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Quality of life of public-service oral health teams from Pedro II, Piauí

Qualidade de vida das equipes de saúde bucal do serviço público do município Pedro II, Piauí

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ABSTRACT

Objectives: To verify the quality of life of oral health teams in the municipal public service. **Methods**: A cross-sectional study was conducted with 24 professionals working in oral health teams in Pedro II, Piauí. Data were collected using a questionnaire containing the WHOQOL-Bref instrument from the World Health Organization and other questions about demographic variables, professional practice, and self-perception of health status and quality of life. Pearson's chi-square test and Fisher's exact test were used to statistically analyze the association between variables. **Results**: The population consisted of dentists (62.5%) and technicians/assistants (37.5%), with a predominance of females (58.3%), aged between 25 and 35 years (41.7%), without postgraduate or complete postgraduate studies (37.5%) and without health problems (66.7%). The majority considered their quality of life good (75.0%) and were satisfied with their health (62.5%). The psychological (23.0) and social relations (12.2) domains presented the lowest mean scores. The majority

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presented low quality of life in the social relations domain (66.7%). **Conclusion**: The physical domain and satisfaction with health, the psychological domain and self-assessment of quality of life, and the social relations domain and self-assessment of quality of life and health status showed statistically significant associations. Financial resources, recreation and leisure, and physical environment were the facets that presented the lowest scores.

Indexing terms: Quality of life. Self concept. Dentists. Dental office assistant.

RESUMO

Objetivos: Verificar a qualidade de vida das equipes de saúde bucal do serviço público municipal. **Métodos**: Foi realizado um estudo transversal com 24 profissionais atuantes nas equipes de saúde bucal de Pedro II – PI. Os dados foram coletados através de questionário contendo o instrumento WHOQOL-Bref da Organização Mundial de Saúde e outras questões sobre variáveis demográficas, exercício da profissão e autopercepção da condição de saúde e da qualidade de vida. Para a análise estatística da associação entre as variáveis foi realizado Teste do Qui-quadrado de Pearson e Exato de Fisher. **Resultados**: A população foi composta por dentistas (62,5%) e técnicos/auxiliares (37,5%) com predominância do sexo feminino (58,3%), idade entre 25 e 35 anos (41,7%), sem pós-graduação ou pós-graduação completa (37,5%) e sem problemas de saúde (66,7%). A maioria considerou sua qualidade de vida boa (75,0%) e estava satisfeito com sua saúde (62,5%). Os domínios psicológicos (23,0) e relações sociais (12,2) apresentaram a média de escores mais baixa. A maioria apresentou baixa qualidade de vida no domínio relações sociais (66,7%). **Conclusões**: O domínio físico e a satisfação com a saúde, o domínio psicológico e a autoavaliação da qualidade de vida e o domínio relações sociais e autoavaliação da qualidade de vida e estado de saúde apresentaram associação estatisticamente significante. Recursos financeiros, recreação e lazer e ambiente físico foram as facetas que apresentaram menores pontuações.

Termos de indexação: Qualidade de vida. Autoimagem. Odontólogos.

INTRODUCTION

Primary Care offers services related to health promotion, prevention and recovery actions, and is the gateway to the SUS. The increase in demand for SUS and the guarantee of access to society has increased demand, so that primary care often has restrictions and low-resolution capacity. This overload situation can negatively impact the quality of life of health center employees, directly influencing the functioning of these organizations [1-4]. Other factors also interfere with the quality of life of workers in Primary Care, such as the work environment, management support, job and salary plans, professional category, compatibility of the activities developed with the position held, job stability, occupational stress, among others [5].

Several studies show that health professionals become ill and experience stress due to work-related situations, and dentistry is one of these professions [6,7]. Dental team members are susceptible to high levels of mental and physical stress [8].

The Family Health Strategy and the implementation of the National Oral Health Policy reaffirmed the dental profession as an essential element in providing and ensuring health to the Brazilian population. However, the professional practice of dentists exposes them to occupational risks arising from the work environment and the profession, which interfere with their quality of life [9,10]. Due to the increase in occupational risks and competitiveness in the job market, the quality of life of dentists has worsened over time [11,12].

Dentists are extremely perfectionist professionals who prioritize their manual skills, even if this means exposing themselves to suffering, stress, anxiety and excessive workload. Added to these conditions are multiple working hours, the lack of health monitoring services for workers and a workload that hinders and reduces the quality of work and care [13].

According to the World Health Organization [14], "quality of life is an individual's perception of his or her position in life in the context of the culture and value system in which he or she lives and in relation to his or her goals, expectations, standards and concerns". This concept was developed by the WHO based on a multicenter project in the 1990s, which also gave rise to the WHOQOL-100 instrument and its reduced version with 26 questions, the WHOQOL-Bref [15]. A good quality of life is always desired by everyone, both in financial and psychological aspects, related to the work, leisure and family environment [16].

Studies on the psychosocial conditions of dentists, including stress, related factors and professional satisfaction, have attracted interest in recent years [17,18]. Considering that quality of life can be negatively influenced by professional practice, the present study aims to verify the level of quality of life of oral health teams in the municipal public service of Pedro II, Piauí.

METHODS

This research was approved by the Ethics Committee under opinion number 1.806.574.

A cross-sectional observational study was conducted with the target population of oral health teams selected from a query in the DATASUS database of the Brazilian Ministry of Health (http://www2.datasus.gov.br/DATASUS/index.php), consisting of 33 professionals who worked regularly as permanent or temporary staff at the Municipal Health Department of Pedro II, Piauí. Those who were not active during the data collection period, i.e.: inactive, on vacation or away from work, were excluded, totaling 26 professionals.

The data collection instrument adopted was a self-administered questionnaire divided into two parts: the first part refers to the sociodemographic characterization and the exercise of the profession, developed and tested by the researchers. The second part included the validated quality of life instrument of the World Health Organization (WHO), in its abbreviated version: WHOQOL-Bref [15].

The WHOQOL-Bref, used to assess the quality of life of adult populations, has 26 items, 24 of which are distributed across four domains: physical, psychological, social relationships and environment. Each domain is represented by several facets (chart 1) and its questions were formulated for a Likert-type response scale, with a scale of intensity (not at all – extremely), capacity (not at all – completely), frequency (never – always) and evaluation (very dissatisfied – very satisfied; very bad – very good) [15].

In addition to the four domains, the instrument presents two general questions, one referring to self-perception of quality of life and the other to satisfaction with health [15].

A pilot study was conducted to pre-evaluate the questionnaire and research procedures with 10 randomly selected dentists who did not participate in the research. After the pilot study and the suggested and implemented modifications, the modified questionnaire was distributed to the population of dentists.

The WHOQOL does not conceptually foresee the use of the global quality of life score, so the score for each domain is calculated. The minimum score for each domain is zero and the maximum value is 100. The score for each domain is obtained on a positive scale, that is, the higher the score, the better the quality of life in that domain [15].

Chart 1 . Domains and facets of the WHOQOL-BREF instrument.

Domains	Facets
Domain I – Physical domain	1. Pain and discomfort
	2. Energy and fatigue
	3. Sleep and rest
	4. Mobility
	5. Activities of daily living
	6. Dependence on medication or treatments
	7. Ability to work
Domain II – Psychological domain	8. Positive feelings
	9. Thinking, learning, memory and concentration
	10. Self-esteem
	11. Body image and appearance
	12. Negative feelings
	13. Spirituality/religion/personal beliefs
Domain III – Social relations	14. Personal relationships
	15. Social support
	16. Sexual activity
Domain IV– Environment	17. Physical safety and security
	18. Home environment
	19. Financial resources

The data were processed using the Statistical Package for the Social Sciences (SPSS) software, version 20.0. In order to analyze the relationship between the WHOQOL-Bref quality of life domains (dependent variables) and the other variables investigated (independent variables), Pearson's chi-square test was performed, and in cases where the observed frequencies were less than 5, Fisher's exact test was adopted. For this, the variables of the domains were transformed into categorical and dichotomized with a cutoff point at the 50th percentile, obtaining the scores of high and low quality of life, respectively, in the physical (28.6- 33.0 and 22.0- 28.5), psychological (22.6- 29.0 and 19.0- 22.5), social relations (12.1- 15.0 and 10.0- 12.0) and environment (26.6- 37.0 and 20.0- 26.5) domains.

RESULTS

Of the 33 professionals from the permanent and temporary Oral Health teams of the Municipal Health Department of Pedro II- PI, who were part of the Family Health Strategy (FHS) and the Center for Dental Specialties (CDS), seven were excluded because they no longer worked in the municipality or were on leave. Twenty-four were present during data collection and agreed to participate in the study, resulting in a response rate of 92.3% (n=24), of which 62.5% (n=15) are dentists and 37.5% (n=9) are oral health technicians/auxiliaries.

The majority work only in Pedro II (58.3%, n=14) and in the public service (54.2%, n=13). The average working hours and number of patients per day were 7.5 (SD=1.5) and 10.2 (SD=3.8), respectively. It was possible to observe a predominance of female professionals (58.3%) with a greater concentration of age between 25 and 35 years (41.7%), single (66.7%), without postgraduate or complete postgraduate studies (37.5%) and without health problems (66.7%) (table 1).

Table 2 shows the results for the two general questions of the WHOQOL-Bref and the self-perception of health status, in which the majority of professionals considered their quality of life to be good (75.0%) and were satisfied (62.5%) with their health. When asked about their current health status, the majority (62.5%) considered it to be good.

Table 1. Population distribution according to demographic variables.

Variable	n	%
Gender		
Male	10	41.7
Female	14	58.3
Total	24	100.0
Age range		
Up to 25 years-old	7	29.2
Between 25 and 35 years old	10	41.7
Between 35 and 50 years old	7	29.2
Total	24	100.0
Marital status		
Single	16	66.7
Married	6	25.0
Living as married	1	4.2
Widowed	1	4.2
Total	24	100.0
Educational level		
No postgraduate studies	9	37.5
Incomplete postgraduate studies	6	25.0
Complete postgraduate studies	9	37.5
Total	24	100.0
Current health problems		
None	16	66.7
High blood pressure	4	16.7
Cancer	1	4.2
Diabetes	1	4.2
Skin disease	1	4.2
Other*	1	4.2
Total	24	100.0

Table 2. Sample distribution, according to self-perception of quality of life, satisfaction with one's own health and current health status.

Variable	n	%
Self-perception of quality of life		
Neither bad / nor good	2	8.3
Good	18	75.0
Very good	4	16.7
Overall	24	100.0
Satisfaction with one's own health		
Dissatisfied	2	8.3
Neither dissatisfied nor satisfied	3	12.5
Satisfied	15	62.5
Very satisfied	4	16.7
Total	24	100.0
Self-assessment of health status		
Neither bad nor good	3	12.5
Good	15	62.5
Very good	6	25.0
Total	24	100.0

The lowest quality of life values were found in the psychological and environmental domains (figure 1).

Table 3 presents the values of the quality of life domains considering their measures of central tendency and dispersion, where the physical domain stands out with the highest mean score (28.3), followed by the environment (26.4), psychological (23.0) and social relations (12.2) domains.

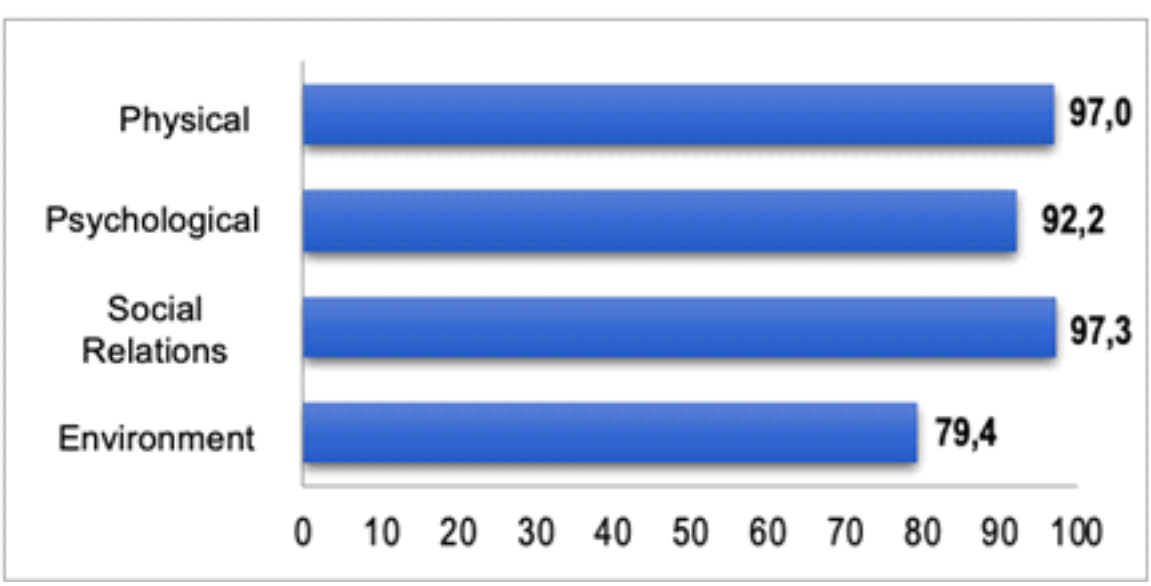

Figure 1. Quality of life values of the WHOQL-Bref domains among oral health teams. Pedro II, PI, 2024.

Table 3 also presents the values of the scores of each domain categorized into two groups, according to high or low quality of life. Most dentists presented low quality of life in the social relations domain (66.7%) and the other domains presented the same result in both low and high quality of life (50.0%).

Table 3. Measures of central tendency and dispersion of WHOQL-Bref domain scores among oral health teams.

	Domain			
	Physical	Psychological	Social relations	Environment
Average	28.3	23.0	12.2	26.4
Standard deviation (SD)	3.2	2.7	1.3	3.8
Median	28,5.	22.5	12.0	26.5
Coefficient of variation	10.5	7.4	1.8	14.8
Minimum value	22.0	19.0	10.0	20.0
Maximum value	33.0	29.0	15.0	37.0
High Quality of Life				
Scores	28.6- 33.0	22.6- 29.0	12.1- 15.0	26.6- 37.0
N (%)	12 (50.0%)	12 (50.0%)	8 (33.3%)	12 (50.0%)
Low Quality of Life				
Scores	22.0- 28.5	19.0- 22.5	10.0- 12.0	20.0 – 26.5
N (%)	12 (50.0%)	12 (50.0%)	16 (66.7%)	12 (50.0)

The Pearson Chi-square and Fisher's exact tests (table 4) showed a statistically significant association between the physical domain and satisfaction with health. The professionals who presented low quality of life in the physical domain were those who reported being neither dissatisfied nor satisfied with their health (p=0.011).

Table 4. Analysis by the Chi-square test and Fisher's exact test between the physical, psychological and social relations domains of quality of life of the WHOQOL-Bref. and the statistically significant independent variables. Frequency distribution of the scores of the oral health teams (n=24).

1 of 2

	Variable	Low / High N (%)	p
	Health satisfaction		
Physical	Dissatisfied	0 (0.0%) / 2 (100.0%)	0,011*
	Neither dissatisfied nor satisfied	3 (100.0%)/ 0 (0.0%)	
	Satisfied	9 (60.0%) / 6 (40.0%)	
	Very satisfied	0 (0.0%) / 4 (100.0%)	
	Total	12 (50.0%) / 12 (50.0%)	

Table 4. Analysis by the Chi-square test and Fisher's exact test between the physical, psychological and social relations domains of quality of life of the WHOQOL-Bref. and the statistically significant independent variables. Frequency distribution of the scores of the oral health teams (n=24).

	Variable	Low / High N (%)	p
Psychological	Self-assessment of quality of life		
	Neither bad nor good	2 (100.0%) / 0 (0.0%)	0,046*
	Good	10 (55.6%) / 8 (44.4%)	
	Very good	0 (0.0%) / 4 (100.0%)	
	Overall	12 (50.0%) / 12 (50.0%)	
Social relations	Self-assessment of quality of life		
	Neither bad nor good	0 (0,0%) / 2 (100,0%)	0,000*
	Good	16 (88,9%) / 2 (11,1%)	
	Very good	0 (0,0%) / 4 (100,0%)	
	Overall	16 (66,7%) / 8 (33,3%)	
	Self-assessment of health status		
	Neither bad nor good	1 (33,3%) / 2 (66,7%)	0,021*
	Good	13 (86,7%) / 2 (13,3%)	
	Very good	2 (33,3%) / 4 (66,7%)	
	Overall	16 (66,7%) / 8 (33,3%)	

*Exact and Fisher Test.

The psychological domain and self-assessment of quality of life also presented a statistically significant association. Professionals who presented low quality of life in the psychological domain were those who evaluated their quality of life as neither bad nor good (p=0.046).

The social relations domain and self-assessment of quality of life and health status also presented a statistically significant association. Professionals who presented low quality of life in the social relations domain were those who evaluated their quality of life as good (p=0.000) and those who evaluated their health status as good (p=0.021).

Pearson's chi-square and Fisher's exact tests showed that there was no statistically significant association between the environment domain and the independent variables in the sample of oral health teams.

Table 5 presents the median score for each question of the WHOQL-Bref, where the lowest values are observed in the questions related to financial resources with 2.7 points and opportunities for leisure activities with 3.0 points. Figure 2 shows the scores for the facets of the WHOQOL-Bref instrument, where the lowest values can be observed in the facets of financial resources with 55.0 points, recreation and leisure with 59.2 points and physical environment with 62.5 points.

Table 5. Distribution of the median scores and standard deviations of the WHOQOL-Bref instrument by question. Pedro II-PI, 2024.

Questions – WHOQOL.Bref	WHOQOL Index Mean (standard deviation))
1 - How would you rate your quality of life?	4.1 (0.5)
2 - How satisfied are you with your health?	3.9 (0.8)
3 - To what extent do you think your (physical) pain prevents you from doing what you need to do?	4.3 (0.8)
4 - How much do you need medical treatment to carry out your daily life?	4.2 (0.7)
5 - How much do you enjoy life?	3.6 (0.6)
6 - To what extent do you think your life has meaning?	4.3 (0.5)
7 - How much can you concentrate?	3.5 (0.7)
8 - How safe do you feel in your daily life?	3.7 (0.7)
9 - How healthy is your physical environment (climate, noise, pollution, attractions)?	3.1 (0.8)
10 - Do you have enough energy for your day-to-day life?	3.8 (0.8)
11 - Are you able to accept your physical appearance?	3.9 (1.0)
12 - Do you have enough money to meet your needs?	2.7 (0.7)
13 - How available is the information you need in your day-to-day life?	3.3 (0.7)
14 - To what extent do you have opportunities for leisure activities?	3.0 (0.8)
15 - How well are you able to get around?	4.2 (0.8)
16 - How satisfied are you with your energy for your day-to-day life?	3.7 (1.0)
17 - How satisfied are you with your ability to perform day-to-day activities?	4.0 (0,8)
18 - How satisfied are you with your work ability?	4.0 (0.4)
19 - How satisfied are you with yourself?	3.9 (0.8)
20 - How satisfied are you with your personal relationships (friends, relatives, colleagues)?	4.0 (0.6)
21 - How satisfied are you with your sex life?	4.2 (0.6)
22 - How satisfied are you with the support you receive from your friends?	4.0 (0.6)
23 - How satisfied are you with the conditions of the place where you live?	3.8 (0.8)
24 - How satisfied are you with your access to health services?	3.4 (1.0)
25 - How satisfied are you with your means of transportation?	3.4 (1.2)
26 - How often do you have negative feelings (bad mood, anxiety, depression)?	3.8 (0.9)

DISCUSSION

Concerns about the quality of life of dental professionals are still little explored, which is why this study analyzed the quality of life of oral health teams in the city of Pedro II, Piauí, emphasizing the importance of managers being aware of and focusing on the mental health and quality of life of workers, with the creation of targeted programs and policies [19].

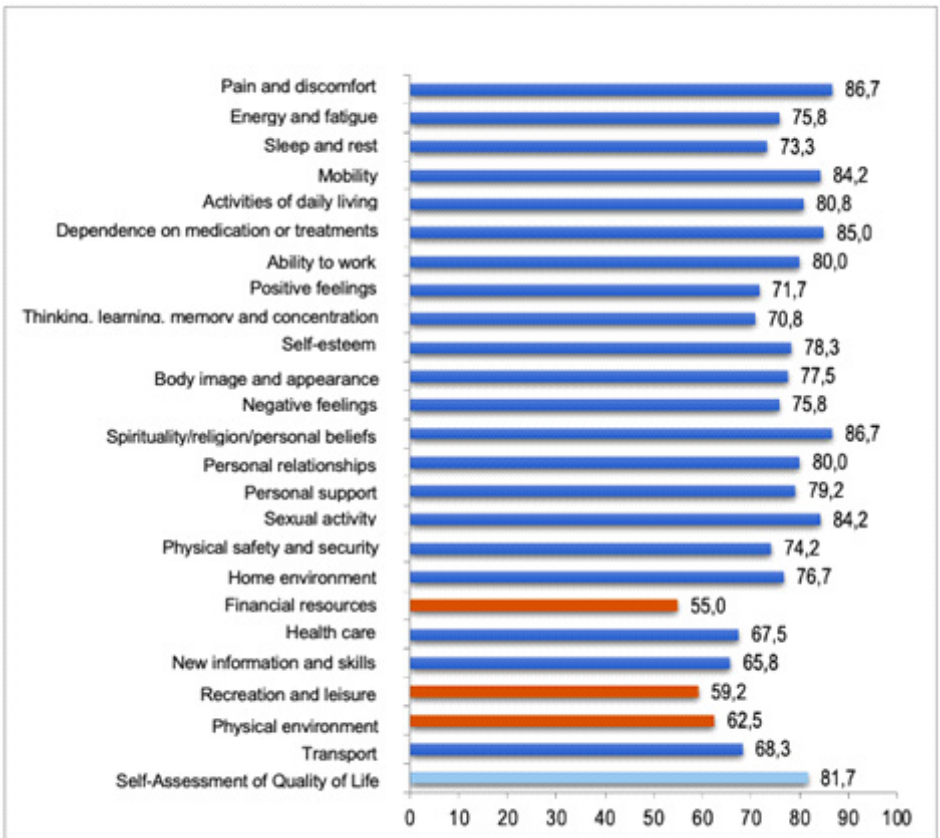

Figure 2. Score of the facets of the WHOQOL-Bref instrument. Pedro II, PI, 2024.

It was observed that the majority of interviewees were female (58.3%). This female presence has been increasing and is confirmed in another similar study (55.4%) [20]. This trend towards feminization can change the pattern of choices of specializations, the length of working hours and, consequently, the profile of the profession and the perception of quality of life.

It is important to highlight that in today's society, women are still the main executors of domestic tasks, thus configuring a double shift, being subject to physical and mental overload. This double shift can influence their quality of life [21].

The age group with the highest prevalence is between 25 and 35 years (42.7%), a value close to that of one of the previous studies, also conducted with dentists from a public service (41.3%) [20].

Regarding self-perception of quality of life, 73.8% of the interviewees classified their own health as good. This is in agreement with another study that, when verifying the quality of life of dentists in the city of Jequeié-Bahia, 66.67% considered their own health to be good [16].

The better the dentists' self-perception of their quality of life, the better their quality of life in the physical, psychological and environmental domains [20].

The quality-of-life domains whose measures of central tendency and dispersion had the lowest scores were psychological (23.0) and social relations (12.2). These values contrast with the results obtained in a similar study in which the Physical (13.8) and Environmental (13.8) domains were the lowest [11].

By categorizing the scores for each domain, most dentists presented low quality of life in the social relations domain (66.7%), and the other domains presented the same result in both low and high quality

of life (50.0%). In contrast, in the previous study, the social relations domain presented high quality of life (50.3%) [20].

The lowest scores found in the facets were financial resources with 55.0 points, recreation and leisure with 59.2 points and physical environment with 62.5 points. In another study, in the environment domain facet, it was found that almost 30% of individuals considered the amount of money to meet their own needs to be insufficient and more than 50% considered it to be more or less [20]. Likewise, the questions that obtained the lowest scores in other studies were related to "the amount of money sufficient to meet their needs" and "how healthy the physical environment was" [11,22].

There is a notable need for intervention in the mental health of professionals in the public sphere and reform of the work environment with support measures that impact not only their quality of life, but also their physical and mental health. Prevention measures and early detection of exacerbated emotional stress developed in the work environment are fundamental, and can thus intervene in the cycle of exhaustion resulting from the profession, in addition to reflecting improvements in the quality of care provided to the population that needs the service [5, 23].

It is relevant to discuss the topic of quality of life of oral health teams to encourage the development of public policies and institutional practices that promote healthy and satisfactory work environments, benefiting both professionals and patients.

CONCLUSION

Although most professionals consider their quality of life to be good and are satisfied with their health, some factors have a negative influence. The social relations and psychological domains presented lower scores than the physical and environmental domains. Financial resources, recreation and leisure, and physical environment are negative aspects for the public service professionals participating in this study.

Collaborators

MS Silva, project administration, formal analysis, conceptualization, data curation, writing-first draft, writing-review & editing, investigation, methodology, funding acquisition, resources, supervision, validation, and visualization. JHS Braga, project administration, conceptualization, data curation, investigation, funding acquisition, resources. KMN Rodrigues, formal analysis, writing-review & editing, validation.

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