4.6 Quality of Life and Well-Being
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Why Measuring Quality of Life in Early Old Age?

One of the innovations of SHARE is the inclusion of a newly developed measure of quality of life in early old age. This innovation is important because the majority of people living in the so called third age are in good health and capable of participating in a variety of activities. It has been repeated again and again that adding life to years is as important as adding years to life. Thus, a measure is needed that identifies and quantifies those aspects of quality of life in early old age that are specific to a stage in the life course characterised by transition from work to retirement, by an increase of personal freedom and by new options of social participation.

In several studies, quality of life was shown to improve health and to promote active ageing. Yet, the degree of this quality critically depends on people’s socio-economic circumstances above and beyond their health status. Poverty, deprivation and chronic social stress go along with poor quality of life, and, thus, reduce the chances of experiencing its beneficial effects (Marmot et al. 2003, Motel-Klingebiel et al. 2004). In this contribution, the following questions are addressed:

- What is the prevalence of the different levels of quality of life in early old age in European countries under study? Can we identify a specific pattern of distribution across countries, e.g. in terms of a North-South gradient?

- How strong is the association between quality of life in early old age on the one hand and socio-demographic and socio-economic conditions on the other hand? In particular, are there differences according to age, education and income? Do these associations vary across countries?

- How strong is the association between quality of life in early old age and health? Does it vary across countries?

Answers to these questions are important because respective information may draw our attention to country-specific or other (socio-economic, health-related) obstacles against successful and sustainable implementation or strategies of active ageing across Europe.

Before answering these questions we explain how quality of life in early old age has been measured. Our approach assumes that quality of life should be assessed as the degree to which human needs are satisfied. In this stage of the life course the following domains of need seem to be particularly relevant: control, autonomy, self-realisation, and pleasure. Control is understood as the ability to actively intervene in one’s environment (Patrick et al. 1993). Autonomy is defined as the right of an individual to be free from the unwanted interference of others (Patrick et al. 1993). Self-realisation and pleasure aim to capture the active and reflexive processes of being human (Tumer 1995). Following Doyal and Gough (1991), our approach treats these four domains as equal rather than hierarchically organised.

The operationalisation of these concepts was performed in a measurement approach termed CASP-19 (C=control, A=autonomy, S=self-realisation, P=pleasure; and 19 refers to the sum of 19 Likert-scaled items measuring these concepts on uni-dimensional scales).
The measurement approach is described in detail elsewhere (Hyde et al. 2003). In summary, the measure displays satisfying internal consistency of the scales, reasonable intercorrelations and high second order factor loadings.

In response to a request for a quality of life measure for consideration for SHARE an abridged version of the CASP-19 was designed. To do so the statistical analysis used to produce the original scale were replicated. Internal consistency analyses revealed those items with the lowest item whole correlations within each of the domains. By removing the item with the lowest value for the Control domain and the two items with the lowest values for each of the other domains we were able to reduce each of the domains to three items each without too great a loss to their internal reliability (Cronbach’s alpha varying from 0.56 to 0.76). A second order factor analysis confirmed quality of life as a single latent factor. The CASP-12 correlated highly with the CASP-19 and the Life Satisfaction Index, a measure of concurrent validity (Blane et al. 1999) which was also included in the original study mentioned above.

CASP-12 has been incorporated in the self-completion questionnaire. Respondents were asked, how often they experience certain feelings and situations on a 4-point scale ranging from ‘never’ to ‘often’. For the total score of CASP-12 values range from 12 to 48, with higher scores indicating better quality of life. These scores are subsequently classified into four levels of quality of life (QL), where 39-41 indicates very high QL, 37-39 high QL, 35-37 moderate QL and values below 35 low QL.

**North-South Gradient of Quality of Life**

An answer to the first question of whether a specific pattern of distribution of quality of life can be identified is given in Figure 1. As can be seen, quality of life scores are comparatively low in Greece, Italy, and Spain and comparatively high in Switzerland, the Netherlands and Denmark. Differences between countries are highly significant (p<0.001) according to the Kruskal-Wallis Test. Thus, there is evidence of a North-South gradient in degree of quality of life across the European countries under study.

This general pattern is also obvious for the mean scores of the four sub-domains mentioned above. Respective figures are given in Table 4A.21 (see Appendix).

As can be seen in Table 4A.22 (see Appendix), gender differences in quality of life are small in most countries. These differences are significant (p<0.01) only in Italy, Spain and Greece. However, consistent age differences are obvious and significant in all countries.

In the SHARE study, we were interested in generational differences of quality of life, in particular in the question of whether these differences between the youngest and the oldest age group of participants follow a specific pattern across Europe. Figure 2 shows that, in fact, these differences are largest in southern European countries (mean difference > 3) and smaller in northern and Central European countries (mean difference < 2). In other words, age is associated differentially with quality of life across Europe, with particularly low levels in the oldest age groups in southern Europe. The North-South gradient is less pronounced in younger old age. It is tempting to interpret this finding with respect to the way of quality of life has been conceptualised in this study. As mentioned above, a special focus is put on needs of autonomy, self-realisation and control, norms that are in accordance with modernisation and individualisation of life and that may be less frequent among older people in southern countries where traditional ways of life (family and community structures) still prevail.
Figure 1. Quality of Life (QL) in nine European countries (CASP-12: means)

Figure 2. Mean differences in Quality of Life (QL) between youngest and oldest age groups in nine European countries
Differences According to Socio-Economic and Health Status

In the second question we were not only interested in age differences, but equally so in socio-economic differences in quality of life across Europe. To this end, Table 4A.23 (see Appendix) shows the quality of life mean scores by education and equivalence household income. As can be seen, people with high education (upper secondary or tertiary according to the International Standard Classification ISCED-97) report a better quality of life in most countries compared to those with low education (primary or lower secondary). These differences are statistically significant except for Switzerland. Furthermore, we observe a strong income gradient of quality of life. Differences between the three income groups are significant in all countries.

Figure 3 CASP-12 for different health indicators (all countries: means)

To explore the third question, that is the relationship between quality of life and health, the following five indicators of health and well-being were analysed: Limitations in activities of daily living (ADL), self-rated health, number of chronic diseases, number of symptoms, and depression defined according to the EURO-D scale (see Contribution 3.5). Figure 3 shows for every health indicator a significant difference in quality of life: Better health is consistently associated with better quality of life. Importantly, this holds true for all nine countries.

Conclusions

This contribution presents results of a new measure of quality of life in older age based on release 0 data from the baseline SHARE investigation. Although evidence is currently restricted to cross-sectional data several robust findings emerge that are relevant both to science and policy:
• We observe cross national variations in quality of life that are consistent with North-South gradient across Europe (relatively low levels of quality of life in GR, ES and IT; relatively high levels in CH, NE and DK)

• The differences in quality of life between youngest and oldest age groups (lower quality of life with older age) are relatively large in southern European countries.

• Quality of life is consistently associated with socio-economic status (educational degree and income).

• Quality of life is clearly related to indicators of health: better health goes along with better quality of life in all European countries under study.

It will be an important aim to follow the SHARE cohort prospectively in order to test to what extent these associations are causal. This latter evidence will be important to develop and direct measures of active ageing policies across Europe.

References


