What is quality of life?

On the whole, social scientists have failed to provide consistent and concise definitions of quality of life. The task is indeed problematic, for definitions of life quality are largely a matter of personal or group preferences; different people value different things.

(George and Bearon 1980: 1)

Introduction

The phrase ‘quality of life’ is now widely used, both in academic writing and everyday life. It is one of those taken-for-granted terms, of which we think we know the meaning. Although there will be some common understanding of what is meant by ‘quality of life’, we may use the term differently in our private and professional lives. We might anticipate considerable variation in its meaning for people of different age groups and cultural backgrounds as well as significant gender differences.

Quality of life is one of a number of social science concepts, which are regularly used in everyday life and have become part of the cultural and political vocabulary. Perhaps the classic example is that of class. Within most sociological theories of social stratification, class refers to the power relations between social groups, particularly in terms of economic power (Giddens and Birdsall 2001). Yet in everyday life it is used in a number of ways, most commonly to describe different social groups in terms of lifestyle and culture. Consequently it is also used pejoratively to stigmatize different social groups, for example the so-called ‘underclass’. Thus in everyday life ‘class’ is used as a descriptive label rather than as an analytical concept. We may describe working-class people as economically less well-off than middle-class people but when invoking the vocabulary of the sociological theories of class, the nature of the power relation between these two groups only remains implicit.
A similar fate has befallen the concept ‘quality of life’. Like ‘class’, ‘quality of life’ has been a part of social science theory for a number of years but in the last forty years it has slowly entered into the cultural and political vocabulary. In social science users of the concept belong to a broad church. Thus uses of the concept encompass the built, physical, economic and social environments, as well as the meaning of life to the individual and the subjective experience of life quality.

The purpose of this book is to examine the concept of ‘quality of life’ as used by social science researchers in studying ageing and the experience of later life from a critical gerontological perspective. We will provide a critical approach to the conceptualization and measurement of quality of life in social gerontology and health and social care research. We are not providing a sourcebook of methods or measures of quality of life since a number of these exist already (for example Bowling (1995a) and Carr et al. (2003)). But we will re-examine what we mean by quality of life in a postmodern world, by exploring the impact of continuous personal and societal changes on the lives of older people. In so doing we will draw on a wide range of studies which have reported on the experiences of older people and which in various ways present their quality of life.

The emergence of the concept of quality of life

Before attempting to understand what we mean by ‘quality of life’, we consider the emergence of the concept in the social science and gerontological literature. Two traditions have dominated the way quality of life has been conceptualized and measured within the social sciences: social indicators research and quality of life outcomes in health and social policy research. Both traditions are supported by a substantial social science research industry sustained by the continuing need of policy makers and politicians to evaluate ‘quality of life’. The policy focus on quality of life in the European Union’s research agenda and the work of the Foresight panels (Foresight Ageing Population Panel 2000) illustrates the continuing importance of the concept of quality of life to European public policy. Consequently both traditions have focused on issues of measurement rather than developing the necessary theory to underpin the concept and its operationalization in public policy.

Social indicators research developed in response to the growing dissatisfaction among policy makers with economic indicators such as Gross National Product (GNP) per capita as measures of societal importance and also to a rising awareness that despite economic prosperity and growth in standards of living in the post-World War II era, groups of the population continued to be dissatisfied with their social well-being (Carley 1981). The emergence of quality of life research in health and social care reflects the shift in medical preoccupation from the management of acute to chronic disease and the focus on morbidity rather than mortality as an outcome of medical intervention. The recognition of the importance of quality as well as quantity of life is captured by the World Health Organization’s definition of health as ‘a state of complete physical, mental and social wellbeing’. Although both
these traditions were responding to different political, economic and social stimuli their parallel development has been important for the understanding of the quality of life of older people.

The term quality of life is a relatively recent term in the academic literature. It did not appear in the International Encyclopaedia of Social Sciences until 1968 and in Index Medicus until the mid-1970s. Life quality, however, was an implicit part of gerontological research in both Europe and North America for some time before. The British tradition emerged in the 1950s as part of the studies undertaken by the Institute of Community Studies (Townsend 1957, 1963; Young and Willmott 1957; Marris 1958; Townsend and Wedderburn 1965). This early work described the low level of material resources experienced by older people living in the East End of London during the postwar years and the poverty of the environment in which many older people lived. The tradition not only focused on the deprivation of urban postwar Britain but investigated the nature of urban communities, particularly the role that social networks and levels of social support played in determining a person’s quality of life (Townsend 1957). Retirement, bereavement, loneliness and isolation were highlighted as important influences on older people’s lives (Tunstall 1966; Townsend and Tunstall 1968). Much of this early work provided the framework for the development of the political economy perspective and the powerful theory of structured dependency (Townsend 1981) (see Chapter 5). The tradition has persisted to the present day through the writings of Chris Phillipson (Phillipson 1982, 1998; Laczko and Phillipson 1991) and Alan Walker (1980, 1981, 2000), among others, to provide a coherent understanding of later life and implicitly the quality of that life.

The American social gerontological tradition, which also emerged during the postwar period, focused more specifically on the subjective experience of later life. A core concept was life satisfaction, developed as part of disengagement theory (Cumming and Henry 1961) in the 1950s. A product of the dominant functionalist social science of the 1960s was the preoccupation with the measurement of life satisfaction (Neugarten et al. 1961) and subsequently ‘quality of life’ in American gerontological research, particularly clinical gerontology. This focus on the measurement of quality of life in older people reflects the dominant activity at the time which still dominates today: the measurement of the quality of life in health and illness. Within North America this has led to a highly productive industry for quality of life researchers and one which is now a global phenomenon. And, because of the preoccupation with health and ageing, it dominates our thinking about quality of life within social gerontology. It would be unfair to characterize the development of the concept in North America as without its critics. In a classic paper Jay Gubrium and Robert Lynott (1983) posed three key questions:

1 What is the image of life and satisfaction presented to subjects in the items of the five most commonly used scales and indices?
2 How might the image enter into the process of measurement?
3 How does the image compare with experiences of life and its satisfactions among older people revealed by studies of daily living?
These remain important questions and ones to which we return in Chapter 6.

**Defining quality of life**

It is not our intention to be typically ethnocentric in our approach to the topic of this book. In reviewing quality of life research it is evident that different studies have used widely different definitions and methods of assessing quality of life. These have been rooted in the cultures and taken-for-granted assumptions of policy makers and researchers. We do, however, need to provide some kind of framework in which to locate our discussion. From a critical social gerontology perspective two key principles have emerged. First, factors and criteria, which define a good quality of life for older people, are likely to apply equally to people from other age groups. Second, the experience of being an older person in contemporary society is determined as much by economic and social factors as by biological or individual characteristics. Thus, for example, in the context of chronic illness, quality of life is an individual experience which for older people will be influenced by their own general expectations and perceptions of older age and of living with ill health or disability.

*Expert definitions*

So what is quality of life? A useful starting point is Farquhar’s (1994) classification of quality of life definitions. She distinguishes initially between expert definitions and lay definitions. Three major types of expert definitions are identified: global, component and focused definitions. Global definitions are rather general. For example Abrams (1973) defines the expression of quality of life as the degree of satisfaction or dissatisfaction felt by people with various aspects of their lives. Or, put more simply, quality of life is the provision of the ‘necessary conditions for happiness and satisfaction’ (McCall 1975). Component definitions emphasize the multidimensional nature of the concept and separate different dimensions of quality of life. George and Bearon (1980) identified four dimensions, two of which are ‘objective’ (general health and functional status; socio-economic status) and two of which are ‘subjective’ (life satisfaction, self-esteem). In contrast, Hughes (1990) highlights eight dimensions, or what she describes as ‘constituent elements’, as part of a conceptual model of quality of life (personal autonomy, expressed satisfaction, physical and mental well-being, socio-economic status, quality of the environment, purposeful activity, social integration and cultural factors). A modified version of this approach has been presented in relation to the quality of life of people with dementia (Bond 1999) and has been further adapted and is presented in Table 1.1 (p.6). The third type of expert definitions, focused definitions, centre on just one or two of these dimensions and tend to reflect the political or professional agendas of different disciplines. For example, within health services research, quality of life often focuses on health and functional status measures (Bowling 1996) and within health economics, on utility assessment (Torrance 1986).
Lay definitions

In recent years there has been a resurgence in the view that lay rather than expert definitions are more appropriate. A good example here is the way that the disability movement has redefined the meaning of disability from the perspective of people who are differently abled. Despite a long tradition in British social gerontology of listening to the voice of older people, there are few studies that have attempted to seek the perspective of older people about their quality of life. Claims are often made that the perspective of the other is being used, for example in the field of health status measurement (Fitzpatrick et al. 1998), but most approaches base this assertion on the fact that older people are providing the data. In this context study respondents will be simply acting ‘as a passive vessel of answers’ (Holstein and Gubrium 1995: 7). A particular issue here is the way that study respondents will structure their responses as either public or private views (Corner 1999). We explore further some of these theoretical and methodological challenges in Chapters 5 and 6.

Population surveys of older people rarely focus on the lay definition of quality of life. They use the standard social epidemiological framework encompassing expert definitions and concepts (see for example Townsend 1957; Hunt 1978b; Bury and Holme 1990; Bowling and Windsor 2001; Phillipson et al. 2001). Yet on those occasions where older people have been asked to describe their quality of life, ‘older people can and do talk about their quality of life’ (Farquhar 1994: 152). Older people talk about quality of life in different contexts but the important components (most frequently mentioned) of a good quality of life are: family (children), social contacts, health, mobility/ability, material circumstances, activities, happiness, youthfulness and living environment (Farquhar 1994, 1995). Older people’s assessments of their quality of life appear to be based on their expectations (Fisher 1992), which in turn are grounded in their life experiences and life biographies. In reporting their experiences older people made comparisons with the experience of their peers as well as within their own lives. ‘They set their lives in context: the context of time’ (Farquhar 1994: 153). In our experience the context of place and time, and the context in which older people are telling their life stories will influence the kinds and detail of experiences which are reported. Thus the perceived status of the listener, for example whether he/she is a health professional or social science university researcher, will have an important bearing on the kinds of stories and the details of life stories reported.

A conceptual model

Accepting that there are a number of caveats, existing research suggests that expert definitions, which use component definitions, are broadly in line with the reports of older people themselves. We can therefore think of no better starting point than to reflect on Beverley Hughes’s account of the concept (Hughes 1990). Quality of life is a multidimensional concept, which has no clear or fixed boundaries. We have briefly seen that there is little agreement about what constitutes specific ‘domains’ of quality of life. Also it is clear that
there are different perspectives on how to assess a ‘high’ or ‘low’ quality of life or who determines the relevance of constituent elements to different individuals.

**Key domains**

Many of the key domains of quality of life identified in social gerontological research reflect the demand for policy research and particularly the evaluation of the physical and social environments in which people live. It is therefore important to distinguish *quality of life* from *quality of care* (Bond and Bond 1987). To some extent the original list of domains generated by Hughes (1990) and her subsequent conceptual model of quality of life has been influenced by that agenda. Successful ageing (Baltes and Baltes 1990a) has not, until relatively recently, contributed enormously to our understanding of the concept. Table 1.1 (adapted from Hughes 1990) lists the key domains that reflect a research agenda, which includes positive as well as negative aspects of ageing.

**Table 1.1** Domains relevant to the quality of life of older people

- **Subjective satisfaction**: global quality of life as assessed by individual older person.
- **Physical environmental factors**: standard of housing or institutional living arrangements, control over physical environment, access to facilities such as shops, public transport and leisure providers.
- **Social environmental factors**: family and social networks and support, levels of recreational activity and contact with statutory and voluntary organizations.
- **Socio-economic factors**: income and wealth, nutrition and overall standard of living.
- **Cultural factors**: age, gender, ethnic, religious and class background.
- **Health status factors**: physical well-being, functional ability and mental health.
- **Personality factors**: psychological well-being, morale, life satisfaction and happiness.
- **Personal autonomy factors**: ability to make choices, exercise control and negotiate own environment.

**Subjective satisfaction**

The most important domain of quality of life, if there is one, must be the overall satisfaction an individual has with life. This was a central part of the research done in the US over the last forty years (Neugarten et al. 1961; Palmore and Luikart 1972; Larson 1978; Campbell 1981; Chipperfield and Havens 2001) and has also been important in Britain (Hall 1976). The methods used to assess subjective satisfaction, however, have come under close scrutiny over the years and there remains considerable debate about what is being measured (Gubrium and Lynott 1983).
Physical environmental factors

The standard of the physical environment has been a significant factor in quality of life research. Housing quality has been judged by occupancy levels, the presence or absence of basic amenities such as indoor WC and hot running water, the presence of central heating in some or all rooms, as well as the general condition and state of disrepair of the building (Bond 1993b). It is noticeable how indicators of the physical environment have changed over the last fifty years, reflecting the relative improvement of housing stock since the 1950s. Similarly, the physical environment of institutional facilities such as nursing or residential homes have been judged by the proportion of single or multiple occupancy rooms, the nature of communal rooms, access for people with disabilities and again the physical condition of the building (Bond 1993b). The physical proximity of both housing and institutional facilities in relation to other community facilities such as shops and recreational facilities has always been seen as significant. But increasingly control over the physical environment has become an important standard of the quality of physical environments (Wagner 1988), reflecting once again the relative values of policy makers and society over time.

Social environmental factors

Family and social support networks have remained fundamental aspects of the social environment from the early community studies to the current day (Wenger 1996). This reflects not only the importance of the family and social networks in our social structure but also the policy maker’s preoccupation with community care (DHSS 1983a). Apart from the family and social networks, levels of recreational activity and social participation (including paid and unpaid work) and the availability of formal and informal services have been widely accepted as important indicators of the quality of the social environment (Willcocks et al. 1987; Allen et al. 1992; Allen and Perkins 1995).

Socio-economic factors

Given the hegemony of the globalized consumer culture and the response of individuals to that culture, income and wealth are seen as the key factors influencing quality of life. In absolute terms the list of the basic essentials of everyday life is increasing. Adequate cover, nutrition and warmth are taken for granted. Inequalities in the overall standard of living continue to dominate academic and political debate. Relative poverty (Townsend 1970) and relative deprivation (Runciman 1966) remain important factors in a person’s quality of life.

Cultural factors

In the social sciences we tend to recognize the presence of cultural differences resulting from the social status attributed to an individual’s age, gender, class
position, ethnic background or religious preference. When conceptualizing quality of life these factors are frequently treated as homogeneous but the reality is that there is often as much individual difference within social or cultural groups as there is between different social or cultural groups.

Health status factors

Later life is often characterized as one of sickness and infirmity. It is also, almost by definition, about the only certainty in life: death. It is therefore not surprising that health status continues to be treated by gerontologists as a very important factor in quality of life. Physical well-being, functional ability and mental health (Gurland and Katz 1992; Mroczek and Kolarz 1998) have all been shown to be associated with quality of life.

Personality factors

An individual’s personality and psychological make-up are often associated directly with mental health but also function indirectly to influence quality of life. Studies have investigated quality of life in terms of psychological well-being, morale, life satisfaction and happiness (George 1979). But perhaps the most important personality factor to quality of life is a person’s sense of self and personal identity (Taylor 1989).

Personal autonomy factors

Linked to personality factors but dependent also on the social and physical environments are personal autonomy factors such as the ability to make one’s own choices, the ability to exercise control and the ability to control or negotiate one’s own physical or social environment (Allen et al. 1992).

Quality of life as a relative concept

Apart from the ontological debate about the constituent elements of quality of life we have already hinted at two other key issues, namely how we define levels of quality in life and from whose perspective. The two are interlinked. Our dominant persuasion is to ‘take the perspective of the other’ and hence older people’s perspectives on quality of life should, in our view, have precedence over experts. But from a societal perspective the views of experts in terms of, for example, resource allocation, will remain important. Therefore, although throughout this book we take the perspective of older people themselves, it is important to recognize that other perspectives cannot be ignored in the study of quality of life.

Determining the quality in life remains particularly problematic. We would probably all agree that a high quality of life is better than a low one. Yet it would be ethnocentric and inappropriate to make a judgement about the quality of life of other cultures, for example, Amazon Indians whose hunter-gatherer existence and low life expectancy is not something usually coveted by the majority of Europeans. (Of course, the concept of quality of life is very
much a modernist concept and may not be one that exercises the thoughts of many people in traditional societies.) A simple solution to the definition of high and low quality would be to take only the perspective of individuals. How we each decide on what we mean by high or low quality of life would be an individual judgement. We can see that group consensus may evolve but within similar social groups there would always be individual preferences. If we reduced our understanding of quality to the sum of individual subjective experiences there would be little point in investigating quality of life. Equally quality cannot be reduced to objective and absolute assumptions determined by experts. From a societal perspective we should also recognize that consensus is not achievable. (Of course it will still be of interest to investigate how individual older people and experts arrive at their particular definition of quality. A good research question from a constructionist perspective would be about how ‘quality’ and ‘quality of life’ are socially constructed.)

Our preferred method of resolving the tensions between individual and societal perspectives on the one hand and objective and subjective definitions on the other hand is to define quality of life, like poverty and relative deprivation, as a relative concept. Such a concept must be grounded in theoretical constructions of ageing, something we return to in Chapter 5. Equally from a societal perspective it must be a concept that is measurable and have meaning for individuals within different social groups. We explore issues of measurement in Chapter 6. But what do we mean, then, when we describe quality of life as a relative concept? It is not simply one of individuals having different expectations of life, although this would be an element of it. Equally it would be inappropriate to regard quality of life simply as an aspect of relative deprivation resultant on the maldistribution of economic and social resources. But as a starting point we would argue that the quality of life of individuals is relative to the historical, economic and social context in which they are situated and will be influenced by individual life experience. We would therefore not expect older people to define their quality of life in the same terms as younger generations. Likewise we would not expect older people with disabilities to use the same criteria when assessing their quality of life as those older people without disabilities. We would expect people of different cultures to view quality of life in different ways. By using ‘quality of life’ in relative terms we are free in the following chapters to examine the concept from a number of perspectives and to ground the concept within a number of specific theoretical contexts.

This book comprises a further six chapters. In Chapter 2 we focus on how older people describe their own quality of life, situating their accounts within the context in which they are constructed. We draw on both explicit and implicit accounts. Chapter 3 summarizes some of the experiences of growing older in contemporary multicultural society. The chapter highlights aspects of the built environment and the living arrangements of older people. Data on standards of living, family and social networks and health and well-being are presented.

What is the meaning of quality of life to older people and how is it presented by the arts and the media? Chapter 4 highlights the enormous
variability in the experiences of older people and focuses on the meaning that quality of life has to older people. It also contrasts the different ways that the arts and the media have explicitly represented quality of life in older people.

How much do existing social gerontological theories reflect the concerns and interests of older people? Chapter 5 evaluates some of the key theories that could be used to explain the quality of later life. The chapter explores institutionalized ageism and structured dependency theory, and social participation and theories of productive ageing. It also examines the importance of self-esteem and other social psychological constructs that mediate the everyday experience of the social world.

How should quality of life be assessed in gerontological research? Chapter 6 reviews the key issues in the measurement of quality of life drawing on the large literature and experience from the health field. It will compare different methods used routinely in research and discuss the importance of gaining the perspective of the older person.

In our final chapter we bring together key issues from the previous six chapters and present an alternative approach to quality of life and older people. We will describe a framework for understanding quality of life that suggests the meaning that individuals give to their quality of life is probably determined by their life context: by the political, economic and cultural influences of the society in which they live; by individual lived experience across the life course; by their current expectations, attitudes and values and by the context in which the individuals reflectively provide this account. We argue for the need to rethink the way we use the concept ‘quality of life’ in gerontological research, policy and practice and suggest how the concept might be used more effectively.