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RESEARCHING QUALITY OF LIFE OF OLDER PEOPLE:
CONCEPTS, MEASURES AND FINDINGS

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Abstract

Quality of life research has emerged as a concept of intense scientific and political interest in the last 25 years. Initially, dominated by the medical establishment, limitations in the bio-medical model approach precipitated social science investigation. Additionally, a shift occurred between a reliance on objective indicators (e.g. income, crime rates, number of cars per household) to include subjective factors (e.g. happiness, life satisfaction) of quality of life. This paper presents first a background on the evolution of quality of life in current discourse. Secondly, it reviews how quality of life has been conceptualised and measured within the health and social sciences; and thirdly, it presents research findings on the relationship between the quality of life of older people and family/friends support, income, crime and health. This includes a look at both the literature and preliminary findings from a series of discussion groups connected to a current research project. The aim of this article is to be informative and to provide a practical guide to the conceptualisation and measurement of quality of life.

Introduction

“So far as name goes, there is a pretty general agreement: for HAPPINESS both the multitude and the refined few call it, and “living well” and “doing well” they conceive to be the same with “being happy;” but about the Nature of this Happiness, men dispute, and the multitude do not in their account of it agree with the wise. For some say it is some one of those things which are palpable and apparent, as pleasure or wealth or honour; in fact, some one thing, some another; nay, oftentimes the same man gives a different account of it; for when ill, he calls it health; when poor, wealth: and conscious of their own ignorance, men admire those who talk grandly and above their comprehension. Some again held it to be something by itself, other than and beside these many good things, which is in fact to all these the cause of their being good”. Aristotle [The Ethics of Aristotle]

Academic, health and political agendas cannot escape the current interest in quality of life research. Since the 1950’s the term has increased in use in both lay and institutional discourse, and interest in research has grown internationally. In 1994, Denmark established a Quality of Life Research Centre. Similarly, in Canada, the Ministry of Health has funded a national study to look at the quality of

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1 The financial support of the Economic and Social Research Council (Grant No. L480254022) is gratefully acknowledged.
life of Canadian citizens. In the UK, the social science research agenda is increasingly influenced by state concerns about improving the quality of life of different groups within the British population. For example, the Economic and Social Research Council (ESRC), under the remit of its Growing Older Programme, is currently supporting 24 projects examining quality of life of older people. Additionally, international organisations such as the World Bank, World Health Organisation and the United Nations are committed to enhancing quality of life in developing and war-torn nations.

Current interest in quality of life research can be attributed to a number of factors. Firstly, there are increasing proportions of older people, presenting challenges in terms of meeting health and social care needs in a time of fiscal constraints. Secondly, medical technological advances have added years to life but not necessarily quality to life. Thirdly, there has been a decisive shift in medical ethos away from a focus on secondary and tertiary implementation, to primary intervention and prevention. Lastly, at a more general level, globalisation has created more international competitiveness, and thus a need for nations to improve the quality of life of their citizens in hope of improving their country’s social, economic and political profile.

This paper stems from initial research undertaken within the context of the ESRC’s Growing Older Programme. A team of researchers is examining the situation of older people living in socially deprived neighbourhoods of England, focussing in particular upon areas of Liverpool, Manchester and London. While the research also addresses such issues as poverty, social exclusion and social capital, this paper concentrates upon ways of exploring the quality of life of older people living in such environments.

An important task of the research team is to come to grips with the increasing complexity of the concept ‘quality of life’ both in theoretical and empirical terms, and specifically in relation to old age (e.g. through discussions with older people). For example, 'how does quality of life affect old age?', 'how does old age affect

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2 Primary, secondary and tertiary denoted grades of medical treatment and specialisation. With primary being the most basic level of admission.
quality of life?’ and specifically, ‘how are the two affected by living in socially deprived areas?’. Related to this was a need to understand how this concept is currently being measured within both health and social science disciplines.

From a human ageing perspective, Hughes (1990) suggests that the study of quality of life engineered the development of both social and critical gerontology in the US and UK. Ironically, despite a half century of development in both areas there still remains a paucity of findings and understanding of old age and quality of life. This paper seeks to provide an analysis of quality of life in general terms and quality of life in relation to old age. The paper is divided into three parts. The first part develops a brief historical overview and then illustrates how quality of life is defined within the academic literature. The second part examines the instruments social scientists are currently using to measure quality of life and well-being. The final part presents findings of quality of life researchers, including some preliminary findings from the research project on which this paper is based.

**Background**

Early notions of quality of life can be dated to Aristotle’s (384-322 B.C.) written concepts of ‘the good life’ and ‘living well’. His social ethics and perfect society doctrines explore both individual and society concepts of quality of life: “the most desirable life for the state cannot be known unless we know the nature of the most desirable life for the individual” (trans. Ellwood). In a computerised search of electronic journal databases, the first use of the term quality and life was found in an article written by James Seth in 1889. In ‘The Evolution of Morality’, Seth talks about a moral end to which mankind can aspire: “we must not regard the mere quantity, but also the quality of the ‘life’ which forms the moral end” (p. 43).

The popularisation of the term 'quality of life' evolved in the second half of the twentieth century. Initially, quality of life was monopolised by economists and political scientists to denote citizens’ material wealth, for example the number of TV’s and cars per household. Within the medical establishment quality of life was, and often still is, used as a measure of disease type and treatment outcome. In the
1990’s dissatisfaction with the biomedical model of disease and illness began to be debated and what emerged was a desire for a more holistic approach to understanding quality of life. “In medicine and nursing science, quality of life offset survival as an aim as awareness that a long life is not necessarily a good life increased” (Farquhar, 1995, p.1440).

The impetus to reach beyond objective measures and encompass more subjective factors was in part precipitated by the birth of humanistic psychology in the latter half of the 1950’s. Maslow’s (1954) Hierarchy of Needs examined five levels of human maintenance and existence. He felt that at the most basic level people needed air, water, food, shelter and safety. Once people had achieved this, they needed to be loved, to belong, have personal self-respect and, ultimately to be self-actualised. However, Maslow felt that few people reach a state of self-actualisation because most fail to have the previous needs fulfilled.

In many respects, medical research has dominated the literature on quality of life. Quality of life has been used as an outcome variable for measurement of disease/illness type (Rapp et al, 1999; Raimer 2000) and treatment (Henderson, 2000; Greendale et al., 2000). However, in recent years there has been a call for the clarification of this term within the medical context, more specifically health-related quality of life (Farquhar, 1995; Bowling, 1995b, 1997). Currently, it is recognised that quality of life extends beyond a strict medical discourse into areas including sociology, psychology, environmental studies, social work and social policy.

Defining Quality of Life

Over the last fifty years a plethora of definitions of quality of life have emerged within health and social science disciplines. However, as yet, there exists no generic definition satisfying all proponents of quality of life research. As Farquhar (1995: 1440) notes “it is a problematic concept as different people value different things”. Similarly, in Aristotle’s understanding of the good life, he explains that each person or even the same person values different things at certain times in their life depending on their situation. For example, an ill person may want to be healthy to enjoy a good life.
Definitions vary widely in their conceptualisation of quality of life; some are very broad accounting for many indicators, others focus on more specific indicators. In Canada, the Ontario Social Development Council defines quality of life as the “product of the interplay among the social, health, economic and environmental conditions which affect human and social development” (http://www.qli-ont.org/indexe.html). Others focus on:

- health and physical function (Mendola and Pelligrini, 1979; Patterson, 1975);
- life satisfaction (Michalos and Zumbo 1999, 2000; Zumbo and Michalos, 2000; George and Bearon, 1980) and self-esteem (George and Bearon, 1980);
- socio-economic factors (George and Bearon, 1980, Sherwood et al., 1996, Haug and Folmar, 1986);
- social support (Sherwood et al 1996; Haug and Folmar, 1986);
- environmental dimensions (Lawton 1991, 1997); and
- market force economics (Welle, 1999).

The World Health Organisation’s (WHO) definition of health, as “a state of complete physical, mental and social well-being not merely the absence of disease”, precipitated the inclusion of well-being variables. It was felt that the measurement of health and effects of health care could not be fully understood without an understanding and measurement of quality of life. WHO defines quality of life as:

“an 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 affected in a complex way by the person's physical health, psychological state, personal beliefs, social relationships and their relationship to salient features of their environment.” (http://www.who.int/msa/mnh/mhp/ql1.htm)

WHO’s focus is necessarily a health-related quality of life approach, specifically one that investigates the individual’s own views in relation their disease or illness. However, unlike the majority of medical quality of life outcome measures, WHO encompasses psychological and social (i.e. relationships and the environmental) factors which may impact well-being.
Lawton (1991) defines quality of life as a collection of dimensions, both objective and subjective interacting together: it "is the multidimensional evaluation, by both intra-personal and socio-economic criteria of the person-environment system of the individual" (pg.6). Current definitions of quality of life address both objective (i.e. income, marital status) and subjective measures (i.e. happiness, life satisfaction) (Flanagan 1978; George and Bearon, 1980; Lawton, 1991, 1997; Centre for Health Promotion, 2000). Some examples of measures that incorporate these dimensions of quality of life are presented below.

Flanagan (1978) constructed a measure that encompasses 15 quality of life elements within 5 domains (Figure 1).

**Figure 1: Domains of Quality of Life**

*Physical and Material well-being*
- Material well-being and financial security
- Health and personal safety

*Relations with other people*
- Relations with spouse
- Having and raising children
- Relations with parents, siblings or other relatives
- Relations with friends

*Social, Community and Civic Activities*
- Activities related to helping or encouraging other people
- Activities relating to local and national governments

*Personal Development and Fulfilment*
- Intellectual development
- Personal understanding and planning
- Occupational role
- Creativity and personal expression

*Recreation*
- Socializing
- Passive and observational recreational activities
- Active and participatory recreational activities

Flanagan’s (1978) definition usefully touches upon two other key dimensions that are relevant to the ESRC project from which this paper derives. Aspects of social capital\(^3\) are addressed under two domains: _social, community and civic activities_,

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\(^3\) Social Capital can be understood as “the propensity of individuals to associate together on a regular basis, to trust one another, and to engage in community affairs”, and “...the extent to which individuals have regular contact with others, beyond the sphere of the family or the market, and notably the kind of face-to-face relations of relative equality associated with participation in common endeavours” (Hall 1999: 417-18).
and recreation. Elements of social exclusion\(^4\) are evident in the domains of physical and material well-being and recreation.

The Centre for Health Promotion at the University of Toronto defines quality of life as “the degree to which a person enjoys the important possibilities of his or her life”. Possibilities are said to result from the opportunities and limitations a person has and is a reflection of the interaction within a personal and environmental milieu. Enjoyment is taken to be “the experience of satisfaction or the possession or achievement of some characteristic”. The example given is “she enjoys good health” (http://www.utoronto.ca/qol/profile.htm). This definition potentially has important explanatory power. Specifically, it may be possible to say that people living in areas of social and economic deprivation may experience a lower degree of quality of life because of limited possibilities and enjoyment. Alternatively, people may accommodate and/or be unaware of these limitations and express satisfaction with their quality of life.

Other definitions encompass a more philosophical view of quality of life (Ruta and Garratt 1994; Hodge 1990; Gerson 1976; Veenhoven 1999; Quality of Life Research Centre 2000). The Quality of Life Research Centre, in Denmark, views objective and subjective elements of quality of life concepts as ‘life surfaces’. Researchers at the Centre “believe that between these two superficial poles of existence, an existential core of experienced life meaning can be found, where the subjective and objective meet and the source of quality of life is found”. Quality of life is constructed around eight theories, organised on a continuum from subjective to objective, called the Integrative Quality of Life Metatheory (illustrated in Figure 2).

\(^4\) Social Exclusion is defined “as the exclusion of individuals and groups from the mainstream activities of that society. Social exclusion is about more than income poverty, but area studies in Britain have yet to demonstrate how social exclusion develops, how far it is an individual or locational problem, and how important area factors in this process.”
Figure 2: Integrative Quality of Life Metatheory.

Subjective

1. Immediate self-experienced well-being
2. Satisfaction
3. Happiness
4. Fulfilment of Needs
5. Experience of objective temporal domains
6. Experience of objective spatial domains
7. Expression of Life’s potential
8. Objective factors

Objective

Source: Quality of Life research Centre (http://home2.inet.tele.dk/fclk/mql2htm)

The premise is that a definition of quality of life must come from some philosophy of human life which can be operationalised into a theoretical frame ‘amenable to practical scientific investigation’.

Hodges (1990) considers quality of life from utilitarian and existential perspectives. Utilitarians assume “that there is a basic structure, called human nature, which constitutes our similarity to each other” (p. 45). This approach seeks to quantify and presuppose some inherent, universal notion of quality of life. Conversely, the existentialist perspective is a pluralistic, self-determined and qualitative approach. The a priori existence of a single, generic notion of quality of life cannot be assumed because of human diversity.

Many definitions of quality of life fail to explore theoretical or philosophical issues. Ruta and Garratt (1994) state that in “trying to arrive at a useful definition of quality of life very few researchers have appreciated the need to distinguish the factors necessary to sustain life, that enhance or impair the enjoyment of living, from whatever it is that we stay alive for”. A clear ‘philosophy of human life’ and a theoretical framework may aid researchers in their understanding and conceptualisation of quality of life.

(Glennerster et. al, 1999: 7). For more information on social exclusion in relation to older people, see Scharf et al. 2000.
Measuring Quality of Life

The lack of a universal definition of quality of life is mirrored by the absence of agreement on its measurement. To a large extent this occurs because of the diversity of measures found between and within disciplines. The medical sciences have a plethora of instruments measuring health-related quality of life in relation to illness and treatment (Bowling, 1995b, 1997; Kliemt et al 2000). Social science measures tend to adopt a more multidimensional approach, encompassing variables such as health, happiness, life satisfaction, income, social networks to name but a few (Haug and Folmar 1986, Abrams (undated)). Haug and Folmar (1986), for example, measured physical health, functional ability, perceived income inadequacy, social contacts, absence of psychological distress and cognitive ability as concepts of an individual’s quality of life. More detailed examples of measurement approaches follow.

1) In the UK, Smith (undated) and Bowling (2000) measure quality of life by asking a series of unprompted open ended questions. Smith asked 1,650 persons aged 65 and over “what would you say makes life really pleasant and satisfying for people of your age?”, followed by “would you say you have these things to a great extent, to a certain extent, hardly at all or not at all?” (pg.12). Each person’s responses were then transcribed verbatim and/or coded (findings are presented later). Bowling (2000), under the remit of the ESRC’s Growing Older Programme, has developed a similar measure to Smith’s, asking people the following question: “Thinking about your life as a whole, what is it that makes your life good – that is, the things that give your life quality?” The survey also asks questions on how the individual feels in comparison with their expectations, what they had in the past and how they feel in relation to others.5

2) The University of Toronto’s Health Promotion Centre has developed a Quality of Life Profile which is composed of three ‘life domains’: being (who one is), belonging (connections with one’s environment), and becoming (achieving personal goals, hopes and aspirations). More appropriate to the study of

5 For further information visit the ESRC’s Growing Older website (for further information see: http://www.shef.ac.uk/uni/projects/gop/index.htm)
ageing populations is a *Quality of Life Profile for Seniors*. On each profile, participants rate items for both Importance and Satisfaction on a Likert scale from *Not Important* or *Dissatisfied* to *Extremely Important* or *Satisfied* (see: http://www.utoronto.ca/qol/assess.htm). Quality of life is rated on the ‘relative importance’ or ‘meaning attached to each particular dimension’ and the extent of the person’s enjoyment on each dimension. “In this way quality of life is adapted to the lives of all humans, at any time, and from their individual perspective”.

The adaptability and comparability of this measure make it potentially attractive to other research projects. Specifically, it might be possible to interject different sub-variables to reflect better individual research project’s needs. The calculation of a quality of life score allows comparability within and between projects.

A limitation with this measure, and one which confounds a lot of quality of life research is that people living in socially disadvantaged areas (i.e. low possibilities and opportunities), commonly rate satisfaction with their quality of life as high. Explanations for this might be that the individual is unaware of anything different or might be engaging in a form of cognitive dissonance.⁶ To account for this the Centre considers that a quality environment provides: 1) basic needs to be met (food, shelter, safety, social contact); 2) a range of *opportunities* within the individual’s potential; and 3) *control* and choice within the environment. Although this is not added into the final score on quality of life, it provides researchers with further analysis and interpretation of scores. However, an important caveat to this is an assumption that individuals want to or should attain a different standard to what their present situation. Specifically, this comes from the assumption or stereotype that, for example, people living in deprived areas should want to change their situation. Whatever the reason, investigators into quality of life research need to decide what is important: is it the ‘individual’s interpretation and perception of their own quality of life’ or some form of objective/subjective reality which constructs what a good quality of life should be?

⁶ Cognitive dissonance is when an individual unconsciously changes their behaviour, beliefs and perception to rationalise their present situation.
3) The Quality of Life Research Centre in Copenhagen measures quality of life according to seven criteria. These being: 1) a definition of Quality of Life; 2) an embedded philosophy of human life; 3) a theory that operationalises this philosophy; 4) quantifiable response alternatives; 5) technical checks (reproducibility, sensitivity, well-scaledness, etc); 6) validation through meaningfulness to investigators, respondents, and users; and 7) aesthetic appeal of the questionnaire. This is a very comprehensive approach to understanding quality of life and has appeal not only for theoretical and methodological construction of quality of life, but potentially provides a valuable guide to measurement (see: http://home2.inet.tele.dk/fclk/mql2.htm).

4) O’Boyle and colleagues (1992) developed the Schedule for the Evaluation of Individual Quality of Life (SEIQoL). SEIQoL is a semi-structured interview with three stages. In the first stage, participants are asked to list five things they deem to be most important for their quality of life. For those who find this difficult, a list of eight prompts are given and from this they are asked to choose five. In the second stage, participants are asked to rate their choices on the visual analogue scale presented in Figure 3 below.

**Figure 3**

As good as it could possibly be

As bad as it could possibly be

An ‘X’ is put anywhere along the spectrum. Participants’ responses are then converted into a bar chart. In the final stage, participants are presented with thirty randomly selected hypothetical profiles, displayed in bar charts tagged with the participant’s chosen areas of quality of life (i.e. friends). They then have to rate the quality of life of each profile on the visual analogue scale (Figure 3). Using multiple regression analysis it is then possible to derive the relative weight given to each area: “An overall quality of life score for each individual is calculated by multiplying each nominated area by its corresponding weight and summing across the five areas to produce an index score between zero and 100” (Ruta and Garratt, 1994: 143). A problem with
this method is the extent to which researchers can or should ‘prompt’ participants. Additionally, analysis requires a certain level of statistical sophistication and this may inhibit some researchers from using the measure.

5) The World Health Organisation has recently developed a 100 question quality of life instrument, referred to as the WHOQOL. This has been supplemented by a 26-item short version. The aim was to develop a quality of life measure that could be used internationally amongst both healthy and ill populations. Since its development the WHOQOL has been translated into over 20 languages and has been tested widely for reliability across cultures, situations and according to the instrument’s format (long and short version) (Harper and Power 1998; Power et al. 1999; Skevington 1999; Bonomi et al. 2000). Although, its suitability for use with older people has been questioned by some academics, WHO is in the process of designing one which is more relevant for an older population. The instrument situates quality of life around six domains: physical health, psychological, levels of independence, social relationships, environment, and spiritual domain (http://chef.who.int/msa/mnh/mhp/ql.htm). An impediment is that WHOQOL was developed within a health-oriented ethos. The instrument specifically aims to ‘improve doctor-patient relationships through better understanding the illness, to assess the effectiveness and relative merit of different treatments, and to evaluate the quality of health services’ (http://www.who.int/msa/mnh/mhp/ql4.htm).

Well-being
Well-being was constructed out of a psychological need to counter research strictly focussed on psychological dysfunction. Specifically, researchers such as Ryff (1995) started to pose questions about ‘the essential features of positive psychological functioning’. Well-being research, coupled with a focus on quality of life have often resulted in the interchangability of the terms. According to Haug and Folmar (1986) “quality of life is a term used loosely to indicate general well-being”. Similar to quality of life research, well-being has been measured across many different disciplines and with a variety of variables. Psychology has measured well-being in relation to self acceptance, purpose in life, environmental mastery, positive relationships, autonomy, personal growth (Ryff 1995, 1996), personality traits (Reis et al. 2000), happiness (Hermon and Hazler 1999) and life satisfaction
(Lu 1999), and loneliness (De Jong-Gierveld and Kamphuis 1985, De Jong-Gierveld 1987). Economists have studied it in relation to income (Ahuvia and Friedman 1998) and unemployment (Wadsworth et. al. 1999), and medical researchers have used it to analyse the causal relationship of illness/disease and mental well-being (Somlai and Heckman 2000; Noll et al. 1999). The World Health Organisation’s European Charter on Environment and Health reported that “good health and well-being require a clean and harmonious environment in which physical, psychological, social and aesthetic factors are all given their due importance” (WHO 1989: 7).

Few studies have gone beyond just measuring well-being in relation to one or two variables to develop a theoretical and/or conceptual understanding of what it is to be ‘well’. In this respect, the approach adopted in the Berlin Study of Aging (BASE) is likely to become increasingly influential in research on older people (see Smith et al. 1999). Based on the work and theory of Campbell et al. (1976), Smith et al (1999) developed a heuristic model, which “posits that overall subjective well-being is a function of the direct and indirect effects of social-structural and demographic variables (e.g. age, gender, marital status), objective life conditions (e.g. housing, income, social network and activities, physical and mental health), and subjective experiences of these domain-specific life conditions” (pg. 452) (see Figure 4). Objective life conditions have an impact on subjective well-being in that they are processed through subjective domain evaluations; objective measures in theory and/or practical terms may have little direct impact on well-being (Campbell et al. 1976).
Subjective well-being was measured in BASE using a translated version of the Philadelphia Geriatric Center Morale Scale (PGCMS), a fifteen-item questionnaire, originally developed by Lawton (1975), that examines agitation, attitudes towards a person’s own ageing, and toward social relationships. BASE researchers also looked at single item measures of past, present and future life satisfaction, and positive and negative affect using the standardised Positive and Negative Affect Schedule (PANAS) measurement scale (Watson et al. 1988).

The attraction of the BASE heuristic model may well be its adaptability to other studies. It is conceivable that socio-demographic variables, subjective domain evaluations and objective life conditions can be changed so that these better reflect the requirements of a researcher’s own investigation. For example, within socio-demographic variables, ethnicity and social class may be important
determinants, and for objective life conditions, housing conditions, access to health and social care services might help explain overall subjective well-being.

Additionally, the substitution of other more suitable standardised measurements may also be possible. The ESRC research team is also considering using two other widely used measures: Diener's (1985) Satisfaction With Life Scale (SWLS) and De Jong-Gierveld's (1985) Loneliness Scale. SWLS measures subjective well-being by seeking responses to five questions (ranked on a Likert scale from strongly agree to strongly disagree). Diener et al. (1985) take Shin and Johnson's (1978) definition of life satisfaction as the global evaluations an individual makes about their quality of life based on their comparison. It has been tested widely on reliability and consistency and across ages (Diener et al. 1985; Pavot et al. 1991; Pavot and Diener 1993). Its brevity and validation with other longer and older life satisfaction scales, specifically PGCMS, makes this a good potential substitute.

The De Jong-Gierveld Loneliness Scale was felt to be appropriate for the ESRC project, because it taps into aspects of social capital and social exclusion. The scale poses eleven statements to which participants are asked to respond either yes, more or less, or no. Examples of statements are 'I miss having a really close friend', 'there are many people I can trust completely' and 'I often feel rejected'. This scale has been found to be reliable (Cramer et al. 1999; van Tilburg and de Leeuw, 1991) and has been tested on older adults (Tijhuis, 1999).

It is evident from the discussion presented that well-being and quality of life share many of the same components, and that positive well being cannot be fully understood or exist in isolation of a good quality of life and vice versa. Whether quality of life and well-being are somehow synonymous or different, and which term is more appropriate for investigation warrants further consideration.

**Quality of Life Findings**

Over the last half century medical sciences have produced a breadth of findings on health-related quality of life. The focus of research has been on disease/illness type and treatment in relation to individual quality of life, specifically physical and mental functioning. In comparison, social science findings are rather limited. Nevertheless, the findings that have been generate encompass a broader, more
holistic paradigm of quality of life than exists in the medical sciences. Concepts of quality of life go beyond just health to include some or all of the following; social support and networks, finances, happiness, life satisfaction, crime and neighbourhood dimensions etc. In a random sample of over 2,000 UK residents, Bowling (1995a) asked ‘what are important areas of your life?’ Most people identified relationships with family/relatives, their health, the health of close others, their finances, social life and leisure activities as being important. Similar results have been reported elsewhere (Michalos et al, work in progress; Michalos and Zumbo 2000; Zumbo and Michalos 2000; Raphael et al., 2000; Hall, 1976; Farquhar, 1995; Rittner and Kirk, 1995; Haug and Folmar, 1986). This section addresses recent social science findings relating to the quality of life amongst older people.

A study that parallels the project from which this paper derives was carried out using the **Quality of Life Profile** in Toronto, Canada, by researchers at the University of Toronto. The area targeted, referred to as Lawrence Heights, is described as a large, culturally diverse, low-income neighbourhood, with a high percentage of women, children and young people, sole-support families, seniors and people who are unemployed and underemployed. The project’s aim was to identify community and neighbourhood factors which impact on the quality of life of Lawrence Heights residents (Raphael et al. 2000). Results show that how neighbours got along with each other contributed to their quality of life. Also important was access to amenities, such as shops, public transport and community centres and services. For seniors, having activities to participate in, as well as groups to belong to, significantly contributed to their quality of life. For those individuals the Lawrence Heights Community Recreation Centre and Community Health Centre was a central focus within the community. Deteriorating housing, fear of crime and lack of personal safety, racial tensions and shortage of services and support was said to detract from residents’ quality of life.

Michalos et al (2000) surveyed 875 Canadians between the ages of 55-95 years on a number of domains relating to happiness, satisfaction with life, and satisfaction with their quality of life. Participants were asked about their health, fear of crime, society’s treatment of old people (i.e. the police are usually helpful and treat me fairly, and I feel that I have all the rights I need), age identity questions
Physically, I feel ...much younger than my age to much older than my age (coded on a Likert scale from 1 to 5 respectively), and preferences and problems (i.e. I worry about my ability to operate bank machines, and the area in which I am now living is a good place to retire). Regression analysis for satisfaction with quality of life revealed that 8 variables out of 22 accounted for 58% of the total variance. These were mental health, satisfaction with present age, financial security, recreational opportunities, neighbourhood, accomplishment in life, and access to retail stores.

In the UK, Abrams (undated) and Farquhar (1995) examined older people and quality of life. Smith surveyed 1,650 people 65+ in areas of Northampton, Hove, Moss Side (Manchester) and Merton (Greater London) on 'pleasant' and satisfying aspects of their life. Good friends and neighbours, good health, happy marriage/family, being content with what you've got and having enough money accounted for almost over two thirds (68.4%) of respondents’ answers. Farquhar (1995) undertook a smaller survey of persons aged 65 and over in Hackney (London) and Braintree (Essex). Hackney represents an inner city borough with high levels of social deprivation, while Braintree is a semi-rural community with low levels of deprivation. Participants were asked five unprompted open ended questions on their quality of life. The first question asked participants to describe their quality of life. The highest percentage of people responding 'very positive' or 'positive' to their quality of life was found amongst the 65<85 cohort in Braintree, with almost 75% responding positively. Conversely, amongst persons 85 and over in Hackney, 25% described their quality of life as very negative. Amongst people who rated their quality of life as generally positive, the majority in Braintree said it was because of their material circumstances, whereas in Hackney individuals between 65<85 years said it was because of their health and mobility. In the 85+ cohort social contact with people was the most important. Of those who described their quality of life negatively, the 65-85 cohort in Essex said it was because of ill health, unhappiness or their material circumstances, similarly results were found in the 85+ cohort in Hackney. Amongst the 64<85 in Hackney 36% reported negative quality of life because of a lack of material circumstances.

Unfortunately, this study is limited by the fact that an 85+ cohort was not sampled in Essex. Therefore, it is not possible to say if the differences between the
Hackney 65-85 and 85+ cohorts and the Essex 65-85 group were a feature of age (e.g. biological and social aspects of ageing), area (e.g. levels of deprivation), or another intervening variable (e.g. personality traits). However, despite overall differences more individuals rated their quality of life positively than did negatively.

Rittner and Kirk (1995) also considered the effects of financial deprivation in their survey of 1,083 low-income seniors who used daytime meals programs in Southern Florida in the US. Low income, socio-cultural and quality of life variables were investigated for effects in take-up of health care and transportation. The survey revealed that this group was more likely to self-report poor or very poor health status, be socially isolated from family or neighbours (which further limited use of transportation), report a high degree of loneliness and either very bad or bad quality of life. An intervening variable in the utilisation of public transportation services and health care were fears of victimisation amongst this group, “over 69 percent (n=757) of the 1,083 respondents answered that they were either “very afraid” or “moderately afraid” of being victimised during the next six months” (p.10).

Wilkening and McGranaham (1978) and Amos et al. (1982) examined economically deprived regions of the American Midwest and the relationship to levels of life satisfaction (which is taken to reflect quality of life). They found no difference between deprived areas and other more affluent regions. As previously explained, individuals may not see their lives and neighbourhoods as any different to others, or they have come to justify and accept their position. A proposed theoretical argument was that people of economically deprived regions are content with less because they aspire for less (Amos et al 1982). This is a contentious philosophical and social issue which perpetuates arguments developed by some researchers during the 1970’s and 1980’s in relation to the existence of an ‘underclass’ within advanced industrial societies (e.g. that poor conditions are largely self inflicted and not changeable) (Byrne 1999).

Findings from Discussion Groups
In order to develop and improve an understanding of quality of life, researchers engaged on the ESRC research project undertook a series of group discussions with older people. Group discussions were undertaken in socially deprived...
neighbourhoods within three English cities. Areas of Liverpool, Manchester and London (Newham) were chosen based on their ranking on the Department of Transport and the Regions (1998) Index of Deprivation. Researchers held discussions with seven groups of older people; three in Newham, one in Manchester, two in Liverpool and one in a more affluent part of central England (selected as a source of comparison). Two groups were made up of people from minority ethnic groups, while the remaining groups were predominantly white, reflecting the ethnic composition of the selected neighbourhoods (for further information see Scharf et al. 2000). Group discussions were tape-recorded and subsequently transcribed verbatim. Any names cited in the text have been changed to guarantee participants’ anonymity.

On balance, findings from the group discussions tended to confirm those of other studies. Health, social contact, family, activities (i.e. centres for older people), safe neighbourhoods (i.e. fear of personal attack, poor lighting, uneven pavements) and having sufficient finances were all mentioned as important for sustaining and experiencing quality of life. In most groups, health and having sufficient finances were the most frequently mentioned factors for sustaining quality of life:

“It's not the quality of life is it? It's the quality of disabilities. I mean, if you can walk, if you are able to do everything, your quality of life when you're a pensioner is good.” (Liverpool)

“The best thing is we can get out and walk on our two legs.” (Newham)

“I can sum it [quality of life] up in one word ‘income’. With income you can do all them things, without it you can do none of them. I mean, somebody mentioned good health and all that lot. We've also mentioned leisure centres. But to get to a leisure centre you need money. You're in a Catch 22 because you need the money to go to the leisure centre to keep fit to be an old age pensioner.” (Central England)
Social contact and activities were also valued in most groups:

“To come to these clubs in an afternoon gives you a breather. Like me I live all on my own so therefore it gets me out to see people, have somebody else to talk to.” (Newham)

“There was nothing good. The only good thing is that once a week we assemble here and we all get together and talk. Once or twice a week we are happy.” (Newham)

Most participants, specifically women, mentioned the significance of family. Many people had regular contact (i.e. telephone chat or visits) with daughters, sons and grandchildren.

For older Liverpool residents the activities provided by an ‘Active Age’ Centre were particularly valued:

“It’s a lovely building … well equipped … we go don’t we? [talking to a friend] …computers, they have an open history [class], keep fit, Tai Chi, snooker and billiards.”

“This Active Age Centre has made a big difference to a lot of us.”

Crime, was also an important concern, participants feared both attack on their property and person. In many cases participants could recount personal attacks or attacks on friends and neighbours:

“I’d just left Sally and Emma. They went that way and I went that way and I hadn’t gone more than a couple of yards when they snatched my bag off my shoulder.” (Manchester)

“One of our friends took some money from a bank and a lady tried to mug him. He was in hospital. He told the police ‘this was the lady’ but nothing was done.” (Newham)
In the majority of groups the fear of crime restricted people’s behaviour in key ways. Specifically, most people would not go out at night and would only answer their door if they were expecting someone. In Liverpool one participant said: “Quality of life ends at half past six. Once it’s half past six pensioners don’t want to go out.” Similar comments were expressed in most of the other discussion groups.

The assumption thus far is that quality of life, through its increasing salience within late twentieth century discourse, is a well understood concept. However, an important caveat needs to be mentioned. Hall (1976) found that “a large number of respondents were unable to specify and referred to being happy, contented or ‘being satisfied inside yourself”. Farquhar (1995) also found this among her participants. Similarly, researchers engaged on the current project found that in some discussion groups the term ‘quality of life’ was not clearly understood. It was found that in some situations quality of life questions need to be asked in a slightly different way. In this respect, for example, Bowling (2000) asks ‘what makes your life good’ and ‘what is it that makes your life bad’. Researchers engaged in the study of quality of life need to give thought as to how they might wish to conceptualise this idea of life without explicitly using the term ‘quality of life’.

Conclusion
The last fifty years have witnessed an explosion in quality of life research within medical and social science disciplines. While medical science emphasises a health-related quality of life approach, the social scientific method embraces health, environmental, economic, social and political indicators. In the last few years what has emerged is a move towards a more holistic quality of life paradigm. The philosophical understanding of ‘what makes life worth living and gives it meaning’ is beginning to be debated at an academic level and within a wider social milieu.

As for the suitability and appropriateness of current measurements, this depends to a large extent on how researchers understand and define quality of life. Instruments range from structured standardised scales (e.g. PGCMS, WHOQOL) to unprompted open-ended questionnaires (e.g. Bowling 2000). They can be domain specific, as in physical health and its affects on quality of life, or they can
include multiple variables (e.g. income, social support, happiness, self-esteem, health), and be age- or group-specific. From the perspective of the current ESRC research project the Berlin Study of Aging’s (BASE) heuristic model provides researchers with a guide to measurements of quality of life (i.e. PGCMS and PANAS) and a model in which to situate socio-demographic, objective and subjective indicators. The substitutability and adaptability of this method make it suitable for other quality of life research projects.

Comparatively, the social scientific investigation of factors determining a ‘good’ quality of life in old age is still largely developmental. However, this may change due to the current saliency of quality of life within popular culture, and academic and political agendas. Although there is unlikely to be universal agreement on defining and measuring quality of life, it is hoped that through replication and emergence of recurrent factors, social science researchers will be able to define the determinants which contribute to a ‘good life’. Lawton (1997) is correct to pose the question: “Is there any chance that we can even measure a construct so complex? I say we can if we respect its complexity”. Only then can we begin to define, measure and understand our potential limitations in understanding this concept. This paper has sought to aid researchers in the conceptual understanding on quality of life. What is key, is that researchers trying to measure quality of life need to have a clear theoretical and philosophical position which helps guide the operationalisation and construction of methodology, and aid in the analysis of results.

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