RESEARCH PAPER

Quality of life of primary health care users in the district of Vila Real

Qualidade de vida dos utentes dos cuidados de saúde primários do distrito de Vila Real
Calidad de vida de los usuarios de la atención primaria de salud del distrito de Vila Real

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Abstract

Theoretical framework: The Quality of Life (QoL) is determined by functional status and health condition, depending largely on individual, socio-economic and cultural resources, and is one of the major challenges of health care.
Objectives: To characterise the QoL of primary health care users in the district of Vila Real (northern Portugal).
Methodology: Cross-sectional descriptive correlational study, involving 6747 subjects. The MOS SF-36 and various socio-demographic variables were used for data collection.
Results: The mean QoL was 67.85 ± 10.809, which indicates that users had a positive perception of QoL. Participants showed better results in the emotional component. An association seemed to exist between QoL and age group, activity sector, monthly income and the centres involved in the study.
Conclusion: The level of QoL reported by sample subjects was positive and higher than in other studies. The identification of the factors that influenced QoL makes it possible to define a set of interventions for users to obtain more health gains.

Keywords: quality of life; primary health care.

Resumo

Enquadramento: A Qualidade de Vida (QV) é determinada pelo estado funcional e condição de saúde, dependendo em grande parte dos recursos individuais, socioeconómicos e culturais e constitui um dos principais desafios dos cuidados de saúde.
Objetivos: Caracterizar a QV dos utentes dos cuidados de saúde primários do distrito de Vila Real (norte de Portugal).
Metodologia: Estudo transversal, descritivo-correlacional, englobando 6747 sujeitos. Na recolha de dados utilizou-se variáveis de caracterização sociodemográfica e o MOS-SF 36.
Resultados: A média da QV é de $67,85 \pm 10,809$, o que quer dizer que os utentes têm uma perceção positiva da QV. Os sujeitos apresentam melhores resultados na componente emocional. Parece existir relação entre a QV e a classe etária, setor de atividade, rendimentos mensais e os centros envolvidos no estudo.
Conclusão: O nível de QV reportado pelos sujeitos da amostra é positivo e acima de outros estudos. O conhecimento dos fatores que influenciam a QV torna possível definir um conjunto de intervenções no sentido dos utentes poderem vir a obter mais ganhos em saúde.

Palavras-chave: qualidade de vida; atenção primária à saúde.

Resumen

Marco contextual: La calidad de vida (CV) se determina por el estado funcional y el estado de salud, depende en gran medida de los recursos individuales, socioeconómicos y culturales y constituye uno de los principales retos de la atención sanitaria.
Objetivos: Caracterizar la CV de los usuarios de atención primaria de salud del distrito de Vila Real (norte de Portugal).
Metodología: Estudio transversal, descriptivo-correlacional que engloba a 6.747 sujetos. En la recopilación de datos se utilizaron variables de caracterización sociodemográfica y el MOS SF-36.
Resultados: La media de la CV es de $67,85 \pm 10,809$, lo que significa que los usuarios tienen una percepción positiva de la CV. Los sujetos muestran mejores resultados en el componente emocional. Asimismo, parece que existe una relación entre la CV y el grupo etario, el sector de actividad, los ingresos mensuales y los centros que participan en el estudio.
Conclusión: El nivel de CV notificado por los sujetos de la muestra es positivo y está por encima de otros estudios. El conocimiento de los factores que influyen en la CV hace posible definir un conjunto de intervenciones para que los usuarios puedan llegar a obtener más beneficios para la salud.

Palabras clave: calidad de vida; atención primaria de salud.

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Introduction

Individual and collective health are key resources in the development of societies and communities, and the greater the incidence and prevalence of chronic and incapacitating diseases, the more important those resources become (Vintém, 2008). Health is, therefore, considered an essential condition of human life, able to provide the individual with a state of well-being and balance that ensures him/her a satisfactory performance in several domains: physical, psychological and social, and, consequently, also in terms of quality of life (Soares, Toledo, Santos, Lima, & Galdeano, 2013). Thus, this study aimed at characterising the QoL of primary health care users in the district of Vila Real (northern Portugal) to help design sustainable strategic recommendations for this region in specific, and observe the relationship between QoL and various socio-demographic variables, in view of the continuous improvement of the users' quality of life.

Background

The concept of health-related Quality of Life (QoL) is becoming an increasingly important measure to assess the quality of health care and health care services, for instance, in the health economic and social areas of a country (World Health Organization Quality of Life, 2005).

Although it is not consensual, the concept of QoL has two known components: an objective or social one, which comprises economic, political and environmental factors (health in general, functional and socio-economic levels); and a subjective or psychological one which reflects personal judgement [self-esteem, satisfaction with life and well-being (WHOQoL, 2005)]. Despite the widespread use of the term, the concept remains difficult to use given the many variables that make up its meaning (Santos, Martins, & Ferreira, 2009). Thus, taking into account the multiplicity of approaches, several authors advocate the multidimensionality of the QoL concept as a point of agreement, encompassing both objective components, such as the satisfaction of basic needs and functionality, and subjective components, such as well-being, happiness, love, pleasure, and personal achievement (Santos et al., 2009; Vilar & Salgadinho,

2009). Given its variability and subjectivity, the QoL is a dynamic concept, which changes over time as situations are experienced. In particular, it represents the individual perception of one's position in life, taking into account the influence of his/her cultural aspects and the specificities of his/her biological and social environment (Santos et al., 2009).

The World Health Organization (WHO) defined QoL as an individual's perception of their position in life in the context of the culture and value system in which they live and in relation to their goals, expectations, standards, and concerns (WHOQoL, 2005). Within this scope, the four basic dimensions of QoL were adopted, which must be given special attention, *i.e.* the physical dimension that concerns the individual's perception of his/her physical condition; the psychological dimension that represents the individual's perception of his/her affective and cognitive condition; the social dimension that reflects the individual's perception of his/her social relationships and the social roles adopted; and, finally, the environmental dimension that translates the individual's perception of various aspects related to the environment in which he/she lives (Tajvar, Arab, & Montazeri, 2008; Campolina, Dini, & Ciconelli, 2011).

The variety of factors involved in the QoL of people recommends that its approach consider all physical, mental and/or clinical features and include aspects of the user's social and economic reality, which may affect his/her life (Bentley et al., 2013).

In fact, nowadays, health outcomes and/or health gains are addressed not only in terms of the reduction of mortality or morbidity rates, but also according to the social consequences and the quality provided to people's lives (Vilar & Salgadinho, 2009). With this in mind, Otero-Rodrigues et al. (2010) argue that changes in the QoL are predictors of mortality in elderly patients, showing that its assessment is a valuable tool to manage health care. This is because higher longevity only makes sense if it corresponds to a good QoL, which is considered to be one of the main challenges of today's society and one of the main goals of health care.

When we refer to health care, both clients and professionals, together with other resources, are the system's main actors. Among health care professionals, the majority group of human resources in health is composed of nurses, and their action should aim at promoting well-being and self-care, and

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facilitating adaptation processes, thus directing their objectives and interventions to improve the client's QoL. These assumptions are explicit in Article 82 of the profession's code of ethics: "to participate in the professional efforts to value life and the quality of life" (Conselho de Enfermagem, 2010). Therefore, nurses integrate in their interventions the assumptions of a continuous QoL improvement, by targeting the person as a whole (both the human being and his/her circumstances), in search of balance and general well-being. From this perspective, the patient's assessment of his/her own health condition plays a decisive role in the planning and implementation of Nursing interventions towards the continuous improvement of the quality of care provided (Santos et al., 2009).

As defined in the Ottawa Charter (World Health Organization, 1986), QoL should be considered an indicator for the promotion of health and well-being of the populations. Thus, as a result of the latest Portuguese reform of primary health care (Decree-Law no. 28/2008), scientific studies on this issue are essential to obtain health gains, which translate into a better QoL.

Research questions

What is the level of QoL of primary health care users in the district of Vila Real (northern Portugal)?
What is the influence of the various socio-demographic variables on the QoL of primary health care users in the district of Vila Real?

Methodology

This study is an integral part of the research project of a multi-institutional team of researchers, financed by the Ministry of Health/INSA, IP, with the reference 2011/EXT456. It is a cross-sectional descriptive correlational study with a quantitative approach.

It was carried out with users from the parishes of the district of Vila Real, corresponding to the Clusters of Health Care Centres (ACES - *Agrupamentos de Centros de Saúde*) *Alto Trás-os-Montes II, Alto Tâmega e Barroso* (ATMATB), and *Douro I – Marão e Douro Norte* (DMDN). This study used a convenience sample of 6747 subjects, according to the following inclusion criteria: being older than 18 years, and

residing and having used the health care centres of both ACES at least once during the last two years.

As regards the ethical procedures adopted, a written request was submitted to the Regional Health Administration of the North. Participation in the study was voluntary and both the confidentiality of results and the respondents' anonymity were ensured. The study was approved and received the favourable opinion of the Ethics Committee of the Regional Health Administration of the North (reference 49/2012 of 4th December, 2012). The principles of the Helsinki Declaration were followed, particularly the non-exploitation of participants, equality and fair treatment, fair selection of the study population, beneficence, non-maleficence, people's autonomy, respect for people's values, and favourable risk-benefit ratio.

Data were collected in the community, between January and June, 2012, by a group of four research grant holders enrolled in the final year of the undergraduate degree in Nursing, who had received specific training to cooperate in data collection. All parish presidents and parish priests were contacted to achieve a greater adherence from participants, who were interviewed either at home or in their places for work and/or leisure. All surveys/subjects with more than five unanswered questions were excluded from the study.

The individuals' participation was voluntary and informed consent was obtained from the moment they accepted to fill out/answer the questionnaire. The questionnaire was drawn up for the specific purpose of this study and was self-completed and/or applied by the researchers. It included variables on socio-demographic characteristics and the Medical Outcomes Study-Short Form (MOS SF-36) to assess/measure the perceived QoL (Ferreira, 2000).

The MOS SF-36 is a questionnaire that allows assessing the individual's perception of his/her general health status and QoL. It consists of 36 items divided into eight dimensions of health status, recording both positive and negative health status. The MOS SF-36 is a generic measure of health status designed to be self-administered, or applied through interview, or by phone, and is currently one of the most widely known generic measures of health status (Ferreira, 2000). It includes multiple-item scales to measure the eight dimensions of health, which are grouped into two components: the physical component that includes

physical functioning, role-physical, bodily pain and general health, and the emotional component that includes role-emotional, vitality, social functioning and mental health. It also covers the health transition scale, which aims at measuring the overall change in health, even though it is not considered a health concept. For each dimension, the score is expressed on a scale from *0* (worst possible health status) to *100* (best possible health status), presenting a wide range of results that show the high reliability, validity and discriminatory power of this measurement instrument (Ferreira, 2000).

Data were analysed and processed using the statistical software SPSS (Statistical Package for the Social Sciences), version 19 for Windows, and a level of significance of 5% ($p \leq 0.05$) was established. The following methods were used: descriptive statistics with measures of location and central tendency (mean, mode and median), absolute measures of dispersion (standard deviation), and inferential statistics using the Chi-square test, Student's t-test for both samples and ANOVA test (Analysis of Variance), in order to check the differences between several variables. The Tukey's post hoc test was also used for multiple comparisons of means. When requirements for the use of parametric tests were not met, the nonparametric alternative tests of Mann-Whitney and Kruskal-Wallis were used. As regards the age groups, the division of the life cycle was used: adult life - participants aged between 18 and 44 years; middle age – participants aged between 45 and 64 years; and old age.

Results

Among the socio-demographic characteristics of the sample (Table 1), it should be highlighted that the largest group was composed of females, aged between 18 and 44 years, married, living with their spouses and children, having a basic education, working as an employee in the tertiary sector, and receiving a monthly income of 451-1000 Euros. This profile repeated itself in both ACES, except in relation to the professional situation, in which pensioners (30.9 %) were the largest group in the ACES ATMATB, and the monthly income, in which the largest group earned 200-450 Euros (40.3%) in the same ACES. This income was lower than the one found in both the total sample and the ACES DMDN.

The mean age was 50.13 ± 20.625 years, with a minimum of 18 years and a maximum 99 years.

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Table 1

Socio-demographic characteristics of the sample by Clusters of Health Care Centres of Vila Real, 2012

Variables	ACES DMDN		ACES ATMATB		Total	
	n	Rf (%)	n	Rf (%)	n	Rf (%)
Gender						
Female	1796	59.2	2256	60.7	4052	**60.1**
Male	1236	40.8	1459	39.3	2695	39.9
Age group						
18-44 years	1575	51.9	1402	37.7	2977	**44.1**
45-64 years	834	27.5	1025	27.6	1859	27.6
Over 65 years	623	20.6	1288	34.7	1911	28.3
Marital status						
Single	813	26.8	993	26.7	1806	26.8
Married	1812	59.8	1976	53.2	3788	**56.1**
Divorced	130	4.3	119	3.2	249	3.7
Widowed	277	9.1	627	16.9	904	13.4
Family household						
Alone	400	13.2	740	19.9	1140	16.9
Spouse	762	25.1	940	25.3	1702	25.2
Spouse and child	1061	35.0	1039	28.0	2100	**31.1**
Children	197	6.5	303	8.1	500	7.4
Parents	539	17.8	634	17.1	1173	17.4
Parents and grandparents	73	2.4	59	1.6	132	2.0
Level of education						
No education	151	5.0	472	12.7	623	9.2
Basic education	1301	42.9	2130	57.3	3431	**50.9**
Secondary education	939	31.0	673	18.2	1612	23.9
Higher education	641	21.1	440	11.8	1081	16.0
Sectors of activity						
Primary	578	19.1	1078	29.0	1656	24.5
Secondary	487	16.1	750	20.2	1237	18.3
Tertiary	1703	56.2	1298	34.9	3001	**44.5**
Non-respondents	264	8.6	589	15.9	853	12.7
Professional situation						
Student	487	16.1	471	12.7	958	14.2
Self-employed	300	9.9	423	11.3	723	10.7
Employee	1280	42.2	1013	27.3	2293	**34.0**
Unemployed	249	8.2	660	17.8	909	13.5
Pensioner	716	23.6	1148	30.9	1864	27.6
Monthly income						
Less than 200 EUR	492	16.2	569	15.3	1061	15.7
200-450 EUR	823	27.2	1498	40.3	2321	34.4
451-1000 EUR	1079	35.6	1317	35.5	2396	**35.5**
More than 1000 EUR	638	21.0	331	8.9	969	14.4

ACES DMDN - Cluster of Health Care Centres Douro, Marão e Douro Norte;
ACES ATMATB - Cluster of Health Care Centres Alto de Trás-os-Montes, Alto Tâmega e Barroso; n - Absolute frequency; Rf - Relative frequency.

Table 2 shows the mean dimensions of the perceived health-related QoL, according to gender, age group and total sample.

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Table 2

Sample distribution regarding the perception of quality of life, according to gender, age group and total sample, Vila Real, 2012

Variables	Gender		Age group			Total
	Female	Male	18-44 Yr	45-64 Yr	≥65 Yr	
Physical Functioning	54.06±21.4	53.74±21.6	53.89±20.9	53.96±21.3	53.97±22.6	53.93±21.5
Role-Physical	76.95±11.2	77.16±10.7	77.28±10.3	76.56±12.0	77.11±11.2	77.03±11.0
Bodily Pain	60.62±24.6	60.36±21.2	61.93±24.2	60.08±24.6	58.77±24.5	60.51±24.4
General Health	58.03±22.6	57.87±20.5	58.30±20.6	57.81±25.0	57.57±20.2	57.97±21.2
Social Functioning	73.90±32.3	72.99±23.2	75.25±34.6	72.66±23.7	71.73±23.2	73.54±30.0
Role-Emotional	69.84±13.9	69.74±14.1	70.34±13.4	69.63±13.8	69.10±14.9	69.80±14.0
Vitality	58.87±15.6	59.23±15.4	59.15±15.8	58.24±15.4	59.53±15.2	59.01±15.5
Mental Health	59.99±16.0	60.61±15.6	61.02±15.9	59.96±15.9	59.30±15.7	60.24±15.8
Physical Component	65.79±12.5	65.27±12.3	65.92±12.1	65.30±13.1	65.30±12.3	65.58±12.4
Emotional Component	67.50±12.8	67.43±12.9	68.13±12.7	66.79±13.1	67.40±12.9	67.47±12.9
SF36	68.03±10.7	67.58±10.9	68.36±10.5	67.25±11.3	67.59±10.8	67.85±10.8

Yr - Years; SF36 - Short Form 36 items.

In the total sample, the users scored a better QoL in the role-physical, social functioning and role-emotional dimensions, which means that these dimensions contributed the most to a better QoL. The dimensions in which the users had a worst QoL were the physical functioning, general health and vitality dimensions, which means that these dimensions contributed the least to QoL. This was true for both the gender variable and the different age groups.

When analysing the means according to gender, males had a higher mean than females in the role-physical dimension, but lower means in social functioning and role-emotional dimensions.

As regards age groups, all higher means of all dimensions belonged to the 18-44 years group. On the contrary, regarding the lower means, the same age group only had the lowest mean in the physical functioning dimension, *i.e.* they had a better perception of QoL than the other age groups.

The emotional component mean was higher than the physical component mean in the total sample as well as the scores of both genders and the different age groups. The overall mean score of the SF-36 was higher in females and the 18-44 years age group, which means that they had a better perception of QoL. The mean QoL in the total sample was 67.85±10.809, which implies that users had a positive perception of QoL. In the analysis of the relationship between QoL and the variables on socio-demographic characterisation of the sample, no statistically significant differences were found between the various groups regarding the gender, education, marital status and functional units variables (Table 3).

Statistically significant differences were obtained (ANOVA: p=0.028) regarding the age group, in which the 18-44 years group obtained a higher mean than the 45-64 years group, *i.e.* they had a better perception of QoL.

Statistically very significant differences were observed (ANOVA: p= 0.005) regarding the sector of professional activity. In that sense, the tertiary sector had a higher mean than the primary sector, which means that users who carried out their activity in the tertiary sector reported better QoL.

Statistically significant differences were also found (ANOVA: p=0.027) between users who earned monthly incomes of less than 200 EUR and those who earned between 450 and 1000 EUR, with the former obtaining a higher mean and a better perception of QoL.

Finally, highly significant statistical differences were also found (*Student's t-test*: p<0.000) between users of both ACES, the users of the ACES DMDN having reported better QoL than users of the ACES ATMATB (Table 3).

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Table 3

Relationship between quality of life and the socio-demographic variables, Vila Real, 2012

Variables Quality of Life	n	Mean	Test	df	Probability
Gender					
Female	2134	68.03	t=1.21	3587	0.227
Male	1455	67.58			
Age group					
18-44 years	1628	68,36[A]	Anova:	3588	0.028
45-64 years	978	67.25[a]	F=3.6		
Over 65 years	983	67.95			
Education					
No education	293	67.58	Anova	3588	0.915
Basic education	1781	67.77	F=0.17		
Secondary education	878	68.00			
Higher education	637	67.97			
Marital status					
Single	1003	68.35	Anova	3588	0.314
Married	2006	67.69	F=1.19		
Divorced	129	68.04			
Widowed	451	67.37			
Activity sector					
Primary	855	66.69[a]	Anova:	3098	0.005
Secondary	581	67.75	F=5.27		
Tertiary	1663	68.2[A]			
Monthly income					
Less than 200 EUR	586	68.65[A]			
200-450 EUR	1194	67.86[a]	Anova:	3588	0.027
451-1000 EUR	1266	67.21	F=3.05		
More than 1000 EUR	543	68.43			
Functional Units					
USF	1864	68.05	Anova:	3515	0.054
UCSP	391	68.47	F=2.92		
Doesn't know	1261	67.24			
ACES					
DMDN	1702	68.80[A]	t=5.03	3587	0.000
ATMATB	1882	66.99[a]			

Statistically significant differences (p≤ 0.05); n - Absolute frequency; df - Degrees of freedom of the test; USF – *Unidade de Saúde Familiar* (Family Health Unit); UCSP - *Unidade de Cuidados de Saúde Personalizados* (Personalised Health Care Unit); ACES – Cluster of Health Care Centres; DMDN - Douro, Marão e Douro Norte; ATMATB - Alto- Trás-os-Montes, Alto Tâmega e Barroso.

Discussion

The socio-demographic characteristics of our sample were very similar to the characteristics of the sample in the study of Praça (2012), which was composed of 1111 users of the ACES Trás-os-Montes I Nordeste (northern Portugal). In this study, most participants were also female (71.4%), in the 18-45 years age group (50%), married (61.8%), and with a basic level of education (32%). However, values were higher in the study of Praça (2012), except as regards the level of education variable. The users' mean age was higher in our study than in the study of Praça (2012),

which had a mean age of 47.6±18.5 years. This is understandable since the minimum age was the same in both studies (18 years), but the maximum age was higher in our study (99 years).

The same was also true in the study of Ferreira & Santana (2003), conducted with a sample of 2459 subjects belonging to a healthy active population of Portuguese individuals, with the aim of measuring the perception of health status and QoL. However, the proportions regarding age and marital status were higher in this study although the categorisation of age groups was different than the one used in our study. Among the characteristics hindering the QoL

assessment, the following stand out: its subjectivity due to the multiplicity of aspects covered in the attempts to define the concept; its dimensionality for life includes many facets and dimensions, such as the physical, psychological and social dimensions; its bipolarity, with both the positive and negative dimensions; and its mutability considering that the QoL assessment changes depending on the time and context (Santos, Sawada, & Santos, 2011).

Recognising the subjective nature of the QoL concept and comparing the means of the dimensions of QoL in this study to those in the abovementioned studies (Praça, 2012; Ferreira & Santana, 2003), we found that in these studies the means were higher in the *physical functioning, bodily pain, role-emotional and mental health* dimensions. This implies that, in the abovementioned studies, participants had a better perception of QoL in those dimensions, *i.e.* they had less limitations with impact on QoL, lower pain intensity and lower discomfort caused, an increased energy level and less fatigue, more social activities planned and of better quality, less anxiety and depression, and better psychological well-being. In turn, the same scenario, with a slight difference, occurred in the study of Fernandes, Vasconcelos, & Silva (2009), which was conducted on a sample of 62 employees of an institution in Belém, Pará (Brazil). According to the authors, the *bodily pain* dimension was no longer among the highest means of QoL in relation to our study, being replaced by the *vitality* dimension.

After analysing the overall mean QoL of this study and the study of Praça (2012), which was 66.28±19.72, we may conclude that the subjects of our sample reported a slightly higher level of QoL than the users of the abovementioned study.

Taking into account the established comparisons, statistically significant differences were only found between the mean total QoL score of the various age groups and monthly incomes, while in the study of Praça (2012) statistically significant differences were found between the various genders, age groups, marital status, levels of education and monthly incomes. However, age classes and monthly incomes were differently categorised.

Both in the present study and the study of Praça (2012), younger people had a better QoL. However, regarding monthly incomes, the association was not linear in our study, *i.e.* users who received less

than 200 EUR per month had a better perception of QoL, followed by those who earned more than 1000 EUR per month (the class with the highest income). On the contrary, in the abovementioned study, the perception increased with the increase of the monthly income. In all other variables with statistically significant differences, men, single people and those living in a marital relationship had a better perception of QoL than widowers and those with higher academic qualifications.

On the other hand, in the study of Ferreira & Santana (2003), the authors also found statistically significant differences in the mean QoL according to gender, age, marital status and level of education, in which men, younger people, single individuals and those with a higher level of education had a better perception of QoL. With respect to the study of Praça (2012), only the scenario regarding the age groups was repeated in the present study, but all other variables under analysis coincided. These differences observed between the abovementioned studies and the present study may be explained by the different characteristics of our sample, which was part of a geographic area with specific particularities.

The other variables involved in the present study, such as the *sector of activity*, *functional health unit to which the user belongs and the respective ACES*, were not studied by the authors mentioned above.

Conclusion

Following a detailed analysis of the results of this study and taking into account the objectives initially set out, we can now present the conclusions defined below.

The profile of the users participating in this study with higher QoL included female individuals, belonging to the 18-44 years age group, single, with the secondary education, exercising their professional activity in the tertiary sector, and earning less than 200 Euros.

The means of the eight dimensions used to characterise the QoL of our sample subjects were all above 50%, being higher in the *role-physical*, *social functioning* and *role-emotional* dimensions. The lowest means were the *role-physical, general health and vitality* dimensions. The QoL of the emotional component was better than that of the physical component. The level of QoL reported by the sample subjects was positive.

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There seemed to be an association between QoL and age group, sector of activity, monthly income and the ACES to which the users belonged. The other variables were not discriminatory.

The study allowed us to identify the QoL of primary health care users in the district of Vila Real, as well as its association with the various socio-demographic variables. Therefore, it may contribute to the development of a set of recommendations that may be translated into a better perception of quality of life.

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