

Factors Related to Quality of Life Among Older Adults with Family Care Vulnerability in Semi-Urban Areas of Thailand

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Objective: The growing population of older adults who are vulnerable to family care issues is primarily due to a lack of family support or their families' inability to provide adequate care, particularly in Thailand's semi-urban regions. Thailand has introduced several policies to support its aging population. However, important gaps remain for older adults with family care vulnerability. This study aimed to investigate factors relating to the quality of life of older adults with family care vulnerability in semi-urban regions of Thailand.

Methods: This study employed a cross-sectional survey using the WHOQOL-BREF instrument. Data were gathered with 119 older adults with family care vulnerability in a semi-urban of Thailand. Data analysis was conducted using descriptive statistics for distributions, Fisher's Exact Test for qualitative factors, and Pearson's correlation for quantitative variables, with significance set at 0.05.

Results: Overall, 86.6% of participants indicated a reasonable quality of life, with the highest satisfaction in life (69.7%), access to news (67.2%), environmental quality (61.4%), satisfaction levels in personal safety (61.3%), and sleep (61.3%), while low satisfaction was exhibited in financial stability, enduring adverse feelings, and sexual health. Significant characteristics associated with quality of life include chronic illness ($p = 0.042$), accompanying individuals at the service center ($p = 0.013$), engagement in community activities ($p = 0.005$), availability of family members for consultation ($p = 0.007$), age ($r = -0.226$, $p = 0.014$), distance from home to the service center ($r = -0.275$, $p < 0.001$), and family income ($r = 0.215$, $p = 0.019$).

Conclusion: This study suggests that enhancing older adults' well-being requires economic security, accessible healthcare, and strong social ties. Policies should reduce isolation and foster community participation to ensure equality and sustainable aging support.

Keywords: quality of life, older adults, family care vulnerability, social support, semi-urban area

Introduction

The aging process and economic growth significantly impact older individuals, especially those residing alone or in homes with familial caregiving vulnerabilities.^{1,2} The term "older adults with family care vulnerability" refers to seniors in a precarious state due to a lack of family support or the inability of their families to provide adequate care. Older individuals experiencing familial care vulnerability, especially those living alone, have poorer health status and health-related quality of life (HRQoL), requiring greater social support and resources from social networks compared to other living situations.^{3,4} The population of older individuals experiencing family care vulnerability has increased markedly.^{5,6} Previous studies indicated that older individuals with familial caregiving vulnerabilities exhibited more pronounced wellness and mental health challenges compared to those in different household and family environments.^{7,8} Globally, population aging is accelerating. In 2021, the world population reached approximately 7.9 billion, with about 1.08 billion people (14%) aged 60 years or older. In the ASEAN region, several countries,



including Thailand, have already transitioned into an aging society, where older adults make up a significant portion of the population.⁹ In addition to demographic changes, psychosocial and economic factors significantly affect the well-being of older individuals, with perceived financial strain being a stronger predictor of psychological distress than objective economic measures, especially among socioeconomically disadvantaged populations.¹⁰ Moreover, the correlation between economic resources and well-being is non-linear; higher income might enhance happiness but may also elevate stress beyond specific thresholds.¹¹ This highlights the intricate financial and psychological dynamics associated with aging. It emphasizes that social factors—especially loneliness, social isolation, and community engagement—play a crucial role in alleviating the negative mental and physical health impacts of living alone among older adults.^{12,13} Furthermore, previous research indicates that sociodemographic factors (age, gender, marital status, education, occupation, living arrangement), health-related factors (chronic illness, medical check-ups, healthcare access), economic factors (income, adequacy, debt, savings), and social/psychological factors (community participation, elderly club membership, work/career opportunities, support networks) are all related to the quality of life in older adults.^{14–18}

In Thailand, the shift towards an aging society is attributable to declining birth and mortality rates, alongside an increase in life expectancy, which rose from 70.67 years in 2000 to 77.74 years in 2022 and is expected to reach 80.72 years by 2040.¹⁹ Older adults may replace younger working-age groups as the main workforce, potentially becoming an issue in terms of health care and quality of life advancement. A study by Pengpid and Peltzer (2023) reported that more than one in five older adults experienced incident loneliness within a two-year follow-up period in Thailand.²⁰ Furthermore, living alone has been consistently associated with increased risks of poverty, unmet healthcare needs, depression, loneliness, and reduced health-related quality of life.^{21,22} Living alone in rural Thailand correlates with social isolation, but family caregivers are crucial in mitigating this isolation and enhancing both physical and mental well-being.²³

A complete aged society is one in which more than 20% of the population is 60 years of age or older, or more than 14% of the population is 65 years of age or older. Out of Thailand's overall population of 66,052,615 in 2023, 13,193,247 people, or almost 19.97%, are 60 years of age or older. Furthermore, the percentage of older adults living alone rose from 8.7% in 2014 to 12.0% in 2021.²⁴ Ubon Ratchathani Province, located in the northeastern part of Thailand, is recognized for having one of the top five largest older populations among all provinces in Thailand.²⁵ Recent Thai studies highlight important aspects of elderly well-being. A cross-sectional survey in Pathum Thani found that over one-third of older adults reported lower happiness than the general population, with key predictors including low income, female sex, chronic illness, cognitive impairment, and limited community participation; this emphasizes the value of social engagement, preventive healthcare, and financial stability.²⁶

Semi-urban communities in Thailand represent transitional settings where older adults face overlapping urban and rural health and environmental risks. Urbanized lifestyles have increased chronic non-communicable diseases, while rural exposures—such as air pollution, agricultural chemicals, and informal employment—persist. Pollution arises from traffic, community activities, and farming, yet environmental management remains underdeveloped. Housing typically consists of detached dwellings that may affect indoor air quality. Healthcare access is moderate, relying on primary care with referrals to urban centers. The Kham Nam Saep Sub-district, near Ubon Ratchathani, exemplifies these semi-urban characteristics. The Kham Nam Saep Subdistrict comprises 10 villages, 1,973 dwellings, and a total population of 7,773 individuals. The pre-survey indicates that there are 1,227 older adults, or 17.71% of the total population, with 119 older adults with family care vulnerability.

There has been a lack of research regarding the quality of life of older adults with family care vulnerability in semi-urban regions, where a higher prevalence of family care vulnerability among older adults is observed.²⁷ Furthermore, Thailand has implemented various policies aimed at supporting its aging population. However, significant gaps persist for older adults who are vulnerable due to a lack of family care. The research team aims to investigate factors relating to the quality of life of older adults with family care vulnerability in semi-urban regions of Thailand, specifically in Kham Nam Saep Subdistrict, to provide crucial data for relevant organizations and to enhance solutions and innovations that promote the health of older people.

Materials and Methods

This research was a cross-sectional survey aimed at examining factors related to the quality of life of older adults with family care vulnerability (Older adults with family care vulnerability are defined as individuals aged 60 years and older who either live alone or reside with family members unable to provide adequate care. This inability may result from factors such as advanced age, illness, disability, or socioeconomic constraints. This status is determined through a pre-survey screening process conducted by trained community health volunteers in collaboration with local health personnel. They use household records and community health information to verify the available level of support) in a semi-urban location, Kham Nam Saep Subdistrict, within 10 communities in Warin Chamrap District, Ubon Ratchathani Province, Thailand.

Population and Sample

The total population of older adults in Kham Nam Saep Subdistrict is 1,227. The population of older adults with family care vulnerability is 119, constituting 9.69% of the total elderly demographic in the whole area. Data were collected from 119 older adults with family care vulnerability (study population) in 10 different communities. All potential participants were informed about the key elements of a research study and what their participation would involve before signing the informed consent form. For participants who had problems with reading and writing, all the questions were read to them, and all their answers were recorded by trained interviewers.

Research Tools

The tools employed in the research comprised a questionnaire with two sections:

General information regarding older adults with family care vulnerability, comprising 32 questions pertaining to characteristics, health data and access to healthcare services, economic information, and social and psychological dimensions, presented in a multiple-choice style.

Quality of life: The data concerning older adults with family care vulnerability comprises 26 quality-of-life inquiries derived from WHOQOL-BREF, as per the study by Phongsiri et al, 2018.²⁸ The WHOQOL-BREF questionnaire consists of 26 items, with 23 items phrased positively and three items (items 2, 9, and 11) phrased negatively. Each item is rated on a five-point Likert scale, where positively worded items are scored from 1 (not at all) to 5 (extremely). Negatively worded items are reverse-coded. The total score can range from 26 to 130, with higher scores indicating a better quality of life. Overall quality of life is categorized into three levels: poor (26–60), moderate (61–95), and good (96–130).

Research Tool Quality Assessment

Content validity was assessed by three experts who evaluated the questionnaire for clarity of language and alignment with the study objectives. The researcher subsequently changed the questionnaire based on expert comments and evaluated its Index of Item-Objective Congruence (IOC) value, which ranged from 0.67 to 1.0.

To evaluate the reliability of the questionnaire used for data collection, the authors referenced the study by Phongsiri et al (2018), which focuses on the Thai version of the World Health Organization Quality of Life (WHOQOL-BREF). The Cronbach Alpha Coefficient was found to be .85, demonstrating satisfactory reliability.²⁸

Data Collection

Data were collected through direct face-to-face interviews by trained community health volunteers. Trained interviewers read the questions aloud to individuals with reading or writing impairments and recorded their responses.

Data Analysis

The researchers employed descriptive statistics to analyze qualitative variables by presenting frequency distributions and percentages. Continuous variables were assessed for normality using the Kolmogorov–Smirnov test. Variables that followed a normal distribution were reported as means and standard deviations, while those that did not meet the normality assumption were described using medians and interquartile ranges (P25–P75). Inferential Statistics: The

analysis of factors associated with the quality of life among older adults with family care vulnerability was conducted separately for each variable. Prior to conducting correlation analysis, the normality of continuous variables was evaluated using the Kolmogorov–Smirnov test. Variables that met the normality assumption were analyzed using Pearson’s correlation coefficient. For qualitative variables, Fisher’s Exact Test was used. The statistical significance level was set at 0.05.

Results

Characteristics of the Included Participants

The demographic characteristics of the sample group revealed that 64.7% were female, with a mean age of 75.37 (S.D. 8.39). Additionally, 54.6% were widowed, 81.5% had attained primary-level education, and 31.5% lived with an elderly spouse, while 23.5% lived alone (Table 1). Furthermore, the health information and access to health services revealed that daily primary caregivers for older adults were predominantly children and spouses, comprising 47.1% and 23.5%,

Table 1 General Characteristics Among Older Adults with Family Care Vulnerability in Semi-Urban Area (n=119)

Factors	n	%
Characteristics		
Age (year)		
Mean (S.D.)	75.37(8.39)	
Gender		
Male	42	35.3
Female	77	64.7
Marital status		
Single	4	3.4
Couple	40	33.6
Widowed	65	54.6
Divorced	9	7.6
Separated	1	0.8
Education level		
Understudied	11	9.2
Primary	97	81.5
Secondary/equivalent	7	5.9
Bachelor’s degree	4	3.4
Living situation		
Individuals residing independently	28	23.5
Living with children/grandchildren under 12 years old/psychiatric patients/dependent persons	22	18.5
Living with elderly spouse	37	31.1
Living with children/grandchildren but not being cared for	28	23.5
Others, please specify (children occasionally take care of)	4	3.4
Health information and access to health services		
Daily primary caregivers		
None	26	21.8
Spouse	28	23.5
Children	56	47.1
Relatives	7	5.9
Neighbors	2	1.7
Medical history (Chronic illness)		
None	30	25.2
Yes	89	74.8

(Continued)

Table 1 (Continued).

Factors	n	%
Chronic illness (More than one answer could be selected.) (n=89)		
Diabetes	26	29.2
Heart Disease	7	7.9
High Blood Pressure	67	75.3
Kidney Failure	8	8.9
Cancer	3	3.4
Dementia	2	2.4
Hyperlipidemia	36	40.4
Alzheimer's	1	1.1
Depression	9	10.1
Other (acid reflux/ psychiatry/ thyroid/ disability/ asthma)	21	23.6
Regular check-ups for congenital diseases (n=89)		
Always check-up	75	84.2
Sometimes check-up	7	7.9
Never check-up	7	7.9
Medical rights (More than one answer could be selected.)		
Universal health insurance card/Thai gold card	117	98.3
Civil servants	8	6.7
Social security	1	0.8
Life insurance/Health insurance	2	1.7
Health service access pattern when sick		
Buy medicine to take by themselves	2	1.8
Access government hospital	115	96.6
Access private hospital	1	0.8
Not treated	1	0.8
Person who takes to health service when sick or to see a doctor as scheduled		
Go by themselves	37	31.1
Spouse	12	10.1
Children	55	46.2
Relatives	6	5.0
Neighbors	7	5.9
Other	2	1.7
Average distance from home to health service facility (kilometers)		
Mean (S.D.)	1.68 (0.87)	
Vehicles used to travel to health facilities		
By walking	11	9.3
Bicycle	9	7.6
Motorcycle	47	39.5
Car/Pickup	33	27.7
Bus/Taxi/Hired	18	15.1
Ambulance/1669	1	0.8
Estimate the cost of each health service visit		
Median (P ₂₅ :P ₇₅)	100 (50:200)	
Annual health check		
Never checked	51	42.9
Have checked	68	57.1

(Continued)

Table I (Continued).

Factors	n	%
Social and mental aspects		
Economic information		
Source of income (More than one answer could be selected.)		
From main and supplementary occupations	44	37.0
Monthly or occasional payments from children and relatives	118	99.2
Elderly allowance	37	31.1
Disabled allowance	1	0.8
Civil servant pension	3	2.5
Others	25	21.0
Average monthly income (Thai Baht)		
Median (P ₂₅ :P ₇₅)	1,700 (1,500:3,000)	
Income adequacy		
Enough to spend	33	27.7
Not enough to spend but no debt	66	55.5
Not enough to spend and have debt	14	11.8
Anything left over is for saving	6	5.0
Current main occupation		
Not working	90	75.6
Agriculture	10	8.4
General employment	8	6.7
Retired civil servant	1	0.8
Private business	8	6.7
Other	2	1.8
Current part-time job		
None	118	99.2
Yes	1	0.8
Career promotion needs		
Not wanted	104	87.4
Wanted	15	12.6
Savings		
No	32	26.9
Yes	87	73.1
Saving pattern (n=87) (More than one answer could be selected.)		
Money savings	10	11.5
Life insurance	15	17.2
Funeral benefits	83	95.4
Total current debt (Thai baht)		
Median (P ₂₅ :P ₇₅)	4,000 (3,000:100,000)	
Career promotion for the elderly in the community		
No	64	53.8
Yes	55	46.2
If yes (n=55)		
Participated in career promotion	7	12.7
Did not participate in career promotion	48	87.3

(Continued)

Table 1 (Continued).

Factors	n	%
Being a member of the elderly club/elderly school		
No	77	64.7
Yes	42	35.3
Community activity participation		
Not participating	62	52.1
Regular participation (8–12 times per year)	36	30.3
Irregular participation (less than 8 times per year)	21	17.6
Have someone or friends who can talk to or consult		
No	8	6.7
Yes	111	93.3
If yes (n=111) (More than one answer could be selected.)		
Family members, children, relatives	102	91.9
Neighbors	63	56.8
Friends on social media	4	3.6
Friends in occupational groups	1	0.9
Others	1	0.9
Support from other agencies		
Social networks or local government organizations	61	51.3
Funds such as sub-district/Long-term care funds	30	25.2
Elderly clubs	28	23.5

Abbreviations: Max, Maximum; Min: Minimum; S.D., Standard Deviation., P₂₅:P₇₅, the 25th and 75th percentiles.

respectively. Among older adults, 74.8% had congenital diseases, including high blood pressure and hyperlipidemia at rates of 75.3% and 40.4%, respectively. Additionally, 84.2% of older adults with congenital diseases regularly underwent check-ups, and 98.3% utilized the universal health insurance card, also known as the Thai gold card. Furthermore, older persons utilize health services through government hospitals at a rate of 96.6%, while children accompanied older adults to health services at a rate of 46.2% (Table 1).

The social and mental dimensions indicated that 99.2% of older adults received monthly or occasional financial support from children and relatives, with a median monthly income (P₂₅:P₇₅) of THB 1,700 (1,500:3,000). This income was insufficient for expenditures, yet 55.5% reported no debt. Additionally, 75.6% of older adults were not employed, and 99.2% did not engage in part-time work, while 87.4% expressed no desire for career advancement. Moreover, older adults have a savings rate of 73.1% in funeral benefits, with a savings pattern of 95.4%. Furthermore, 64.7% of older adults were not members of the senior club or school, and 52.1% did not engage in community activities. In total, 93.3% of older adults have individuals or friends with whom they may communicate or seek counsel (Table 1).

The Quality of Life Among Older Adults with Family Care Vulnerability in Semi-Urban Areas

According to the study's findings, 86.6% of older adults with family care vulnerability in semi-urban areas had an overall quality of life that was at the moderate level (Table 2). The quality of life among older adults tends to be at a moderate level across various dimensions, including satisfaction with life (69.7%), being informed about essential news (67.2%), contentment with the health-affecting environment (61.4%), perceptions of security regarding life and property (61.3%), and satisfaction with sleep (61.3%) (Table 3).

Table 2 Level of Quality of Life Among Older Adults with Family Care Vulnerability in Semi-Urban Areas

The Level of Quality of Life	n	%
Good	3	2.5
Moderate	103	86.6
Poor	13	10.9

Table 3 Quality of Life Among Older Adults with Family Care Vulnerability in Semi-Urban Area in the Past Two Weeks (n=119)

No.	Quality of Life	Opinion (%)				
		Extremely	Frequently	Moderately	A Little	Not at All
1	Satisfied with current health	5.0	7.6	55.5	25.2	6.7
2	Feel that illness is a problem that prevents from doing what they want to do*	0.8	7.6	53.8	18.5	19.3
3	Have enough energy to do things each day (work or daily life)	0.8	7.6	59.7	21.8	10.1
4	Satisfied with sleep (sleep well and soundly)	2.5	16.0	61.3	16.0	4.2
5	Satisfied with life (e.g. happy, peaceful, hopeful)	2.5	21.0	52.2	15.1	9.2
6	Have the ability to concentrate on tasks	1.7	11.8	54.6	24.3	7.6
7	Have pride in oneself	5.9	20.1	58.0	11.8	4.2
8	Accept one's appearance	7.6	19.4	58.8	13.4	0.8
9	Have negative feelings such as feeling depressed, disappointed, anxious*	0.8	5.0	28.7	25.2	40.3
10	Satisfied with being able to complete daily routines	1.7	15.2	56.3	21.8	5.0
11	In daily life, there is a need to use medicine or medical treatment in order to work or live*	2.5	29.5	52.9	10.9	4.2
12	Satisfied with being able to work	0.0	15.2	52.9	22.7	9.2
13	Satisfied with making friends or getting along with others as you used to	3.5	31.9	54.6	9.2	0.8
14	Satisfied with the help received from friends or other people	4.2	35.3	51.3	8.4	0.8
15	Both life and property are secure and safe	0.8	18.5	61.3	16.0	3.4
16	Satisfied with the current condition of the house	4.2	23.5	54.6	14.3	3.4
17	Have enough money to spend as is needed	0.0	9.2	59.7	19.3	11.8
18	Being satisfied with access to public health services as is needed	0.8	31.9	58.1	4.2	5.0
19	Being informed about necessary news in daily life	0.0	11.8	67.2	14.3	6.7
20	Have the opportunity to relax and relieve stress	2.5	21.0	50.4	22.7	3.4
21	Satisfied with the environment that affects health	5.0	16.8	61.4	15.1	1.7
22	Satisfied with traveling (transportation) to various places	0.0	12.5	51.3	24.4	11.8
23	Feel that life has meaning	3.4	26.9	56.3	12.6	0.8
24	Able to go anywhere well	1.7	14.2	43.7	20.2	20.2
25	Satisfied with sex life	1.7	0.8	13.4	11.8	72.3
26	Satisfied with life	10.1	7.6	69.7	8.4	4.2

Note: (*) means negative question.

Factors Related to the Quality of Life of Older Adults Who are Family Care Vulnerable

We started by analyzing factors associating the quality of life of older adults with family care vulnerability analyzed one variable at a time and identified seven variables initially associated with the quality of life of older adults: chronic illness ($p = 0.042$), accompanying individuals at the service center ($p=0.013$), engagement in community activities ($p=0.005$), availability of family members or friends for discussion and consultation ($p=0.007$), age ($r = -0.226$, $p = 0.014$), distance from home to the service center ($r = -0.275$, $p<0.001$), and family income ($r = 0.215$, $p = 0.019$). Other characteristics were not statistically significantly correlated with the quality of life of older adults with family care vulnerability (Table 4 and Table 5).

Table 4 Correlation of Factors Associating the Quality of Life of Older Adults with Family Care Vulnerability, Categorized by Variables (n=119)

Factors	Quality of Life Level			Fisher's Exact Test	p-value
	Good	Moderate	Poor		
Chronic illness				6.195	0.042
No	0 (0.0)	30 (100.0)	0 (0.0)		
Yes	3 (3.4)	73 (80.2)	13 (14.6)		
Person accompanying to the service center				19.519	0.013
Go alone	2 (5.4)	32 (86.5)	3 (8.1)		
Spouse	0 (0.0)	12 (100.0)	0 (0.0)		
Children	7 (12.7)	48 (87.3)	0 (0.0)		
Relatives	0 (0.0)	6 (100.0)	0 (0.0)		
Neighbors	2 (28.6)	5 (71.4)	0 (0.0)		
Others	2 (100.0)	0 (0.0)	0 (0.0)		
Engagement in community activities				12.072	0.005
Not participating	0 (0.0)	50 (80.6)	12 (19.4)		
Regular participation	2 (5.6)	33 (91.7)	1 (2.8)		
Irregular participation	1 (4.8)	20 (95.2)	0 (0.0)		
Availability of family members or friends for discussion and consultation				9.371	0.007
No	0 (0.0)	4 (50.0)	4 (50.0)		
Yes	3 (2.7)	99 (89.2)	9 (8.1)		

Table 5 Correlation of Factors Associating the Quality of Life of Older Adults with Family Care Vulnerability, Categorized by Variables (n = 119)

Factors	Mean (S.D.)/Median: P25,75	(r)	p-value
Age (Mean, S.D.)	75.37 (8.39)	-0.226	0.014*
Distance from home to the service center (Mean, S.D.)	1.68 (0.87)	-0.275	<0.001
Family income (Median: P25,75)	1,700 (1,500:3,000)	0.215	0.019*
Cost of receiving service (Median: P25,75)	100 (50:200)	-0.158	0.087
Debt (Median: P25,75)	4,000 (0:100,000)	-0.023	0.807

Note: *Correlation is significant at the 0.05 level (2-tailed).

Discussion

The study of 119 older adults with family care vulnerability in a semi-urban area indicated that the predominant demographic was female (64.7%), with an average age of 75.4 years. A majority were widowed (54.6%) and possessed just primary education (81.5%), and a quarter (23.5%) resided wholly alone. Healthwise, 74.8% suffered from chronic disorders, primarily hypertension (75.3%) and hyperlipidemia (40.4%); nonetheless, 84.2% of these persons attended regular check-ups. Almost all participants (98.3%) utilized Thailand's universal health insurance card, most older adults primarily received financial assistance from family members, particularly their children and other relatives (99.2%). A smaller proportion received support from the government, such as the elderly allowance. Additionally, most participants accessed healthcare services through government hospitals under the universal coverage scheme (96.6%), whereas just 27.7% indicated that their income was sufficient. The majority of individuals, 75.6%, were unemployed, with 73.1% primarily saving for funeral benefits. Despite restricted income, debt levels remained very low (median THB 4,000). Significantly, social isolation was mitigated by strong family connections—93.3% indicated having someone to converse with, predominantly children and neighbors. These findings align with recent research indicating that older adults with family care vulnerability, especially women, face economic vulnerability due to significant dependence on family support and chronic health issues.^{6,7} The results are also consistent with those of Meemon and Paek (2020), who indicated that

the majority of older adults are unemployed, with no part-time jobs available.²¹ In addition, their children's support is the main source of their monthly income.²⁹

A study of older adults with family care vulnerability in a semi-urban location found that the majority were widowed women with low levels of education who relied on financial support from their families. Access to healthcare was adequate, despite the high prevalence of chronic illness. Economic uncertainty was prevalent, as evidenced by limited income and reserves mainly being used for funeral costs. Strong ties to family, however, reduced social isolation. To increase economic security and well-being, future studies need to examine gender-specific interventions, community engagement programs, and sustainable income frameworks. For the purpose of monitoring changes in the social and health conditions of older adults living on their own, longitudinal studies are vital.

Just 2.5% of older adults with family care vulnerability rated their quality of life as "good," and 10.9% rated it as "poor." The majority of these individuals (86.6%) reported a moderate quality of life. Feelings of safety (61.3%), satisfaction with the environment (61.4%), satisfaction with sleep (61.3%), knowledge of daily news (67.2%), and satisfaction in life (69.7%) were the dimensions with the highest levels of satisfaction. On the other hand, the categories that had the lowest levels of satisfaction were financial adequacy (only 27.7% reported adequate income), persistent negative emotions (40.3%), and sex life (72.3% unsatisfied). In a finding that echoes prior research, the majority of older adults expressed a moderate level of life satisfaction,³⁰ and Eltaybani et al found that the greatest mean score of 7.4 (S.D. = 2.5) was obtained by older adults receiving home care who reported feeling secure in their lives.³¹ Future studies ought to investigate targeted interventions that address the specific areas of dissatisfaction among older adults with family care vulnerability, with a focus on emotional health, financial stability, and close relationships. A qualitative study is recommended to have a better understanding of how these unmet demands affect daily life and long-term well-being. Research contrasting rural, semi-rural, and urban settings may help clarify how context influences quality of life. Additionally, evaluating the results of financial literacy programs, age-friendly environments, and community-based mental health services may help identify practical strategies for improving quality of life above the moderate level that most people currently report.

The research investigated factors related to the HRQoL of older adults with family care vulnerability. Among the several sociodemographic and social involvement characteristics examined, seven exhibited significant correlations. Negative correlations were observed between age and quality of life ($r = -0.226$, $p=0.014$), suggesting that older participants generally reported diminished quality of life, consistent with previous findings that indicate a relationship between increasing age and reduced physical capacity as well as heightened susceptibility.³² In contrast, elevated family income had a positive correlation with quality of life ($r = 0.215$, $p=0.019$), indicating the significance of financial security in facilitating sufficient nutrition, healthcare, and social engagement.^{33,34} The health status was notable; individuals without chronic illness had superior quality of life ($p = 0.042$), aligning with existing evidence that associates multimorbidity with functional deterioration and diminished life satisfaction.³⁵ Social engagement constituted a significant association. Consistent engagement in community activities was markedly related with improved quality of life ($p=0.005$), supporting evidence that active community participation fosters psychological well-being and diminishes feelings of loneliness.^{5,36} The presence of relatives or friends for consultation enhanced quality of life ($p=0.007$), which illustrates the importance of informal social networks for emotional support.^{37,38} The significant association between volunteer-based accompaniment to health centers and improved quality of life highlights the importance of community social support for older adults with family care vulnerability. Volunteer assistance may enhance healthcare access, reduce social isolation, and strengthen emotional support among older adults lacking adequate family care. A crucial aspect is the enhancement of social support systems. This can be accomplished by establishing volunteer-based accompaniment programs that facilitate older individuals' attendance at health services or community events, thereby mitigating mobility-related obstacles and improving emotional well-being. This finding suggests that community volunteer networks could serve as a practical and low-cost strategy for local health systems and policymakers to strengthen long-term care support for vulnerable older populations in semi-urban communities. Addressing economic insecurity is crucial; enhancing financial assistance programs or offering microgrants will enable older individuals with restricted income to sustain sufficient nutrition, healthcare, and social engagement. Ultimately, priority management of chronic diseases should be implemented through community-oriented health promotion and early intervention techniques, focusing on prevalent

health concerns among the elderly population. These integrated interventions would enhance immediate quality of life while simultaneously fostering long-term health and autonomy. Furthermore, the distance to service centers had a negative correlation with quality of life ($r = -0.275$, $p < 0.001$), aligning with research indicating that increased travel distance diminishes healthcare accessibility and social engagement.³⁹

However, this study characterizes older adults with family care vulnerability as individuals who reside independently, as well as those cohabiting with family members who are incapable of offering support. Consequently, it is imperative to convey these matters to pertinent agencies to devise suitable policies or solutions. Due to the highly skewed distribution of quality-of-life categories, several contingency table cells contained small or zero counts, which may reduce the reliability and statistical power of categorical analyses. Therefore, results from Fisher's exact test should be interpreted with caution. To mitigate this limitation, continuous WHOQOL-BREF scores were also analyzed. Multivariable modeling was not performed due to concerns regarding model instability arising from sparse data.

This study was conducted in a single semi-urban subdistrict characterized by a limited and relatively homogeneous population. This homogeneity may restrict variability and reduce the generalizability of the findings. Consequently, the results should be interpreted as context-specific and may not accurately represent broader populations. Additionally, the quality-of-life assessments in the survey are based solely on self-reported data; the presence of trained interviewers asking questions may unintentionally introduce social desirability bias, particularly regarding sensitive subjects such as sexual health or family neglect. This scenario presents a potential limitation in the data collection methods, which may not accurately reflect the true information. Future research should aim to include larger, multi-site samples to enhance external validity and support more robust inferences.

Conclusion

This study explored the HRQoL of 119 older adults with family care vulnerability in a semi-urban area. Most participants were elderly women, widowed, and had only primary school education. Many of them reported chronic illnesses, mainly hypertension and hyperlipidemia, and they regularly used healthcare services under Thailand's universal coverage. Although income sufficiency was low and nearly all relied financially on family, most reported a moderate quality of life. Satisfaction was highest in the categories of personal safety, environmental quality, sleep, and access to news, while dissatisfaction centered on financial stability, persistent negative emotions, and sexual health. Significant factors relating to HRQoL included age, income, accompanying individuals at the service center, chronic illness, social participation, and support networks. The findings indicate that economic stability, accessible healthcare, and strong social ties promote well-being, whereas physical limitations and isolation reduce it. Improving HRQoL requires expanding service accessibility, encouraging community involvement, providing volunteer-based assistance, enhancing financial support, and implementing targeted chronic disease interventions. Future research should adopt longitudinal and qualitative methods to assess changes over time and capture lived experiences. Comparative studies with multigenerational households may clarify protective and risk factors, guiding policies that ensure independence, dignity, and active engagement for older adults.

Ethics Approval

This study was conducted in accordance with the Declaration of Helsinki and approved by the Human Research Ethics Committee of Ubon Ratchathani Provincial Health office (code SSJ.UB 2567-125). Informed consent was obtained from all subjects involved in the study.

Informed Consent Statement

Informed consent was obtained from all older adults involved in the study. The researcher gathered data anonymously without including individual names or specific data. All research data shows combined outcomes without revealing the identities or names of the individuals involved. Three years after the research project is finalized, the researcher will dispose of all research records by shredding them into bits.

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