nevertheless, the study limitations should be taken into account, like the way the sample size was planned and the intentional selection of the subjects, which does not permit the generalization of results like in randomized sampling.

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