QUALITY OF LIFE IN OLD AGE
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QUALITY OF LIFE IN OLD AGE
International and Multi-Disciplinary Perspectives

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Springer
Heidrun Mollenkopf would like to dedicate this book
to her grandchildren Anne Sophie, Marie Claire, Mathieu,
and Joscha, and Alan Walker to his children Alison and Christopher.
We hope that their later lives will be high-quality ones.
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This book started its life during a symposium we organised on Quality of Life in Old Age at the Fifth Conference of the International Society for Quality of Life Studies (ISQOLS) in Frankfurt in July 2003. We are extremely grateful to Alex Michalos for sponsoring that session, encouraging us to use the symposium presentations as the basis for a book and for his support during the commissioning and editing process. We are also very grateful to the authors of this volume for the prompt delivery of their manuscripts and responses to our editorial comments. Finally our special thanks to Marg Walker for her expert and efficient preparation of the manuscript for publication.

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SECTION I

UNDERSTANDING QUALITY OF LIFE IN OLD AGE
Quality of life (QoL) is a multidimensional, holistic construct assessed from many different perspectives and by many disciplines. Moreover, the concept of QoL can be applied to practically all important domains of life. Thus, QoL research has to include social, environmental, structural, and health-related aspects, and be approached from an interdisciplinary perspective. This holds even more when QoL in old age is the focus because ageing itself is a multidimensional process. General QoL studies have used age for many years as a social category like gender or social class, but apart from a few exceptions (e.g. Diener and Suh, 1997; Michalos, 1986; Michalos et al., 2001) they have largely neglected older people.

Recent research in gerontology has begun to systematically study QoL – following the World Health Organization (WHO) dictum ‘years have been added to life and now the challenge is to add life to years’. However, there are very few overarching texts available on this topic and none of an international and multidisciplinary nature. Given the size and growth of this population, it is time to publish a volume on this topic that systematically pursues a comprehensive perspective and includes theoretical approaches and empirical findings with respect to the most important components of QoL in old age.

This volume brings together leading researchers on QoL in old age and summarises, on the one hand, what we know and, on the other, what further research is needed. It consists of three main parts with an extended introduction, the main chapters on the various aspects of what contributes to ageing people’s QoL, and finally a concluding chapter pointing to knowledge gaps and necessary further developments in theory and methodology.

The introductory part emphasises the amorphous, multidimensional and complex nature of QoL as well as the high level of inconsistency between scientists in their approach to this subject. Drawing on an extensive literature review (Brown et al., 2004), eight different models of QoL are distinguished. These range from objective social indicators, subjective indicators of life satisfaction and well-being, health and functioning, to interpretative approaches emphasising the individual values and theories held by older people. Moreover, this chapter summarises the main areas of consensus about QoL in old age: its dynamic multifaceted nature, the combination of life course and immediate influences, the similarities and differences in the factors determining QoL between younger and older people, the most common associations with QoL and the likely variations between groups, and the powerful role of subjective self-assessment.

The main part of the book spans the whole range of the most important issues in ageing people’s QoL: their subjective evaluations (Chapter 2), personal control

beliefs (Chapter 3), economic resources (Chapter 5), and social relations and networks (Chapter 4). The impact of diverging national welfare systems and social policies is investigated (Chapter 6) and environmental conditions are explored to detect their supporting or hindering potential with respect to older people’s well-being (Chapters 8 and 9). Differences in the conditions of ageing between Asia and Europe are highlighted (Chapter 10) as is the diverging conditions of ethnic groups ageing in different host countries (Chapter 11). Last but not least, QoL in the case of decreasing health (Chapter 12) and the challenge of care (Chapter 13) are considered.

Not unexpectedly in view of the various topics and the empirical and scientific backgrounds, the contributions differ in approach, style, and degree of differentiation. Some of them provide a comprehensive overview on the available knowledge in the domain they deal with while others focus on a specific study. Some throw light on the micro cosmos of the individual, investigating psychological aspects and their role for well-being with increasing age, while others locate individual QoL in the meso and macro contexts of family, networks, cultural habits, societal structures, and national or regional conditions.

We did not try to level out these differences. More important in our view, as editors, was that the authors explained carefully their theoretical frame of reference and methodological approach and that their specific contributions deepened our knowledge about what makes up a good QoL in old age in different parts of the world. That said, we have simultaneously touched a limitation to this volume: it was not possible to consider, in fact, all parts of the world. However, our aim was not to establish a global map of older people’s living conditions. Instead, this volume provides a comprehensive perspective on what we know – and what we do not know – about the most important components of QoL in old age from as many national and disciplinary perspectives as possible.

Finally, the main research priorities and gaps in knowledge are outlined together with the key theoretical and methodological issues that must be tackled if comparative, interdisciplinary research on QoL is to develop further. That part draws on the conclusions stated by the authors of this volume and charts, as an outlook, the recent evolution of a new perspective on ageing.

THE SCOPE OF RESEARCH ON QoL IN OLD AGE

QoL is a rather amorphous, multilayered, and complex concept with a wide range of components – objective, subjective, macro societal, micro individual, positive, and negative – which interact (Lawton, 1991; Tesch-Römer et al., 2001). It is a concept that is very difficult to pin down scientifically and there are competing disciplinary paradigms. Three central limitations of QoL are its apparent open-ended nature, its individualistic orientation, and its lack of theoretical foundations (Walker and van der Maesen, 2004). The widely acknowledged complexity of the concept, however, has not inhibited scientific inquiry. As Fernández-Ballesteros (1998a) has
shown, in the final third of the last century, there was a substantial increase in
citations of QoL across five different disciplinary databases. While the growth was
significant in the psychological and sociological fields, in the biomedical one, start-
ing from a lower point, it was ‘exponential’ (e.g. increasing from 1 citation in 1969
to 2,424 in 1995 in the ‘Medline’ database). This reflects the fact that in many
countries recent discussions of QoL have been dominated by health issues, and a
subfield, health-related quality of life (HRQoL), has been created which emphas-
izes the longstanding pre-eminence of medicine in gerontology (Bowling, 1997;
Walker, 2005b).

Another key factor behind this growth in scientific inquiry is the concern among
policymakers about the consequences of population ageing, particularly for spend-
ing on health and social care services, which has prompted a search for ways to
enable older people to maintain their mobility and independence, and so avoid cost-
ly and dependency-enhancing institutional care. These policy concerns are not
peculiar to Europe but are global (World Bank, 1994); nor are they necessarily
negative because the new policy paradigms such as ‘a society for all ages’ and
‘active ageing’, both of which are prominent in the 2002 Madrid International Plan
of Action on Ageing, offer the potential to create a new positive perspective on age-
ing and a major role for older people as active agents in their own QoL. A signifi-
cant part of the impetus for this positive approach comes from within Europe
(Walker, 2002).

MODELS OF QoL

Given the complexity of the concept and the existence of different disciplinary per-
spectives, it is not surprising that there is no agreement on how to define and mea-
sure QoL and no theory of QoL in old age. Indeed, it is arguable whether a theory of
QoL is possible because, in practice, it operates as a meta-level construct, which
encompasses different dimensions of a person’s life. Nonetheless, a theory would
not only lend coherence and consistency but also strengthen the potential of QoL
measures in the policy arena (Noll, 2002). As part of the European FORUM project,
Brown and colleagues (2004) prepared a taxonomy and systematic review of the
English literature on the topic of QoL. In this, Bowling (2004) distinguishes between
macro (societal, objective) and micro (individual, subjective) definitions of QoL.
Among the former, she includes the roles of income, employment, housing, educa-
tion, and other living and environmental circumstances; among the latter, she
includes perceptions of overall QoL, individuals’ experiences and values, and relat-
ed proxy indicators such as well-being, happiness and life satisfaction. Bowling also
notes that models of QoL are extremely wide-ranging, including potentially every-
thing from Maslow’s (1954) hierarchy of human needs to classic models based
solely on psychological well-being, happiness, morale, life satisfaction (Andrews,
1986; Andrews and Withey, 1976; Larson, 1978), social expectations (Calman, 1984),
or the individual’s unique perceptions (O’Boyle, 1997; Brown et al., 2004, p.4).
She distinguishes eight different models of QoL which may be applied, in the adapted form here, to the gerontological literature:

1. Objective social indicators of standard of living, health, and longevity typically with reference to data on income, wealth, morbidity, and mortality. Scandinavian countries have a long tradition of collecting such national data (Hornquist, 1982; Andersson, 2005). Recently, attempts have been made to develop a coherent set of European social indicators (Noll, 2002; Walker and van der Maesen, 2004) but, as yet, these have not been applied to subgroups of the population.

2. Satisfaction of human needs (Maslow, 1954), usually measured by reference to the individual’s subjective satisfaction with the extent to which these have been met (Bigelow et al., 1991).

3. Subjective social indicators of life satisfaction and psychological well-being, morale, esteem, individual fulfilment, and happiness usually measured by the use of standardised, psychometric scales and tests (Bradburn, 1969; Lawton, 1983; Mayring, 1987; Roos and Havens, 1991; Suzman et al., 1992; Veenhoven, 1999; Clarke et al., 2000).

4. Social capital in the form of personal resources, measured by indicators of social networks, support, participation in activities and community integration (Wenger, 1989, 1996; Bowling, 1994; Knipscheer et al., 1995; see also Chapter 4).

5. Ecological and neighbourhood resources covering objective indicators such as levels of crime, quality of housing and services, and access to transport, as well as subjective indicators such as satisfaction with residence, local amenities and transport, technological competence, and perceptions of neighbourliness and personal safety (Cooper et al., 1999; Kellaher et al., 2004; Mollenkopf et al., 2004; Scharf et al., 2004). Recently, this approach to QoL has become a distinct subfield of ecological or architectural gerontology, with German researchers playing a prominent role (Mollenkopf and Kaspar, 2005; Wahl and Mollenkopf, 2003; Wahl et al., 2004; Weidekamp-Maicher and Reichert, 2005).

6. Health and functioning focussing on physical and mental capacity and incapacity (e.g. activities of daily living and depression) and broader health status (Verbrugge, 1995; Deeg et al., 2000; Beaumont and Kenealy, 2004; see also Chapter 12).

7. Psychological models of factors such as cognitive competence, autonomy, self-efficacy, control, adaptation, and coping (Brandstätter and Renner, 1990; Filipp and Ferring, 1998; Grundy and Bowling, 1999; see also Chapters 3 and 9).

8. Hermeneutic approaches emphasising the individual’s values, interpretations, and perceptions usually explored via qualitative or semi-structured quantitative techniques (WHOQoL Group, 1993; O’Boyle, 1997; Bowling and Windsor, 2001; Gabriel and Bowling, 2004a). This model, which is growing in its research applications, includes reference to the implicit theories that older people themselves hold about QoL (Fernández-Ballesteros et al., 1996, 2001). Such implicit theories and definitions may be of significance in making cross-national comparisons by providing the basis for a universal understanding of QoL (and will be revisited later). A common feature of all of these models identified by Brown et al. (2004) is that concepts of QoL have invariably been based on expert opinions rather than on those
of older people themselves (or, more generally, those of any age group). This limitation has been recognised only recently in social gerontology but has already led to a rich vein of research (Farquhar, 1995; Grundy and Bowling, 1999; Gabriel and Bowling, 2004a, b). This does not mean, however, that QoL can be regarded as a purely subjective matter, especially when it is being used in a policy context. The apparent paradox revealed by the positive subjective evaluations expressed by many older people living in objectively adverse conditions, such as poverty and poor housing conditions, is a longstanding observation in gerontology (Walker, 1980, 1993).

The processes of adjustment involved in this ‘satisfaction paradox’ have been the focus of interest in recent research (Mollenkopf et al., 2004; Staudinger and Freund, 1998), and this is emphasised in Chapter 5. As Bowling (2004, p.6) notes, there may be a significant age-cohort effect behind the paradox, as older people’s rating of their own QoL is likely to reflect the lowered expectations of this generation, and they may therefore rate their lives as having better quality than a person in the next generation of older people in similar circumstances would do (Schilling, 2006).

Empirical research is required to test whether or not the satisfaction paradox is a function of age-cohort but, nonetheless, the caution concerning subjective data on older people’s QoL is particularly apposite in a comparative European context where expectations may differ markedly on the north/south and east/west axes (Mollenkopf et al., 2004; Polverini and Lamura, 2005; Weidekamp-Maicher and Reichert, 2005). For example, there are substantial variations in standards of living between older people in different European countries: in the ‘old’ EU 15 the at-risk poverty rate among those aged 65 and over varied, in 2001, from 4% in the Netherlands to more than 30% in Greece, Ireland, and Portugal (European Commission, 2003).

A recent review of QoL in old age in five European countries found a fairly widespread national expert consensus about the range of indicators that constitute the concept, particularly in the two countries with the most developed systems of social reporting, the Netherlands and Sweden, but with a dominance of objective measures (Walker, 2005b). The southern European representative, Italy, does not consistently distinguish older people’s QoL from the general population and frequently does not differentiate among the older age group. In all five countries health-related QoL is the most prevalent approach in gerontology. Also, while there is no consensus on precisely how QoL should be measured, there is evidence of some cross-national trade in instruments, such as the adaptation of the Schedule for the Evaluation of Individual Quality of Life (SEIQOL) for use in the Netherlands (Peeters et al., 2005; see also Chapters 3, 6 and 8).

UNDERSTANDING QoL IN OLD AGE

In the light of the wide spectrum of disciplines involved in research on QoL in old age and their competing models, is it possible to draw any conclusions about how it is constituted? The answer is ‘yes’, but because of the lack of either a generally agreed definition or a way to measure it, such conclusions must be tentative. Firstly, although there is no agreement on these two vital issues, few would dissent from the
idea that QoL should be regarded as a dynamic, multifaceted, and complex concept, which must reflect the interaction of objective, subjective, macro, micro, positive, and negative influences. Not surprisingly, therefore, when attempts have been made to measure it, QoL is usually operationalised pragmatically as a series of domains (Hughes, 1990; Grundy and Bowling, 1999).

Secondly, QoL in old age is the outcome of the interactive combination of life course factors and immediate situational ones. For example, prior employment status and midlife caring roles affect access to resources and health in later life (Evandrou and Glaser, 2004). Fernández-Ballesteros et al. (2001) combined both sets of factors in a theoretical model of life satisfaction. Recent research suggests that the influence of current factors such as network relationships may be greater than the life course influences, although, of course, the two are interrelated (Wiggins et al., 2004). What is missing, even from the interactive approaches, is a political economy dimension. QoL in old age is not only a matter of individual life courses and psychological resources but must include some reference to the individual’s scope for action – the various constraints and opportunities that are available in different societies and to different groups, for example, by reference to factors such as socio-economic security, social cohesion, social inclusion, and social empowerment (Walker and van der Maesen, 2004). Hence, a consideration of the overarching and framing macro conditions, which is a matter of course in general QoL research and is the case in most of the contributions to this volume, should also become accepted practice in research on QoL in old age (see, e.g. Heyl et al., 2005).

Thirdly, some of the factors that determine QoL for older people are similar to those for other age groups, particularly with regard to comparisons between midlife and the third age. However, when it comes to comparisons between young people and older people, health and functional capacity achieve a much higher rating among the latter (Hughes, 1990; Lawton, 1991). This emphasises the significance of mobility as a prerequisite for an active and autonomous old age (Banister and Bowling, 2004; Mollenkopf et al., 2005), as well as the role of environmental stimuli and demands, and the potential mediating role of technology, in determining the possibilities for a life of quality (Mollenkopf and Fozard, 2004; Wahl et al., 1999; see also Chapter 7). In practice, with the main exception of specific scales covering physical functioning, QoL in old age is often measured using scales developed for use with younger adults. This is clearly inappropriate when the heterogeneity of the older population is taken into account, especially so with investigations among very frail or institutionalised older people. Older people’s perspectives and implicit theories are often excluded by the common recourse to predetermined measurement scales in QoL research. This is reinforced by the tendency to seek the views of third parties when assessing QoL among very frail and cognitively impaired people (Bond, 1999). Communication is an essential starting point to involving older people and understanding their views, and recent research shows that this can be achieved successfully among even very frail older people with cognitive impairments (Tester et al., 2004).
Fourthly, the sources of QoL in old age often differ between groups of older people. The most common empirical associations with QoL and well-being in old age are good health and functional ability, a sense of personal adequacy or usefulness, social participation, intergenerational family relationships, availability of friends and social support, and socio-economic status (including income, wealth, and housing) (Lehr and Thomae, 1987; Mayer and Baltes, 1996; Knipscheer et al., 1995; Bengtson et al., 1996; Tesch-Römer et al., 2001; Gabriel and Bowling, 2004a, b; see also Chapter 2). Still, different social groups have different priorities. For example, Nazroo et al. (2004) found that black and ethnic minority elders valued features of their local environment more than their white counterparts (see also Chapter 9). Differences of priority have been noted in Spain between older people living in the community and those in institutional care, with the former valuing social integration and the latter, the quality of the environment (Fernández-Ballesteros, 1998b). Other significant priorities for older people in institutional environments are control over their lives, structure of the day, a sense of self, activities, and relationship with staff and other residents (Tester et al., 2004). This emphasises the importance of the point made earlier about the need to communicate with frail older people in order to understand their perceptions of QoL: although some recent research has begun to address this (Gerritsen et al., 2004), the QoL of the very old is still a relatively neglected area of gerontology (see Chapters 3 and 13). Comparative European research also points to different priority orders among older people in different countries: e.g. the greater emphasis on the family in the South compared to the North (Walker, 1993; Polverini and Lamura, 2005). Another example of variations within Europe is the greater impact of objective living conditions on subjective QoL in former socialist countries like East Germany and Hungary compared to the more developed and affluent countries of most of the northern, western and southern parts of Europe (Mollenkopf et al., 2004).

Fifthly, while there are common associations with QoL and well-being, it is clear that subjective self-assessments of psychological well-being and health are more powerful than objective economic or sociodemographic factors in explaining variations in QoL ratings (Bowling and Windsor, 2001; Brown et al., 2004). Two sets of interrelated factors are critical here: on the one hand, it is not the circumstances per se that are crucial but the degree of choice or control exercised in them by an older person; on the other hand, whether or not the person’s psychological resources, including personality and emotional stability, enable him or her to find compensatory strategies – a process that is labelled ‘selective optimisation with compensation’ (Baltes and Baltes, 1990). There is some evidence that the ability to operationalise such strategies, e.g. in response to ill health, disability, or bereavement, is associated with higher levels of life satisfaction and QoL (Freund and Baltes, 1998). Feelings of independence, control and autonomy are essential for well-being in old age (see Chapter 3). Moreover, analyses of the Basle Interdisciplinary Study of Aging show that psychological well-being is more strongly associated with a feeling of control over one’s life than with physical health and capacity among the very elderly than among the young-old (Perrig-Chiello, 1999).
With this contextual background in mind, we hand the baton over to the authors of the subsequent chapters who deal with the various components of QoL in old age. Our concluding chapter highlights the main knowledge gaps and the next steps for theory and methodology in this field.

NOTES

1. The following sections include parts of an article published previously in the *European Journal of Ageing* (Walker, 2005a).

REFERENCES


2. QUALITY OF LIFE IN OLDER AGE

What older people say

INTRODUCTION

The increasing number of older people, with higher expectations of ‘a good life’ within society and with their high demands for health and social care, has led to international interest in the enhancement, and measurement, of quality of life (QoL) in older age. UK Government policy is also concerned with enabling older people to maintain their independence and active contribution to society and, in effect, to add quality to years of life. QoL has thus become commonly used as an endpoint in the evaluation of public policy (e.g. in the assessment of outcomes of health and social care). This indicates that a multifaceted perspective of QoL is required, with a shift away from single-domain approaches that focus only on single areas of life (e.g. physical health and/or functioning, mental health, social support, life satisfaction, and well-being) towards one that also reflects the views of the population concerned.

A measure of QoL requires a definition of the concept. QoL theoretically encompasses the individual’s physical health, psycho-social well-being and functioning, independence, control over life, material circumstances, and external environment. It is a concept that is dependent on the perceptions of individuals, and is likely to be mediated by cognitive factors (Bowling, 2005a,b).

It reflects macro, societal, as well as micro, individual, influences, and it is a collection of objective and subjective dimensions which interact (Lawton, 1991). Lawton (1982, 1983a, b) developed a popular model and proposed that well-being in older people may be represented by behavioural and social competence (e.g. measured by indicators of health, cognition, time use, and social behaviour), perceived QoL (measured by the individual’s subjective evaluation of each domain of life), psychological well-being (measured by indicators of mental health, cognitive judgements of life satisfaction, positive-negative emotions) and the external, objective (physical) environment (housing and economic indicators). He thus developed a quadripartite concept of the ‘good life’ for older people (Lawton, 1983a), which he later changed to ‘quality of life’ as the preferred overall term, accounting for all of life. However, there is no consensus within or between disciplines about conceptual definitions or measurement of QoL.

Most investigators have based their concepts and measures on experts’ opinions, rather than those of lay people ( Rogerson et al., 1989; Bowling, 2001). Consequently, there is little empirical data on the extent to which the items included in most measurement scales have any relevance to people and their everyday lives. In addition, a pragmatic approach prevails in the literature, clarification of the...

concept of QoL is typically bypassed and justified with reference to its abstract nature, and the selection of measurement scales often appears *ad hoc* (Carver *et al*., 1999). This has resulted in many investigators adopting a narrow, or discipline-bound, perspective of QoL, and selecting single-domain measures such as scales of physical functioning, mental health, broader health status, life satisfaction, and so on. Some have used broader measures that aim to assess a person’s needs for resources or services, which also overlap with QoL domains. Others have selected combinations of single-domain measures, in an attempt to adopt a broader view of QoL, although this often results in lengthy schedules with high respondent and researcher burden (see Bowling, 2005a and Haywood *et al*., 2004 for reviews of measures).

Moreover, the models of QoL that have been developed are not consistent. Some have incorporated a needs-based satisfaction model, according to Maslow’s (1954, 1968) hierarchy of human needs for maintenance and existence (physiological, safety and security, social and belonging, ego, status and self-esteem, and self-actualisation). Higgs *et al*. (2003), for example, based their model of QoL in older age on self-actualisation and self-esteem. In contrast, traditional US social science models of QoL have been based primarily on the overlapping, positive, concepts of ‘the good life’, ‘life satisfaction’, ‘social well-being’, ‘morale’, ‘social temperature’, or ‘happiness’ (Andrews, 1986; Andrews and Withey, 1976; Lawton, 1996). The focus among psychologists is on psychological resources (Baltes and Baltes, 1990). The World Health Organization quality of life (WHOQoL) Group adopted a multifaceted approach, while emphasising subjective perceptions, values and cultural context, from which was developed their WHOQoL (100 items and brief version) (WHOQoL Group, 1993; Skevington, 1999; Skevington *et al*., 2004). Stenner *et al*. (2003), on the basis of ‘importance items’, agreed with the WHOQoL Group during the development and testing of the WHOQoL-100. The analyses showed that the common factors that emerged included areas relating to family relationships, independence, a ‘can do’ and positive approach to life, health and religious trust. The version for use with older people – the WHOQoL-OLD – is being field tested (http://www.euro.who.int/ageing/quality). Brown *et al*. (2004) reviewed the literature on QoL and developed a taxonomy of QoL comprising the following components: objective indicators; subjective indicators; satisfaction of human needs; psychological characteristics and resources; health and functioning; social health; social cohesion and social capital; environmental context; ideographic approaches.

What about the public views? Brown *et al*.,’s (2004) review concluded that older people’s views of QoL overlapped with theoretical models. However, theoretical models need to be multidimensional in order to encompass people’s values and perceptions. At present, QoL measures are based on the disciplines and perspectives of investigators (see earlier). Bowling’s (1995a,b) earlier research on the most important things in people’s lives, based on a random sample of adults in Britain, found that people prioritised their finances, standard of living, and housing; relationships with relatives and friends; their own health; the health of a close other;
and social and leisure activities. But there were variations by age and gender. For example, social relationships and work have been reported to be prioritised more by younger than by older adults, and health and family, more by people aged 65 and over (Brown et al., 1994; Farquhar, 1995; Bowling, 1995a,b, 1996; Bowling and Windsor, 2001). Also, people who have social care needs, particularly those living in nursing and residential homes, might prioritise the ability to control their lives and the way they structure their days as most important (Qureshi et al., 1994). Fry’s (2000) research, based on a combination of survey data and in-depth interviews with older people living in Vancouver, reported that people valued most their personal control, autonomy and self-sufficiency, their right to pursue a chosen lifestyle, and their right to privacy.

It is increasingly important to develop a multidimensional model of QoL, for use in both descriptive and evaluative research (e.g. in health and social policy), which reflects the views of the population concerned. Such a model also needs to be developed on the basis of results from longitudinal and repeated cross-sectional research in order to measure any dynamic features, response shift, cohort, and ageing effects. Longitudinal research is also required to ascertain whether attempting to engineer gains in subjective QoL is a realistic policy goal.

AIMS AND METHODS

The primary aim of this chapter is to explore the constituents of perceived QoL in older age in order to deconstruct the concept of QoL. The second aim is to make comparisons between older people’s perceptions of QoL and the content of existing QoL measures.

The Sample

Data were derived from a national interview survey of QoL in older age in Britain. Age 65 and over was taken to denote older age. The sample of people aged 65 and over was derived from four quarterly Office for National Statistics (ONS) Omnibus Surveys. Of the sample of 1,299 eligible respondents sifted by ONS from the Omnibus Survey, the overall response rate for the four QoL Surveys was 77% (999) (range over the four surveys: 69–83%); 19% refused to participate; and 4% could not be contacted during the interview period. The interviews were conducted in respondents’ own homes. The sociodemographic characteristics of the sample were similar to those from mid-year population estimates for Great Britain (estimated from the last census). Full details of the method and sample have been published elsewhere (Bowling et al., 2002, 2003; Bowling and Gabriel, 2004; Gabriel and Bowling, 2004).

Further in-depth interviews about QoL were carried out 12–18 months later with a subsample of 80 of the 999 participants in the QoL Survey. They were purposively sampled, using a quota matrix based on respondents’ sociodemographic characteristics and health status, QoL ratings, and region of residence. The aim was to interview a broad cross section of respondents in order to obtain a better understanding of people’s interpretations of QoL.
Open-Ended Survey Questions on QoL and Analysis

A series of open-ended questions were asked at the beginning of the interview in order to elicit people’s views of the things that gave their lives quality, the things that took quality away from their lives, their priorities, and how QoL could be improved for themselves as well as for other people their age. Also included was a self-rating of QoL overall on a 7-point Likert scale, ranging from ‘as good as can be’ to ‘as bad as can be’. The open-ended questions were used as the opening survey questions in order to prevent respondent bias towards the other, more specific questions and scales included in the questionnaire (see Bowling et al., 2002 for details of the structured items and scales).

The detailed coding frames for the open-ended survey responses were developed after AB and two coders independently read all of the scripts of responses, and were refined as coding took place. The coding was carried out by two coders and checked by an independent researcher. Main themes and detailed subthemes were coded in order to capture the essence of people’s definitions and exactly what made the QoL good and bad, and how life could be improved. These were entered onto SPSS and merged with the main quantitative data-set. The main themes only are presented here. Detailed subcategories for each theme were also coded and, along with verbatim statements from respondents as examples, have been reported elsewhere (Bowling et al., 2003).

In-Depth Interviews and Analyses

The subsequent in-depth interviews with a subsample of respondents were based on a semi-biographical interview technique, whereby the interviewer asked respondents first to describe key events in their histories, including marriage, work, and/or parenthood where relevant. This aimed to facilitate people talking about QoL in the context of their overall life, and to enhance the researchers’ understanding of people’s perspectives on life. Then the interviewer used a checklist and asked respondents what they thought of when they heard the words ‘quality of life’, to describe their QoL, what gave their life quality and what took quality away from it, how it could be improved, what would make it worse, and about any changes since the survey interview. The interviews were audio-recorded, transcribed, categorised by one researcher, and checked by an independent researcher. They were analysed using NU*DIST (version 5).

RESULTS

The Survey Data

About half, 48% (480), of the QoL Survey respondents were female and 52% (519) were male. The comparable figures for respondents aged 65 and over to the British General Household Survey (GHS) in 2000 were 51% female and 49% male (Walker et al., 2001). Of the QoL Survey respondents, 62% (624) were aged 65–74 and 38% (375) were aged 75 and over; the comparable figures for the 2000 GHS were 58%
and 42% respectively. A total of 98% (983) of QoL respondents were white, as would be expected from national statistics.

Similar proportions of men and women, within each age group, rated their overall QoL as good or less than good (see Figure 1). Just 4% (21) of males and 6% (32) of females rated their QoL as ‘so good it could not be better’; 78% (404) of males and 70% (362) of females labelled it as ‘very good’ or ‘good’; and the remainder rated it as ‘alright’, ‘bad’, ‘very bad’, or ‘so bad it could not be worse’. Associations with QoL ratings have been reported elsewhere (Bowling et al., 2002).

The main themes categorised from responses to the open-ended survey question on the constituents of the ‘good things’ that gave quality to life were, in order of magnitude: social relationships (81%), social roles and activities (60%), solo activities (48%), health (44%), psychological outlook and well-being (38%), home and neighbourhood (37%), financial circumstances (33%), and independence (27%). Smaller numbers mentioned a wide range of other things. Poor health was most often mentioned as the thing that took ‘quality away’ from their lives (by 50%). Other commonly mentioned things that took quality away from life were home and neighbourhood (30%), financial circumstances (23%), and psychological outlook (17%). Good health, followed by better finances (i.e. having enough or more money), were the two most frequently mentioned things that respondents said would improve their QoL. While a common core of main constituents of QoL clearly emerged from the data, there was more variance in the subthemes underlying these, reflecting individual circumstances. These are displayed, under each main theme, in Appendix 1.

Figure 1. Quality of life ratings
In-Depth Follow-Up Interviews

Of the 80 survey respondents who were re-interviewed in-depth 12–18 months later, 40 were male and 40 female; 26 were aged 65 < 70, 20 were 70 < 75, 20 were 75 < 80, and 14 were 80 and over. As many as 37 were married and the rest were single: never married (5), married but separated (1), divorced (6), or widowed (31). They were purposively selected using a grid to ensure representation of people across social classes, with different levels of abilities in activities of daily living, and in QoL ratings, with a range of income, and with a wide geographical spread.

The main themes categorised from the in-depth interviews with the subsample of respondents on the ‘good things’ that gave quality to life were, in order of magnitude: social relationships (96%), home and neighbourhood (96%), psychological outlook and well-being (96%), solo activities (93%), health (85%), social roles and activities (80%), financial circumstances (73%), and independence (69%). Poor home and neighbourhood, poor health, and poor social relationships were the themes most often mentioned as those that took quality away from their lives (by 84%, 83%, and 80% respectively). These were followed by psychological outlook and well-being (63%), not having enough money (53%), and losing independence (46%). A range of other areas were mentioned by smaller numbers. The most commonly mentioned things that respondents said would improve their QoL were having a better home and neighbourhood, enough money, and better health.

Comparison of Lay Views and Regression Modelling

In sum then, the most frequent QoL themes raised by older people, both in the main survey and in the in-depth follow-up were: social relationships, social roles and activities, other leisure pursuits and activities enjoyed alone, health, psychological outlook and well-being, home and neighbourhood, financial circumstances, and independence. Modelling, using multiple regression, of the main independent predictors of QoL ratings (using the theoretically important structured scales and items administered in the survey) confirmed the importance of most of these themes (see Bowling et al., 2002 for details of approach and results). The main independent indicators of self-rated good QoL in the regression model, which explained most of the variance in QoL ratings, were: (downward) social comparisons between oneself and others, positive social expectations of life, optimism, better reported health and functional status, more social activities and social support, less reported loneliness, better ratings of the quality of local facilities (in their area of residence) and perceived safety of the area. None of the sociodemographic and socio-economic indicators were statistically significant in the model. Although self-efficacy (and sense of control over life), level of income, and other indicators of socio-economic status were not significant in the modelling, it is important to include these areas in the concept and measurement of QoL, given that older people themselves raised financial circumstances and independence in, and control over, their daily lives, as important to their QoL.