

Elderly people's perspectives on quality of life

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ABSTRACT

Quality of life has become increasingly important as an outcome in medical research. The influence of health status is often emphasised, but other dimensions are important. In order to improve quality of life, there is a need to know what people themselves consider important to their perception of quality of life. The aim of this study was to investigate what older people consider to be important for their quality of life, and to explore the impact of gender, education and health status on individual perceptions. The study was of 141 randomly selected people aged from 67 to 99 years that formed a control sample for a study of suicide among older people. They were interviewed in person about their health, socio-demographic background and, using an open-ended question, what they considered to constitute quality of life. Their answers were grouped into eight categories, with social relations being the most frequent response, followed by health, activities, functional ability, wellbeing, personal beliefs and attitudes, their own home and personal finances. In addition, they were asked to choose from a 'show card' three items that they regarded as important to quality of life. Functional ability was the most frequently selected domain, followed by physical health, social relations and being able to continue to live in one's present home. Our conclusion is that social relations, functional ability and activities influence the quality of life of elderly people as much as health status.

KEY WORDS – quality of life, aged 80 plus, health status, socio-economic factors.

Introduction

Quality of life has become increasingly important as an outcome in medical research and there is a vast literature on the topic. A *Medline* search with quality of life as the MeSH Major Topic for publications during January 1990 to May 2004 yielded over 15,000 hits. Many quality of life instruments have been developed during recent decades (Anderson

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et al. 1996; Wood-Dauphinee 1999). The impact of health status on the quality of life is often emphasised; indeed, many quality of life instruments measure general health status rather than quality of life (Faden and German 1994; Leplege and Hunt 1997; Carr and Higginson 2001). Some use the term health-related quality of life (Faden and German 1994; Leplege and Hunt 1997) to emphasise that they measure the quality of life as influenced by health status, but the two terms are sometimes confounded (Gill and Feinstein 1994; Albert 1998). There are many dimensions of quality of life besides health status; many quality of life instruments include different dimensions or domains such as physical functioning, emotional functioning, cognitive functioning, social functioning, life satisfaction, health perceptions, economic status, recreation, sexual functioning and energy and vitality (Arnold 1991).

The influence of health status on the quality of life is not easily understood. Functional status and symptoms may well have an impact on quality of life, but they are not synonymous with quality of life (Hunt 1997). Assumptions about the overall quality of life of individual patients should not be based on measures of their health status alone (Covinsky *et al.* 1999). As Albrecht and Devlieger (1999) pointed out, many people rate their quality of life as 'good' or 'very good' despite poor health status – the 'disability paradox'. Quality of life is a dynamic construct (Allison, Locker and Feine 1997). It varies among individuals and also for one person at different stages in life and by health status and experience (Carr, Gibson and Robinson 2001). Psychological phenomena such as adaptation, coping, expectancy, optimism, self-control and self-concept modify the individual's conception of quality of life (Allison, Locker and Feine 1997).

Quality of life measurements have been criticised on the grounds that there is no clear definition of what quality of life is and how it is operationalised (Hunt 1997). Gill and Feinstein (1994) found that only 11 of 75 articles that measured quality of life actually defined the concept. They concluded that quality of life can only suitably be measured by determining the opinions of patients and by supplementing (or replacing) the instruments developed by 'experts'. If social and health services are to assist people improve their quality of life, they need to know what aspects of their lives people themselves consider to be important, but few studies have asked individuals to define what these are (Carr and Higginson 2001). Bowling (1995) asked a random sample of 2,000 British adults about the most important things in their lives. They most frequently mentioned relationships with family or relatives, followed by their own health. Similar results were reported by Farquhar (1995), who found that among 204 British people aged 65 or more years, social contacts and health status were

similarly valued components of a good quality of life. A Swedish study asked 87 healthy elderly people about what quality of life meant to them, and found an emphasis on health and independence, contentment and a peaceful life, and personal integrity in terms of moral and caring attitudes (Nilsson *et al.* 1996).

Quality of life among older people has also been studied in projects funded by the UK Economic and Social Research Council (ESRC) *Growing Older* Programme (Walker 2004). In one of these, Gabriel and Bowling (2004) found the main quality of life themes to be social relationships, home and neighbourhood, social capital, psychological wellbeing and outlooks, activities and hobbies, health and functional ability, and social roles and activities. In another study, Wiggins *et al.* (2004) found the quality of life in early old age to be influenced by social support and participation, the quality and quantity of social contact, feelings of trust and reciprocity about local neighbourhood, health and security. Despite these studies, information on what older people consider constitutes a good quality of life remains scarce. The aim of this study was to investigate what elderly people consider to be important for their quality of life, and to explore the impact of gender, education and health status on individuals' perception of quality of life.

Study population and methods

The study population was Scandinavian-born men and women aged 65 or more years who lived in the City of Göteborg and an extensive rural area in the west of Sweden in 1997. The elderly (65 + years) population of the study area was 210,703. The subjects were a control sample in a study of suicide among older people, and were randomly chosen from the roster of the regional tax authorities, living in the same area and with the same sex and birth year (+/− 2 years) as the study cases in the suicide study (Rubenowitz *et al.* 2001): 240 people were invited and 153 participated (response rate 64 per cent). The reasons for non-participation included poor health (13), social reasons (8) and lack of interest (60). This study included those who were interviewed in person (face-to-face or by telephone) and answered the questions on quality of life. Thus, we excluded ten proxy interviews (due to dementia) and two interviews lacking responses to the quality of life questions. A total of 141 people (79 men, 62 women) participated in this study, of whom six were interviewed by telephone (by their choice). Socio-demographic background data for the participants are shown in Table 1. The over-representation of men was because the subjects were chosen as a control group in a study on suicides.

TABLE I. *Characteristics of the participants*

Attribute	Men	Women
Age groups (years)		
65–69	7	4
70–74	27	14
75–79	15	21
80–84	8	11
85–89	14	9
90–94	4	2
95+	4	1
Marital status		
Never married	8	2
Married/cohabitating	50	21
Divorced	3	3
Widow/widower	18	36
Educational level		
Elementary only	38	30
Above elementary	41	32
Social class¹		
I	22	11
II	25	21
III	32	30
Total (sample sizes)	79	62

Notes: 1. According to the *Swedish Socio-economic Classification*. Social class I (SEI > 47) are professionals and other higher non-manual employees, or self-employed; social class II (SEI 33–47) are lower to intermediate non-manual employees; and social class III (SEI 11–22) are manual workers (*Swedish Socio-economic Classification* 1995. Statistics Sweden, Stockholm.).

The median age was 76 years for both men (range 67–98 years) and women (range 67–99 years).

The interviews were carried out using a semi-structured questionnaire during March 1998 to September 1999. The subjects were sent a letter with information about the study and later telephoned. The interviews were undertaken by a geriatrician (KW), a psychiatric occupational therapist (CA), and a psychiatric nurse, all being experienced interviewers. Most took place in the participants' homes, although a few chose the interviewer's office. The questionnaire covered the informant's socio-demographic characteristics and what they considered to be their quality of life and health status. There was an open-ended question, 'What is quality of life for you?' Then, they were asked to choose three statements from a show card about things that might influence the quality of life.¹ They were not asked to place them in rank order.

Among the respondents, 138 people (77 men and 61 women) answered the open-ended question. The answers were categorised by two of the authors (KW, CA) after reading all the answers. Each response was

fragmented into statements in different categories, but each response could only contribute once to a category. The categorisation was re-evaluated until the various categories accorded with the original statements and all the statements were categorised.

Turning to the responses to the show card list, 139 people (77 men and 62 women) gave three answers, but two men (aged 84 and 90 years) did not choose any item from the show card (one said that all were equally important). The single items were grouped into domains after all the interviews were complete, and it was found that the domains included different numbers of items (Tables 3–4). If a participant selected more than one item from the same domain, the answer was included only once.

We used the *Cumulative Illness Rating Scale for Geriatrics* (CIRS-G) (Miller *et al.* 1992) to assess 'illness burden'. This rating scale is a modification of the *Cumulative Illness Rating Scale* that indicates the common health problems of older people (Linn, Linn and Gurel 1968). The revised scale provides ratings of disability in 13 somatic organ systems plus psychiatric disorders. The scores range from '0' (no problems) to '4' (severe illness/severe impairment in function).² Severe illness was defined as a rating above '2' in any category.

Statistical analyses

Since men were over-represented, the results were calculated for men and women separately. Statistical tests of the differences between subgroups yielded no more significant results than mere chance.

Results

The informants descriptions of quality of life

Analysis of the open-ended question 'What is the quality of life for you' resulted in eight categories (Table 2). The most frequently mentioned domain was *social relationships*, followed by *health*, *activities* and *functional ability*. This rank order was similar for men and women, although the ordering differed by gender for the less frequently mentioned domains *own home*, *finances* and *personal beliefs and attitudes*. The frequencies of the most common answers did however differ greatly between men and women, partly because on average women gave 27 per cent more answers than men. *Social relations* were cited by 72 per cent of women but only 44 per cent of men, and *health* by 52 per cent of women and 38 per cent of men.

The references to *social relations* included answers that directly described contacts with other people, and references to people, actions or states that implied contact with other people, *e.g.* 'friendship, honesty', 'children,

TABLE 2. *Response categories to the open-ended question, ‘What is quality of life for you?’*

Category	Men		Women	
	Number	Per cent	Number	Per cent
Social relations	34	44	44	72
Health	29	38	32	52
Activities	27	35	20	33
Functional ability	25	32	19	31
Wellbeing	11	14	15	25
Living in one’s own home	8	10	7	11
Personal finances	4	5	6	10
Personal beliefs and attitudes	10	13	5	8
Number of respondents	77	191 ¹	61	242 ²
Total number of statements	148	100	148	100

Notes: Shown as number and percentage of statements. Each response can be represented in more than one category. 1. On average, each man gave 1.9 statements. 2. On average, each woman gave 2.4 statements.

grandchildren’, ‘helping others’, ‘to be needed’, ‘good relations’, ‘light, warmth, kind people’, ‘live in harmony’, and ‘have a wife who fries meatballs and mends stockings’. Statements about *health* included references to symptoms and being healthy, such as ‘to be healthy’, ‘not being depressed’, ‘good health’, ‘breathe easily’ and ‘not having pain’. Statements about *activities* referred to doing things, such as ‘travel’, ‘music’, ‘leisure-time’, ‘to be occupied’, ‘go for a walk’, ‘play bridge’, ‘flowers’, ‘a good book, a good wine’ and ‘experience things’.

The replies categorised as *functional ability* included references to independence and the ability to do things, such as: ‘not being dependent on others’, ‘good sight’, ‘to have energy to go to the forest’, ‘to get up in the morning and be able to exercise’, ‘to be able to remember’, ‘to be able to go out’, ‘be able to walk’, and ‘be able to sing’. If the respondent used the word ‘able’, the statement was considered to belong to this category, despite the fact the respondent might have thought of the activity rather than the ability to perform the activity. Statements about *wellbeing* included references to various feelings and experiences of life, such as: ‘to be content with one’s existence’, ‘feeling good’, ‘to get on well with oneself and the surroundings’, ‘humour’, ‘the days I feel better’, ‘to get on well with the work’ and ‘to flourish’.

Answers that referred to *own home* included descriptions of the home environment and the ability to continue to live in the home, such as: ‘a good home’, ‘remain living in the nursing home’, ‘everything around you’ and ‘have a home you like being in’. It is therefore apparent that ‘home’ was the present accommodation that might be a residential

institution. The *finances* domain included statements regarding economic independence and not worrying about one's personal finances. Statements about *personal beliefs and attitudes* included references to religion and attitudes about ways of living, such as: 'eating the right sort of food so you feel well', 'not denying yourself' and 'contact with church'.

Show card domains and items

Tables 3 and 4 present the show card domains and items selected by the men and women informants. The most frequently selected show card domain for both was *functional ability* (Table 3). *Physical health* was the second most common domain in men, followed by *the own home*, *social relations* and *mental health*. As single items, *physical health* was chosen by more than 50 per cent of the men, followed by *remain living in one's home* and *contact with friends and relatives*. The second most common domain among women was *social relations*, followed by *physical health*, *own home* and *mental health*. The single item most frequently selected by women was *remain living in one's home* followed by *contact with friends and relatives* and *physical health*. Women selected *functional ability* and *social relations* more often than men, while men selected *physical health* more often.

Both men and women aged 80 or more years selected *functional ability* and *remain living in one's home* relatively more frequently and *social relations* less frequently than their younger counterparts (Table 3). Both men and women who had a severe illness (having at least one CIRS-G rating of '3' or '4') selected *social relations* more frequently (Table 4). Women with a severe illness also selected *functional ability* more often than healthier women. Men with a severe illness selected *physical health* less often than healthier men. Within the domain *physical health*, both men and women with severe illness tended to select the item *having no pain*, in contrast to those without severe illness who preferred the item *physical health*. For women there was also a shift within the domain *functional ability*, in the sense that those with severe illness included *ability to do housework* less often, and *ability to manage personal hygiene* more often, than those without severe illness. Men with education beyond the mandatory level selected *physical health* more often and *remain living in one's home* less often than men with only elementary schooling. Women with extended education selected *mental health* and *social relations* more often and *functional ability* less often.

Discussion

This exploratory study has collected information from a relatively small sample and, as a result, few findings are statistically significant. Nor was

TABLE 3. *The domains and single items identified as influencing quality of life by gender and age group*

Domain and items	Men Age group (years)			Women Age group (years)		
	Less than 80	80 or more	All	Less than 80	80 or more	All
Physical health	65 (50–78)	57 (37–76)	62 (51–73)	49 (32–65)	48 (27–69)	48 (35–61)
Physical health	53 (38–67)	50 (31–69)	52 (40–63)	44 (28–60)	30 (13–53)	39 (27–52)
Having no pain	18 (9–32)	4 (0–18)	13 (6–23)	5 (1–17)	17 (5–39)	10 (4–20)
Not feeling tired	6 (1–17)	4 (0–18)	5 (1–13)	3 (0–13)	9 (1–28)	5 (1–13)
Mental health	33 (20–47)	46 (28–66)	38 (27–49)	49 (32–65)	26 (10–48)	40 (28–54)
Mental health	24 (13–39)	25 (11–45)	25 (16–36)	20 (9–36)	4 (0–22)	14 (7–26)
Cognitive function	14 (6–27)	21 (8–41)	17 (9–27)	31 (17–48)	22 (7–44)	27 (17–40)
Functional ability	59 (44–73)	71 (51–87)	64 (52–74)	62 (44–77)	87 (66–97)	71 (58–82)
Able to do housework etc ¹	16 (7–30)	14 (4–33)	16 (8–26)	28 (15–45)	22 (7–44)	26 (16–38)
Able to manage personal hygiene etc ²	26 (15–41)	18 (6–37)	23 (14–34)	26 (13–42)	35 (16–57)	29 (18–42)
Able to read	10 (3–22)	11 (2–28)	10 (5–19)	18 (7–34)	26 (10–48)	21 (12–33)
Able to hear well	6 (1–17)	11 (2–28)	8 (3–16)	3 (0–13)	4 (0–22)	3 (0–11)
Energy to do what you want to	12 (5–25)	25 (11–45)	17 (9–27)	13 (4–27)	22 (7–44)	16 (8–28)
Able to feel engaged	2 (0–11)	14 (4–33)	6 (2–14)	3 (0–13)	4 (0–22)	3 (0–11)
Social relations	43 (29–58)	36 (19–56)	40 (29–52)	54 (37–70)	44 (23–66)	50 (37–63)
Contact with friends and relatives	29 (17–43)	29 (13–49)	29 (19–40)	46 (30–63)	30 (13–53)	40 (28–54)
Participation in clubs and organisations	2 (0–11)	0	1 (0–7)	3 (0–13)	0	2 (0–9)
Not feeling lonely	12 (5–12)	0	8 (3–16)	8 (2–21)	13 (3–34)	10 (4–20)
Feeling needed	10 (3–22)	11 (2–28)	10 (5–19)	8 (2–21)	0	5 (1–13)
Own home						
Remain living in one's home	41 (27–56)	50 (31–69)	44 (33–56)	36 (21–53)	52 (31–73)	42 (30–55)
Economy						
Not worrying about personal finances	14 (6–27)	11 (2–28)	13 (6–23)	8 (2–21)	0	5 (1–13)
Sample sizes	49	28	77	39	23	62

Notes: The figures are the percentages that selected the domains and items from the show card. Each informant could contribute up to three items, therefore the sums of all domains/items are more than 100 per cent. 95 % confidence intervals in brackets. 1. Able to do activities of daily living, such as cleaning, cooking and shopping. 2. Able to manage personal hygiene, dressing *etc.*

the sample totally representative of the older population, since men were over-represented. The separate results for the male and female subsamples may be taken as representative of elderly men and elderly women. When comparing studies of quality of life from different countries, one must be aware that linguistic as well as cultural – including ethnic, political and civic – differences might be influential (Bajekal *et al.* 2004; Warnes *et al.* 1999). The Swedish word for quality of life, *livskvalitet*, has the same meaning and nuances as the English term. Nonetheless, different languages make it difficult to compare our findings with studies done in other countries, especially when the respondents had to choose from the show card. Cultural differences might have especially influenced the answers to the open-ended question.

Although the conclusions must be cautiously drawn, several findings are striking and in accordance with previous studies. In answer to our question on what they themselves considered to constitute quality of life, all but a few had no difficulty understanding the term 'quality of life'. Even though many authors have emphasised that quality of life is individual and is best evaluated by the individual (Gill and Feinstein 1994; O'Boyle 1997), there have been few similar, systematic and comparable studies (Bowling 1995; Farquhar 1995; Nilsson *et al.* 1996; Gabriel and Bowling 2004).

Both an open-ended question and the selection of items from a show card were used. There were some discrepancies in the responses to the two approaches. Showing a list clearly prompts the participant to choose items from that list (Bowling 1995). *Social relations* dominated the answers to the open question, while *functional ability* was the domain most frequently chosen from the show card. *Remain living in one's home* was frequently chosen from the show card, but seldom mentioned in the responses to the open-ended question. *Activities* were not included on the show card, but were commonly mentioned among the responses to the open question. The importance of *activities* and *functional abilities* was in accordance with the representation of good health in old age as including the ability to 'go and do' meaningful activity (Bryant, Corbett and Kutner 2001), and with the main quality of life themes in the study by Gabriel and Bowling (2004). The order of the items on a show card might also influence the answers, including the frequency of references to different domains. The fact that there were more references to *functional ability* than any other domain on the show card may be a reason for the high number of responses that referred to this domain. The use of pre-coded responses might also influence the answers. These methodological influences must be borne in mind when interpreting results from different quality of life instruments.

TABLE 4. Domains and single items that influence quality of life by severe illness, loneliness and education and by gender

Gender, domains and items	Severe illness ¹		Loneliness ²		Education ³	
	No	Yes	No	Yes	Low	High
A. MEN						
Physical health	67 (52–80)	55 (36–74)	63 (51–75)	56 (21–86)	55 (38–71)	69 (52–83)
Physical health	58 (43–72)	41 (24–61)	53 (40–65)	44 (14–79)	50 (33–67)	54 (37–70)
Having no pain	8 (2–20)	21 (8–40)	13 (6–24)	11 (0–48)	13 (4–28)	13 (4–27)
Not feeling tired	4 (0–14)	7 (1–23)	4 (1–12)	11 (0–48)	3 (0–14)	8 (2–21)
Mental health	42 (28–57)	31 (15–51)	40 (28–52)	22 (3–60)	34 (20–51)	41 (26–58)
Mental health	33 (20–48)	10 (2–27)	28 (18–50)	0	16 (6–31)	33 (19–50)
Cognitive function	15 (6–28)	21 (8–40)	16 (8–27)	22 (3–60)	24 (11–40)	10 (3–24)
Functional ability	65 (49–78)	62 (42–79)	62 (49–74)	78 (40–97)	60 (43–76)	67 (50–81)
Able to do housework etc ⁴	17 (7–30)	14 (4–32)	12 (5–22)	44 (14–79)	13 (4–28)	18 (8–34)
Able to manage personal hygiene etc ⁵	23 (12–37)	24 (10–44)	25 (15–37)	11 (0–48)	21 (10–37)	26 (13–42)
Able to read	15 (6–28)	3 (0–18)	10 (4–20)	11 (0–48)	10 (3–25)	10 (3–24)
Able to hear well	8 (2–20)	7 (1–23)	7 (2–16)	11 (0–48)	10 (3–25)	5 (1–17)
Energy to do what you want to	15 (6–28)	21 (8–40)	16 (8–27)	22 (3–60)	16 (6–31)	18 (8–34)
Able to feel engaged	8 (2–8)	3 (0–3)	7 (2–16)	0	10 (3–25)	3 (0–13)
Social relations	35 (22–51)	48 (29–67)	41 (29–54)	33 (7–70)	42 (26–59)	38 (23–55)
Contact with friends and relatives	27 (15–42)	31 (15–51)	29 (19–29)	22 (3–60)	34 (20–51)	23 (11–39)
Participation in clubs and organisations	0	3 (0–18)	2 (0–8)	0	0	3 (0–13)
Not feeling lonely	4 (0–14)	14 (4–32)	7 (2–16)	11 (0–48)	5 (1–18)	10 (3–24)
Feeling needed	12 (5–25)	7 (1–23)	12 (5–22)	0	8 (2–21)	13 (4–27)
Own home						
Remain living in one's home	42 (28–57)	48 (29–67)	43 (31–55)	56 (21–86)	50 (33–67)	38 (23–55)
Finances						
Not worrying about personal finances	8 (2–20)	21 (8–40)	13 (6–24)	11 (0–48)	13 (4–28)	13 (4–27)
Sample sizes	48	29	68	9	38	39

B. WOMEN

Physical health	49 (32–65)	48 (27–69)	48 (34–63)	50 (21–79)	50 (31–69)	47 (29–65)
Physical health	41 (26–60)	35 (16–57)	38 (25–53)	42 (15–72)	33 (17–53)	44 (26–62)
Having no pain	5 (1–17)	17 (5–39)	10 (3–22)	8 (0–38)	13 (4–31)	6 (1–21)
Not feeling tired	5 (1–17)	4 (0–22)	4 (0–14)	8 (0–38)	10 (2–27)	0
Mental health	46 (30–63)	30 (13–53)	44 (30–59)	25 (5–57)	30 (15–49)	50 (32–68)
Mental health	15 (6–31)	13 (3–34)	14 (6–27)	17 (2–48)	10 (2–27)	19 (7–36)
Cognitive function	31 (17–48)	22 (7–44)	32 (20–47)	8 (0–38)	20 (8–39)	34 (19–53)
Functional ability	64 (47–79)	83 (61–95)	68 (53–80)	83 (51–98)	80 (61–92)	62 (44–79)
Able to do housework etc ⁴	31 (17–48)	17 (5–39)	26 (15–40)	25 (5–57)	37 (20–56)	16 (5–33)
Able to manage personal hygiene etc ⁵	23 (11–39)	39 (20–61)	28 (16–42)	33 (10–65)	37 (20–56)	22 (9–40)
Able to read	23 (11–39)	17 (5–39)	20 (10–34)	25 (5–57)	17 (6–35)	25 (11–43)
Able to hear well	3 (0–13)	4 (0–22)	4 (0–14)	0	7 (1–22)	0
Energy to do what you want to	13 (4–27)	22 (7–44)	18 (9–31)	8 (0–38)	17 (6–35)	16 (5–33)
Able to feel engaged	5 (1–17)	0	4 (0–14)	0	0	6 (1–21)
Social relations	46 (30–63)	56 (34–77)	50 (36–64)	50 (21–79)	43 (25–63)	56 (38–74)
Contact with friends and relatives	38 (23–55)	44 (23–66)	40 (26–55)	42 (15–72)	30 (15–49)	50 (32–68)
Participation in clubs and organisations	3 (0–13)	0	2 (0–11)	0	3 (0–17)	0
Not feeling lonely	10 (3–24)	9 (1–28)	10 (3–22)	8 (0–38)	13 (4–31)	6 (1–21)
Feeling needed	5 (1–17)	4 (0–22)	6 (1–17)	0	3 (0–17)	6 (1–21)
Own home						
Remain living in one's home	44 (28–60)	39 (20–61)	38 (25–53)	58 (28–85)	43 (25–63)	41 (24–59)
Finances						
Not worrying about personal finances	3 (0–13)	9 (1–28)	4 (0–14)	8 (0–38)	7 (1–22)	3 (0–16)
Sample sizes	39	23	50	12	30	32

Notes: One person can contribute up to three items, so the sum of all domains/items is more than 100 per cent. 95 per cent confidence interval in brackets. 1. Severe illness: at least '3' or '4' on CIRS-G. 2. Yes or no to the question, 'Do you have problems with loneliness?' 3. Low education: mandatory years only or less. High education: more than mandatory years. 4. Able to do activities of daily living, such as cleaning, cooking and shopping. 5. Able to manage personal hygiene, dressing etc.

Neither the open-ended question nor the show card generated *health* as the most frequently mentioned category or domain, and *social relations*, *activities* and *functional ability* were valued as equally important. This was true for men and for women, accorded with Bowling's (1995), Farquhar's (1995), Gabriel and Bowling's (2004) and Wiggins *et al.*'s (2004) results, and emphasises the important role of non-health dimensions in quality of life. In Bowling's study, more than 50 per cent of the respondents mentioned finances, standard of living, or housing. Gabriel and Bowling (2004) and Wiggins *et al.* (2004) also found that the home, neighbourhood and finances were important aspects of quality of life. These findings contrast with those of Nilsson *et al.* (1996) and our own, that *own home*, *finances* and *not worrying about finances* were among the least commonly cited domains and items. On the other hand, when selecting from the show card list, the ability to *remain living in one's home* was highly valued. Given the wording 'to be able to remain living in your home', the responses might have been grouped within the *functional ability* domain.

Wellbeing and *personal beliefs and attitudes*, while not mentioned as frequently as *social relations*, *health*, *activities* and *functional ability*, were also important aspects of quality of life, as acknowledged in earlier studies. Bowling (1995) included items on religion and spiritual life, and *The World Health Organisation Quality of Life Assessment Group* (WHOQOL 1998) has the domain 'spirituality/religion/personal beliefs'. Psychological wellbeing has been recognised as important in many studies (*e.g.* Costantini *et al.* 2000; Gabriel and Bowling 2004).

There were few statistically significant differences between the subgroups (results not shown), indeed no more than could be expected by mere chance, which partly reflects the small sample sizes, but nonetheless there were interesting findings. The fact that women included *functional ability* and *social relations* more frequently than men can be seen as part of women's greater responsibility for the household and social networks. This finding is congruent with that of Bowling (1995), that women valued social relations more than men. Growing old increases the risk of functional impairment and thereby increases the risk of having to move to a nursing home. This might explain why men and women aged 80 or more years valued *functional ability* and *remain living in one's home* more than the younger respondents. These results are similar to those of Farquhar (1995), who asked elderly people what would improve their quality of life. Those aged 85 or more years answered *to be more mobile/able* more than twice as often as those aged 65–85 years. People with severe illness chose the item *having no pain* instead of *physical health*, compared to those not having any severe illness. This might be an adaptation to the reality of having a severe

illness, with a focus on the symptoms. There was a shift from *able to do housework* to *able to manage personal hygiene* for women with severe illness, which also can be seen as an adaptation in persons who require help with the housework.

As Allison, Locker and Feine (1997) pointed out, quality of life is dynamic and modified by psychological phenomena such as adaptation and coping. 'Response shift', which involves changing internal standards, values and the conceptualisation of quality of life, can be an important mediator of this adaptation process (Sprangers and Schwartz 1999). One way of enhancing quality of life for those with chronic illness is by helping them adjust their expectations and adapt to their changed clinical status (Carr, Gibson and Robinson 2001). Albrecht and Devlieger (1999) stated that quality of life is dependent upon the individual finding a balance among body, mind and spirit, and on the ability to establish and maintain a harmonious set of relationships given the person's social context and external environment. Those with severe illness also selected *social relations* more frequently than their healthier counterparts. That social relations are highly valued by people with severe disease such as cancer has previously been shown (*e.g.* Costantini *et al.* 2000). Gabriel and Bowling (2004) pointed out that there is a dynamic interplay between people and the surrounding social structures of a changing society. Facilitating social relations and activities, and enhancing functional ability, might improve the quality of life of elderly people as much as medical treatment.

Conclusion

Quality of life is a dynamic concept, and its interpretation is influenced by many individual factors such as age and illness. Determining the factors that influence quality of life among older people needs to draw on the perspectives of the individuals involved. To summarise the findings of this exploratory study, it has been shown that there were clear differences in what was perceived to be important to quality of life among different subgroups. Those aged 80 or more years particularly valued functional ability, and those with severe illness placed a relatively high valuation on social relations. Further research is needed to confirm these differences. The essential point is that other dimensions besides health status are important to the quality of life of elderly people. Our conclusion is that social relations, functional ability and activities may influence the quality of life of elderly people as much as health status. This is important to bear in mind whenever including quality of life as an outcome.

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NOTES

- 1 The list on the show card was prepared by one of the authors (KW), who has several years' experience in geriatrics and research interviewing. The list included several items that are often used in quality of life instruments (Arnold 1991; Carr and Higginson 2001), which were adapted, drawing on our clinical geriatric experience. The items covered (in this order): physical health; mental health; cognitive function; having no pain; to be able to do activities of daily living, such as cleaning, shopping, cooking; to be able to manage personal hygiene, dressing etc.; to have contact with friends and relatives; to be able to read; to be able to hear well; participation in clubs and organisations; not feeling lonely; not feeling tired; energy to do what you want to; to be able to feel engaged; to feel needed; to be able to remain living in your home; not to worry about personal finances; and other things. The list was read out loud (several times if needed) for the six people interviewed by telephone.
- 2 A rating of '0' indicates no problem; of '1' indicates current mild problem or past significant problem; of '2' moderate disability or morbidity, or requires 'first line' therapy; of '3' severe/constant significant disability, or 'uncontrollable' chronic problems; and of '4' extremely severe problems, or immediate treatment required, or end-stage organ failure, or severe impairment in function.

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