

CHAPTER II

LITERATURE REVIEW

The aim of this study was to assess and explore the health related quality of life of Myanmar migrant workers in Takuapa and Kuraburi Districts, Phangnga Province, Thailand. In this chapter, the reviews of the concepts of migration and of health related quality of life had been explored. The literature review of both concepts has been presented as follows:

2.1 Concepts of migration

Literature review of concepts, theories and relevant studies suggested that migration had been defined by individuals or different experts in different regions under diverse culture.

Migration itself, as mentioned in World Migration Report 2005, is a multifaceted and complex global issue caused by many “push and pull factors”. It is a process of moving, either across an international border, or within a state. The concept includes migration of refugees, displaced persons, uprooted people, and economic migrants. (IOM, 2005)

Migration, stated by Vapavee Sripiean in 2001, is the behavior that responds to situation of economic, social population and politics of the areas that in-migration and out-migration take place. The pattern of migration in general is to move out of the

area with high pressure on economic, social, population and politics or any other to the area with lower pressure.

It can be summarized that migration, in general means, is a shifting of residence from one place to another whether temporarily or permanently and no matter it is near or far from the original community, driving by many factors under any kind of circumstance.

2.2 Concepts of health related quality of life

The meanings of quality of life have been defined by several scholars and expertise and many prestigious agencies, including the World Health Organization, over years. Here are some of the definitions of health related quality of life.

The World Health Organization (1997) termed quality of life as individuals' 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. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, level of independence, social relationships, personal beliefs and their relationship to salient features of their environment. (WHO, 1997)

The instrument can be used in particular cultural settings, but at the same time results are comparable across cultures. The WHOQOL instruments, by focusing on individual's own views of their wellbeing, provide a new perspective on disease. Systematic development and applicable to different users with different forms are also two of the strengths of WHOQOL instruments. The core WHOQOL instrument can assess health related quality of life in a variety of situations and population groups (WHO, 1997).

The term “quality of life” was originally coined in the USA in the post-war period to describe the effect of possession of cars, houses and other consumer goods on people’s lives and was subsequently broadened to encompass education, health and welfare, economic and industrial growth, and defense of the ‘free world’. (Carr et al., 1996)

In the socio-medical literature, quality of life has been equated with a variety of terms, including life satisfaction, self-esteem, wellbeing, happiness, health, the value and meaning of life, functional status and adjustment. In addition, there are several differing expert opinions as to what constitutes health related quality of life (Carr et al., 1996).

The United Nations Development Program examines the health related quality of life by measuring life expectancy, educational achievement and standard of living (United Nations [UN], 1997).

The Center for Health Promotion at the University of Toronto (2001) defined quality of life as the degree to which a person enjoys the important possibilities of his/her life. Possibilities result from the opportunities and limitations each person has in his/her life and reflect the interaction of personal and environmental factors. Enjoyment has two components: the experience of satisfaction and the possession or achievement of some characteristics, as illustrated by the expression: “She enjoys good health”. Three major life domains are identified: Being, Belonging, and Becoming. Each domain is further classified into physical, psychological and spiritual sub-domain (Center for Health Promotion., 2001).

Health related quality of life can also be viewed as self-assessed health status, perceived health, individual health evaluation, general health status, overall health status and so forth. (Avery et al, 2006)

Uses of the WHOQOL instruments (WHO 1997)

The World Health Organization (1997) stated that under different circumstances that the WHOQOL instruments can be utilized. These circumstances are in medical practices, in improving doctor-patient relationship, in assessing the effectiveness and relative merit of different treatment, in health care services evaluation, in doing research and in policy making.

WHOQOL 100

The WHOQOL-100 is a generic, self-administered, patient-completed measure of health-related health related quality of life that was simultaneously developed in 15 sites worldwide. It is focused around the definition of health related quality of life by World Health Organization, which include the culture and context influencing an individual's perception of health. (American Thoracic Society) Moreover, disease-specific and population-specific modules are being developed for the WHOQOL 100.

The WHOQOL 100 (WHO, 1997) includes six broad domains of health related quality of life, and the twenty-four facets. These six domains are Physical Health, Psychological Health, Level of independence, Social relationships, Environment and Spiritual. Four items are included for each set, as well as four general items covering subjective overall health related quality of life an health,

producing a total of 100 items in the assessment. All items are rated on a five point scale (1-5). (WHO, 1997)

WHOQOL-BREF

This set of questionnaires contains a total of 26 questions in order to provide a broad and comprehensive assessment; one item from each of the 24 facets contained in the WHOQOL-100 had been included. In addition, two items from the overall QOL and general health facets have been included as well. One of the advantages of this 26-item WHOQOL-BREF is that it can be applied, instead of WHOQOL 100, where time constraints are taken into consideration. The main four domains are Physical Health, Psychological Health, Social Relationship and Environment. (WHO, 1997)

Health-related quality of life (HRQOL)

In medical research and evaluation, there is an increasing interest in instruments used to measure health related quality of life (HRQOL) in general population surveys, as well as across a variety of diseases and conditions. HRQOL is a multi-dimensional concept that includes physical, psychological and social domains of health and is generally accepted as an important outcome measure of health care. (Kontondimopoulos et al., 2007). Although information about the health related quality of life of lower socio-economic status groups and ethnic minorities remained limited, measures of health related quality of life had been found to be sensitive to differences in socio-economic status.

Muldoon et al. (1998) also stated that Measures of disease status alone are insufficient to describe the burden of illness; health related quality of life factors such

as pain, apprehension, depressed mood, and functional impairment must also be considered (Muldoon et al, 1998).

The two domain approaches to measuring HRQOL are generic and disease-specific instruments, and the majority of experts recommend the use of both concurrently.

Besides, generic HRQOL instruments are designed to be applicable across a wide range of populations and interventions, whereas, specific HRQOL measures are designed to be relevant to particular interventions or in certain subpopulations with some diseases, for instances, cancer, heart disease and the like. Hundreds of generic and specific HRQOL instruments have been developed through years. (Coons et al, 2000) The specific HRQOL instruments, however, are not going to discuss in this study.

Some of the generic HRQOL instruments have been examined as follow:

The Nottingham Health Profile

The Nottingham Health Profile (NHP) was developed to reflect any lay rather than professional perceptions of health (Coons et al., 2000) .It is not an index of disease, disability or illness, but relates to how people feel when experiencing various states of ill health. Although it has been widely for years, the instrument has several drawbacks. It only explores more severe ill health which results in skewed data and means that it is only always appropriate for measuring change over time. The dimensions of pain and mobility are confounded, and the method of weighing the

severity of items has been criticized as producing illogical and incoherent result (Carr et al., 1996).

The Sickness Impact Profile (SIP)

The SIP was constructed as a measure of sickness in relation to impact on behavior rather than feelings and clinical reports. According to Coons, they are among the longest of the generic measures (136 items measuring 12 dimensions of health), but have gained widespread use. These measures, however, have been criticized for omitting pain measures and the sensitivity of FLP, their modified English version the Functional Limitation Profile, to clinical change has not been established (Carr et al, 1996).

The Quality of Well-Being (QWB) Scale, the Health Utilities Index (HUI) and the EuroQol Instrument (EQ-5D) are preference-based measures designed to summarize HRQOL in a single number ranging from 0 to 1, i.e., dead or alive (Coons et al., 2000).

Short Form 36 (SF 36)

The Medical Outcomes Study 36-item Short Form (SF 36) Health Survey is the most commonly used HRQOL measure to come out of the Medical Outcomes Study. The SF 36 includes multi-item scales to measure health status on the following eight dimensions: Physical Functioning (PF), Role Physical (RF), Bodily Pain (BP), General Health (GH), Vitality (VT), Social Functioning (SF), Role Emotional (RE), and Mental Health (MH). Each dimension is scored on a 0-100 scale with 0 and 100

corresponding to worst and best HRQOL respectively, and the eight dimensions can be summarized into Physical Component Summary (PCS) and Mental Component Summary (MCS) (McDowell., 2006).The SF 36 measures done in Taiwan by Tseng et al, however, suggested that health-related health related quality of life (HRQOL) measures may need to be interpreted within a cultural framework. (Tseng et al., 2003)

Short Form 1 (SF 1)

The SF 1 had been adapted from the first question of the Medical Outcomes Study Short Form 36 and Short Form 12, and is commonly referred to as the SF 1. The SF 1, according to Avery et al (2006) also known as self assessed health status, perceived health, individual health evaluation, general health status, single item health status, overall health status and quality of life. Avery et al used the SF1 to assess the health related quality of life of Australian aged 18 years and over by demographic, social and other health indicators. The results showed SF 1 to be a valid tool in assessing the subjective health status of the South Australian general population. This single item question had such great advantages as brevity, decreased cost, less time-demanding and easy to be interpreted (Avery et al, 2006). Although SF 1 had been tested in general population and in various disease groups, such as diabetes, asthma, cancer or patients undergoing specific treatments around the globe, a study in the US to assess the health related quality of life of ethnic population, such as Latino, was found having limitations in predicting mortality risks for this population. So, it can be concluded that the use of self rated health for across ethnic comparisons may be problematic (Lubetkin & Gold, 2000).

Short Form 12 (SF 12)

The Medical Outcomes Study Short Form 12 Health Survey (SF 12), a subset of SF 36, was derived in the United States from the twelve questions of the SF 36, which make up the MCS (Mental Component Summary) and PCS (Physical Component Summary) scales, in order to provide a shorter measure health status (Avery et al., 2003). Its main application, according to John E. Ware, Jr., is in surveys and in outcome studies where space and time constraints prevent use of the SF 36. The first version of the SF 12 was introduced in 1994 and a second version was presented in 1998 (McDowell, 2006).

Two recall periods of acute (one week) and standard (four weeks) were used under different circumstances. The standard 4-week recall period was adopted for the SF 36 and SF 12 Health Surveys to maintain comparability with the long-form Medical Outcome Study (MOS) measures from which it was derived. However, there are many instances in which a 4-week recall period is not appropriate, particularly in studies that require relatively short intervals between follow-up assessments because changes in health status occur more rapidly (Ware et al, 1996).

The acute form of the SF 12, however, was designed for applications in which health status would be measured weekly or biweekly. It was created by changing the recall period for six SF 12 scales (Role Physical, Bodily Pain, Vitality, Social Functioning, Role Emotional, and Mental Health) from “the past four weeks” to “the past two weeks”. Two SF 12 scales, Physical Functioning and General Health, do not have a recall period, so are identical across acute and standard forms (Ware et al, 1996).

The rationale behind the use of the 1-week recall period for the SF 12 was that shorter recall periods would be more sensitive than longer recall period to recent changes in health status. A study conducted by Ware et al to patients with asthma to compare responses to SF 36 items with 1-week and 4-week discovered that the answers to questions with a 1-week recall period tended to be more responsive to recent changes in disease state as defined by several clinical criteria of asthma. Changes in SF 36 scale scores with the 1-week recall period were generally more highly related to 1-week changes in asthma severity, as hypothesized. Since the SF 12 is a subset of the SF 36, the outcomes from this study can be applied to 1-week recall studies in SF 12 as well (Ware et al, 1996).

This study was conducted by Short Form 12 with two-week recall period because no any related study was done on Myanmar migrant workers in Phangnga province and to reduce the recall bias as well. Disease specific instruments will not be discussed here.

2.3 Related studies

The generic measures about the health related quality of life of migrant workers evaluating by SF 12 are very rare. On the other hand, however, disease specific measures are very plentiful in various diseases and in variety age groups which are not an interest in this study.

However, there are some SF 36 studies on rural to urban migration of Vietnamese young adult migrants in Ho Chi Minh City (Landingham, 2003), on Afghanistan, Iran and Somalia refugees at the age of 18 or older on health and health care utilization in the Netherlands (Gerritsen et al., 2004), on Taiwanese general

population (Tseng et al., 2003) and on non-American patients at a community health care center in New York City (Lubertkin & Gold et al., 2000).

One study in Australia analyzed data collected in South Australian population surveys by using the SF 1 for adults aged 18 years and over by demographic, social and other health indicators (Avery et al., 2006).

One study in China using SF 12 to assess quality of life of rural-to-urban migrants in Nanjing and Beijing reflected the very closed and high sensitivity in nature of study, in terms of studied population, occupation of samples and so on (Li et al., 2006).