Adding Quality to Quantity: Older People's Views on their Quality of Life and its Enhancement
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This study set out to explore older peoples' definitions of, and priorities for, a good quality of life. Nine hundred and ninety nine randomly sampled people aged 65 and over, living at home in Britain, were interviewed for the study.

Summary of key findings

Most men and women rated their quality of life as good in varying degrees, as opposed to just alright or bad. Quality of life deteriorated with older age, with almost three-quarters of the group aged 65-69 rating their lives overall as 'So good it could not be better' or 'Very good' in comparison with about half to a third of those in older age groups.

The main building blocks, or drivers, of quality of life in older age were:
- people's standards of social comparison and expectations in life;
- a sense of optimism and belief that 'all will be well in the end' rather than a tendency to think the worst (or glass 'half full' rather than 'half empty' perspective on life);
- having good health and physical functioning;
- engaging in a large number of social activities and feeling supported;
- living in a neighbourhood with good community facilities and services, including transport;
- feeling safe in one's neighbourhood.

Self-efficacy, and having a sense of control over one's life was possibly a mediating variable. These factors contributed far more to perceived quality of life than indicators of material circumstances, such as actual level of income, education, home ownership, or social class.

The results of the quantitative research were supported by the open-ended survey responses and by the qualitative interviews, with the addition of some other key factors – particularly, the importance of the perception of having an adequate income, and of retaining independence and control over one's life.

The main themes forming the foundations for a good quality of life which emerged from both the open-ended survey responses and the in-depth, follow-up interviews overlapped considerably. They were:
- having good social relationships with family, friends and neighbours;
- having social roles and participating in social and voluntary activities, plus other activities/hobbies performed alone;
- having good health and functional ability;
- living in a good home and neighbourhood;
- having a positive outlook and psychological well-being;
- having adequate income;
- maintaining independence and control over one's life.

Each of these areas was categorised by detailed sub-theme.

Wider society and political issues were mentioned most in relation to factors which took quality away from their lives.
(e.g. government policies on pensions, the environment, foreign policy issues).

Things which would improve the quality of their own lives, mentioned most often by respondents at both their survey interview and later at in-depth interview, were having better health and physical mobility, more money, better social relationships and living in a better home and neighbourhood.

It appears that, in older age when incomes are more levelled due to people's reliance mainly on pensions (although a wide range of annual income still exists), objective indicators of financial status are less sensitive than perceived financial circumstances. This finding has implications for the design of measurement instruments (i.e. perceptions are important to tap).

Self-efficacy (a measure of self-mastery and control over the important things in life), while significant in the early modelling, did not retain statistical significance in the final regression mode. It is possible that the measure of self-efficacy was either mediating between variables or it was insensitive to maintaining control over life, and thereby independence, in older age. Again, the implication is that, as people themselves say that this area is important for quality of life, then improved measures are needed.

Respondents often commented on the multifaceted nature of quality of life, and the interdependency of its components. For example, retaining one's independence and social activities were often described as being dependent on retaining good health and an adequate financial situation, as well as access to transport.

Older people's lives

Just over half said they had done most or all the things they had wanted to do in life, over a third said they had done some things, and about one in ten people said they had done few or none of the things they had wanted to.

Just over a fifth said they were less well off financially than they had expected to be, less than half said they were better off and just over a third said they were about as well off as they had expected to be.

About two-thirds of people were rated as optimists in their outlook on life.

Less than half of respondents felt they had 'A lot' of control over the important things in their lives, and less than half, felt they had 'Some' control; about one in ten people said they had 'Little' or 'No' control.

Over a third rated their health status as either 'Excellent' or 'Very good', about a further third rated it as 'Good', and just over a quarter (27 per cent) 'Fair' or 'Poor'.

Most respondents led an active life. Three-quarters of men and women equally said they had been on holiday or on outings in the last 12 months (although this dropped to about two-thirds of men and women aged 75 and over).

The majority said they had engaged in social or leisure activities, voluntary work or helped look after someone/child minded in the last month.

While most men and women said they had someone who would help them in various situations if necessary, those aged 75+ were less likely than those aged 75+ to say they had someone.

Most people rated the quality of the facilities in their area as either 'Very good', 'Good' or 'Average'. The facilities which were most likely to be rated as 'Poor' or 'Very poor' were social and leisure facilities, facilities for people aged 65+, transport, and closeness to shops.

Just over half rated their neighbourhoods as 'Very safe' to walk alone in during the daytime; most of the remainder said it was 'Fairly' to 'Very unsafe'. However, just one in eight people rated their neighbourhoods as 'Very safe' to walk alone in after dark, and the rest said that they felt it was 'Fairly' to 'Very unsafe or said they never went out after dark.

In the postal follow-up survey, the most commonly listed best things about growing older were: doing things one wants to/pleases self/independence and freedom/free from time constraints, the slower pace of life, having more time to pursue own interests/hobbies.

Most responses to the question on the worst things about growing older related to: poor health and deteriorating senses, loss of independence due to deteriorating health and functioning, being unable to do what one wants (from getting out and about to going on holiday). One in eight said that they were afraid of dying, and not knowing how long they had left to live.
Similarly, the most commonly mentioned fear about growing older was ill health and deteriorating physical ability, followed by physical dependency.

Respondents were asked how old they felt in comparison with their actual age. Most respondents felt younger than their ages; in fact about a third felt between 10<25 years younger. How old they considered someone to be old was associated with their own age (the older they were, the later old age was said to commence).

Conclusions
The comparison of results from the three different research approaches indicated that overall, quality of life is built on a series of inter-related drivers (main themes), which reflected a common consensus; while individuals also emphasised constituent sub-themes which reflected the variation between their lives (this was captured in the categorisation of the detailed information collected about their relationships, activities, home neighbourhood and so on).

In sum, the central drivers of quality of life, which were consistently emphasised by the three methods, were self-constructs and cognitive mechanisms (e.g. psychological outlook, optimism-pessimism), health and functional status, personal social networks, support and activities, and neighbourhood friendliness and support. The lay models also emphasised the importance of financial circumstances and independence, which need to be incorporated into a definition of broader quality of life.

The study also highlighted how areas of quality of life were inter-linked and had knock-on effects on each other (e.g. ill-health could lead to inability to drive a car, which in turn led to social isolation, loss of independence and to dependency on help from others, for example, for shopping).

Greater recognition is needed in definitions of quality of life research that influencing variables are not only people’s own personal characteristics and circumstances, but that there is also a dynamic interplay between people and their surrounding social structures in a changing society. Moving beyond health and functional status, and their impact on life, as a proxy concept and measure for quality of life, is important in order to achieve a better understanding of the quality of later life.

These findings contribute to the theoretical and practical, policy oriented body of knowledge on quality of life. They are unique in that they were empirically grounded in older people’s views, elicited using a triangulated approach, and also in how they highlight the way areas of quality of life are inter-linked and effect each other.

How quality of life in older age can be improved: the policy implications of the research

The more detailed results from each approach gave valuable indicators about how quality of life might be improved in older age for both men and women. People’s views, which have implications for policy, generally focused on enabling older people to maintain their health and independence, social activities, and relationships. Respondents emphasised the importance of living in a neighbourly and safe area, and having good local facilities to promote friendly and helpful relationships with other people, including neighbours. This was also seen to be important in preventing loneliness and isolation. Having good local facilities (shops, markets, post-office), health services, good local council services (street lighting, refuse collection, police, repairs), including a good local mobile/library, and having a pleasant landscape/surroundings was said to be important to their quality of life. Creation of local opportunities to meet other people and to maintain a role in society (e.g. work or voluntary work), access to transport and having enough money was said to be important for retaining independence.

The results indicate that: people should be encouraged to develop positive thinking and direct their perceptions upwards; they need to learn to be, and to feel, more in control of their everyday lives and competing demands on their lives; these characteristics are likely to enhance their coping skills in the face of the challenges of older age. People also need to involve themselves in social activities, and build up their support networks from a young age onwards. The importance of health and functioning underlines yet again the need to adopt healthy lifestyles and preventive health strategies throughout life in order to help retain independence.

Society also needs to work harder, and in partnership with local people, to promote local communities with good facilities, opportunities for social participation, increase independence, affordable and accessible trans-
port and services, and environments which are perceived to be safe. Society also has a collective responsibility to ensure that retirement pensions are adequate. These factors can lead to the experience of enhanced perceptions of quality of life in older age.

About the study
A survey of the quality of life of a random sample of 999 people aged 65 and over, living at home in Britain, was undertaken (the 999 people represented a response rate of 77 per cent). Participants were sampled over four seasons in 2000-2001 by members of the Office for National Statistics (ONS) from their national Omnibus Survey respondents, and invited by them to participate in the Quality of Life Survey. The 999 who consented were re-interviewed by ONS field staff two months after their Omnibus Survey interview. The respondents were similar in their socio-demographic characteristics to those of people aged 65+ in Britain from mid-term population estimates from the 1991 Census, and compared with respondents aged 65+, living at home, to the comparable General Household Survey.

The Quality of Life Survey was semi-structured, involving both open ended questions on people's perceptions of quality of life, and how it can be improved, followed by a broad range of structured measures of their psychological, social, health, environmental and socio-economic characteristics and circumstances (references available from the authors). The ONS Question Testing Unit also organised three focus groups with older people to inform the content of the questionnaire.

Interviews were conducted with the 999 people in their own homes. In addition, 80 of these survey respondents were followed up further by Zahava Gabriel, and interviewed in-depth in order to explore their perceptions of quality of life in greater detail. A BSc student attached to the project, Priya Solanki, conducted a postal follow-up survey of respondents at 12-18 months post-baseline survey interview.

Publications in scientific journals/chapters
(Other papers are in preparation or have been submitted for publication)

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