Global Perspective on Quality in Later Life

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Abstract

Despite controversies in theory and in practice when measuring wellbeing and quality of life, there is sufficient agreement to consider these constructs to be relevant in the context of elderly people to identify factors that affect living conditions and quality of life at older-adult ages. This chapter is drawn from a wider perspective on theory and empirical research in quality of life and wellbeing. Based on the analyses of the backgrounds on quality of life throughout the literature to review the concept, domains and measurements instruments, we look into several ageing longitudinal works in order to analyze the factors that most contribute to quality of later life within a worldwide context and from a longitudinal approach. We finish with a reflection on public policy and quality of life related to old people.

Keywords

Old people
Population ageing
Quality of life
Wellbeing
Analytical approaches
Longitudinal studies
Explaining factors
Active ageing
Policy
Research

The Ageing of the World: Current Figures and Prospective

Ageing is a demographic phenomena of great global importance, due both to the size of its figures and how fast it is occurring, and due to its countless social, economic and political implications at different levels.

According to United Nations figures (UN, Population Division United Nations 2013), by 2010, the world’s population aged 60 and over (the most widespread statutory retirement age) amounted to 765 million, this figure having been reached in a relatively short period of time, because in 1950 there were just over 200 million people of this age (Table 20.1). This rapid evolution has been more marked above all from 1970 among the so-called developing countries (fundamentally in the Asian region), where nearly 2/3 of this population lives at present. Most of these elderly people are women, with a worldwide ratio ranging from...
84 men for every 100 women aged 60 and over to only 61 men aged 80 and over. This gender gap is more pronounced in the developed countries’ figures, where for the same age groups there are only 75 and 52 men for every 100 women, respectively (UN, Population Division United Nations 2012).

Table 20.1 Ageing in the world: figures and living conditions

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<tr>
<th></th>
<th>World</th>
<th>More developed regions</th>
<th>Less developed regions</th>
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<tbody>
<tr>
<td>Population 60+ (number in thousands)</td>
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<tr>
<td>1950</td>
<td>201,775</td>
<td>93,822</td>
<td>107,953</td>
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<tr>
<td>1970</td>
<td>305,699</td>
<td>146,745</td>
<td>158,954</td>
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<tr>
<td>1990</td>
<td>490,269</td>
<td>202,922</td>
<td>287,348</td>
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<tr>
<td>2010</td>
<td>764,852</td>
<td>270,791</td>
<td>494,061</td>
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<tr>
<td>2050</td>
<td>2,031,337</td>
<td>418,326</td>
<td>1,613,011</td>
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<thead>
<tr>
<th>Projection % (2050): mid-range estimate</th>
<th>60+/Total population</th>
<th>80+/60+</th>
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<tr>
<td>World</td>
<td>22</td>
<td>29</td>
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<tr>
<td>More developed regions</td>
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<tr>
<td>Less developed regions</td>
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<tr>
<th>Sex ratio men *100 women</th>
<th>60+</th>
<th>80+</th>
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<tr>
<td>World</td>
<td>84</td>
<td>61</td>
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<tr>
<td>More developed regions</td>
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<td>Less developed regions</td>
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<tr>
<th>Life expectancy at 60 (years)</th>
<th>Men</th>
<th>Women</th>
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<tr>
<td>World</td>
<td>18</td>
<td>22</td>
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<tr>
<td>More developed regions</td>
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<td>Less developed regions</td>
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<tr>
<th>% living independently 60+</th>
<th>Men</th>
<th>Women</th>
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<tbody>
<tr>
<td>World</td>
<td>40</td>
<td>39</td>
</tr>
<tr>
<td>More developed regions</td>
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<tr>
<td>Less developed regions</td>
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<tr>
<th>% in labor force 60+</th>
<th>Men</th>
<th>Women</th>
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<tbody>
<tr>
<td>World</td>
<td>42</td>
<td>20</td>
</tr>
<tr>
<td>More developed regions</td>
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<td>Less developed regions</td>
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<tr>
<th>Non-communicable diseases death rate (2008) * 100,000</th>
<th>Men</th>
<th>Women</th>
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<tbody>
<tr>
<td>World</td>
<td>705</td>
<td>520</td>
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<tr>
<td>More developed regions</td>
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<td>Less developed regions</td>
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<tr>
<th>Total dependency ratio</th>
<th>0–14 &amp; 65+/15–64 *100</th>
<th>52.2</th>
<th>48.1</th>
<th>53.2</th>
</tr>
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<tbody>
<tr>
<td>Old-dependency ratio</td>
<td>65+/15–64 *100</td>
<td>11.7</td>
<td>23.8</td>
<td>8.9</td>
</tr>
<tr>
<td>Potential support ratio</td>
<td>15–64/65+ *100</td>
<td>8.6</td>
<td>4.2</td>
<td>11.2</td>
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<tr>
<td>Gross national income PPP ($)</td>
<td></td>
<td>10,760</td>
<td>33,460</td>
<td>5,900</td>
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Sources referenced in the text (Made by authors)

However, demographic ageing must be assessed while taking into account the proportion of this population group with regard to other age groups. Accordingly, at present 1 in every 10 people in the
world is aged 60 and over, and percentage figures have also evolved substantially from 1950 until today, particularly in the more developed countries, where their elderly population, into proportion to their total population, has doubled, the highest proportions being observed in the countries of the regions of Europe (22 %), North America (19 %) and Oceania (15 %). Furthermore, the developing countries in the Asian, Latin American and Caribbean regions are converging in the same trend towards a fast and sharp demographic ageing, with proportions of around 10 %, while only Africa currently has a relative figure of little more than 5 % of older adults.

Ageing and its worldwide distribution is the result of two fundamental factors, fertility and life expectancy. In developed countries, a situation marked by a trend of falling fertility and rising life expectancy has been visible for decades, while in developing countries, a rising life expectancy still coincides with a high level of fertility, and the gap between both groups of countries is almost 10 years in Life Expectancy at Birth (78 vs 68, respectively) and one point in the Total Fertility Rate (1.6 vs 2.6, respectively). As a result, 2050 projections (United Nations 2012) predict that 22 % of the world’s population will be 60 or older on that date, a larger proportion of elderly people being seen in the more developed countries, which will have one third of their population in this age group. Meanwhile, countries in the less developed regions will start a period of fast demographic ageing, accounting for a quarter of the population in Asia, Latin America and the Caribbean, and even Africa’s proportion of elderly population will see its current figures double (5–10.4 %). This situation will be accompanied by over ageing or ‘ageing of ageing’, such that 1 in every 5 people aged 60 and over in the world will be 80 or older in 2050, and the proportion of this subgroup of elderly people will exceed 9 % in all the more developed countries, approaching 4 % in the less developed ones.

A direct result of this demographic structure can be drawn from the Total and Old Age Dependency Ratio and Potential Support Ratio figures for 2010 (UN, Population Division United Nations 2013). On a worldwide scale, the Total Dependency Ratio (ratio of population 0–14 and 65+ per 100 population 15–64) exceeds 50 % and is even higher among the less developed countries, particularly in Africa with more than 80 %, attributable above all to the size of its younger population. The demographic ageing is best reflected by the Old Age Dependency Ratio (ratio of population 65+ per 100 population 15–64), a useful indicator of trends in potential support needs, which shows that in the more developed countries, fundamentally of Europe (24 %) and North America (20 %), the world average of nearly 12 people aged 65 and over for every 100 people aged between 15 and 64 is almost double, while in the less developed countries it barely exceeds 10 % in Asia or Latin America and the Caribbean and is little more than 6 % in Africa.

If one considers that only one third of the countries, in general in the more developed regions, have comprehensive social security system plans, the majority of which only cover people who have a job in the structured economy, then less than half of the world’s economically active population would be entitled to that protection (UNFPA and HelpAge International 2012). Accordingly, the dependency ratio situation would be especially critical in the less developed regions, which would explain why, in these regions, 50 % of men and 22 % of women stay on the job market after turning 60 years old, as opposed to 26 % and 15 % respectively in the more developed countries (UN, Population Division United Nations 2012). Complementarily, in these latter countries one also observes a smaller Potential Support Ratio (ratio of population 15–64 per 100 population 65+), that indicates how many potential workers there are per older person. By way of example, one would only find between 4 and 5 potential workers in Europe or North America, respectively, as compared to 10 in Asia or Latin America and the Caribbean or 16 in Africa. As a result, in the developed countries more and more questions are being asked about ways of maintaining pensions systems in the future and, accordingly, the statutory retirement age tends to be higher than in the less developed countries and with a tendency to increase it.

The Old Age Dependency Ratio does not express that all the elderly people in a population depend necessarily on other younger people. However, disability estimates from the Global Burden of Disease study for 2004 show that more than 45 % of the people aged 60 and over, without gender differences,
have a moderate or serious disability (WHO World Health Organization 2011). Once more, a more critical situation is observed between people who live in low-income countries, with a prevalence of between 7 and 12 percentage points more than among the older adult population in high-income countries.

Moreover, to the disability and dependency figures one must add the figures about other living conditions related to the population’s health, like those that have to do with non-communicable diseases (NCD), such as cardiovascular diseases, cancers, diabetes, and chronic lung diseases, that are now the leading causes of death in all regions in the world. Contrary to popular perception, the NCD death rate in 2008 was higher in less developed countries than in more developed countries, with different results by gender, figures between 734 deaths for every 100,000 men and 561 for every 100,000 women, in the former, and 563 and 340, respectively, in the latter (Population Reference Bureau 2012). Although differences exist between mortality rates in more and less developed regions, and particularly also for causes tied to chronic diseases that are normally more prevalent among the older adult population, the fact is that life expectancy at 60 does not differ much from one region to another, even though in all cases it is higher among women, with a gap of 2–4 years always in their favour vis-à-vis men. This would also explain the difference between the sizes of the female and male populations. Consequently, the world average of life expectancy at 60 is 18 more years for men and 22 for women, with 16 and 18 years, respectively, for men and women in Africa, as the region with the lowest figures.

One way to assess whether the family network is available to provide support and care is to consider the living arrangements at older ages and particularly what is referred to as living independently, i.e., either living alone or only with one’s spouse. This is the dominant living arrangement in developed countries, with 3 out of every 4 men and women aged with 60 and over living this way. However, this is rare among older persons in the less developed countries, with only 28 % of men and 25 % of women living alone or only with one’s spouse, and the proportion is even smaller in Africa (UN, Population Division United Nations 2012). Older men are more likely to be married than older women (81 % of older men compared to only 50 % of older women) and sex differences in the proportion married are largest in least developed countries (85 % for men compared to 38 % for women). Furthermore, women are more likely to outlive their spouses because they live longer and are, on average, younger than their husbands, such that older women are more likely to be widowed and living alone (UN, Population Division United Nations 2012). Throughout the world, most of the care given to the disabled population is provided by the family and social network. This so-called informal care is not always available nor is it appropriate, while the provision of formal services is insufficient in many places, in particular in the low-income countries (WHO World Health Organization 2011). Within the family network, care tends to be provided by women of all ages, yet with a significant proportion of elderly women who look after husbands, children and grandchildren (WHO World Health Organization 2011).

Other differences between the world’s regions that affect the population’s living conditions are also seen in the economic context. According to figures from the Population Reference Bureau (2012), the Gross National Income per capita at purchasing power parity (GNIPPP) in 2010 was US$10,760 and 5 times higher in the more developed countries than in less developed regions (US$33,460 and US$5,900, respectively) with an even larger gap if one compares Africa, with US$2,630, and North America, with US$46,400. In the ageing context, investments in pensions systems are regarded as one of the most important means of ensuring financial independence and reducing poverty in old age, in addition to constituting, in times of economic crisis, a main input in many younger population’s households; while the challenge in the less developed countries is still the very development and coverage of social security and health systems (UNFPA and HelpAge International 2012).

The falling fertility and rising life expectancy trends are unlikely to change, so population ageing is now an irreversible phenomenon on a worldwide scale and, according to the general data available, a demographical success especially in the most advanced societies. Even though this entails major challenges in the quality-of-life field, also and particularly for countries in the less developed regions.

The Importance of Quality of Life in an Ageing Society
The longevity revolution has been underway for over a century in the developed countries, this being a consequence of the amazing social development, rather than of biological evolution (Butler 1994). This has kept pace with progress in other technological, socio-economic and public health fields. On another note, as has been seen, developing countries are ageing very rapidly, but at different timing in relation to wealth generation (WHO 2002), so much so that this process will have a very heavy impact on the social and economic fields of these countries.

It is only recent that policy makers and planners have begun being concerned with this ageing phenomenon (Phellas 2013), and especially with ‘ageing of ageing’, in other words, with the rising population aged 80 years or older, more prone to frailty, this being broadly understood as a ‘syndrome of loss of reserves’ in different life dimensions (health, functioning, cognition, socio-economic conditions, social networks) that increase vulnerability (Malaguarnera et al. 2013) and, consequently, the demand for assistance and care services.

In the scientific realm, as a source of knowledge to provide accurate information to society, ageing research is interesting for the purposes of integrating all disciplines around this process (biology of ageing, health, social and behavioural aspects) to improve the quality of life as one ages (Butler 1994). The study of living conditions and quality of life at old age is relatively recent and growing, inasmuch as not only is it positive to live ‘more’ but also ‘better’ and without frailty so as to face up to and prolong the expectations of a good life as one ages.

Increased frailty conditions in the elderly population entails a growing demand for several kinds of needs (personal, health and social services, financial resources, the physical environment, etc.) that, when met, help to face the consequences of ageing. The positive balance between the population’s demands and expectations in their ageing process, on the one hand, and personal perception of the level of satisfaction with them, on the other, is what underlies a good quality of life for individuals. Contrarily, when that balance is negative, this is too. In this context, ageing and quality of life are a social and political challenge, but also for individuals, as society has to provide the resources for ageing well and individuals are ultimately responsible for this.

The rising numbers of the elderly population, its causes and implications are of interest in ageing research insofar as how one ages in good conditions often acts as a cause and at other times as a result of wellbeing and quality of life. Lying behind this scientific interest is social policy designers’ and managers’ concern with the consequences of ageing in different areas, especially about spending on social security and pensions systems and socio-sanitary services (Bowling 2005; OECD 1998; Walker and Mollenkopf 2007). In this respect, maintaining or improving the population’s quality of life as it ages is of extraordinary interest to ensure that older adults remain independent and in their usual residential environment as long as possible (Rojo-Pérez et al. 2007). This would help to ease the burden on the public social services system, but also on the family and the individuals themselves by becoming a resource for society, family and the economy.

Knowing and measuring the quality of later life is useful for assessing the need for social policies but also for assessing the results of these policy interventions. Therefore, its study and analysis is justified by the evidence that quality of life is a desirable goal for people and countries alike, as it produces beneficial results that feed one another or interact. Back in the 1980s, George and Bearon (1980) noted that quality of life is an important issue in both social science theory and social policy, and underpins the interests of basic research, applied research and the population’s social support services. So the question is to know what quality of life is and how individuals perceive and rate it according to their circumstances, to design action policies that help to maintain or improve the quality of life as one ages.

In short, the increased general life expectancy and good health is a positive feature associated with the last century, especially in Western societies. Yet the rising amount of very old people will inevitably lead to...
the incidence of various factors associated with frailty in ageing, especially those related to the decline in health and functioning and other social conditions (Grewal et al. 2006), that must be answered from various sectors (community, family and individual) to minimise the consequences. Hence the great interest of research into ageing and quality of life to provide information to social policy designers and managers and to individuals to face up to these facts.

Quality of Life Theoretical Issues: Concept, Definitions, Components and Objective-Subjective Approaches

The relatively recent interest in the subject of quality of life, and specially regarding the elderly population, could explain why the conceptualisation of this term is not uniformly accepted among scholars. Indeed, one can find as many conceptual approaches as researchers, and that also depends on subject areas and study objectives. It has even been claimed that there may be as many definitions of quality of life as people (Hoe et al. 2011).

In a brief summary of the conceptual evolution, although attempts have been made to see analogies between the term “quality of life” and the notion of “the good life” expressed by Aristotle (Fayers and Mackhin 2007), the emergence of the term “quality of life” only dates back to the 1950s and 1960s to refer to the problems of the deteriorating living environment ensuing from the industrialisation process (Katz and Gurland 1991). It is only later that this term attracts the interest of professionals and scientists from both medical science, because they believed that health was the domain responsible for quality of life, and economists, for whom the material wealth indicator was the primary criterion for measuring social progress (Noll 2002). As this very same author noted, the term “quality of life” emerged in the late 1960s as a non-material alternative to the era’s terminology, dominated by society’s material growth and wealth. Further details of the historic-conceptual evolution of this term can be seen in other publications (Fayers and Mackhin 2007; Noll 2002; Walker and Van der Maesen 2004).

In the scientific realm, the use of the term “quality of life” has been explored by various authors through systematic reviews and by searching in various bibliographical databases. For instance, (Lawton 1991) confirmed that the number of references to “quality of life” rose considerably between 1985 and 1988. Analysing a broader time period, an exponential increase has been observed in the scientific use of the term “quality of life” (Fernández-Ballesteros 2011), especially in medical databases (Martínez Martín and Frades Payo 2006) and, to a much lesser extent, in social science and psychological databases. In the same vein, other authors have noted the development of quality-of-life measuring instruments (Netuveli and Blane 2008), to a very large extent in the health domain (Fernández-Mayoralas and Rojo Pérez 2005), and either as generic or specific instruments (Fayers and Mackhin 2007).

However, despite having a growing scientific use and being a highly topical term, few studies define the concept of quality of life and, consequently, address research based on that definition. For instance, in a recent review of the literature on quality of life in the elderly population, Halvorsrud and Kalfoss (2007) found that 87% of the references analysed lacked any conceptual framework, just over half did not report on the methodological considerations and one third did not express a formal definition of quality of life. This might explain why the term has evolved relatively little conceptually and the fact that its meaning is not uniformly accepted. Most experts steer their conceptual approaches towards their own disciplinary fields (Bowling 2013; Fernández-Ballesteros 2011; Walker and Lowenstein 2009) and the elements deemed most important in each discipline. In this state of uncertainty, quality of life does not suffice as an indicator for tackling the design and planning of social policies.

The most recent literature reviews on quality of life among older adults not only note the absence of an agreed definition of quality of life, but also on how to measure it (Bowling 2005, 2007; Fernández-Ballesteros 2011; Halvorsrud and Kalfoss 2007; Hoe et al. 2011; Kelley-Gillespie 2009; Netuveli and Blane 2008). However, there is a general agreement to consider that, as a concept, quality of life is rather amorphous, hard to measure, multidimensional, multifaceted, and one that affects diverse life domains
observed from different contexts (Walker and Lowenstein 2009) and that can interact (Lawton 1991).

One influential definition was established by Lawton (Lawton 1991), who describes quality of life as “the multidimensional evaluation, by both intrapersonal and social-normative criteria, of the person-environment system of an individual in time past, current and anticipated”. This is a broad definition of quality of life that takes into consideration objective and subjective dimensions that can report on quality of life facets; it is an intrapersonal valuation insofar as quality-of-life aspects can be measured by people in different directions (positive vs negative, good vs. bad) according to intrapersonal standards; the social-normative aspects of quality of life are related to objective facets of life that can be measured; the person-environment system alludes to the possible interaction of the elements of the person-environment duo; the time perspective is related to the dynamic nature of the person/environment system insofar as past events can influence the present and the future, and because the population’s circumstances may change over time. This broad conceptualisation connects with other postulates that recommend the need for a longitudinal approach to measure the dynamic characteristics of ageing’s effects on quality of life (Bowling 2007; Hickey et al. 1999; Martínez-Martin and Frades Payo2006).

Another conceptualisation that is also important in quality of life research stems from the WHOQOL Group (The WHOQOL Group 1995), which defines it as “the individual’s 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 that incorporates the person’s physical health, psychological state, level of independence, social relations, individual beliefs and their relations with their environment. And under this meaning, it emphasises the subjective and multifaceted dimension of quality of life in several domains (physical, psychological, level of independence, social relationships, environment and spirituality/religion/personal beliefs) and subdomains including the positive and negative perceptions of them.

A complementary perspective may be found in the definition given by Cummins (Cummins 1998), for whom quality of life is “a universal construct both objectively and subjectively defined, where the objective domains would include culturally relevant measures of objective wellbeing, and the subjective domains would include satisfaction with different dimensions weighted by their importance to the individual”.

The definitions mention numerous components or aspects of life that might affect the measurement of its quality. Netuveli and Blane (2008) present a taxonomic synthesis of quality-of-life models based on the dual consideration of objective and subjective dimensions and diversity of domains (health, psychological, social) and measuring instruments (general and specific).

In a systematic review of the literature on quality of life components in elderly population, Brown et al. (2004) found the following: family relationships, relationships/contact with others, emotional wellbeing, religion/spirituality, independence/mobility/autonomy, social/leisure activities and community, finances/standard of living, own health, health of others. These same authors concluded that, independently of the type of residence, sample size and methods used, the results are consistent.

More recently, Fernández-Ballesteros (Fernández-Ballesteros 2011) has established a classification of the multidimensionality of quality of life components in old age according to different contexts (individual/microlevel context vs. population/macrolevel context) and approaches (objective conditions vs. subjective perception). The objective perspective refers to personal or environmental characteristics independent of human perception, including demographic, physical environment and residential aspects, economic, social, health and functioning factors, with the result that most of the objective components, be it at the macro or micro level, are similar but measured at different levels (Fernández-Ballesteros 2011). For its part, the subjective perspective relates to how individuals assess their circumstances or life domains (micro level), and to the conditions and stereotypes attributed to a population context (macro level).

The subjective perspective of quality of life is operationalised in different ways, using a wide variety of
indicators, often with meanings that hardly differ from one another, such as wellbeing, subjective quality of life, subjective wellbeing, happiness, life satisfaction, personal fulfillment, moral, affection, self-esteem, control, autonomy, expectations, aspirations, perceived physical and mental health, perception of social network and support, etc., all of which are names derived largely from different types of models (psychological, philosophical, human need satisfaction, health and performance, physical and environmental, etc.).

Just like the term “quality of life”, **wellbeing** is also relatively hard to define and measure. Like other general and omnicomprehensive concepts, it serves to refer to a person’s condition characterised by good health, happiness, prosperity, satisfaction with life, … in short, all positive components. In essence, a subjective wellbeing (Diener and Lucas 1999; Ryan and Deci 2001) that is multidimensional in nature (Demakakos et al. 2010). Beyond a grammatical definition, more characteristic of dictionaries, wellbeing analysis is widely used in the scientific world, yet it is not easy to approach, nor is there an accepted way of measuring it, nor even have boundaries been defined to keep it separate from other concepts such as quality of life. Ever since the 1970s, there has been concern about its conceptualisation, measurement and differentiating between its multiple types (Levy and Guttman 1975). In recent years, many disciplines have approached this concept, each with its own set of meanings and methodology (Chavez et al. 2005; McGillivray 2007; White 2010). However, to mention a few examples, certain authors have opted for some of its basic dimensions, such as the personal one, from psychology (Linley and Joseph 2004; Ryff 1995), from geography, especially related to health geography (Fernández-Mayoralas et al. 2007; Fleuret and Atkinson 2007), or the relational dimension such as sociology – social inequality, participation, support, … (Veenhoven 2008), or the material dimension, within the domain of economics, where it interacts with other material aspects (Gasper 2004; Stiglitz et al. 2009).

On the other hand, the concept of wellbeing has not been free of critical approaches, some connected to its compartmentalisation in dimensions according to various disciplinary interests (Chavez et al. 2005), others to its role in the structuring of developed societies as a ‘collateral victim of late modernity’ (Carlisle et al. 2009); and yet others related to its cultural entrenchment in social environments (White et al. 2012) and developing political societies (Deneulin and McGregor 2009).

Based on the review of the literature to understand the relationship between the concepts used in quality of life and subjective wellbeing, Camfield and Skevington (2008) point out that the subjective perspective of quality of life has pushed aside the objective perspective; and suggest that Subjective Wellbeing (SWB) and subjective QoL are virtually synonyms.

In any case, whatever the study perspective, the analyses are based on designs made by experts or professionals from the disciplines under which the research is broached. In these circumstances, the population’s opinions are not usually taken into account, insofar as the measuring instruments generally used are designed from the expert’s perspective and their study objectives. On the other hand, some authors acknowledge that the population has an intuitive idea of what the term “quality of life” means and can give its opinion even if it does not know the meaning (Bowling 2007; Fayers and MacHhin 2007; Fernández-Mayoralas et al. 2011; Netuveli and Blane 2008). In this regard, a more recent trend is to address methodologies that take account of individuals’ opinions using broadly-designed tools based on open questions about subjective quality of life indicators. This approach prevents the risk of a person’s quality of life or wellbeing being judged by others, avoiding “diminishing empowering people” in evaluating their own wellbeing (Rojas 2011).

The next two relevant studies mentioned have been performed with this methodology. One was conducted among older adults in Spain (Fernández-Mayoralas et al. 2011) and used an ideographic instrument like the SEIQoL-DW (Browne et al. 1997), based on the phenomenological perspective and individual assessment. With this instrument, individuals are asked to mention the five most important areas of their life, rate their level of satisfaction or functioning in each of those areas, and their relative satisfaction. The results of this research showed that, of among nineteen nominated, the five most important areas in the elderly’s quality of life were health, family network, financial situation, social network and leisure and...
free time. Of these, the best rated in satisfaction or functioning terms was the family, but other areas not
nominated as often, like religion / spirituality and residential environment reached a high level of
satisfaction.

Another type of research was conducted in Great Britain (Bowling et al. 2003; Bowling and Gabriel
2004; Bowling 2005, 2007) to ascertain how older people themselves perceive and define a good quality
of life. A dual methodological approach was used. Based on a semi-structured questionnaire, open-ended
questions were asked at the beginning of the survey to elicit the individuals descriptions of both good and
bad quality of life, their prioritisation of these descriptions and the way as their quality of life can be
improved. The themes and sub-themes obtained by this method were subsequently validated through
qualitative methodology using in-depth interviews of a subsample of respondents. The results of both
methods showed that the themes mentioned most often were social relationships, social roles and
activities, other leisure pursuits and activities enjoyed alone, health, psychological outlook and wellbeing,
home and neighbourhood, financial circumstances, and independence. A comparison of the dimensions
obtained in this research with those analysed using several instruments for measuring overall or domain-
specific quality of life in the population concluded that many of the dimensions are absent from these
instruments (Bowling 2007, p. 21).

The controversy about quality-of-life definitions and the appropriate terminology for addressing this
construct, but also the large number of issues in quality of life research from various disciplines, from
health and functioning, epidemiology, psychology, economics, sociology and so on, has led to a wide
variety of measuring instruments and scales being devised to respond to the research questions. No
scale provides a comprehensive view of people’s life nor is it relevant for everyone (Hoe et al. 2011).

In general, there are many measures of quality of life and wellbeing, that are either general or refer to
specific or multiple domains. Similarly, there are several information-collection methods that can range
from the self-reporting type to simple indicators, composite measures and direct observation. Studying
quality of life and wellbeing is even more complex in the case of specific groups of people with some kind
of disease that makes it harder for them to express how they conceive and rate these constructs. Thus, in
the case of people with cognitive impairment or people with dementia, particularly in severe stages, the
proxy method of information can be valid for ascertaining the population’s quality of life and wellbeing
(Blesa González 2006).

The dominant quality of life instruments include those connected with the discipline of physical and
mental health and functioning, insofar as quality of life research has been traditional in these disciplines
and also because, as discussed in other works, very often the approach taken is a reductionist perspective
of quality of life (Fernández-Ballesteros 2011) limited to health issues. In line with the larger amount of
research into health-related quality of life, many of the collections of quality of life instruments are so in
the context of the discipline. In this respect, Fayers and MacHhin (2007), in a book that provides a
comprehensive analysis and assessment of the measurement of quality of life and use of statistical
techniques, compile a list of generic measurement tools (or general-use tools covering a wide range of
health conditions), disease-specific instruments (intended to detect the consequences of specific diseases
in quality of life) and instruments for specific quality of life aspects. In a major compendium of quality of
life consumer-related measures, Sirgy (2001) establishes a classification of instruments according to the
analysis scale (individual, family, regional, nationwide), indicators used (objective, subjective, both), and
the overall or domain-specific approach of the measure.

In this sense, many quality of life measures for the general population have been used as well to analyse
the quality of life of specific groups, such as the elderly population, so a suitable measure must be selected
in order to address the study objective. One section of the Sirgy’s book (2001) is given over to the elderly
population, insofar as it is a growing group and, consequently, may represent consumer potential because
the new-age elderly are better off financially, have fewer health problems and are more satisfied with their
lives. Hoe et al. (2011) conduct a review of measures of quality of life in old age but oriented to quality of
life related to health. There are no comprehensive compilations about the elderly population and from
other non-Health Science disciplines, although the studies of Steward and King (1994), and the more recent reviews of Bowling (2007), Brown et al. (2004) and Fernández-Ballesteros (2011) may be very helpful. Later on, this chapter lists a series of quality of life and wellbeing indicators used in longitudinal studies.

Another topic of interest in quality of life studies refers to its measurement in a given period (cross-sectional measurement), which is useful for comparing living conditions in connection with other variables at the same time. This type of data also enables one to make comparisons of two or more independent cross-sectional studies from different times and samples; however, the direction of the associations between the outcome variable and possible influential factors cannot be ascertained. These are the kind of studies usually conducted, largely due to the availability of this type of data and the fact that it costs less to obtain them. However, the ageing process per se means that the population’s characteristics are always changing, and it is very interesting to know what these changes are, detect if they are prompted by new circumstances, what these are and their impact on quality of life, and what attitudes the population takes throughout their life cycle. If one considers that quality of life at older ages “is the outcome of the interactive combination of life course factors and immediate situational ones” (Walker and Lowenstein 2009, p. 63), then the longitudinal studies would allow this approach and consequently provide information on the cause-effect relations to determine the changing situation of quality of life during the ageing process. This type of analysis has a relatively recent tradition in elderly population. An extensive review of scientific literature on longitudinal studies, either on the elderly population, or on elderly adults, may be seen in Seematter-Bagnoud and Santos-Eggimann (2006).

Measuring Concepts from a Longitudinal Perspective

International research widely recognises the difficulties involved in operationalising concepts such as wellbeing and quality of life, as has been seen. There is no consensus about the concept that has to be translated into measures (Bowling 2009), or about the most suitable types of measures, the simplest vs. the most complex (Bowling et al. 2013), the objective vs. the subjective vs. the general (Chen et al. 2013), or about the factors and dimensions that should be associated (Newton 2007). Even the most established, and largely harmonised international longitudinal studies, have failed to establish uniform measuring instruments (Hauser and Weir 2010).

A review of the elderly population longitudinal studies that are significantly harmonised, and referring to the US Health and Retirement Study from the National Institute on Aging (Table 20.2), have shed light on two important facts: first of all, wellbeing and quality of life indicators are proposed and present in all the studies evaluated yet, secondly, they are not done so homogeneously, although some of them predominate over other more specific instruments that measure emotional distress, positive and negative emotions, the psychological wellbeing or the use of time.

Table 20.2

Longitudinal ageing studies around the world

<table>
<thead>
<tr>
<th>Longitudinal study</th>
<th>Wellbeing – life satisfaction – quality of life</th>
</tr>
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<tbody>
<tr>
<td>Chinese Health, Ageing and Retirement Longitudinal Study (CHARLS)</td>
<td>Single item life satisfaction</td>
</tr>
<tr>
<td>English Longitudinal Study of Ageing (ELSA)</td>
<td>Diener’s 5-item life satisfaction questionnaire; satisfaction with job, satisfaction/perceptions of aging, quality of life scale (CASP 19/12)</td>
</tr>
<tr>
<td>Brazil Study Description (ELSI)</td>
<td>Diener’s 5-item life satisfaction questionnaire; satisfaction with job, satisfaction/perceptions of aging, quality of life scale (CASP 19/12)</td>
</tr>
<tr>
<td>Rand Survey Metadata Repository (2011)</td>
<td>(Made by authors)</td>
</tr>
<tr>
<td>Longitudinal study</td>
<td>Wellbeing – life satisfaction – quality of life</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
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</tr>
<tr>
<td>Health, Aging, and Retirement in Thailand (HART)</td>
<td>Domain-specific satisfaction (physical health, economic status, relationship with spouse, relationship with children, and over-all life satisfaction), quality of life scale: not included in the pilot, but considered for the national baseline</td>
</tr>
<tr>
<td>Health and Retirement Study (HRS)</td>
<td>Single item life satisfaction, Diener’s 5-item life satisfaction questionnaire</td>
</tr>
<tr>
<td>Indonesia Family Life Survey (IFLS)</td>
<td>Diener’s 5-item, single item (Campbell), domain-specific satisfaction (job, financial, health care, etc.): life satisfaction and domain satisfaction (income, health) added in IFLS Wave 3</td>
</tr>
<tr>
<td>Japanese Study of Aging and Retirement (JSTAR)</td>
<td>Domain-specific satisfaction (job, family relationship, friendship) questionnaire, quality of life scale (CASP-19)</td>
</tr>
<tr>
<td>Korean Longitudinal Study of Ageing (KLoSA)</td>
<td>Domain-specific satisfaction (health, financial, spouse, family relationship), quality of life scale (CASP-19)</td>
</tr>
<tr>
<td>Longitudinal Aging Study in India (LASI)</td>
<td>Diener’s 5-item life satisfaction and domain-specific satisfaction (job, financial, family relationship) questionnaire, quality of life scale (CASP-19): not included in the pilot, but considered for the baseline</td>
</tr>
<tr>
<td>Mexican Health and Aging Study</td>
<td>A life satisfaction questionnaire was included in 2003</td>
</tr>
<tr>
<td>Survey of Health, Ageing and Retirement in Europe (SHARE)</td>
<td>LOT-R (Life Orientation Test: pessimism/optimism), quality of life scale (CASP-12)</td>
</tr>
<tr>
<td>Irish Longitudinal Study on Ageing (TILDA)</td>
<td>Diener’s 5-item, single item (Campbell), domain-specific satisfaction (job, financial, health care, etc.), quality of life scale (CASP-19)</td>
</tr>
<tr>
<td>Rand Survey Metadata Repository (2011) (Made by authors)</td>
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</tbody>
</table>

Outside the scope of longitudinal studies, measuring instruments are even more heterogeneous and diverse, attached to specific and particular research strategies, as mentioned above, that depend heavily on data that can be accessed but not always compared with contexts other than those of the research itself, and that pay little attention to harmonisation with general studies, largely longitudinal in nature. Precisely the latter are held in higher regard because they are based on prior knowledge of people’s reality in their ageing process, and they address research holistically (multiple dimensions and factors that affect the population), putting the focus on individuals’ life course in their living environments.

For instance, to judge the practical importance of these measuring instruments in international literature on wellbeing and quality of life in the elderly population, we have selected those that share certain essential traits, namely: having a more general application in longitudinal studies, being supported theoretically in the individual context of wellbeing and quality of life from a holistic approach, and considering several joint parameters of people’s behaviour to form a global index, rather than just assessing some aspects of life satisfaction. In this respect, the CASP instrument seems to be the most adequate and widely used. There are two essential versions of this instrument, CASP-19 and CASP-12. The first is an index formed by 19 questions asked in a positive and negative sense and structured in four fundamental domains, ‘Control’, ‘Autonomy’, ‘Self-realisation’ and ‘Pleasure’, whose initials are used to form the instrument’s name. Each item is assessed on a four-point Likert scale (rated ‘this applies to me: often, sometimes, not often, never’). The resulting scale scores are summed to form an index that ranges between 0 and 57 (Blane et al. 2008; Howel 2012; Zaninotto et al. 2009), with the highest reporting a higher perceived quality of life in the 4 domains, and vice versa. While control and autonomy document individual capabilities (interaction with the environment and freedom of action), the other domains reflect a personal construction effort (Netuveli et al. 2007; Sim et al. 2011).
This instrument’s design is based on theoretical approaches associated with satisfying individual needs in the social environment (Bowling 2009), but not in the medical or biological sphere (Higgs et al. 2003; Blane et al. 2007; Sim et al. 2011), and is intended to be applied to adults and elderly people overcoming negative stereotypes often applied to this life stage (Jenkins and Mostafa 2013). Precisely this is a period in which ‘there is room for reflection and pleasure’ (CEDEFOP 2012) or the relaxation of family ties (Howel 2012). Even so, this instrument is evidently linked to other dimensions of the individual, like health and physical functioning (Breeze and Stafford 2010) or economic resources and social networks (Wiggins et al. 2004). Although in more complex analyses, each of the four domains can be used separately, they are worth less than when used together, with a large degree of internal consistency and other psychometric properties (Blane et al. 2004; Wiggins et al. 2008; Zaninotto et al. 2009; Sim et al. 2011).

The second, CASP-12, is an abbreviated instrument with only 12 questions, 3 in each domain, which has also been validated psychometrically, statistically well-related with CASP-19 and therefore recommended for application in subjective wellbeing and quality of life studies (Wiggins et al. 2008), although it may have a certain ceiling effect (Howell 2012).

CASP-19 tends to heavily complement other instruments that measure aspects of wellbeing or people’s other dimensions. The fundamental idea that emerges from the research carried out in the environment of longitudinal or similar studies is that many of these instruments preferably suit one of the dimensions and that they are statistically related to each other when used as triangulation and validation components. For instance, CASP-19 is related to other simpler life satisfaction measures such as Diener’s Satisfaction with Life Scale (SWLS), evolving in the same sense as CASP-19 (Sim et al. 2011) or to the Life Satisfaction Index (Hyde et al. 2003).

As was to be expected and like others instruments, CASP-19 is subject to certain limitations. The most evident is the difficulty of apprehending broad and complex concepts, such as quality of life and wellbeing (Walker and Mollenkopf 2007), with synthetic instruments that fail to appreciate transitions between processes, relations between generations or cultural differences (Niedzwiedz et al. 2012), or between different populations in diverse contexts (Sim et al. 2011). There are just as many problems with obtaining self-reported information, ceiling and/or floor effects or the different internal consistency of the instrument’s four dimensions (Sim et al. 2011), or the loss of sample in longitudinal studies with various waves (Zaninotto et al. 2009).

In the field of health-related quality of life, CASP-19 has often been triangulated with more specific instruments like WHOQOL-OLD (World Health Organization Quality of Life, Older adults questionnaire) (Power et al. 2005) or OPQOL (Older People’s Quality of Life) (Bowling 2007, 2013). Compared to WHOQOL-OLD, CASP-19 is an independent instrument in the sense that it is not a module of other, broader questionnaires (like WHOQOLD-OLD), and is designed from the perspective of the positive sense of quality of life, moving away from the orientation towards health-related quality of life (Zaninotto et al. 2009). Even so, it evolves in the same direction as other instruments that measure health-related quality of life, so high scores in CASP-19 also tend to match high scores in SF-12 (Sim et al. 2011).

Another instrument widely used in harmonised longitudinal ageing studies (Table 20.2) is the Diener’s 5 item life satisfaction scale. This scale is a short 5-item instrument designed to measure global cognitive judgments of satisfaction with one’s life. Participants indicate how much they agree or disagree with each of the 5 items using a 7-point scale that ranges from 7 (strongly agree) to 1 (strongly disagree) (Diener et al. 1985). The scale shows a valid and reliable measure of life satisfaction, and is suited for use with a wide range of age groups and applications, which makes possible the savings of interview time and resources, compared to many measures of life satisfaction (Pavot et al. 1991). This scale has shown sufficient sensitivity to be potentially valuable to detect change in life satisfaction during the course of clinical intervention (Pavot and Diener 1993).

The longitudinal study review (see Table 20.2) has failed to detect any study that uses either of the
quality of life measuring instruments designed specifically for the elderly population, WHOQOL-OLD or OPQOL. The first was designed by the WHO and is an adaptation of the WHOQOL to assess the older adult population’s quality of life. It consists of 24 items structured in six dimensions (1- sensory abilities; 2- autonomy; 3- past, present and future activities, 4- social participation, 5- death and dying, 6- intimacy) (WHO 2008; The WHOQOL Group 1998; Lucas-Carrasco et al. 2011) of four items each, in a 5-point Likert scale, but with differing assessment terminology (not at all to an extra amount; completely/extremely; very poor to very good; very unhappy to very happy; very dissatisfied to very satisfied). Higher scores indicate higher QoL. This instrument has been tested in the elderly population of different countries (Bunot et al. 2012; Power et al. 2005; Lucas-Carrasco et al. 2011) with good results and psychometric properties for measuring the quality of life in elderly people. However, Bowling (2007) notes that the questionnaire is still being tested, is very long and the scale on which it is presented is difficult, especially for use with the elderly population. Fang et al. (2012) have developed several smaller versions of this instrument and tested its psychometric properties, yet in doing so have lost the multidimensionality of the full version.

The 35-item OPQOL instrument was originally designed on a broad conceptual basis and considering the older individuals’ own perspective (Bowling 2009). This scale measures the level of disagreement/agreement in a 5-point Likert scale (strongly disagree to strongly agree) about several spheres of life: life overall, health, social relationships and social participation, independence, control over life and freedom, home and neighbourhood, psychological and emotional wellbeing, financial circumstances, culture and religion. An abbreviated version (OPQOL-brief) has been developed subsequent (Bowling et al. 2013). The scale has proven to be more valid and reliable than other quality of life measures like CASP-19 and WHOQOL-OLD (Bowling et al. 2013), and compared to the latter, covers a broad spectrum of life domains rated by the elderly population itself, although its psychometric properties are more modest when an ethnically diverse population is involved (Bowling 2009).

In short, the elderly population is a heterogeneous group and assessing its circumstances is a challenge to be tackled in the scientific realm. Therefore, within the wide range of scales that measure quality of life and wellbeing, it would be ideal to choose and include a measuring instrument that is brief, simple to use and understand, and that is valid, reliable and sensitive to change (Hoe et al. 2011) but that also includes the relevant items for addressing the multidimensionality of quality of life in old age (Bowling 2007).

Quality of Life Associated Factors Throughout Longitudinal Studies

As explained earlier (Table 20.2), CASP-19 and other similar instruments appear quite generally within the set of tools used to assess the situation and conditions in which the population ages, as reflected in various studies; and those that have been in use longest have managed to transfer their experience to others that have appeared more recently. The former include the US Health and Retirement Study (HRS), the UK’s English Longitudinal Study on Ageing (ELSA) and the Study on Health, Ageing and Retirement in Europe (SHARE) (Blane et al. 2007; Cardona 2010; Howel 2012; Schuller et al. 2012). Although other longitudinal studies reportedly used CASP (Brazil, Japan, India, Korea,…) no wellbeing and quality of life analysis and publications based on their data have been found. Its use is also widespread in other cross-sectional and smaller-scale studies (Wiggins et al. 2008; Zaninotto et al. 2009; Wikman et al. 2011; Schuller et al. 2012). A further use has been in assessing the influence of multiple dimensions of individual wellbeing, in order to generate explanatory models that employ a range of personal, social, economic, health and cultural factors in a fairly complex manner. Even though regularities can be found in how these factors influence individual wellbeing, it is not always the same factors that are associated with wellbeing, nor do they influence it in the same way.

From a demographic viewpoint, it seems to be a general rule, essentially using data from the English Longitudinal Study of Ageing (ELSA), that the younger elderly report higher CASP values than their elders, together with other explanatory factors, such as ties to the place of residence or its degree of
economic deprivation (Gilleard et al. 2007), or placing under control other factors, such as socio-economic status or depression (Netuveli et al. 2006; Banks et al. 2010). Some studies go so far as to establish a specific age (68 years), after which a change is noted in the assessment of wellbeing (Netuveli et al. 2006), with individual wellbeing following a downward trend as age increases (Banks et al. 2012), and other studies have even recorded a loss of 1.8 points in the wellbeing indicator between each longitudinal wave (Zaninotto et al. 2009; Banks et al. 2010).

However, people’s life course does not seem to have a bearing on how they rate their wellbeing upon reaching later ages (Blane et al. 2004). The door remains open to clarifying age’s effect when other factors can be analysed in a more complex way, especially the degree of general wellbeing that society does (or does not) enjoy at any given time. In such cases, the older-elderly might tend to “subjectively compensate” for the loss of wellbeing by better adapting to their social or community environments (Motel-Klingebiel et al. 2009).

In contrast, longitudinal studies have found no conclusive evidence of a relationship between gender and wellbeing assessment. As with age, gender exerts its influence through other factors, and its role remains difficult to identify individually. When this happens, women seem to express (slightly) higher scores than men in wellbeing and quality of life indicators (Netuveli et al. 2006; Zaninotto et al. 2009), except when men are living with a partner, in which case they are more satisfied with life. However, when the influence is exerted from other aspects of life such as depression, the relationship exists in the opposite direction (Wikman et al. 2011).

Other socio-demographic factors, like education (Litwin and Stoeckel 2013), have recognisable effects on wellbeing, but sometimes these effects are mediated by health or economic resources (Newton 2007).

Without a doubt, socio-economic factors tend to have the strongest influence on perception of quality of life and individual wellbeing. The general rule that is established is normally regarded as being true: the more financial means you have throughout your working life, the higher you rate your wellbeing, as has been documented in various studies with European longitudinal data like the English ELSA (Banks et al. 2012) or the Irish TILDA (Barrett et al. 2011). Even so, this relationship is qualified by certain very important aspects. One is that research does not distinguish between economic resources and other dimensions of individuals’ lives, such as health, well above other determinants (social networks, community participation) (Blane et al. 2004) that very clearly remain in the background. These authors refer precisely to economic and health resources as ‘the infrastructure of people’s quality of life’. A second aspect has to do with the role played by economic resources (or economic standing in general) in the assessment of individual wellbeing, and the influence of other phenomena such as depression or loneliness. In such cases the relationship stays in the same direction: the greater one’s economic wealth, the less depressed or lonely one feels (Banks et al. 2010). A third fact to consider is how the assessment of quality of life upon the retirement is affected by the importance of the individual’s life course (Von dem Knesebeck et al. 2007), through specific pre-retirement events, such as home ownership, enjoying early retirement, the effects of disabling processes, the impact of ‘structural dependence’ processes, etc. (Blane et al. 2004).

Not to be overlooked is another interesting relationship discovered in longitudinal wellbeing studies using SHARE data about several European countries, namely how quality of life is influenced by the effects of social services under the welfare state in certain countries (Motel-Klingebiel et al. 2009). When establishing a comparison between countries in assessing the importance of economic resources as determinants of quality of life, the differences between countries tend to be defined very clearly (Von dem Knesebeck et al. 2007), in the same way as the differences between population subgroups within a country, from different patterns of behaviour in people’s activities (‘social productivity’ in the terminology of Wahrendorf et al. 2006) and in the transfers of care received and given (Ateca-Amestoy and Ugidos 2013), in terms of efforts, rewards and reciprocity (Siegrist and Wahrendorf 2009).

Worth mentioning too is another unique feature that affects the determination of what economic resources
are deemed to mean, and the indicators employed derives largely from the characteristics of the database used. Without being exhaustive, there is very wide range of variables, such as home ownership, obtaining social benefits of a monetary nature, (Blane et al. 2004), owning vehicles (Netuveli et al. 2006), savings and debts, or receipt of non-pension related income. Its effects are not always assessed in the same direction, due to the use of absolute or relative values, as noted by Newton (2007) who, referring to several studies in the UK, warns that “high aspirations and expectations have negative impact on subjective wellbeing (SWB) yet are raised by higher incomes. This reinforces findings that perceptions of financial status have stronger predictive power than actual income” (Newton 2007, p. 14).

Similar controversies can be identified when using subjective socio-economic indicators, such as economic self-positioning of the individual or household, the use of class or social status indicators and their effects on quality of life indicators (Netuveli and Bartley 2012) through hypotheses such as the ‘social gradient’ or ‘different groups’ (Blane et al. 2007), or assessing household spending or its material needs (Newton 2007).

Learning formal and informal activities plays a very prominent role in retirement as a socio-economic indicator that predisposes a positive assessment of individual wellbeing, as Jenkins and Mostafa (2013) have demonstrated using ELSA data, differentiating its effects by age groups and gender in relation to the type of learning. Other indirect economic value factors, such as perception of the general or residential environment (noise, hazards, deterioration, insecurity) have far more diffuse effects (Newton 2007; Mottus et al. 2012).

As mentioned earlier, health is one of the most salient factors that are best associated with assessing wellbeing and quality of life, playing a fairly well-defined role: the better one’s diagnosed or referred health, the higher the level of wellbeing, as demonstrated in some longitudinal studies (Barrett et al. 2011; Steptoe et al. 2012) and systematic reviews (Chen et al. 2013). Unlike economic resources, health is identified by a set of physical (long-term illness) and mental indicators (depression), that impact people’s functional limitations (mobility difficulties) (Blane et al. 2004; Netuveli et al. 2006), especially when age advances (Blane et al. 2007). According to Cardona (Cardona 2010), functional physical impairment is an essential determinant of satisfaction with life, and through this criterion, of quality of life in general. A controversy arises when analysing the effect of both the physical and mental dimensions, in the assessment of quality of life measured by complex indicators, and although no general rule can be singled out, psychological factors seem to play a larger role in reducing the quality of life (Zaninotto et al. 2009).

When controlling for other social factors, having or not having any chronic diseases is a decisive factor in the reduction of individual wellbeing, even though the effects of several kinds of diseases do not always move in the same direction and as strong as one another (Wikman et al. 2011), not so much on account of the risk of death that they may involve, but because they limit the performance of daily activities. Indeed, these limitations also have a negative bearing on the reduction of individual wellbeing (Banks et al. 2010), which becomes stronger when this relationship is measured longitudinally. When the relationship is established with anthropometric measures, no meaningful relationships are seen, probably because its effect has already been included when respondents reported a poor state of health, as a global factor. However, there is another health component, the strain involved in caring for people when the caregiver is elderly, especially in the case of the husband or wife, which is also clearly identified as a factor that tends to reduce people’s wellbeing. This is influenced by three elements: the number of hours spent caring, the number of people cared for and the sense of having a duty to provide care (Banks et al. 2010).

Finally, an interesting issue in the context of research into quality of life and wellbeing in older population, from a longitudinal approach, is the study of how different geographical and cultural environments affect the assessment of individual wellbeing. The main problem faced by many studies of this kind, which rely on surveys as their data collection method, is questionnaire standardisation. More than often, they are not standardised, making them very difficult to compare, especially in the event of a comparison between countries. If the measures can be standardised or harmonised proxy measures are used, the problem is likely to be solved (Netuveli et al. 2007; Motel-Klingebiel et al. 2009; Niedzwiedz et al. 2012), by using...
data both from longitudinal studies and systematic bibliography reviews. However, when the objective is to compare individual wellbeing in different geographical areas, it is found that, indeed, and within Europe, the Northern countries differ clearly from the Mediterranean countries when one analyses individual wellbeing indicators based on several reference longitudinal studies in the UK and Europe (SHARE) (Netuveli et al. 2007; Siegrist and Wahrendorf 2009; Ateca-Amestoy and Ugidos 2013), or the type of wellbeing system (Motel-Klingebiel et al. 2009; Siegrist and Wahrendorf 2009). If the inequalities are established between groups with cultural, ethnic or racial differences, the interpretation of the cultural effects on the assessment of individual wellbeing is not so evident or easy to address (Niedzwiedz et al. 2012) because there are plenty of possible general factors that may be interfering with that interpretation.

In conclusion, scientific analyses of the quality of life and wellbeing of older people exhibit results that have both common similarities and many differences, due to the difficulties to standardize the conditions for the analysis. This does not prevent, however, that these can be translated to society when care policies for the elderly are implemented by policy makers and governments.

**Quality of Life and Wellbeing at Old Age: Policy and Scientific Interests**

Political interest in quality of life and wellbeing in old age is not new, as evidenced by the International Plan of Action on Ageing adopted by the United Nations at the first World Assembly on Ageing held in Vienna in 1982 (United Nations 1983). The Preamble of this plan acknowledges that “…quality of life is no less important than longevity, and that the aging should therefore, as far as possible, be enabled to enjoy in their own families and communities a life of fulfillment, health, security and contentment, appreciated as an integral part of society”. However, most of the recommendations to be found throughout the Plan are for governments, institutions, organisations, etc., even for families and caregivers, while the older person is regarded as a passive subject whose health, safety and wellbeing must be protected.

More recently, ageing policies have been overhauled in line with a series of paradigm shifts whose origin lie in the Political Declaration and Madrid International Plan of Action on Ageing adopted by the Second World Assembly on Ageing in 2002 (United Nations 2002). This is an ambitious programme to address the ageing challenge in the twenty-first century in three priority areas: older persons and development; advancing health and wellbeing into old age; and ensuring enabling and supportive environments. Both Political Declaration and Plan of Action were joined by a Policy Framework of the World Health Organization to the Second United Nations World Assembly on Ageing, which recognises the success of public health and economic and social development policies in the achievement of an ageing global population, but also the need for a positive experience, that is, active ageing, defining it as “the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age” (WHO World Health Organization 2002).

These United Nations action frames have organised the political and research strategy guidelines over the last decade all over the world, and prompted paradigm shifts in active aging policies in order to enhance quality of life. The first has to do with individuals being regarded as active players and responsible, therefore, for their ageing process, a responsibility that they share with society, which has to provide appropriate political, legal and societal structures that offer more opportunities for individuals to age actively. In this respect, policies on active ageing are intended to improve both societal wellbeing and individual quality of life. The second paradigmatic shift focuses on regarding old age as the result of a process rather than a status, in other words, adding a life-course approach that recognises that older people are not one homogeneous group and that individual diversity tends to increase with age. The third shift comes from the mainstreaming of gender and equal opportunities for men and women, in the recognition that both experience old age differently, that gender relations structure the entire life course, influencing access to resources and opportunities, and that women are more vulnerable to discrimination in areas such as employment, education, health, or ill-treatment. Finally, there has been a general and conceptual shift, in the sense that active ageing would be a broader and more inclusive concept than
others such as successful ageing, healthy ageing or productive ageing, and its development, based on three pillars -health, participation and security-, would make it possible to include the whole population as it ages, without putting the focus only on one of its dimensions, although health always appears as being most influential on people’s quality of life and wellbeing.

In an active ageing framework, policies and programs that promote mental and social connections are as important as those that improve physical health status, as the first pillar underpinning active ageing. A life course approach would support the inclusion of preventive, curative and long-term policies, that is, policies to promote health and healthy lifestyles, disease prevention, development of rehabilitation services and new technologies. Meanwhile the gender perspective supports policies for equality between men and women in the field of health and access to services. Co-responsibility between individuals and society also underpins policies aimed at training the people who look after and care for elderly people, including elderly people themselves. Not forgetting long-term care in community care settings for frail elderly people or the development of care systems for ageing at home.

Active ageing is also an integrating concept in its participation pillar that includes social, economic, cultural, spiritual and civic affairs, not just the ability to be physically active or to participate in the labour force. A life course approach pursues the inclusion of all ages and the promotion of intergenerational solidarity, and would be a cornerstone of policies for the flexibilisation of working careers, breaking down the barriers between its three traditional phases: qualification phase, working phase and retirement phase, and allowing the employment effort to be distributed throughout life and access to learning and promotion at all ages. One particular aspect would be policies for promoting volunteer work and leisure activities to improve social inclusion. Meanwhile, the gender perspective would favour equality in the realm of family, social and support networks, and in labour market participation, and underlies policies designed to foster a the work/life balance for men and women alike. Policies against discrimination in any field and improving the image of old age must serve to make individuals and society share responsibility.

The third pillar of the active ageing framework has to do with security, also understood in a broad sense that encompasses financial income security and the fight against poverty in old age, an adequate protection, security and care when people require assistance, and a secure physical and social environment. Policies designed to develop social security and pension systems are based on this pillar and on society’s responsibility through government regulations. On another note, the promotion of age friendly environments, including aspects such as the dwelling’s location, barrier-free access to services, the distance to friends and relatives or an adequate work environment, would contribute positively to staying autonomous and independent in old age and staying on the labour market. Other policies in this field have to do with ensuring safe social environments, preventing and avoiding elder abuse, through information for its recognition and the involvement of all sectors of society, including older people themselves.

In short, the growth of the older population throughout the world, the political and social interest in tackling its causes and consequences and the need to design public policies to extend the quality of life of older people are reasons that underlie the scientific interest in addressing these problems. As stated, scientists still fail to agree on the different aspects of quality of life and wellbeing (definition, study methods, tools, domains), and no less complicated is the study of these constructs in elderly population subject to some type of cognitive impairment. Research from the life course perspective adds a further complexity. Yet scientists are not unaware of this problem, hence the wealth and complementarity of quality of later life studies with which to ascertain the heterogeneity of this population, its needs and expectations.

The continuing lack of agreement about quality of life studies must be solved by combining several facts, including the following: (i) the building of a greater consensus about how to define and measure quality of life, but also considering regional and cultural specificities; (ii) research into quality of later life also requires a greater theoretical impetus and strengthening of the multidisciplinary perspective to understand the integration of the different quality of life domains; and (iii) a more older-person centred approach is needed to delve deeper into their circumstances, perceptions, experiences and expectations, and thereby...
assist in defining the quality of life concept.

The European Union, to quote just one example, has committed heavily to ageing research, and several years ago began funding initiatives like the European Research Area in Ageing (ERA-AGE) and ERA-AGE 2 programmes, within the European Research Area Network scheme (ERANET), as a basis for coordinating ageing research in terms of research projects, postdoctoral fellowships, summer schools for future leaders in ageing research in Europe and other actions to promote research in aging. More recently, the FUTURAGE (A Road Map for Ageing Research) programme has sought to create the multidisciplinary strategy in ageing in Europe, for the next years 15 years from seven priority areas.

Some of the key contents to be researched and detected in these initiatives have been included in the new instrument for future research in Europe, Horizon 2020. Its many outstanding aspects include orienting future research to solving social challenges, one of which is demographic change, essentially population ageing, associated with people’s health and wellbeing. Although there is a clear relationship between health and wellbeing, it is not so obvious that definite steps have been taken to conduct a detailed analysis of wellbeing as a measurable concept, even if this wellbeing stems from the improvement of the population’s health conditions, and from measures to improve food and weather conditions. The development of work programmes in the next few years must steer future research in this field. Also in connection with individual wellbeing, emphasis is placed on active ageing as an expected and desired outcome of improved health conditions, but there is no description of what it means to age actively and how to analyse and foster it as an instrument for improving the quality of life of older people. However, there are several initiatives within the European Union that promote scientific cooperation in the field of ‘active and healthy ageing’ to access financial resources. Worth highlighting are the ‘European Innovation Partnership on Active and Healthy Ageing’ (http://ec.europa.eu/research/innovation-union/index_en.cfm?section=active-healthy-ageing) and the ‘Joint Programming Initiative’ ‘More Years Better Lives. The challenges of the demographic change’ (http://www.jp-demographic.eu).

In short, the general concepts such as demographic change, wellbeing or active ageing are present in many of the European Union’s programmatic documents. Yet these concepts are not developed when it is a matter of defining major research topics that, in the field of ageing, mainly refer to caring for the population’s health, the treatment of diseases and the use of applicable technologies in the older person’s life.

In the light of these facts, one would hope for an increase in research into the elderly population and quality of life and its interaction with various disciplines whose study objectives include improving quality of life as one ages. Hopefully too, this research effort will succeed in transferring results to the public sector but also to society and the elderly, insofar as research methods are supplemented by new methodologies that recommend engaging the studied population itself in the research process.

References


