

# Active Ageing and Personal Wellbeing Among Older Adults in Spain

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## Synonyms

Active ageing; Active Ageing Index (AAI); Lay -perspective; Personal Wellbeing Index (PWI) of older Spaniards; Qualitative methodology; Quantitative methodology; Subjective Wellbeing (SWB)

## Definition

This essay offers a summary of **personal wellbeing** and describes its relationship with sociodemographic parameters and other relevant **quality of life (QoL)** domains, as well as its association with **Active Ageing (AA)**. Based on a positive and holistic viewpoint, **AA** is constructed around **various four pillars** (health, **lifelong learning**, **participation**, and **security**) and interacting determinants that indicate whether a person is experiencing an **active ageing AA** with good **quality of life (QoL)** (WHO 2002; ILC-BR 2015). In this paradigm, QoL is structured as an outcome measure of AA. Based on the seminal conceptualization of **AA**, the

Active Ageing Index (AAI) has been designed to identify the level of AA in Europe (Zaidi et al. 2013). As an indicator of QoL, the Personal Wellbeing Index (PWI) has been developed to evaluate subjective wellbeing in its global and domain-specific contexts (IWG 2013). Other qualitative sources are used in this essay to analyze the lay perspective of the relationship between the two constructs, of AA and QoL.

## Description

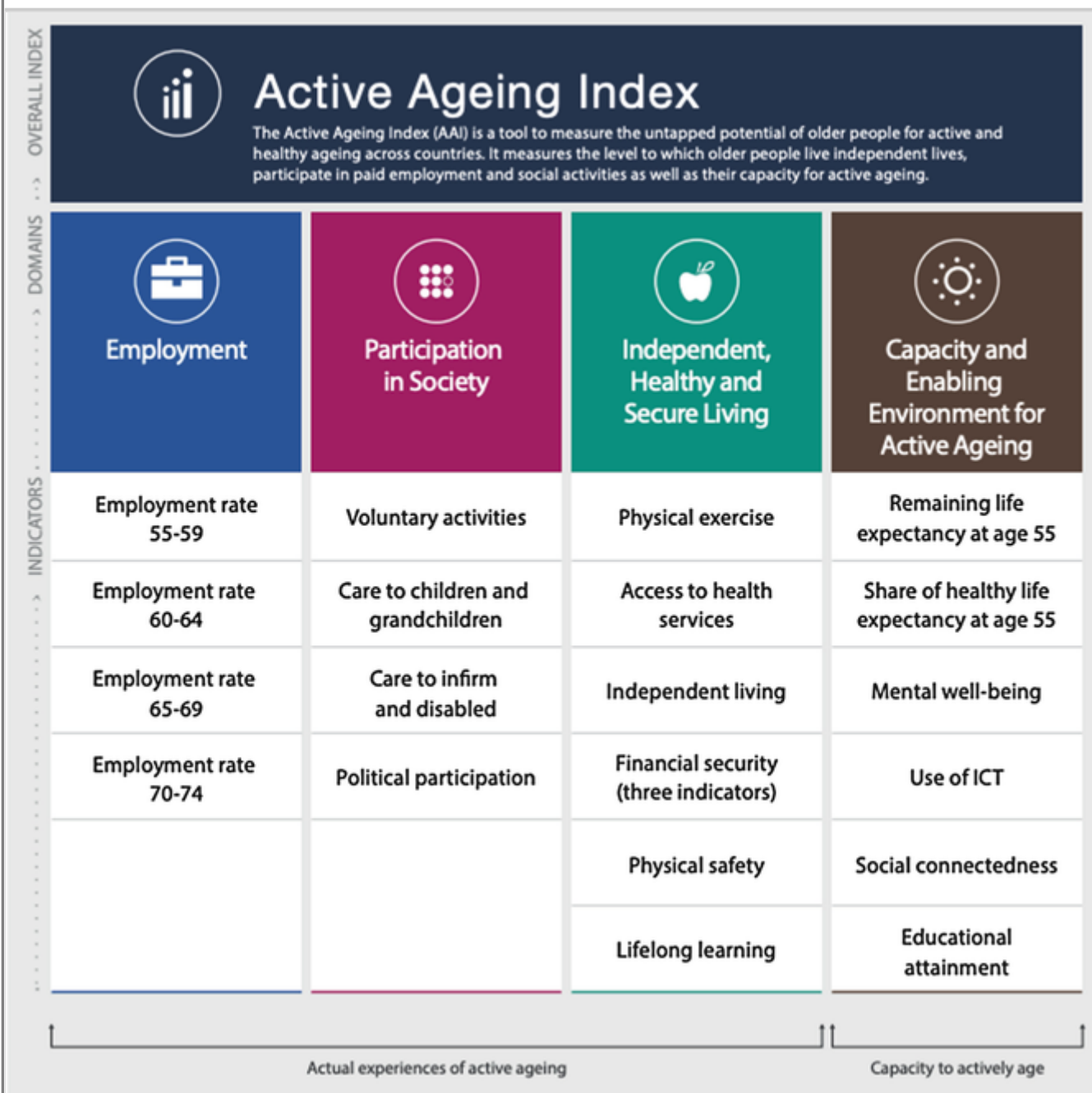
### Methods Used to Research on Active Ageing and Quality of Life Among Older Persons in Spain

Essential contemporary social research strategies include cross-sectional and longitudinal studies, objective and subjective measures, and a combination of quantitative and qualitative methods. The use of validated and comparable scales and instruments is one of the outstanding challenges in the analysis of social phenomena, regardless of the meaning and function of the indicators constructed for the geographical area in question. This point has been made in many international scientific references (Yang 2014; Bericat 2019; Corlet-Walker and Jackson 2019).

The AAI offers a macro view that is analogous to the PWI, using the basic geographic and statistical scale in Spain (the region) and based on the AA paradigm as the theoretical reference point. The AAI was established in 2012 and designed to cover the social, economic, and environmental dimensions affecting older adults in Europe. Its 22 indicators were clustered in four domains (employment, participation in society, independent, healthy and secure living, and capacity and enabling environment for AA). The AAI is constructed by using the subnational entities for which secondary data are available in Europe. The indicators comprising the employment domain measure the proportion of people working in different age groups (UNECE/European Commission 2019). Participation in society relates to aspects concerning the activities carried out by older people, including caring for different family members, volunteering and political involvement. Economic components are measured to gain insights regarding the extent to which older people have healthy, independent, and secure lives according to the AA pillars (physical exercise, access to health services, being able to live independently, financial security, physical safety, and lifelong learning). In turn, the fourth AA domain is designed to reflect the degree to which individuals are living in an environment that enables AA. It does so by taking into account personal capacities (healthy life expectancy, mental wellbeing) as well as social factors (ICT use, friend and family relationships, and education) (Fig. 1).

#### Fig. 1

AAI components and indicators. Source: AAI project. <https://statswiki.unece.org/display/AAI/Active+Ageing+Index+Home>



As shown in Fig. 1, many of the components of **AAI** are dimensions related to the wellbeing and **QoL** of older people (Petrová Kafková 2018; Lardies-Bosque et al. 2015; Rodriguez-Rodriguez et al. 2017, 2017b; Zaidi 2017; Zaidi et al. 2017). Of the many instruments that can be taken into account when researching wellbeing, the **PWI Personal Well-being Index** was designed as a **tool an instrument** to study the subjective dimension of **quality of life QoL** of the general population (IWG 2013). The **PWI** has been used with older adults in community dwellings in Spain as part of the Spanish Longitudinal Study of Ageing (**ELES Project**: <http://proyectoeles.es/>), with a weighted sample of 1,357 individuals.

The aim of the **ELES project** is to analyze **ageing** among the Spanish population, based on monitoring of population cohorts born after 1960 and deploying an interdisciplinary scope. The project has combined various strategies to collect data in several biological and physical areas (biomarkers such as blood and saliva, stress exercises, and anthropometric measurements), as well as certain dimensions of older adults' lives (such as demographic, social and economic resources, life behaviors, physical and psychological health, residential environment,

work/retirement, and leisure activities). ~~via~~ Data collection methods ~~such as~~ was set up in several phases through telephone interview, nursing visits, computer-assisted personal interview (CAPI), and self-administered questionnaires. More information on the ELES project is available elsewhere (Rodríguez Laso et al. 2013; Teófilo Rodríguez et al. 2011).

AQ3

Satisfaction with living conditions among older individuals and their Please, note that the term "personal wellbeing" is to be included as index term under "personal wellbeing".

I did not it as the electronic system did not allowed me to do it. personal well-being have been treated as fundamental to the overall structure of the ELES Project, as a key research issue in Spain. In addition to overall satisfaction with life and other domains relevant to QoL for older adults (Fernández-Mayoralas et al. 2011), the PWI was selected due to its widespread use in social research, its relationship with other available instruments designed for the same purpose, and its validation in different geographical and cultural contexts and among diverse demographic groups (Rojo-Perez et al. 2012). The PWI was included in the CAPI questionnaire, in line with the practice of other studies (Cummins et al. 2014; Jovanović et al. 2019; Richardson et al. 2016).

To avoid the difficulties experienced by individuals in rating life satisfaction by using the two-way dissatisfaction-satisfaction response scale (IWG 2013), the ELES pilot study used the PWI on a 1–10 unipolar response scale anchored by “not satisfied at all” and “completely satisfied” in order to obtain a response concerning satisfaction with the eight life subdomains (standard of living, health, achieving in life, relationships, feeling of safety, feeling part of the community/community connectedness, future security, and spirituality or religion). The item scores can be used individually or to produce a PWI composite index offering an average satisfaction level for the eight subdomains.

The data on overall or domain-specific satisfaction from the PWI have been standardized in units ranging from 0.0 to 100.0. The PWI was designed as a transculturally valid measure, has been translated into different languages, and has been validated and used in multiple studies (Cummins and Theofilou 2013). ~~Just~~ to refer to ~~only~~ some of the more recent publications in this regard, the PWI has been used with data from the general Indian population (McIntyre et al. 2019 first online), from Australia, Bosnia and Herzegovina, Croatia and Serbia (Jovanović et al. 2019), and from the child population (Tomyn et al. 2016). It has been validated in Spain and for the older adult population by Forjaz et al. (2012), Rodríguez-Blazquez et al. (2011), and Rojo-Perez et al. (2012).

In order to supplement the quantitative results and from a lay perspective, this essay also ~~takes into account~~ allows the understanding and perceptions of older adults themselves in relation to their AA and QoL. This has been achieved by applying a qualitative methodology. Research that provides a joint analysis of AA and QoL remains scarce, and this is particularly the case with respect to the use of qualitative methodologies (Rojo-Pérez and Fernández-Mayoralas 2020, forthcoming). The usefulness of this methodological approach lies in the fact that it places the person in the prominent position in the study process (Tonon 2015). To this end, in the present work a qualitative study with ~~semistructured focus groups and in-depth interviews was run in several residential environments. The study involved~~ in-depth interviews (with older adults in family housing and cohousing, and key informants at senior centers, institutional services centers, and civil society organizations); as well as focus groups (with older adults at long-term residential homes and participants at senior centers) was run.

Fieldwork was carried out from April to June 2017. An intentional sampling strategy was used based on the context being studied. Bioethical/biosecurity aspects were approved by the CSIC Bioethics Subcommittee. Interviewees signed an informed consent form. Thematic and content analyses were applied using ATLAS.ti. Interviews were coded based on theoretical approach (in line with the scientific literature) and the meaning of the emerging discourse (grounded in the data). More detailed information regarding the design of this qualitative study can be found in Fernández-Mayoralas et al. (2020, forthcoming).

## Active Ageing in Spain

Following the UNECE recommendations (UNECE/European Commission 2019), various approaches have been implemented in order to measure the AAI on national and subnational scales in Spain. These attempts have been made in spite of the difficulties of matching the statistical data and indicators to the Spanish scenario (Bacigalupe et al. 2018; Del Barrio et al. 2018; Marsillas et al. 2017; Rodríguez-Rodríguez et al. 2017, 2017b). The AAI results reported to the EU show that Spain scores lower than the EU average, forming part of the bottom cluster together with other southern and eastern European countries. A gender gap is observed for the four domains. The increasing rate of AA between 2010 and 2018 demonstrates that these southern/eastern European countries are improving their conditions so as to offer the older population better AA in the future (Table 1). The distribution of the AAI across Spain indicates a generally clear difference between the more urban northern regions (in addition to Madrid and the Balearic Islands), with their more competitive services-based economy, and the more rural southern areas of the country, especially Andalusia and Extremadura (Rodríguez-Rodríguez et al. 2017, 2017b).

**Table 1** In table 1, cells of the clusters (column 1) have to be coloured, as in the original Table 1. This has a correspondence with figures 1 and 2. Otherwise, readers do not understand the meaning. Cluser 1: green colour  
Cluser 2: red colour  
Cluser 1: blue colour  
Cluser 1: yellow colour

Evolution of overall AAI score in EU countries between 2010 and 2018, by cluster

Cluster	Country	2010	2012	2014	2016	2018	Change 2010–2018	
1 As there is a connection of this table with figures 2 and 3 this cell is to be coloured in green.	Bulgaria	27.7	29.4	29.9	31.1	31.8	4.1	2.7
	Greece	28.9	29.2	27.7	27.4	27.7	−1.2	
	Croatia	27.5	31.2	31.7	29.4	29.3	1.8	
	Romania	29.5	29.6	29.9	30.9	30.2	0.7	
	Hungary	26.2	27.5	28.4	28.9	30.5	4.2	
Data source: <a href="https://statswiki.unece.org/pages/viewpage.action?pageId=76287845">https://statswiki.unece.org/pages/viewpage.action?pageId=76287845</a>								
Cluster typology is based on methodology applied by UNECE/European Commission (2019, p. 20)								

Cluster	Country	2010	2012	2014	2016	2018	Change 2010– 2018	
	Slovenia	30.1	30.5	29.9	31.0	31.1	1.0	
	Poland	27.0	27.2	28.2	30.4	31.0	4.0	
	Slovakia	26.9	27.8	28.6	30.7	32.3	5.5	
	Italy	30.1	33.8	34.1	33.0	33.8	3.8	
	Spain	30.3	32.6	32.8	32.4	33.7	3.4	
<b>2</b> As there is a connection of this table with figures 2 and 3, this cell is to be coloured in red.	Luxembourg	32.0	35.2	35.6	36.5	35.2	3.2	4.9
	Malta	28.3	30.7	31.6	34.7	35.4	7.1	
	Cyprus	32.5	35.6	34.1	34.3	35.7	3.2	
	Austria	30.8	33.4	33.9	34.9	35.8	5.0	
	Belgium	32.4	33.2	33.8	37.2	37.7	5.3	
	France	33.0	34.2	35.8	37.9	38.6	5.5	
<b>3</b> As there is a connection of this table with figures 2 and 3, this cell is to be coloured in blue.	Lithuania	30.2	30.8	31.5	31.8	33.4	3.2	3.4
	Portugal	32.5	34.3	34.3	32.9	33.5	1.0	
	Latvia	32.2	29.8	31.7	34.3	35.3	3.1	
	Czech Republic	31.2	33.9	34.5	34.9	36.5	5.3	
	Estonia	33.5	33.0	34.7	36.6	37.9	4.3	
<b>4</b> As there is a connection of this table with figures 2 and 3, this cell is to be coloured in yellow.	Ireland	35.9	38.7	38.7	37.6	39.1	3.2	4.1
	Germany	34.4	34.5	35.6	37.5	39.6	5.1	
	Finland	36.9	38.4	39.0	40.2	40.8	3.9	
	United Kingdom	38.1	39.8	39.9	40.6	41.3	3.2	
	Netherlands	38.5	39.0	39.8	41.5	42.7	4.1	
	Denmark	38.7	39.9	40.3	41.8	43.0	4.2	
	Sweden	42.3	43.6	44.5	46.6	47.2	4.9	
	EU average	32.1	33.5	33.9	34.9	35.7	3.7	

Data source: <https://statswiki.unece.org/pages/viewpage.action?pageId=76287845>

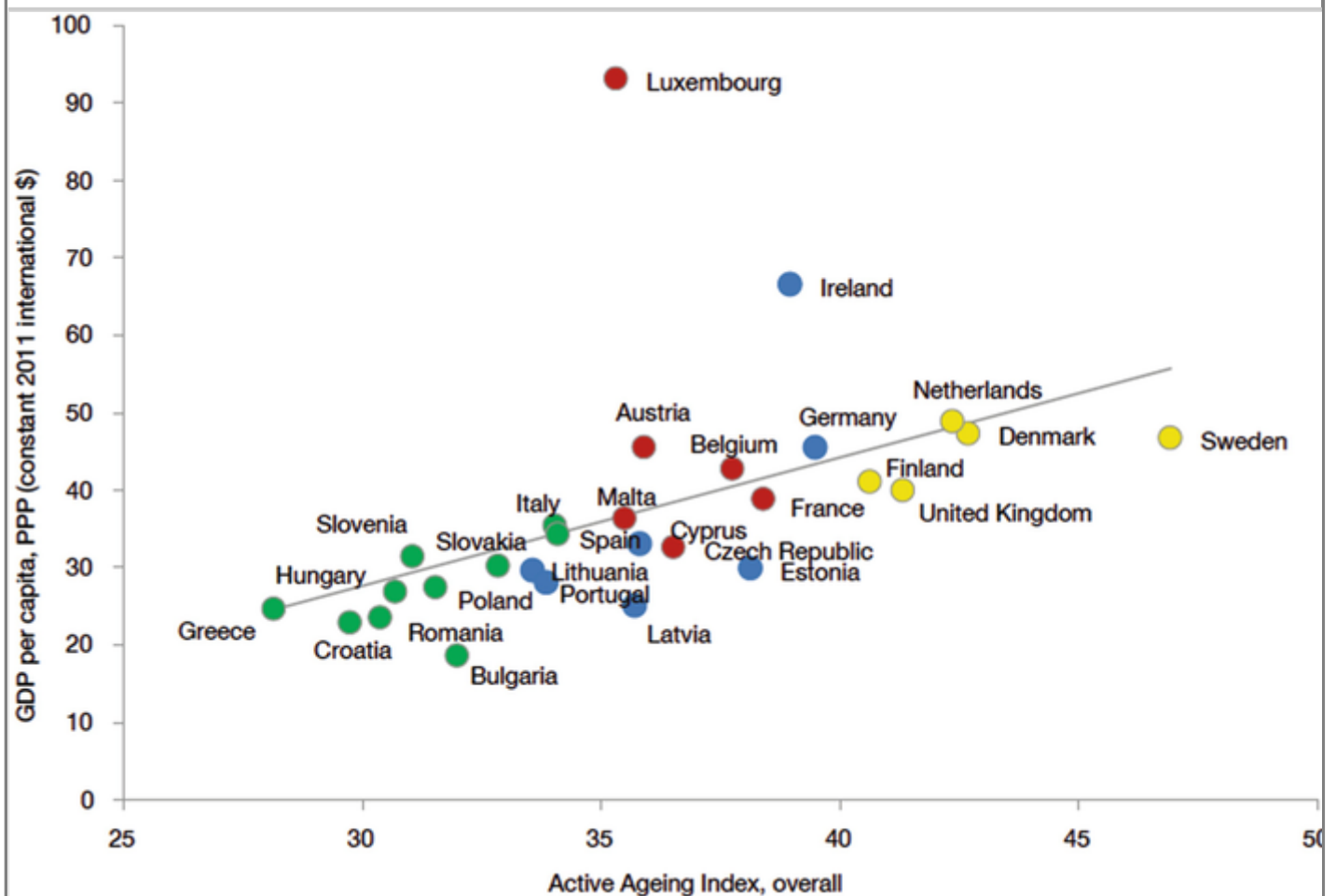
Cluster typology is based on methodology applied by UNECE/European Commission (2019, p. 20)

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The results also show that the EU AAI and the general and regional scores for Spain are closely related to general constructs such as Gross Domestic Product (GDP) and the Life Satisfaction Index, permitting assessment of whether the validity of the AAI is proven. Two direct relationships emerge to demonstrate that the higher the AAI, the higher the GDP and life satisfaction in the countries grouped by cluster (Figs. 2 and 3). Although wealth and happiness are not causally linked to AAI, older people in EU countries are “becoming more active where they are more satisfied with life or vice versa; possibly, activity and satisfaction go hand in hand” (UNECE/European Commission 2019, p. 56).

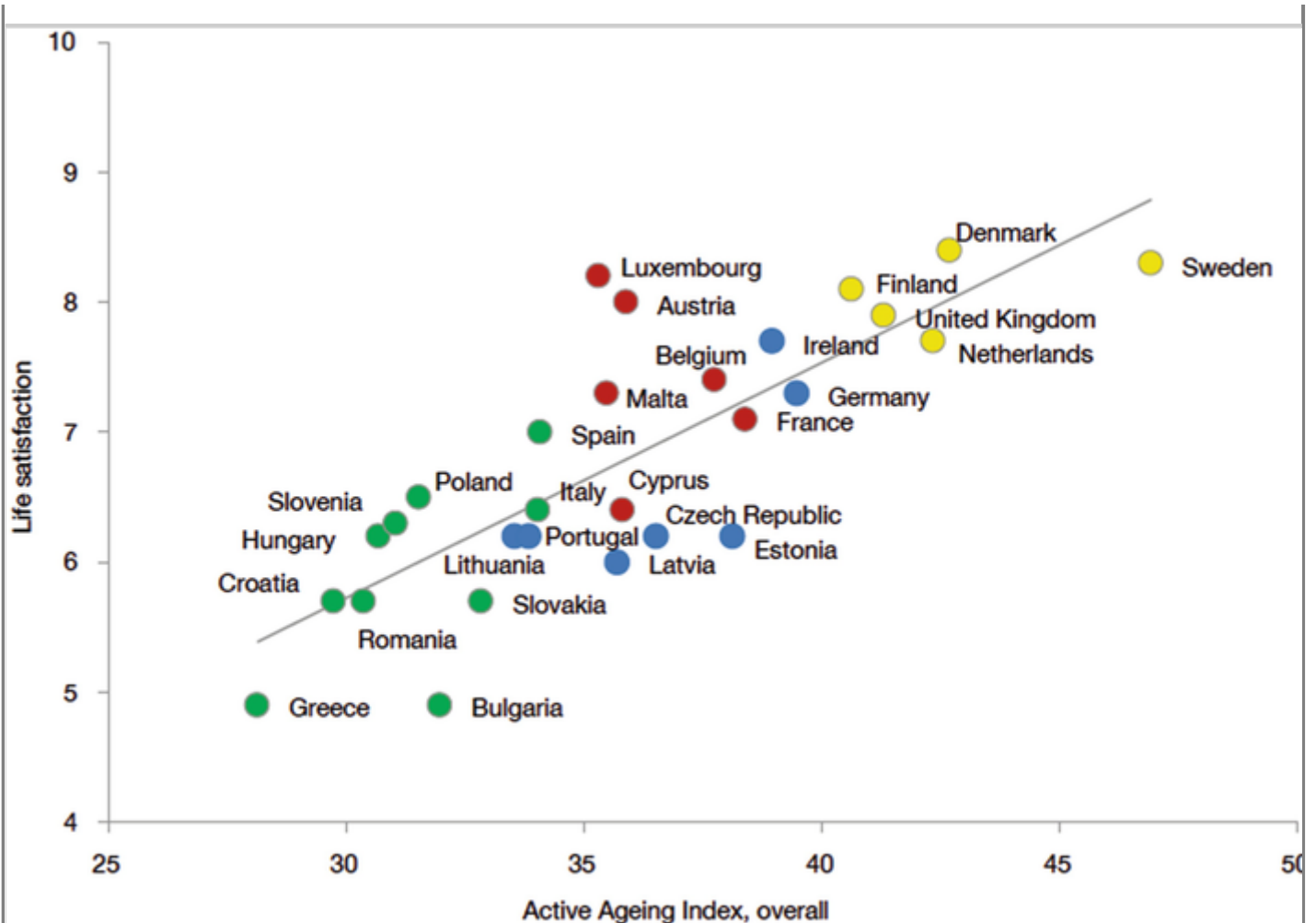
**Fig. 2** Figures 2 and 3 are related to table 1. This is why that the cells in "Cluster" column of this table are to be coloured.

AAI scores (overall) and GDP per capita in the EU28, 2018. Source: UNECE/European Commission (2019, p. 54)



**Fig. 3**

AAI scores (overall) and life satisfaction among people aged 65+ in EU28, 2018. Source: UNECE/European Commission (2019, p. 56)



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(standard of living, health, achieving in life, relationships, personal safety, feeling part of the community/community connectedness, future security, and spirituality or religion)

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## Personal Wellbeing Among Older Adults in Spain

The average **PWI** score among the **older adult population** in Spain was 74.2/100 according to data obtained as part of the **ELES project**. The highest-scoring domains were satisfaction with **personal relationships** (82.2), **personal safety** (78.8), and the **feeling part of the community or group of people** (77.0). The lowest scores were observed for satisfaction with **health** (69.6) and **future security** (67.8). Intermediate scores were reported for satisfaction with **life achievements** (73.9), **spiritual life/religious beliefs** (72.4), and **standard of living** (71.4).

When sociodemographic **features characteristics** were taken into account, statistically significant differences were found for personal characteristics relating to marital status, educational level, social class, and relationship with activity (Table 2). The **PWI** was higher among people who were married or living with a partner, with significant differences in comparison with those who were divorced or separated. Respondents with secondary or higher educational qualifications reported statistically significant differences in terms of having higher personal wellbeing in comparison with those who had not completed primary education. Being a member of the social class of non-manual workers (covering officers, administrative employees, professionals and supervisors of manual workers) and being retired also produced statistically significant



differences. Additionally, perceiving one's health status to be good, not suffering from illness and having large family and social networks were associated with a higher level of personal wellbeing. The PWI was independent of sex, age, and size of residential area.

**Table 2**

PWI 8 domains: mean score according to sociodemographic and personal characteristics

Variable	Category	Mean
Gender	Male	74.0 <sub>a</sub>
	Female	74.5 <sub>a</sub>
Age (years)	50–64	73.7 <sub>a</sub>
	65–74	75.5 <sub>a</sub>
	75+	73.9 <sub>a</sub>
Marital status	Single	73.8 <sub>a<sup>7</sup>,b</sub>
	Married/living with partner	74.8 <sub>a</sub>
	Widower/widow	73.4 <sub>a,b</sub>
	Divorced/separated	69.6 <sub>b</sub>
Educational level	Lower than primary	72.9 <sub>a</sub>
	Primary	74.9 <sub>a,b</sub>
	Secondary or university degree	75.1 <sub>b</sub>
Social class	Nonmanual work	75.1 <sub>a</sub>
	Manual work	73.4 <sub>b</sub>
Relationship with current activity status	In work	74.0 <sub>a,b</sub>
	Retired	75.4 <sub>a</sub>
	Housework, caregiving	74.0 <sub>a,b</sub>
	Inactive (unemployed, student, disabled, other)	71.4 <sub>b</sub>
Size of residential area (inhabitants)	≤10,000	73.5 <sub>a</sub>
	10,001–100,000	74.0 <sub>a</sub>
	101,000–500,000	74.8 <sub>a</sub>
	≥501,000	74.9 <sub>a</sub>
Perceived health status	Very bad	53.5 <sub>a</sub>
Tests adjusted for all pairwise comparisons using post hoc test (Bonferroni correction)		
Values in categories of each variable not sharing the same subscript (a, b, c, d) are significantly different at $p < 0.05$		

Variable	Category	Mean
	Bad	66.7 <sub>a,b</sub>
	Fair	70.7 <sub>b</sub>
	Good	76.1 <sub>c</sub>
	Very good	80.3 <sub>d</sub>
Morbidity (diseases)	0	77.4 <sub>a</sub>
	1–2	75.1 <sub>a</sub>
	3+	72.4 <sub>b</sub>
Size of family network (number of people)	1–7	73.9 <sub>a</sub>
	8–11	73.8 <sub>a,b</sub>
	12+	76.1 <sub>b</sub>
Size of social network (number of people)	0	71.6 <sub>a</sub>
	1–4	73.5 <sub>a,b</sub>
	5–6	75.8 <sub>b,c</sub>
	7 +	76.3 <sub>c</sub>
Tests adjusted for all pairwise comparisons using post hoc test (Bonferroni correction)		
Values in categories of each variable not sharing the same subscript (a, b, c, d) are significantly different at $p < 0.05$		

In terms of the **personal wellbeing** subdomains, age group showed significant differences for satisfaction with **health** (best wellbeing in the 50–64 years age group), **feeling of safety** ( $\geq 77.6$  for all age groups), **spiritual life and religious beliefs** (best wellbeing at  $\geq 75$  years of age), and **feeling of belonging to a community or group of people** ( $\geq 76.2$  for all age groups,  $p$ -value = 0.079). Women reported higher scores in the subdomains related to satisfaction with **personal relationships**, **feeling of safety**, **feeling of belonging to a community or group of people**, and **spiritual life and religious beliefs**.

## How Do Older Adults Perceive AA and QoL?

**AA** may be understood by considering the ongoing participation of an older person in all aspects of life, with the purpose of improving **QoL** as they age. It is with good reason that the domains and factors determining **AA** in its seminal conception (WHO 2002) and in its updated version (ILC-BR 2015) are also recognized as relevant to **QoL** (Rojo-Perez et al. 2015). This has led some authors to argue that **QoL** is an outcome measure of **AA** (Van Malderen et al. 2016).

However, there are still few studies that engage in a joint analysis of **AA** and **QoL** (Rodriguez-Rodriguez et al. 2017a) This reference is to be changed by: (Rojo-Pérez et al., 2020 forthcoming).

It has been properly corrected in References section. According to a recent study based on qualitative methodology and conducted in Spain regarding the lay perspective of AA (Rodríguez-Rodríguez 2020, forthcoming; Rojo-Pérez and Fernández-Mayoralas 2020, forthcoming), when one asks how older adults and other key respondents perceive the relationship between AA and QoL, neither of the two constructs is generally defined. However, it is categorically affirmed that the relationship between them is a very close one, such that “one concept” is considered to lead to the “other,” and they are seen as two interdependent elements. In this regard, it is sometimes thought that having an adequate level of QoL is what enables people to age actively, while on other occasions, it is argued that being able to age actively will also improve QoL.

In line with the WHO’s interpretation of AA, lay perspectives also recognize that living actively must not only take place during old age: if one is ageing from birth, it is necessary to be active throughout one’s life.

Key respondents from institutions related to health and social care services for older adults and from civil society organizations believe that the relationship between the constructs is based on an overall awareness of health and its prevention. They understand health from a holistic standpoint; that is, the physical, mental, and social perspectives and healthy habits. Underpinning this idea is the sense that (good) health is a condition enabling one to carry out activities, hence serving as a basis for AA and consequently meaning that an adequate level of QoL can be maintained.

Other outlooks focus the relationship between the constructs on support in other dimensions of life, such as social integration, having a life partner and maintaining a good relationship, having financial resources that provide security and peace of mind, being active, and avoiding being sedentary or engaging in passive activities. Involvement in volunteering and community activities is also seen as a way of pursuing an active and high-quality life.

In summary, when qualitative studies are conducted with a view to identifying perspectives regarding the relationship between AA and QoL, the findings may involve the identification of a range of dimensions, both global and domain-specific. But according to some authors (Schalock 2004), the number of dimensions does not appear to be so significant as their multidimensionality and interaction, and particularly how older adults themselves perceive and experience them. And social action policies, based on scientific evidence, should be designed and established to enable people to live and age with high QoL.

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## Cross-References

Active Ageing

[A](#) Other cross-reference to be inserted is:

Active Ageing Index \_geing

International Wellbeing Group

Personal Wellbeing Index

Quality of Life

Satisfaction with Life

Satisfaction with Quality of Life Domains

Spain

Spain, Personal [Well-Being](#) Well-Being has to be changed by Wellbeing that is, without hyphen [Index](#); Validation with Older Adults

Subjective Wellbeing

**Reference** Changes made in References section: as we cannot insert corrections in the reference list, we write them in this comment:

The following reference

Kafková, M. P. (2018). The Active Ageing Index (AAI) and its relation to the quality of life of older adults. In Zaidi, A., Harper, S., Howse, K., Lamura, G., & Perek-Bialas, J. (Eds.). (2018). Building Evidence for Active Ageing Policies. Active Ageing Index and its Potential (pp. 55-74). London: Palgrave Macmillan.

Is to be change by:

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