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QUALITY OF LIFE: THE DIFFERENTIAL CONDITIONS[1]

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Quality of Life is a complex concept that is difficult to operationalise. Nevertheless, it is possible to establish one principal characteristic: its multidimensionality, Like life itself, quality of life has multiple ingredients. Moreover, quality of life among the elderly is dependent on the context or circumstances in which people live. Subjects over 65 living at home or in public or private institutions, with different ages, of either gender, and with different socio-economic status were interviewed about various quality of life dimensions. The conclusion was that quality of life ingredients are dependent on lifestyle (at home or in institutions) and personal conditions (age and gender).

La calidad de vida es un complejo concepto cuya definición operacional resulta francamente difícil. Sin embargo, es posible establecer una de sus esenciales condiciones: su multidimensionalidad Es decir, la calidad de vida (como la vida misma) cuenta con ingredientes múltiples. En el presente trabajo se sostiene que la calidad de vida en la vejez, como concepto multidimensional, está, además, en dependencia del contexto o de ciertas circunstancias del individuo. Este planteamiento se examina a través del análisis de múltiples indicadores de calidad de vida evaluados en sujetos mayores de 65 años que cuentan con distintas condiciones: viven en su propio domicilio o en instituciones (públicas y privadas), cuentan con distintas edades, pertenecen a distinto género y están adscritos a distintas posiciones sociales. La conclusión final es que durante la vejez la posición social, la edad y el género son más importantes circunstancias que el vivir en el propio domicilio o en una residencia para la mayor parte de las dimensiones de calidad de vida.

INTRODUCTION

A considerable number of works have, in recent years, attempted to define or study the concept of quality of life (QoL) (for a review, see Fernández-Ballesteros 1993, 1998). It can indeed be said that the progress of research on this construct, which can be found in a variety of different bibliographical databases –ecological ("Urban"), biological ("Biosis"), medical ("Medline"), psychological ("Psychlit") and social ("Sociofile")– has been extraordinary. For example, in 1969 there were 0 references in "Urban", 1 in "Biosis", 1 in "Medline", 3 in "Psychlit" and 2 in "Sociofile"; in 1995, we find, for the same databases, 112, 1379, 2242, 187 and 137, respectively. From the cumulative frequencies for each of these databases, shown in Table 1, we can conclude that there has been a growing interest in quality of life in various scientific fields, but that, while the progression has been arithmetical in the fields of urban studies, psychology and sociology, in the biological and medical literature it has been exponential.

As it has been pointed out elsewhere (Fernández-Ballesteros, 1998), from a semantic perspective, the term "quality" refers to certain attributes or characteristics of a particular object (life), and "life", in turn, is a wide-ranging term that involves human beings. The initial problem is that life can be analysed from different perspectives, so that quality of life must necessarily be a multidisciplinary concept. Ecologists and biologists are

TABLE 1
Increase in references to "quality of life" in five databases

	URBAN	BIOSIS	MEDLINE	PSYCHLIT	SOCIOFILE
1969	1	1	1	3	2
1995	112	1.379	2.242	187	127
1967-1974	-	20	61	62	109
1975-1979	14	160	1.051	162	346
1980-1984	33	394	1.695	404	507
1985-1989	200	1.575	3.685	877	640
1990-1995	593	5.821	10.641	1.583	881

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concerned with the quality of the ecological niches that contain more or less complex forms of life, and use indicators such as purity of the water, natural balances among species, deforestation, and so on. Social scientists (economists, sociologists, etc.) are preoccupied with the well-being of populations, and use socio-economic measures (such as Gross Domestic Product or per capita income), or social ones, such as crime rate, indicators of family disintegration, etc. Finally, from a medical point of view, in order to assess health quality, epidemiological and socio-demographic indicators have been used (such as mortality rate, life expectancy or infant mortality). However, per capita income, crime rate or life expectancy, despite being important indicators of the level of economic, social or health development of a given human group, do not appear to give an adequate reflection of human well-being.

On attempting to define the QoL concept, two main controversies are debated: 1) Some postulate that quality of life refers, exclusively, to the subjective perception of the individual about certain conditions, while others consider that the concept must include a consideration of both subjective conditions (relating to the subject's evaluation or appreciation of different life conditions) and objective conditions (the same conditions, but evaluated independently of the subject); 2) There is disagreement about whether quality of life should refer to an ideographic concept, in the sense that it is the subject that must establish its ingredients, or whether a general quality of life criterion can be established for all subjects –that it is a nomothetic concept.

With regard to the objective/subjective controversy, as pointed out elsewhere (Fernández-Ballesteros and Maciá, 1993), and contrary to what is proposed by those authors who define quality of life as a subjective variable (see, for example, WHOQOL, 1993), we maintain that a reductionist operationalisation of quality of life –either exclusively subjective or exclusively objective– can only impoverish and invalidate a concept which, by its very nature, is extraordinarily diverse. Life lays down objective conditions and human existence brings awareness and reflection –i.e., subjectivity– into play. Neither type of condition can be ignored in any consideration of the quality of life of a given subject or group of subjects. Thus, for example, while we might consider as an unquestionable QoL ingredient the social support a subject enjoys (this is, after all, a basic human need), this is related to an objective fact, that is, the number of social relationships a given subject establishes or maintains in a given period of time (without human relationships there can be no support); no less important, though, is the subjective condition of the satisfaction felt by the subject in his/her social relationships (see Lawton, 1991). At the same time, Sampson (1981) alerts us to the danger of proposing exclusively subjective definitions of social concepts: it means, obviously, abandoning objectives for modifying relevant *real* (and possibly unjust) social conditions, and concentrating solely on the cognitions of people who, in fact, may be living in a false paradise.

Let us now consider the equally important question of whether it is possible to establish a nomothetic, or general, concept of quality of life applicable to all individuals, or whether, on the other hand, the concept should be defined by the subject him/herself. Since QoL refers (though not solely) to subjective aspects, some authors maintain that only the subject can decide which elements determine the quality of *his* or *her* life (see, for example, Browne, O'Boyle, McGee, Joyce, McDonald, O'Malley and Hiltbrunner, 1994). As I stressed elsewhere, given that basic human needs are quite general, it is fairly improbable that the QoL components listed by two different human beings will differ to any great extent; what is probable is that certain components will have greater weight than others at given moments or in certain situations. Thus, for example, health is an indisputable ingredient of quality of life; however, for healthy young people its importance is secondary to that of work or social relationships (Ruiz and Baca, 1993), while for the elderly health (whose loss is feared or already a partial reality) takes on great importance, over and above that of any other condition. In sum, our proposal is based on the notion that it is possible to establish a general or nomothetic concept of quality of life, though it is also possible to attribute relative weights –depending on the subject– to the variables involved, resulting in a quasi-ideographic QoL concept (Fernández-Ballesteros, 1998: Fernández-Ballesteros, Zamarrón and Maciá, 1996).

However, what is clear is that, leaving aside subjective/objective or nomothetic/ideographic conceptualisations, quality of life is expressed in different contexts. In other words, the circumstances in which a given person finds him/herself permits the explanation –at least up to a point– of his/her particular quality of life. Age, gender, social position, living at home or in an institution are, wit-

hout doubt, variables that allow us to predict a person's quality of life. In this sense, old age constitutes one of the contexts in which quality of life has been most researched. The general assumption is that people, as they become elderly, begin to lose or experience deterioration in the conditions or ingredients that commonly form part of human life, and that, therefore, their quality of life suffers. Social policies geared towards the elderly have precisely the objective of improving their quality of life.

Summarising, in the last twenty years, quality of life has emerged as a powerful construct that has even given rise to a change in social goals. Social policy no longer aims only for more economic growth, a better distribution of wealth or an increase in the life expectancy of its population, but also to make some positive impact on the well-being of the communities attended and to influence the way social programmes are evaluated by citizens. As Tolman (1941) underlined, the concept of "homo economicus" has been substituted by "homo psychologicus": variables such as the perception of control, perceived social support, or even satisfaction with life are important conditions for social well-being (Campbell, 1981). This situation implies the introduction of a subjective (and, therefore, strictly psychological) component in social goals that has been termed "quality of life". Nevertheless, and although this component is stressed in the context of every discipline that deals with it, psychologists are less involved than other scientists in its operative definition, in its measurement and in discussion of its nature (see Table 1), which undoubtedly has a negative effect on research, and which should serve as a call for psychology to pay more attention to it. Lastly, it is important to emphasise the point that quality of life, as a multidimensional concept, is not independent of the different contexts that life produces and to which the subject belongs. The majority of studies on quality of life refer to specific life situations, i.e., quality of life in persons with different pathologies (diabetics, AIDS victims, etc.), different ages (adults, children), different income levels, and so on. Within these contexts, age appears to be a determinant personal factor in QoL, and a great deal of the research in this area has focused on this bio-psycho-social condition.

In view of the above, over the last few years, from the Laboratory of Gerontology in the Psychology Faculty at the Autónoma University of Madrid (*Universidad Autónoma de Madrid*), in close collaboration with the National Institute of Social Services (*Instituto Nacional de Servicios Sociales*, INSERSO), a series of studies have been carried out with the aim of producing an operational concept of QoL in old age, of examining the repercussions of institutionalisation and other factors on QoL and, finally, of designing an easily applicable instrument for assessing the concept that would permit the evaluation of gerontological programmes and services[3]. The present work represents a summarised presentation of the results obtained.

ANTECEDENTS

As already stated, quality of life can be described, from the outset and *a priori*, as a multidimensional macroconcept involving different components or conditions, whose weight or importance varies according to a series of personal parameters (such as age or gender) or social ones (such as socio-economic or educational conditions). Moreover, though, quality of life has great relevance, not just scientific but also social, given that it has become the objective *par excellence* of the welfare state and, indeed, of the socio-economic policies of all modern and democratic states of whatever political position.

Some years ago we presented a concept of quality of life for old age based not merely on theory but on empirical findings (Fernández-Ballesteros and Maciá, 1993). After establishing a theoretical and *a priori* concept of QoL, listing its constituent elements, we investigated how this compared with the "ingredients" proposed by ordinary people, which we called the *popular concept* ("pop") of QoL. Our method was to ask a representative sample (N = 1200) of the Spanish population over 18 about the aspects they considered to be important with regard to the quality of life of elderly people.

From both a theoretical perspective and an empirical one, the conditions that seem to determine quality of life are the following[4]: health (to enjoy good health), functional abilities (to be able to look after oneself), economic conditions (to have a good pension and/or income), social relationships (to maintain relationships with family and friends), activity (to stay active), social and health services (to have good social and health services), quality in the home and the immediate context (to have

[3] A Brief Questionnaire on Quality of Life (*Cuestionario Breve de Calidad de Vida, CUBRECVI*) has already been developed and published in Fernández-Ballesteros, Zamarrón and Maciá (1996).

[4] We add in brackets the QoL aspects as they appeared in our list (Fernández-Ballesteros and Maciá, 1993).

a good house in a good quality environment), life satisfaction (to feel satisfied with life) and cultural and educational opportunities (to have the opportunity to learn new things). These ingredients or conditions were mentioned as essential for the quality of life in old age, and did not vary according to the gender, age or social status of the interviewees.

We also sought to examine empirically the construct validity of both the theoretical and "pop" QoL concepts, taking in turn each of the above aspects (perceived health, personal autonomy, income, satisfaction, social support received, activity level, social and health services, housing and environment quality, economic and cultural resources), both directly (by asking the elderly interviewees themselves) and indirectly (by asking those close to them[5]. In the factorial analysis we separated the responses of the over-65s about themselves and the under-65s about their older proxy or relative. The two analyses gave a very similar factorial distribution, coinciding with the previously-established QoL concept. We were therefore able to establish a concept of quality of life in old age on which to base ourselves when researching into the personal and social conditions that determine greater or lesser quality of life (for more details, see Fernández-Ballesteros, 1993, 1996).

However, one of the conditions that supposedly most influences quality of life in the elderly is where they live –in their own home or in an institution. Social policy with regard to the elderly is based on attempting to maintain them in their own home, and elderly people themselves reject the idea of moving to a residence. In sum, the general opinion is that those living in institutions (either public or private) have a lower quality of life than those that continue to live in their own home. Thus, it seemed to us eminently relevant to look into the quality of life of elderly people living in their own home and those living in public and private residences. However, what other personal conditions (such as age or gender) and social conditions (such as social class) have an influence, and to what extent, on the quality of life of elderly people?

Quality of life in different contexts[6]

With the aim of evaluating a series of ingredients or aspects that compose or shape the wide concept of "quality of life", in different potentially relevant situations, a sample of 1014 subjects over 65 was selected. The selection was made in three different contexts:

a) 507 subjects living in their own homes: 170 were aged 65 to 69 years, 124 were aged 70 to 74 years, 101 were between 75 and 79, and 111 were over 80 years old; 210 were male and 297 female; 26 were upper and upper-middle social class, 103 were middle class, 130 were lower-middle class, 102 were lower class and 145 were categorised as housewives[7].

b) 256 subjects living in public residences throughout Spain[8]. 72 were between 65 and 69 years old, 80 were between 70 and 74, 56 were between 75 and 79, and 43 were over 80. There were 105 males and 151 females. 15 were upper class, 54 middle class, 71 lower-middle class and 50 low class. 64 were housewives.

c) 251 subjects living in private residences throughout Spain. 63 were between 65 and 69 years old, 71 were between 70 and 74, 60 were between 75 and 79, and 43 were over 80. 99 were men and 152 were women. 27 were upper and upper-middle class, 59 were middle class, 64 were lower-middle class, 32 were low class and 66 were housewives.

The characteristics of the three samples assessed allow us to examine (with a sampling error of ±3%) the effects on QoL ingredients –in addition to the conditions "living at home" or "living in a residence"– of age (65 and over), gender and other various conditions and contexts.

With the purpose of investigating quality of life in the different subjects of the sample, and based on the concept previously established, a questionnaire was designed, with the following sections:

Health. We used subjective indicators (such as percei-

[5] Those under 65 were asked to think of a person over 65 whom they knew well, and all of the questions about health, functional abilities, etc. were asked in relation to that person (for an extension of the procedure, see Fernández-Ballesteros and Maciá, 1996).

[6] "Quality of life in different contexts" was a research project carried out in collaboration with INSERSO between 1993 and 1994, and whose results have been published by INSERSO (see Fernández-Ballesteros, Zamarrón and Maciá, 1996).

[7] Selected on the basis of 1991 census data, proportional in terms of sex, age, size of locality and Autonomous Region (sampling error ±3%). Social class was obtained from income and professional level (according to official indicators). The special category "housewives" grouped together widows with no specific profession.

[8] Those included in the sample were selected from the public and private residences listed in the document "*Bases para una planificación de centros residenciales para la tercera edad*" ("Bases for the planning of Residential Centres for Senior Citizens", INSERSO, 1989).

ved health or reports on mental disorders) and objective ones (e.g., number of medicines taken, number of pains reported, etc.).

Functional abilities. Assessment of one's own independence and degree of difficulty in carrying out a series of everyday activities.

Activity level and leisure activities. Type of activity performed daily; frequency of and degree of satisfaction with leisure activities.

Social integration. Size of social network and satisfaction in interpersonal relationships.

Life satisfaction. We used Lawton's (1975) "Philadelphia Geriatric Center Morale Scale" (PGC) and two general questions about current satisfaction and comparative satisfaction in relation to subject's age.

Social and health services. We assessed knowledge of, use of and satisfaction with 19 services.

Environmental quality. We operationalised environmental quality of subject's own home or of his/her room/apartment, as well as of the neighbourhood or surroundings, through a series of questions put to the subject and to the interviewer.

With the aim of taking into account *economic, cultural and educational* conditions, we studied a series of socio-demographic variables.

Also, given that some of the subjects examined may have suffered from cognitive disorders, we administered the SPMSQ ("Short Portable Mental Status Questionnaire", Pfeiffer, 1975). In the case of a subject committing more than three errors (criterion score for suspecting the existence of cognitive deterioration), a friend or relative was asked to help him/her to answer the questions of an objective nature (how many medicines taken, pension received, etc.). The field study was carried out by Intercampo in May 1994.

Statistical analysis was carried out on the total sample and on the different sub-samples referring to home, public residences and private residences and other potentially relevant variables, such as age, gender and social class[9]. Since the full results of this work have already been published elsewhere (Fernández-Ballesteros, Zamarrón and Maciá, 1996) we shall confine ourselves here to a presentation of the most noteworthy results in the different sections corresponding to quality of life aspects.

[9] The analyses in the original work also took into account size of locality (see Fernández-Ballesteros, Zamarrón and Maciá, 1996).

Mental state

As stated above, mental state was evaluated (by means of the SPMSQ) with the purpose of optimising the reliability of the data and involving, in the case of suspected dementia, a relative or friend in the responses to the objective-type questions. In any case, only 7% of the total sample reached the criterion score for suspecting dementia, a result that concurs with other epidemiological data (Lobo et al., 1991). No differences were found with regard to mental state between subjects living at home and those living in residences, either public or private. *Age* is, of course, a relevant variable as far as mental state is concerned: while 17% of subjects over 80 reached the criterion score (leading us to suspect dementia), only 3% of those between 65 and 69 did so. *Gender*, closely linked to socio-economic and educational levels, also appears to be a condition relevant to mental state: while 8% of the women made more than 3 errors, only 6% of the men reached this criterion score. The most powerful variable for discriminating mental state was found to be *social class*: while 100% of upper and upper-middle class subjects made only 3 errors or less, 11% of middle-low and low class subjects made more than three errors.

Health

Subjects living in their own home differ only very slightly from those living in public or private residences with regard to subjective health (how one judges one's own health to be), mental health and objective health (number of medicines taken, number of pains and chronic problems reported).

Age, on the other hand, seems to determine great differences in the majority of the objective health indicators. As age increases, and although perceived health does not change significantly, subjects report more chronic problems, more pains, more mental disorders, they have spent more days confined to bed in the previous month, and they have more hearing problems (though they do not report taking more medicines).

Gender seems also to be a relevant personal variable that has an influence on health. Women, by comparison with men, perceive themselves to have worse health, and report having poorer mental health and more chronic problems and pains, and take more medicines.

A similar pattern is presented with regard to *social status*: as socio-economic conditions improve, subjects report fewer chronic health problems, fewer pains, better mental health, and report having been admitted to hospital fewer times in the previous year.

In sum, health –as an important ingredient of the quality of life– does not appear to be functionally related to whether subjects live at home or in a residence (be it private or public), whilst sex, age and social status appear to be relevant conditions with regard to health in old age.

Functional abilities

Whether we consider the subject's personal appreciation of his/her own functional independence or whether we ask him/her about the difficulties he/she has for carrying out various everyday activities, we find differences related to where subject lives (at home or in a public or private residence), to age, to sex and to social class. Thus, people that live in their own home (with respect to those that live in public or private residences[10]), younger subjects (with respect to older ones), men (with respect to women) and those of the higher social classes consider themselves to be more able to fend for themselves and report fewer difficulties for carrying out daily life activities.

Activity level and leisure activities

Although activity level [from *totally inactive* (1) to *regular physical activity* (5)] of these elderly subjects is very low (attaining a mean value of 1.8 on the 5-point scale), we find significant differences in accordance with the relevant variables. Thus, less physical exercise is reported for the older subjects compared to the younger ones, for women compared to men and for the lower social classes compared to the higher ones. No significant differences appear with regard to residential situation –that is, those living at home do not differ from those living in institutions, though those that do most physical exercise are most certainly those living at home.

As far as leisure activities and free time are concerned, *watching TV* and *listening to the radio* are the two activities most frequently found among the elderly (of those interviewed, on average, 77% watch TV and 60% listen to the radio frequently). Those living at home watch significantly more television and listen to the radio significantly more than those living in residences, as do older subjects compared to younger ones, women compared to men and lower class subjects compared to higher-class ones.

Walking is the third most frequent leisure activity (an average 62% of subjects report walking as a frequent activity). Significant differences exist according to personal circumstances: subjects living in private residences report walking more frequently than either those living at home or those in public residences; meanwhile, younger subjects walk more than older ones, men more than women and higher-class subjects more than those from the lower classes.

Reading, understood in a general sense, is not a frequent activity among these subjects (only 35% report reading frequently). Significant differences were found with regard to reading according to our relevant variables: thus, subjects that live in residences (both public and private) read more than those living at home, men read more than women and those from the higher classes read more than those of lower social status.

Visiting friends or relatives (23% report frequent visits and 41% occasional ones) is a very common activity among those interviewed. In general terms, those living at home make significantly more visits than those living in residences, the younger subjects visit more than the older ones and those from the higher social classes make more visits than those from the lower classes. There are no differences with regard to gender. Other activities listed, such as going to the cinema, theatre or shows, going on excursions or playing games occur quite infrequently.

With the aim of measuring the *satisfaction* produced by these activities, we obtained a coefficient of satisfaction (the result of multiplying the frequency of an activity by the satisfaction it produces for each subject). Marked differences were found according to this satisfaction coefficient. Subjects living at home were found to be more satisfied than those living in either type of residence, younger subjects were more satisfied than older ones, and men had higher satisfaction coefficients than women, as did subjects of higher socio-economic status compared to those with lower status. These results on satisfaction were corroborated with the question about general satisfaction referring to how the subject employs his/her free time. It should be stressed that 76% of all those interviewed answered that they were satisfied with the way they used their free time. Nevertheless, we found the same differential profile in that subjects living

[10] This result should in no way be understood as an "effect" of the institutionalisation. We are aware, on the one hand, that the fundamental reason why such people request being put in a residence is that they cannot fend for themselves; on the other hand, we are also aware that it is necessary to fulfil certain conditions to accede to public residences. The fact that people living in residences report having more problems of functional independence than those living at home is a cause of the institutionalisation and not, by any means, an effect.

at home and in public residences (compared to those in private ones) are more satisfied in the way they use their free time, as are younger subjects (compared to older ones), men (compared to women) and upper-middle and middle class subjects (compared to lower-middle class and low class ones).

Social integration

Given that the fact of living alone or with (an)other(s) is an important indicator of integration, we considered first the question referring to with whom the subject lives. Obviously, very few subjects in residences live with relatives (2% in public residences and 1% in private ones live with their partner). However, the family pattern of subjects living at home and that of those living in residences is totally different. Thus, 20% of those living in their own home live alone, while the rest live with their partner (40%), with their partner and their children (15%), with their children (15%), with their children and/or grandchildren (3%), or with other relatives (5%). The number of children subjects have had differs significantly between those living at home and those in residences: whilst the formers' average approaches three children, that of the latter group report having had, on average, only one child. Neither age nor sex have an influence in this respect, though upper and upper-middle class subjects report having had significantly fewer children than those from the middle, lower-middle and lower classes.

With regard to the frequency of social relationships (average 2.5 on a 4-point scale), this is related to whether subjects live at home or in a residence. Those living at home report more frequent contact with relatives, friends and neighbours than those living in residences. Meanwhile, whilst age appears to be a variable functionally related to social integration (older subjects report less frequent contact than younger ones), no significant differences were found with regard either to gender or to socio-economic status.

As far as satisfaction with social relationships is concerned, this factor was measured with two indicators: on the one hand the satisfaction produced by each interpersonal relationship; on the other, an index obtained from the product of the number of social relationships maintained by the satisfaction each one provides. These two indicators –satisfaction in social relationships and index of satisfaction– differ, exclusively, according to the context in which the subject lives: those living at home are more satisfied than those in residences (both public and private).

We examined sexual relationships as one type of interpersonal relationship. On average, 28% of subjects interviewed reported having sexual relationships. Highly significant differences were found according to the context: subjects living in their own home reported more frequent sex (18%) than those living in either public residences (11%) or private ones (3%). On the other hand, age appears to be a decisive condition with regard to sexual relationships: the younger subjects (38% of 65 to 70-year-olds report having sex) more frequently maintain sexual relationships than the older ones (only 3% of over-80s). Finally, gender seems to play an important role here: while 29% of the men report maintaining sexual relationships, only 3% of the women do so.

Life satisfaction

Since life satisfaction is a personal variable that appears implied in quality of life, we assessed this aspect through three indicators: satisfaction as a personality trait, current satisfaction, and comparative satisfaction related to age (whether one is more satisfied or less satisfied than one was five years ago or will be five years hence).

In none of these three satisfaction variables did people living in their own home differ from those in public or private residences. However, our three measures indicated significant differences according to age, gender and social class. Older subjects (compared to younger ones), women (compared to men) and lower-middle and lower class subjects (compared to the other classes) presented significantly lower scores in life satisfaction, and also considered that the older one becomes, the worse one lives.

Social and health services

We examined the levels of knowledge of, use of and satisfaction with 19 social and health services. The data obtained is complex (see Fernández-Ballesteros, Zamarrón and Maciá, 1996), but we can summarise our findings by saying that our subjects showed themselves to have little knowledge of the existing services. In general, those living in public residences are better informed about and make more use of these social and health facilities and services. We should also point out that a very high proportion of the people using these services are satisfied with them.

Finally, 96% of those interviewed reported having Social Security cover. This aspect did not differ in relation to residential category, age, gender or social class.

Environmental quality

With regard to the subject's own house, apartment or room, assessed by the subjects themselves, those living in residences were more satisfied than those living in their own homes and, within the former category, those living in private residences were the more satisfied. In the same line, when subjects were asked about any repairs needed in their house, apartments or room, it was those living in their own home that reported the greatest number of repairs necessary.

On being questioned about the surroundings of their home or residence, those living in residences report more favourably than those living in their own homes. Comparing public and private in terms of a series of aspects, we can summarise by saying that people in private residences are more satisfied than those in public ones as regards not only physical and architectural characteristics, but also organisation, staff and even the other residents, as well as the residence in general.

No differences were found with regard to sex or gender in these environmental aspects, though social status did have an influence. In general, those from the higher social classes reported more favourably about their house, apartment or residence.

The observations on environmental quality made by the trained interviewers provide quite similar results, which corroborate the above. Thus, residences (both public and private) have lower noise levels, better lighting, are better constructed, more well-organised and cleaner, with better furnishings, better surroundings and more attractive grounds than the private homes. Contrary to what would be expected, no significant differences were found due to social class with respect to environmental quality as assessed by our interviewers. Only with regard to the state of furnishings were any significant differences found.

Economic conditions

The average pension received by our subjects is between 45.000 and 75.000 pesetas (roughly between EUR270 and EUR 450 per month), and differs according to residential context (those living at home receive higher pensions than those in residences), age (older subjects report having better pensions or incomes than the younger ones), gender (men report higher pensions than women) and social class (those from the higher classes report better pensions or incomes than those from the lower classes).

Educational and cultural conditions

Educational conditions for the purposes of this research are based on subjects' qualifications or years of study; the criterion for cultural conditions is constituted by cultural activities they report. In general terms it can be stated that, with regard to subjects living at home, a higher proportion were educated only to primary level, whilst a higher proportion of those in private residences completed secondary education or university. Those living in public residences have lower educational levels than either those living at home or those in private residences. By contrast, subjects living in public residences appear to carry out more cultural activities than the other two groups.

CONCLUSIONS

People that live in their own home do not differ from those in public or private residences with regard to most of the health indicators. However, there are marked differences in health in relation to age, gender and social class.

As far as functional abilities are concerned, those living at home, the younger elderly, men, and those from the middle, upper-middle and upper classes report better functional abilities, both in terms of their subjective appreciation and of the number of difficulties encountered in carrying out daily life activities.

People living in public residences report carrying out more leisure activities, and being more satisfied with them, than those living at home or in private residences. Likewise, the older elderly (compared to the younger ones), women (compared to men) and lower class subjects (compared to those from the higher classes) report carrying out fewer leisure activities and being less satisfied with these activities.

People that live in their own home present, without doubt, greater social integration, both in terms of their network of social support and of the satisfaction their social relationships provide. Whilst differences exist in the frequency of interpersonal relationships due to age, no significant differences were found for any of our indicators that could be attributed to gender or social status.

Although there seems to be widespread ignorance with regard to social and health services, the majority of those people who know of and make use of these services report being satisfied with the benefits they provide. It was also found that those living in private residences were more satisfied than those in public residences.

Environmental quality (of both the place of residence and its surroundings) appears to be superior for those living in institutions (both public and private), compared to those living at home. This is the case according to both the subjects' own evaluations and those of the trained observers.

With regard to economic and educational conditions, people living in their own homes report receiving higher pensions or incomes than those in residences. On the other hand, people living in private residences report having a better level of education, while those in public institutions carry out more cultural activities. Generally speaking, age, gender and social class account for differences in pension or income received, educational level and the cultural activities carried out.

To summarise, it can be stated that a multidimensional concept of quality of life demands a careful diagnosis of the quality of life that can be predicted in different contexts. Thus, for example, social integration is a QoL ingredient that is favoured by the "living at home" context, whilst environmental quality is favoured by the "residence" condition. If we draw up an index combining all of the subjective ingredients, people living in their own home would seem to differ significantly from those living in residences. However, if from this indicator we eliminate personal satisfaction with interpersonal relationships, these differences disappear. In other words, the three contexts studied differ, essentially, in terms of the satisfaction of individuals in their interpersonal relationships. This is not the case with other relevant variables, such as age, gender and social class, in their influence on those ingredients considered to constitute quality of life: the older elderly, with respect to the younger ones, men, with respect to women, and those from the upper, upper-middle and middle classes, with respect to those from the lower-middle and lower classes, all enjoy, in general terms, a better quality of life.

REFERENCES

Browne, J. P., O'Boyle, C. A., McGee, H. M., Joyce, C. R. B., McDonald, N. J., O'Malley, K. and Hiltbrunner, B. (1994). Individual quality of life in the healthy elderly. *Quality of Life Research, 3,* 235-244.

Campbell, A. (1981). *The Sense of Well-being in America*. New York: McGraw Hill.

Fernández-Ballesteros, R. (1993). The construct of Quality of Life among the Elderly. In E. Beregi, I. A. Gergely and K. Rajzi (Eds.): *Recent advances in Aging and Science*. Milan: Mondussi Ed., pp. 1927-1930.

Fernández-Ballesteros, R. (1998). Quality of Life: Concept and Assessment. In J. Adair, D. Belanger and K. Dion (Eds.): *Advances in Psychological Science*. *Vol. 1* Sussex, UK: Psychology.

Fernández-Ballesteros, R. and Macia, A. (1993). *Calidad de vida en la vejez* (Quality of life in the elderly). *Intervención social, Vol. II, 5,* 77-94.

Fernández-Ballesteros, R. and Macia, A. (1996). *Informes de allegados sobre los mayores y de éstos sobre sí mismos* (Reports on the elderly by proxies and elderly`s self-reports). *Revista de Gerontología, 6,* 20-30.

Fernández-Ballesteros, R., Zamarron, M. D. and Maciá, A. (1996). *Calidad de vida en distintos contextos en la vejez* (Quality of life in different contexts in the elderly). Madrid: INSERSO.

INSERSO (1989): *Bases para una Planificación de Centros Residenciales para la Tercera Edad* (Bases for the planning of Residential Centres for Senior Citizens). Madrid: Instituto Nacional de Servicios Sociales.

Lawton, M. P. (1975). The Philadelphia Geriatric Center Morale Scale: A revision. *Journal of Gerontology, 30,* 85-89.

Lawton, M. P. (1991). A Multidimensional View of Quality of Life in Frail Elders. In J. E. Birren et al. (Eds.): *The Concept and Measurement of Quality of Life in the Frail Elderly.* San Diego: Academic Press, pp. 3-27.

Lobo et al. (1991). *Estudios de salud mental en la tercera edad en España* (Studies of mental health in the elderly in Spain). In FIS (coord.): *Epidemiología del envejecimiento* (Epidemiology of aging). Madrid: Fondo de Investigaciones Sanitarias (pp. 195-207).

Sampson, E. E. (1981). Cognitive Psychology as Ideology. *American Psychologist, 36,* 730-743.

Tolman, E. C. (1941). Psychological Man. *Journal of Social Psychology*, *13,* 205-218.

Pfeiffer, E. (1975). A short portable mental status questionnaire for the assessment of organic brain deficit in the elderly patient. *Journal of American Geriatrics Society, 23,* 47-52.

WHOQOL (1993). Study for the World Health Organization project to develop a Quality of Life assessment instrument (WHOQOL). *Quality of Life Research, 2,* 153-159.