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1. INTERNATIONAL AND MULTIDISCIPLINARY PERSPECTIVES ON QUALITY OF LIFE IN OLD AGE

Conceptual issues

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

H. Mollenkopf and A. Walker (eds.), Quality of Life in Old Age, 3–13.

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[1]

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, starting 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 emphasises 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 spending 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 costly 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 ageing and a major role for older people as active agents in their own QoL. A significant 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 perspectives, it is not surprising that there is no agreement on how to define and measure 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, education, and other living and environmental circumstances; among the latter, she includes perceptions of overall QoL, individuals' experiences and values, and related proxy indicators such as well-being, happiness and life satisfaction. Bowling also notes that models of QoL are extremely wide-ranging, including potentially everything 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 (Brandtstädter 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).

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