The evidence on quality of life for older people

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Quality of life is a major concern for older people and many factors contribute to how this group perceive the concept. Quality of life relates to the individual person therefore a good quality of life means different things to different people. Health care professionals must place an emphasis upon promoting quality of life and educating older people on how it can be optimised.

The Population Reference Bureau (2004) suggests that there will be a total of 10.5 million older people in the UK (16 per cent of the population) by 2050. The health service will have to adapt. The term ‘quality of life’ is frequently used when examining health care issues of older people. However, there is no general consensus as to what this term means.

Walker (2004) describes the promotion of terms such as ‘successful ageing’, ‘positive ageing’ and ‘healthy ageing’ in attempts to define quality of life. The two main empirical scales used to evaluate quality of life from more rigorous and scientific perspectives are the health-related quality of life scale and the schedule for the evaluation of individual quality of life. The first scale is concerned with how overall quality of life is influenced by an individual’s general state of health and the second focuses on how an individual defines the term quality of life for themselves (Walker, 2004). These types of empirical tool are useful developments and guiding mechanisms.

Many studies show that the majority of people over the age of 65 identify their health as being the main determinant in evaluating their quality of life (Gabriel and Bowling 2004; Walker, 2004). The focus of this article is to determine the factors that influence quality of life for older people and to identify what the term means to this group.

As people grow older, they are more likely to become ill, although old age in itself is not an illness. Age-related physical and psychological changes are commonplace. McGhie and McClellan (1997) identify physical changes as alterations to vision, hearing, balance, coordination and temperature control. They also suggest that psychological changes such as depression and insidious cognitive impairment may or may not be due to pathology directly related to ageing. Older people therefore have specific and unique health care needs (Hamilton, 2005).

Schaefer (2005) states that older people are primarily concerned with their health, the majority having at least one chronic illness. Chronic pain may have a negative impact upon all aspects of health-related quality of life, if accompanied by a chronic illness (Dysvik et al, 2004). Vaillant and Mukamal (2001), in a longitudinal study, show that education regarding health issues makes a substantial positive difference in longevity and quality of life throughout old age. Effective interpersonal communication on the part of health care professionals is, therefore, vital in allaying fears and offering support to older people (Devito, 2000; Mart, 1992; Scammell, 1990).

People react in a variety of ways when presented with news of illness (MacPherson, 1995). Some prefer to research their condition as a means of coping with stressful news; others avoid seeking information on their care, treatment, diagnosis and prognosis. Each person has their own way of coping with illness, and older people are no exception.

Endless sources of information are available. Older people obtain the vast majority of health information via personal contact with their family members, as well as from professionals such as nurses, doctors and social services staff. This is an example of microsociology in action, a concept put forward by George Herbert Mead. This sociological perspective states that people’s behaviour in society is influenced by their interactions with other people.

Other sources of information, such as government publications and Department of Health reports, are disseminated on a more national level and may not be accessible to the entire population, especially older people. Collecting such information may require use of the Internet, which many older people may be unfamiliar with and reluctant to access and use as a result. In light of this, researchers and scholars suggest young adults should play an ever-increasing role in teaching older people about social, cultural and technological changes (Uhlenberg and De Jong Gierveld, 2004). It is vital for older people to be integrated into society, as illustrated by the spectrum of sociological thinking.

Gabriel and Bowling (2004) suggest that good relationships with friends and family enable older people to feel valued and cared for. This, in turn, has a positive impact on their sense of well-being and...
contact and interaction to be the vehicle through which older people are most influenced.

Factors influencing quality of life
There are a plethora of factors that damage older people’s quality of life. Society may display negative attitudes, creating barriers that are difficult for older people to overcome. Many older people regard themselves as being in conflict with society’s stereotypes of what the terms old or elderly mean.

Ageism is still found in all areas of society, with health care being no exception. Ageism can be defined as ‘the expression of negative attitudes towards the aged’ (Béphage, 2000). Many health care professionals see ageing and its health-related consequences as inevitable, therefore causing them to believe that older people should not be entitled to the same treatment as others. Hought (2002) showed that, even with minimal specialist training to counteract stereotypes (as little as 12 hours), significant changes were observed in the attitudes of medical students. The attitudes of senior staff were also investigated in this research. If senior staff displayed positive attitudes, the medical students were more likely to manifest and mirror these attitudes in their clinical behaviour.

A common perception is that older people have ceased to be of worth. Many are no longer able to work due to fatigue, illness and perhaps decreasing cognitive and mental capacity, while others are simply expected to fulfil the ‘role’ of being old. Béphage (2000) says: ‘This is a dehumanising and devaluing process and shows a lack of respect and sensibility.’ Freedom of choice may be undermined or removed altogether as older people are expected to fit a mould society has created. Ultimately, many fall into this menial role and research shows they subsequently behave accordingly.

A study by Levy et al (2002) shows that older people who have negative ideas of what it is to be old live an average of seven-and-a-half years less than those who are positive in their attitudes. This underpins a self-fulfilling prophecy. Many people feel that, as they age, society expects them to act accordingly by giving up work and becoming preoccupied with their health. By assuming this imposed role, many older people begin to obsess about ageing and illness, which directly damages their overall physical condition and psychological outlook. They may succumb to this conditioning then proceed to assume the sick role, even though their health is not compromised in any way.

Attitudes play a critical role in quality of life. Good health habits have been shown to increase good health and delay the onset of certain diseases. Exercise is essential, even in the frailest of patients (Simkin, 2002). A meaningful role in society is vital for a sense of self-worth. It does not have to be a working role. Younger adults often rely upon older people to provide childcare. Older people who can meet the physical demands of childcare may find the responsibility provides them with a useful role within the family and society in general. Others, who are unable to achieve this level of physical activity, often find social activities give them a useful societal role as well as a sense of structure and safety. As Gabriel and Bowling (2004) remind us, keeping busy is vital for the maintenance of psychological well-being.

Implications for practice
Many wish to approach the final phase of life in the most peaceful and dignified manner possible. The Institute of Medicine recommends that health care professionals of all disciplines commit to improving the care and treatment of dying patients (Knebel, 2002). Furthermore, death happens in an instant so there is great importance in treating a dying patient as a living person up until the moment of death (Kessler, 2001).

An area that raises fears, particularly among older people, is that of euthanasia. This topic has attracted a considerable amount of media interest in recent years as society attempts to determine the appropriateness of assisting patients to end their lives in cases of severe physical or mental health impairment. This issue has particular clinical salience in the arena of care of older people, where many patients have terminal illnesses or conditions such as dementia that severely impair quality of life. Many fear a time will come when the choice of life or death will be taken out of their hands. While a full discussion of these subjects is beyond the scope of this article, it should be noted that euthanasia and quality of life are inextricably linked.

People are living longer and, with primary health care service provision about to undergo a radical shake-up, the ethical and clinical implications for health professionals of all disciplines in relation to the care, treatment and quality of life of older people are extensive.

Our focus must remain person-centred and holistic, the needs of the individual superseding those of the various health care organisations. The fact that people are living longer is a testament to advances in medical interventions and health care. However, if the necessary health and social services are not in place to complement the unique needs of older people, crisis is inevitable.

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REFERENCES

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