



Facultad de Psicología
Departamento de Psicología Biológica y de la Salud

**Calidad de Vida en la vejez. Contrastación transcultural
de un modelo multidimensional, objetivo-subjetivo.**

España - México

*QoL in ageing. Transcultural testing of a multidimensional,
objective-subjective model.*

Spain - Mexico

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Madrid, Febrero 2015

A mis padres,
mis modelos, mis fuentes
de refuerzo inagotables.

Y a Toni,
por ser mi compañero
de vida.

Agradecimientos

Y ¡por fin! he llegado a la meta. Y como en cualquier carrera, una no va sola. Están los que te entrenan, los te que animan y contra los que compites (el camino, tú mismo, tus compañeros/amigos y los demás). En esta carrera exigente, tediosa, que requiere tener una mente abierta, estar preparada para los cambios de nivel, donde la fuerza física y psicológica son necesarias para continuar y acabar, es indispensable recordar y agradecer a los que te acompañan que no hubiera sido posible sin el trabajo, el apoyo y las energías que han invertido en ti.

En primer lugar, quiero dar las gracias a mi principal entrenadora Rocío Fernández-Ballesteros, no solo porque sin ella esta tesis doctoral no hubiera sido posible, que desde luego, sino porque me ha enseñado un estilo de vida, por ser la mejor embajadora de aquello que investiga y por enseñarme que “en casa del herrero, cuchillo de hierro”.

Pero no ha sido la única. Gracias Pei-Chun Shih Ma por introducirme en el mundo de la investigación, demostrarme que confías en mi esfuerzo, mis habilidades y seguir contando conmigo. También, gracias M^a Oliva Márquez, por ese papel más en la sombra, darme consejo, seguridad y abrirme puertas para mejorar mi carrera docente, investigadora y clínica.

Para realizar una buena carrera, hacer un buen trabajo, también es importante un buen equipo, que te “preste” sus habilidades, te aconseje, enseñe y te anime a continuar. Por ello, quiero dar las gracias a los componentes del grupo EVEN y, en especial, a Antonio, por su inmensa paciencia para ayudarme con los análisis; a M^a Ángeles, por leerse mi trabajo y escuchar mis desahogos en la recta final; y a Rocío Schettini, que ha estado ahí en diferentes momentos del proceso. No me puedo olvidar del equipo Mexicano, Elva y Neyda, investigadoras de la Universidad de Guadalajara, sin las que, sin ninguna duda, este proyecto no hubiera existido.

Por el camino, me han abierto las puertas otros equipos de investigación que me han permitido crecer como investigadora y, sobretodo, como persona. Quiero expresar mi especial agradecimiento a Michael Bolk del Instituto Gerontológico de Heidelberg (Alemania) por abrirme los ojos sobre la importancia de vivir una experiencia internacional y facilitarme, junto con Andreas Kruse, que lo hiciera durante un año en esa maravillosa ciudad (Ich habe mein herz in Heidelberg verloren). También, a Nancy A. Pachana por aceptarme en la Universidad de Queensland (Australia); lo que ha supuesto una de las experiencias más enriquecedoras de mi vida en un período tan corto de tiempo. También a Nicole Walker, mi tándem, mi lazarillo, quien me mostraba cada día los beneficios que reporta ayudar a los otros.

También quiero dar las gracias a mis compañeros, que aunque de otros equipos, han compartido el mismo lugar de entrenamiento (laboratorio 6 – y 7) durante los dos últimos años. Gracias por todas las experiencias vividas juntos que han hecho de esta carrera un evento muy especial, en el que ha dado cabida tanto estrés, frustración y lágrimas, como euforia, risas y mucha diversión. Áreas diferentes, metas distintas, formas variadas de ver la psicología, el trabajo, caldo de cultivo de un ambiente enriquecedor, retador, estimulante, ... Carlos, Javi, Miri y Sandri sois estupendos y me habéis hecho el día a día más fácil y ameno.

Aludiendo al laboratorio 6, no me puedo olvidar de todas las personas importantes que han pasado por allí, y que, de una forma u otra, han sido testigos y estimuladoras de mi carrera como investigadora: Agus, Patri, Ana, Elena C. La difusión de conocimiento en congresos nacionales e internacionales ha sido especialmente divertida con vosotros (Grecia, Estonia, Tenerife...).

Por su puesto, cualquier deportista sabe que todo esto no hubiera sido posible sin su afición incondicional. Gracias a mis chicas, Diana, Ire, Laura, y Cris, por admirar mi trabajo, sacarme de la cueva cuando necesitaba despejarme, y dedicarme una sonrisa cuando estaba más bajita de ánimo. Gracias a mis psicólogas, Ana, Elena Capote, Elena Cerrato, Julia y Yoli. Gracias al equipo de AVANCE que me allana el camino para que pueda llevar dos entrenamientos en paralelo. Gracias a mi hermano mayor, con el que he vivido los peores y los mejores momentos, que ha escuchado lo que nadie más podía escuchar. Y gracias a las pequeñas de la familia, mi hermana y mi sobrina, cuya presencia es la mejor medicina para desconectar y sonreír.

Y gracias a todos los que alguna vez me han preguntado “¿cómo vas?”.

Gracias al deporte, a mis monitores del “poli de Sanse”, a mis compañeras y amigas de gimnasio (Ana, Marta e Irene) y a mi equipo de triatlón; porque al final de cada intensa jornada laboral (a veces dura y mezclada con un dolor de cabeza insoporw, ojos irritados, tensión en el cuello...), sacan mi mejor rendimiento, me quitan cualquier molestia, y me permiten llegar a casa como nueva.

Para acabar, a sabiendas de cómo funciona la memoria y dejando que el efecto de primacía y recencia hagan su trabajo, dejo en último lugar a Toni y mis padres. Gracias a Toni porque me proporciona tranquilidad, me alimenta, me anima, me distrae, me aguanta, me acompaña, me admira, no pregunta, pregunta,... A mi padre porque es mi pódium, está “ahí abajo” para cumplir su función de refuerzo negativo contingente, sabe tranquilizarme, hacer que deje de llorar y sacarme una sonrisa de inmediato. *A mi madre porque lo sabe TODO.*

Prefacio

Mi aproximación al tema de la “Calidad de Vida” ha sido progresiva, lenta y fluctuante. Recuerdo con perfección mi primer encuentro científico y conceptual con el término. Fue en la asignatura de Psicología de la Vejez en mi último curso de la carrera. Me resultó francamente difícil entender y valorar el ímpetu con que la profesora, que luego se convertiría en mi tutora de tesis, lo distinguía del término con el que lo comparaba, el “Envejecimiento Activo”. Así pues, como persona responsable y aplicada que soy, presté especial atención a estudiar esta diferencia para mi examen, y, aunque no acababa de entender la importancia de incidir en esta diferencia, me sirvió para aprobar el examen; y con buena nota.

Durante el transcurso de la asignatura, inicié mi primera colaboración en el área de investigación del envejecimiento, participando en el proyecto que en ese momento estaba en curso: “Estudio Longitudinal del Envejecimiento Activo” (ELEA). Mi tarea consistía en localizar a las personas que habían sido evaluadas tres años antes, quedar con ellas en centros de mayores o en sus propios domicilios y evaluarlas aplicando el mismo protocolo que habían completado la vez anterior para realizar un seguimiento. De ahí surgió mi primer proyecto de tesis. Estaba especialmente interesada en saber cómo la actividad física (aunque también la cognitiva) y los estilos de vida, en general, favorecían el mantenimiento de un buen funcionamiento cognitivo y físico durante la vejez. En definitiva, quería responder a una pregunta que permanentemente me rondaba la cabeza ¿qué tenía que hacer para asegurarme, a mí misma, un buen envejecimiento? Pero, ese proyecto ya estaba coordinado por otra persona, había muchas personas implicadas en la publicación de sus resultados y había dos personas interesadas en realizar una tesis doctoral con los datos obtenidos. Así que había pocas opciones.

Entre medias, tuve la oportunidad de escribir mi primer artículo sobre Calidad de Vida. El editor de la “International Encyclopedia of Rehabilitation” solicitó a la profesora Rocío Fernández-Ballesteros escribir un artículo sobre la Calidad de Vida en la vejez y ésta, a su vez, me pidió que colaborara en la elaboración del mismo. Este artículo se dividió en dos partes; la primera, constituyó una crítica a la conceptualización que se está haciendo de la Calidad de Vida en diferentes campos de estudio y que es el hilo conductor de esta tesis y común a todos los artículos. La segunda parte, en la que se centró mi aportación, consistió en una revisión de los instrumentos que se utilizan para medir Calidad de Vida y que emanan esencialmente de la mala operacionalización que se hace del término. Éste pasó a ser, por tanto, uno de los artículos que componen esta tesis doctoral.

No fue hasta un año después, cuando recibí una llamada telefónica de mi directora de tesis, para informarme rápida y superficialmente sobre la concesión de un nuevo proyecto (CASOENAC) en colaboración con el gobierno de un estado mexicano, llamado Colima, y la Universidad de Heidelberg. En pocas palabras “me vendió” que podría ser una magnífica oportunidad para desarrollar mi tesis doctoral; y para lo que tenía que decidir ya si quería participar y acompañarla a México un mes después, puesto que tenía que reservar los billetes cuanto antes para que los precios no se dispararan ¿Cómo iba a rechazar tan magnífica propuesta? ¿Y los detalles? Más tarde...

Así, se podría decir que mi relación con el estudio de la Calidad de Vida, se inicia de forma fortuita, estaba en el momento justo y en la situación apropiada para recibir esta propuesta: licenciada, matriculada en programa de doctorado, participando en proyectos liderados por la profesora Rocío Fernández-Ballesteros y sin un proyecto de tesis definido.

Fue a partir de ese momento cuando estreché mi relación con el concepto de Calidad de Vida y, desde entonces, ha sido una relación fluctuante, de amor y odio. Aunque este es un sentimiento expuesto y compartido por muchos doctorandos con sus respectivos temas de estudio y tesis doctorales. En mi caso, creo que es, si cabe, más justificable. La Calidad de Vida, abarca un abanico tan grande de ciencias (política, economía, salud,...) y de áreas de aplicación que frecuentemente resulta inabordable y te hace permanecer en constante sentimiento de dualidad, que lo sabes todo, pero que no sabes nada. Sin embargo, tras cada bache, desencuentro, sentimiento de divagación... he conseguido reconciliarme con ella, la Calidad de Vida, y entender la relevancia e implicación que tiene en el ámbito científico llamar a cada cosa por su nombre.

Este proyecto y su subvención económica acabaron en 2011, mismo año en el que recibí la Beca de Formación de Personal Universitario (FPU). La aceptación de la beca, de cuatro años de duración, me exigía no leer la tesis doctoral hasta 2 años después de haberla recibido para no perder la dotación económica. La sensación de mucho tiempo por delante, por un lado, y la oportunidad de participar en nuevos proyectos, por otro; me llevaron a un proceso de procrastinación de la tesis doctoral, en la cual, cuanto más tiempo pasaba de la finalización del CASOENAC más oportunidades me surgían para iniciar proyectos nuevos y diferentes a la tesis doctoral y cuanto más embaucada estaba en los nuevos proyectos menos tiempo tenía para centrarme en mi tesis.

Finalmente, y después de este largo camino que me ha proporcionado un sinfín de nuevas experiencias enriquecedoras, nacionales e internacionales y llenas de emociones de todo tipo, tengo el inmenso placer de estar presentando esta tesis doctoral. Así que, sin más dilación y después de este comienzo auto-biográfico, que consideraba esencial para entender mejor el trabajo realizado; abandono este tono más literario y personal para presentar esta tesis doctoral.



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CALIDAD DE VIDA EN LA VEJEZ

Presentación

PRESENTACIÓN

El trabajo realizado en esta tesis doctoral tiene como objetivo profundizar en el cuerpo conceptual y científico de la Calidad de Vida en la población mayor y validar su potencial transculturalidad. Además, pretende servir de guía para realizar un buen diagnóstico de la Calidad de Vida de un determinado contexto y poder elaborar propuestas de intervención social y política que la mejoren.

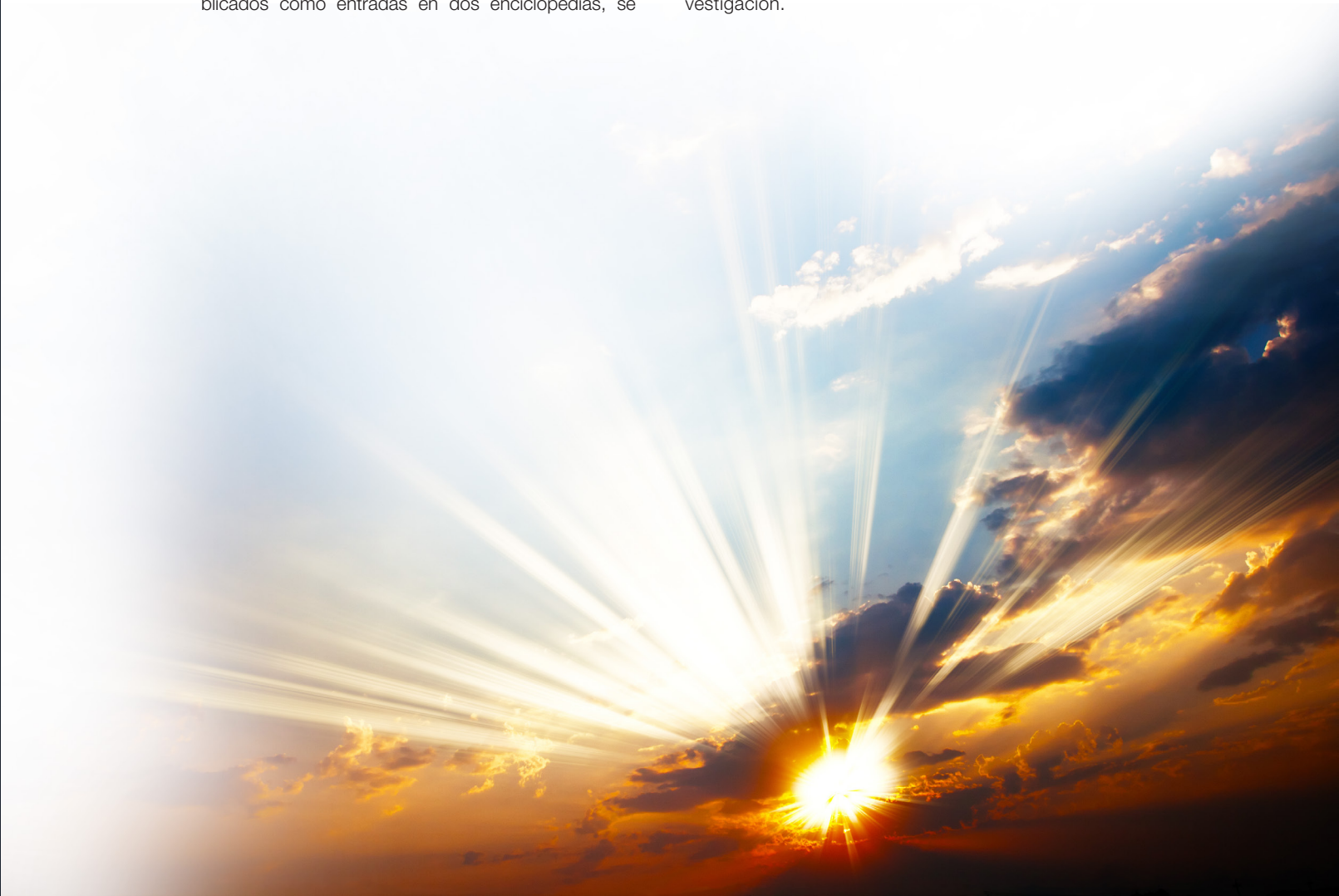
La tesis doctoral producto de artículos y capítulos de libro ya publicados, se divide en tres partes: una primera parte empírica, una segunda parte aplicada y una tercera parte de discusión y conclusiones.

En la primera parte, se introduce el cuerpo teórico de la Calidad de Vida, organizado en tres apartados: una breve reseña histórica del constructo; una descripción de las características de este concepto en el ámbito de la vejez y de los aspectos problemáticos que lo rodean; y, por último, una revisión de los instrumentos que se utilizan para su evaluación. En esta parte se incluyen tres artículos teóricos. El primero, titulado "Geropsychology in Spain" analiza las aproximaciones científicas al estudio de la Calidad de Vida en España, en el marco de la psicogerontología de nuestro país. Los otros dos artículos titulados "Quality of Life: Problematic Issues" y "Aging and Quality of Life", publicados como entradas en dos enciclopedias, se

centran en la conceptualización de la Calidad de Vida, los problemas que supone y el análisis de los instrumentos de evaluación que habitualmente se utilizan para medirla.

En la segunda parte, se hace una descripción detallada de la investigación de la que emerge la tesis: un proyecto internacional denominado CASOENAC (Cambio Sociodemográfico y Envejecimiento Activo -Contribución Científica para Políticas Públicas Previsoras), financiado por la Unión Europea y Los Estados Unidos Mexicanos. Aquí se recogen las publicaciones de los resultados obtenidos en el estudio. Se presenta el trabajo titulado "Quality of Life in Mexico and in Spain", que compara la Calidad de Vida en dos muestras representativas procedentes de España y México. También se incluye, el artículo "Multidimensional/ Multisystems/ Multinature Indicators of Quality of Life: Cross-cultural evidence from Mexico and Spain", cuyo objetivo es justificar la necesidad de utilizar un modelo de Calidad de Vida multidimensional con indicadores objetivos y subjetivos. Para ello, se aporta evidencia empírica del modelo con las dos muestras representativas de referencia: España y México.

Finalmente, en el Capítulo III se recoge la discusión, las principales conclusiones, y futuras líneas de investigación.



Parte I

Calidad de vida en la vejez

Capítulo 1
Historia del concepto, Características y Evaluación

Capítulo 2
Geropsychology in Spain

Capítulo 3
Quality of Life. Problematic issues

Capítulo 4
Aging and Quality of Life

Parte I

Calidad de vida en la vejez

Capítulo 1
Historia del concepto, Características y Evaluación

Capítulo 2
Geropsychology in Spain

Capítulo 3
Quality of Life. Problematic issues

Capítulo 4
Aging and Quality of Life

HISTORIA DEL CONCEPTO, CARACTERÍSTICAS Y EVALUACIÓN

Historia del concepto de calidad de vida

El concepto de Calidad de Vida nace a finales de los años 60 y su crecimiento desde entonces ha sido exponencial. Surge en dos contextos simultáneamente: el sociopolítico y el biomédico. En ambos casos, con el objetivo de sustituir las medidas socioeconómicas tradicionales que se utilizaban para describir la evolución y el desarrollo de personas y poblaciones – renta per cápita, producto interior bruto – por otras que representaran mejor los cambios globales de un determinado entorno. En esa época Wilson (1968) promueve en Estados Unidos la necesidad de explorar las “nuevas fronteras” de los indicadores de cambio social. Su propuesta identifica los siguientes aspectos como importantes en el ámbito de la Calidad de Vida: el estado de los individuos, la equidad de los individuos, educación, crecimiento económico, cambio tecnológico, agricultura, condiciones de vida, salud y bienestar.

Diez años más tarde, en la Conferencia de la Organización Mundial de la Salud en 1978, celebrada en Alma Ata, se declara que la salud es un estado de completo bienestar físico, mental y social y que no se limita a la ausencia de salud o enfermedad (Declaración I). Asimismo, establece que la promoción de la salud es esencial para la sostenibilidad del desarrollo económico y social de una nación y contribuye a tener mejor Calidad de Vida (Declaración II). (Fernandez-Ballesteros y Santacreu, 2013).

Estos dos hitos, derivados del campo político y médico, respectivamente, marcan un antes y un después en la conceptualización e importancia del término Calidad de Vida y en el tipo de indicadores utilizados para medir los cambios sociales e individuales.

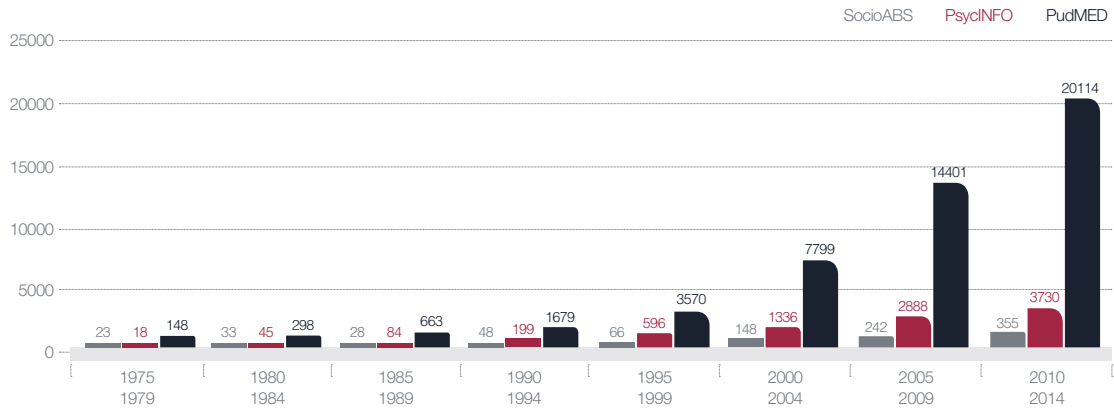
En los últimos 50 años la Calidad de Vida se convierte en una palabra clave y de referencia tanto a nivel político, convirtiéndose en el objetivo de la aplicación de políticas sociales destinadas a diferentes tipos de población (ONU, 2002); como a nivel científico, siendo

objeto de estudio en diversidad de marcos científicos (Fernández-Ballesteros, 1996, 2011; Fernández-Ballesteros y Santacreu, 2013; Santacreu, 2012); también, a nivel social, convirtiéndose en el objetivo de programas sociales; como los programas universitarios para mayores (PUMAS) (Fernández-Ballesteros et al., 2013).

La Calidad de Vida como concepto sociopolítico está presente en las Políticas, Planes, Programas y Proyectos que a nivel Internacional, Nacional, Regional y Local pretenden aplicar los gestores públicos. La presencia a nivel político de la Calidad de Vida se extiende desde un nivel macro, como fue incluida en el II Plan Internacional sobre Envejecimiento de Naciones Unidas (ONU, 2002) y, en su versión regional para América Latina, publicada por CEA; así como a nivel micro, en planes políticos regionales como el “Plan Regional del Estado de Colima” realizado el 2010, en el que está enmarcado esta tesis doctoral.

Su relevancia en el marco científico se constata en el incremento de la literatura científica que hace referencia a la Calidad de Vida. Este término está presente en las bases de datos de la investigación bio-médica y de otras ciencias de la salud; así como, en diferentes ciencias sociales como la psicología, la sociología, la ciencia política o, incluso, en las ciencias ambientales, jurídicas, etc. (ver Fernández-Ballesteros, 1996). En la **Figura 1** podemos examinar su crecimiento a lo largo de las últimas décadas entre distintas bases de datos especializadas en las distintas áreas de investigación en las que cabe el estudio de la Calidad de Vida: PubMed, PsycINFO (ProQuest) o Sociological Abstracts (ProQuest). Mientras en los años setenta el número de publicaciones científicas en Calidad de Vida apenas llegaba a una centena, en el primer lustro del siglo XXI ha crecido de manera extraordinaria; esencialmente en el ámbito de la medicina, seguido por la psicología y, de una forma mucho más lenta, en el campo de lasociología.

FIGURA 1 EVOLUCIÓN DEL ESTUDIO DE LA CALIDAD DE VIDA EN EL ÁMBITO DEL ENVEJECIMIENTO EN TRES BASES DE DATOS (1975-2014)



... Sistema de búsqueda en Bases de Datos realizada el: 03/11/2014. Referencia de búsqueda: "quality of life" AND ("age" OR "ageing" OR "aging" OR "old people" OR "elders"). Restricciones añadidas "fecha inicio"- "fecha fin".

En la actualidad, también, podemos encontrar once revistas de difusión científica internacional cuyo objetivo es difundir resultados sobre Calidad de Vida y otros conceptos relacionados: bienestar, felicidad y salud (Tabla 1). La primera en fundarse fue Social Indicators Research en 1974 y nació con el objetivo de "become regarded as the leading journal for the publication of the results of research dealing with problems related to the measurement of all aspects of the quality of life". Diez años más tarde surge la primera revista en incluir Calidad de Vida en su título: Quality of Life Research.

A partir del año 2000 se producen dos oleadas de nuevas revistas relacionadas con Calidad de Vida. En la primera, entre el 2000 y 2005, se empieza a dar máxima relevancia a los indicadores subjetivos. En la segunda, entre 2010 y 2012, surgen revistas esencialmente de carácter interdisciplinar. Durante la última década, se observa como la psicología como disciplina científica y atendiendo a aspectos subjetivos y emocionales se interesa por la Calidad de Vida.

TABLA 1 REVISTAS DE CARÁCTER CIENTÍFICO SOBRE CALIDAD DE VIDA

Revista	Año de inicio	Campo científico	Factor de Impacto
Social Indicators Research	1974	Ciencias sociales	1.452
Quality of Life Research	1997	Ciencias de la Salud	2.864
Journal of Happiness Studies	2000	Interdisciplinar	1.77
Health and Quality of Life Outcomes	2002	Ciencias de la Salud	2.099
Journal of Positive Psychology	2003	Psicología	1.200
Applied Research in Quality of Life	2003	Ciencias sociales	0.642
British Journal of Wellbeing	2010	Ciencias de la Salud	-
Psychology of Wellbeing	2011	Psicología	-
International Journal of Wellbeing	2011	Interdisciplinar	-
International Journal of Happiness and Development	2012	Interdisciplinar	-
Journal of Happiness and Wellbeing	2012	Interdisciplinary	-

Fuente: <http://www1.eur.nl/fsw/happiness/journals.htm> (03/10/2014)

Por último, a nivel social, la calidad de la vida se ha convertido en el objetivo último de muchos programas de intervención. Por ejemplo, el objetivo general de un proyecto internacional financiado por UAM- Santander y dirigido por Fernández-Ballesteros denominado CAVIPUMA (Calidad de Vida en Programas Universitarios para Mayores) fue medir el impacto en la Calidad de Vida de los participantes en programas universitarios para personas mayores de cinco universidades en cuatro países distintos - Universidad Pontificia Católica de Chile; Universidad de La Habana (Cuba); Universidad Nacional Autónoma de México; Universidad Autónoma de Madrid y La Salle (España) –(Fernández-Ballesteros et al., 2013). Encontramos otro ejemplo en la Universidad Nacional de Educación a

Distancia (UNED), en la cual existe un diploma de experto universitario titulado “Intervención en Calidad de Vida de Personas Mayores” (https://formacionpermanente.uned.es/tp_actividad/idactividad/6647).

En conclusión, esta descripción de diferentes espacios en los cuáles el tema de la Calidad de Vida está presente refleja su gran importancia y elevada presencia en los ámbitos socio-político y de investigación.

El exponencial crecimiento de las personas mayores a nivel mundial, como se describe a continuación, ha facilitado que la Calidad de Vida haya calado especialmente en este sector de la población.

Envejecimiento de la población

El último informe de Naciones Unidas (2013) sobre el envejecimiento de la población indica que este fenómeno ya se ha generalizado a casi todos los países del mundo (p. xii). La proporción mundial de personas mayores de 60 años o más aumentó de un 9,2% en 1990 al 11,7% en 2013 y se calcula que seguirá creciendo, alcanzando el 21,1% en 2050. A nivel mundial, se estima que el número de personas mayores de 60 años en 2013 (841 millones) pasará a ser más del doble en 2050 (superior a 2 mil millones).

Como ya se ha descrito en numerosos informes sobre el envejecimiento de la población a nivel mundial, europeo y nacional (UN, 2002, 2007, 2009 y 2013; Eurostats, 2007; Giannakouris, 2008; CSIC, 2010), puede considerarse un logro del desarrollo humano y social que se ha producido durante los últimos años, pero también supone un gran reto por el impacto económico y social que conlleva. Las tasas de dependencia en la población mayor, es decir, el número de personas en edad de trabajar por cada persona mayor de 64 años ya es bajo en las regiones más desarrolladas y en algunos países en desarrollo, y se espera que siga bajando en las próximas décadas con la consiguiente presión fiscal sobre sistemas de pensiones y seguridad social. Además, con el aumento de personas mayores en casi todo el mundo también ha aumentado la prevalencia de enfermedades crónicas y/o degenerativas, y con ello el gasto en el cuidado de personas en situación de dependencia.

Sin embargo, el envejecimiento de la población no solo conlleva consecuencias negativas. También ha crecido el número de personas mayores que pueden vivir de forma independiente (solos o con su cónyuge) y en la mayoría de los países, las personas mayores contribuyen a su propia economía y a las de sus familiares manteniendo ingresos laborales, ingresos de sus activos, etc. (UN, 2013).

Además de tener en cuenta el envejecimiento como fenómeno poblacional, podemos analizar el envejecimiento y los cambios que éste produce a nivel individual. Como señala Baltes (1978), hacerse viejo supo-

ne un continuo balance entre estabilidad, ganancia y declive. A lo largo de la vida, podemos distinguir cambios en dos tipos de sistemas: aquellos que ocurren a nivel bio-físico y que declinan a medida que envejecemos; y los que ocurren a nivel psico-social, cuyas funciones pueden permanecer estables, mejorar o declinar influidos por factores biológicos, por supuesto, pero en interacción con el contexto y los comportamientos de cada individuo (Ver: Fernández-Ballesteros y Santacreu, 2013).

Como se ve reflejado a nivel poblacional, el envejecimiento no siempre viene asociado con enfermedad y discapacidad. Por ello, los expertos insisten en mantener una distinción entre envejecimiento primario, aquel en el que los cambios y declives ocurren por la edad, y el envejecimiento secundario, en el que se produce deterioro por la presencia de una enfermedad. Por esta razón, en contraposición a una percepción negativa de la vejez, siempre es importante recordar que cualquier condición humana, entre ellas el envejecimiento, está sujeta a cambios por la interacción de lo bio-físico, lo comportamental y lo psico-social y es susceptible de mantenerse estable, mejorar o empeorar dependiendo de las circunstancias (Fernández-Ballesteros, 2008).

Así pues, el resultado de cómo una persona envejezca y de cómo sea su Calidad de Vida dependerá de la interacción entre un variado número de circunstancias tanto a nivel macro (cultura, sistema de seguridad social, nivel de educación y desarrollo, etc.) como a nivel micro (funcionamiento bio-psico-social de una persona, salario, nivel educativo), etc. Y, por tanto, el estado en que se encuentre en un determinado momento requerirá la evaluación de todo este conjunto de variables. La definición de este conjunto de variables y la identificación de indicadores para medirlas ha sido una de los temas de investigación más relevante en el estudio de la Calidad de Vida en la vejez, que se detalla a continuación.

Definición de calidad de vida en la vejez

La Calidad de Vida, a pesar de ser un término ultra utilizado, carece de una definición comúnmente consensuada y sus conceptualizaciones son casi tan variadas como los contextos y autores que hacen alusión a ella. Existen multitud de artículos que hacen referencia a la acertada definición que hace Walker (2005a) de la Calidad de Vida: “an amorphous, multilayered and complex concept with a range of components – objective, subjective, macro-societal, micro-individual, positive and negative – which interact together” (p. 3) (Fernandez-Ballesteros, 2011; Halvorsrud and Kalfoss, 2007; Vaarama, 2009).

Descomponiendo esta descripción del término, encontramos tres fuentes de variabilidad que favorecen esta diversidad de definiciones. Como concepto multidimensional, los expertos no se ponen de acuerdo sobre el número y tipo de indicadores que deben utilizarse para medirla. En cuanto a la naturaleza de sus indicadores, algunos autores defienden la utilización de indicadores objetivos, otros promueven la utilización de indicadores subjetivos; y la mayoría toman una posición holística y consideran necesaria la mezcla de ambos. Por último, el hecho de que sea un término multinivel aplicable tanto a individuos (micro) como agrupaciones de individuos o poblaciones (macro), proporciona variabilidad en el tipo de indicadores que se utiliza en cada nivel. Veamos estos tres puntos con más detalle a continuación.

COMPONENTES DE CALIDAD DE VIDA EN LA VEJEZ

A pesar de que los autores coinciden en que la Calidad de Vida es un concepto multidimensional, y debe incluir varios indicadores para medirla, no hay acuerdo sobre los ingredientes principales que la componen. Como su propio nombre indica, ésta podría incluir tantos elementos como la vida misma, infinitos (Hagerty et al., 2001); por eso, resulta difícil acotar y resumirlo en unas pocas áreas. Así, la selección de indicadores varía según las disciplinas y los contextos en los que se utiliza y según las características de las poblaciones e individuos a las que se aplica.

Entre las líneas de investigación abiertas para determinar los ingredientes de la Calidad de Vida, encontramos autores que se centran en estudiar qué componentes deben ser incluidos a partir de lo que las personas reportan que es importante para su Calidad de Vida. Con este objetivo, diferentes autores han preguntado a las propias personas mayores qué ingredientes incluirían para definir su propia Calidad de Vida (e.g. Bowling, 2005; Farquhar, 1995) y así generar un modelo de Calidad de Vida en la vejez. Otros autores, consideran que debe ser cada persona quien seleccione qué elementos contribuyen a su propia Calidad de Vida en cada momento. Con este fin, han desarrollado instrumentos abiertos en los que cada persona selecciona un número preestablecido de elementos importantes y señala su satisfacción con los mismos (ej.: Schedule for Evaluation of Individual Quality of Life – SEIQOL; McGee et al., 1991). Por el contrario, otros autores defienden que para hacer comparable la Calidad de Vida entre poblaciones y/o individuos es necesario utilizar ingredientes de Calidad de Vida estándar para todos y representativos de varias áreas de la vida (Fernandez-Ballesteros, 1998, 2011; The economist, 2005), que permitan obtener targets de intervención para mejorarla, puesto que es el fin último para el que se desarrolló este constructo.

La selección de los componentes de la Calidad de Vida también dependen del área de estudio en la que nos encontremos; en el área biomédica y de la salud los componentes considerados para Calidad de Vida son esencialmente relacionados con enfermedad, síntomas o limitaciones que genera una determinada condición de salud (hasta desarrollarse el término “Health Related Quality of Life”) (Naughton and Wiklund, 1993); en el área de la psicología, la Calidad de Vida resulta de la satisfacción con la vida (Palys and Little, 1983); y desde una perspectiva social la Calidad de Vida es equivalente a bienestar (Campbell 1981).

A continuación, a modo de resumen, se señalan las áreas o elementos que han sido destacados tanto por científicos como por la población general como componentes de Calidad de Vida.

- Calidad ecológica y medioambiental: como indicadores se utilizan condiciones del agua, recursos energéticos, forestación, disponibilidad de zonas verdes, contenedores de una ciudad o porcentaje de personas que reciclan.
- Recursos económicos: medido por el producto interior bruto (PIB); el presupuesto de una determinada región, distrito, comunidad de vecinos; el salario.
- Aspectos bio-médicos y salud: incluye índices epidemiológicos, como mortalidad, morbilidad, esperanza de vida y esperanza de vida libre de discapacidad. Aquí se incluye, accesibilidad a servicios sanitarios, estado de la salud, salud percibida y satisfacción con la salud; así como actividad física.
- Variables sociopolíticas y culturales: en este apartado se incluye índices de seguridad (prevalencia de crímenes, suicidios, violencia pública, número de divorcios), aspectos políticos y de organización (como recursos educativos), percepciones del clima social, valores sociales y estereotipos culturales.
- Aspectos psicosociales: centrados a nivel individual, incluyen red y apoyo social, frecuencia de relaciones sociales, satisfacción con las relaciones sociales y actividades de ocio.
- Componentes psicológicos y comportamentales: hacen referencia a salud percibida, independencia, actividades de ocio, condiciones laborales, satisfacción con la vida, bienestar, salud mental (depresión/felicidad, ansiedad/relajación, demencia/preservación de la memoria, etc.) y apreciaciones subjetivas de cualquier condición de la vida entre otros.

NATURALEZA DE LOS INDICADORES DE CALIDAD DE VIDA EN LA VEJEZ

En el concepto de Calidad de Vida se han incluido tanto elementos objetivos como subjetivos en todas las áreas científicas, aunque según el contexto, los modelos y/o autores se han utilizado más unos que otros. Así, por ejemplo, podemos encontrar contextos en los que se prioriza la utilización de indicadores de Calidad de Vida únicamente subjetivos – como satisfacción con la vida en el ámbito psicosocial-; otros en los que se prioriza la inclusión de elementos claramente objetivos – como la renta, la pureza del agua o la accesibilidad a asistencia médica en los ámbitos políticos y ambientales-. Por ejemplo, el modelo *The Economist* (2005), aunque varios indicadores, solo incluye aspectos de carácter objetivo. Éste consiste en la combinación de 9 factores (bienestar económico, salud, libertad política, seguridad en el empleo, vida familiar, clima y geografía, estabilidad política, igualdad

de género, vida comunitaria) medidos por diferentes indicadores objetivos (ej.: PIB, esperanza de vida, tasa de desempleo, tasa de divorcio, etc.) para elaborar un índice global de Calidad de Vida que permita comparar países según la puntuación obtenida en una escala total de 1 a 10.

Varios autores, rechazan esta aproximación únicamente subjetiva u objetiva, y resaltan la importancia de combinar ambos tipos de factores. Señalan que tan importantes son los indicadores objetivos de una determinada condición (ej.: número de enfermedades para medir salud, salario para medir bienestar económico) como la percepción que un individuo tenga de esa misma condición (ej.: percepción subjetiva de salud, satisfacción con salario) (Cummins, 2000; Fernandez-Ballesteros, 1998, 2011; Lawton, 1991).

NIVELES DEL CONCEPTO DE CALIDAD DE VIDA

El término de Calidad de Vida se considera un concepto multinivel, puesto que puede hacer referencia tanto a un individuo como a unidades contextuales agregadas (poblaciones) de un país, una cultura o tipos de individuos (por raza, edad, sexo, etc.). Por ejemplo, el área ecológica y medioambiental, puede incluir los siguientes indicadores de naturaleza objetiva: espesor de la capa de ozono en una determinada área geográfica, pureza del agua en un determinada región (a nivel poblacional) y número de recursos energéticos de los que dispone una determinada persona (a nivel individual). Pero además, en esta misma área los indicadores subjetivos podrían ser la medida de

satisfacción que una población tiene con los recursos energéticos de su país (poblacional) y la satisfacción que una persona tiene con las zonas verdes que existen cerca de su vivienda.

Con el fin de resumir los posibles indicadores que se pueden utilizar para medir la Calidad de Vida, Fernández-Ballesteros (2010) ha establecido un sistema de clasificación en el que los potenciales componentes se sitúan sobre un doble eje dicotómico: la primera dimensión representa la división entre Poblacional / Individual y, en la segunda, se sitúa lo objetivo versus lo subjetivo; como se ve reflejado en la **Figura 2**.

FIGURA 2 SISTEMA DE CLASIFICACIÓN DE LOS FACTORES MÁS COMUNES DE LA CALIDAD DE VIDA (FERNÁNDEZ-BALLESTEROS, 1993)

Nature	Unit	Population / Context	Individual
Objective	1	<ul style="list-style-type: none"> - Demographics (aging rates, density...) - Physical factors (latitude, residential facilities, protective assistance...) - Economic factors (pension system...) - Social factors (social networks, social services availability...). - Equality legislation. - Health factors (life expectancy, health security system...). - Disability/ability prevalence in old age. 	<ul style="list-style-type: none"> - Demographic characteristics (age, sex, education, SES...) - Physical conditions (home, residence, neighborhood...) - Economic factors (income...) - Social factors (family support, social network...) - Functional abilities and activity (ADL...) - Health conditions (medical records, prescriptions, days spent in hospital...) - Physical fitness (balance, strength, BMI)
		2	<ul style="list-style-type: none"> - Subjective conditions such as well-being, life-satisfaction, control perception, etc. - Any personal appraisal about his/her conditions in box 2. or about external conditions in box 1
Subjective			4

En este cuadro podemos apreciar como las dos fuentes de diferenciación de la Calidad de Vida son la unidad de análisis (o nivel poblacional/contextual o individual) y la naturaleza de la variable examinada (objetiva y subjetiva). En cada casilla se ve representada la multidimensionalidad del concepto. Así pues, en el Bloque 1, se encuentran ingredientes de la Calidad de Vida referidos a unidades poblacionales /contextuales y a elementos objetivos de Calidad de Vida. Aquí estarían los datos demográficos, la existencia de un sistema de pensiones, la renta per cápita... Pero también a nivel poblacional o contextual estarían aquellos elementos subjetivos, percibidos que corresponden a ese contexto, por ejemplo, las percepciones sociales, el bienestar agregado, su sentido de eficacia colectiva, sus valores como conjunto.

Esta información formaría el Bloque 2, que está referido a los elementos subjetivos extraídos en agregado del conjunto de individuos presentes en una población/contexto. El bloque 3 y el bloque 4 resumen la información necesaria para definir la Calidad de Vida cuando el foco de atención es un determinado individuo atendiendo a aspectos objetivos y subjetivos, respectivamente. Así en el bloque 3, estarían los datos demográficos, salario, tamaño de la red social, etc. de los individuos. Mientras que en el bloque 4 se situaría

cualquier apreciación subjetiva sobre los elementos del bloque 1 y 3. Con la combinación de indicadores de Calidad de Vida de los cuatro bloques, podríamos obtener una fotografía completa de la Calidad de Vida de una persona o grupo de individuos.

En base a esta propuesta se realiza el estudio empírico que se presenta en este trabajo. En Fernández-Ballesteros et al. (2012) se presenta una fotografía completa de la Calidad de Vida de ambos países (España y México), teniendo en cuenta tanto indicadores poblacionales, tomados de grandes bases de datos; como indicadores individuales, tomados de muestras representativas de cada país. En Santacreu, Bustillos y Fenandez-Ballesteros (In press), se toman como referencia los datos individuales para avalar empíricamente la multidimensionalidad y doble naturaleza de este concepto.

A pesar de que existen ciertos acuerdos acerca de la definición de Calidad de Vida, de su carácter multidimensional y de la necesidad de poder describirla mediante indicadores objetivos y subjetivos, existe mucha controversia alrededor del término y una utilización inadecuada del mismo de forma generalizada en muchos ámbitos, como se detalla en el siguiente apartado.

Aspectos problemáticos de la calidad de vida

Un nuevo concepto nace en la literatura científica, por la necesidad de definir una situación que no había sido descrita antes; para aportar algunas ventajas sobre términos ya existentes. Como ya se ha dicho, la Calidad de Vida nace como concepto para aventajar algunas aproximaciones simplistas al término bienestar (“welfare state”), medido únicamente con indicadores objetivos en el contexto económico; y con el afán de superar la conceptualización de la salud como simple ausencia de enfermedad en el modelo médico. De ahí, el empeño de muchos autores en centrar sus esfuerzos en proveer un modelo científico del concepto de Calidad de Vida que mantenga las exigencias y características por las que fue creado: multidimensional, con naturaleza objetiva y subjetiva y aplicable a diferentes niveles contextuales (individual/poblacional) (Cummins, 2000; Fernández-Ballesteros y Santacreu, 2013; Hagerty et al., 2001; Lawton, 1991; Walker, 2005).

Sin embargo, el concepto de Calidad de Vida ha sido difuso y controvertido desde su nacimiento. Los esfuerzos por encontrar los indicadores idóneos para medirla han sido constantes y, como se ha mostrado ya, el éxito en conseguir acuerdo ha sido escaso. Esencialmente, el concepto de Calidad de Vida ha sufrido dos tipos de amenazas que hemos descrito como reduccionismo y subjetivación (Fernández-Ballesteros y Santacreu, 2012, 2013). El primer término hace referencia a que la Calidad de Vida ha sido frecuentemente reducida a alguno de sus componentes, obviando su carácter multidimensional. El segundo, hace alusión a que la Calidad de Vida ha sido reducida o confundida con términos e indicadores únicamente subjetivos; el impetuoso intento por huir de aproximaciones únicamente objetivistas, ha hecho que se llegara al extremo contrario, en el que la vida se ve reducida a percepciones subjetivas.

Este tipo de errores no es exclusivo de un determinado dominio o área de estudio y se ve esencialmente reflejado en estudios empíricos en los que la evaluación de la Calidad de Vida se ve reducida a un mínimo número de indicadores; que con frecuencia solo hacen referencia a la salud o a aspectos subjetivos. De hecho, podemos encontrar ejemplos en todas las áreas que usan este constructo para describir personas o poblaciones, aportar resultados sobre la aplicación de un determinado programa o reportar el impacto de una determinada enfermedad o condición social. A continuación se exponen con más detalle estos errores.

REDUCCIONISMO

En el campo de la medicina, donde el uso del concepto de Calidad de Vida es masivo (Figura 1), también lo es la frecuencia con la que la utilización del término es errónea (Michalos, Ramsey y Eberts, 2011). En este ámbito, la Calidad de Vida se ve reiteradamente reducida a salud y/o al impacto que tiene una determinada enfermedad o tratamiento, en términos de síntomas, funcionamiento físico o percepciones subjetivas de su estado de salud.

La extensión del término salud propuesta por la Declaración I de Alma Ata favoreció que las ciencias biomédicas adaptaran el término de Calidad de Vida a su ámbito de aplicación, apareciendo un nuevo término: Health Related Quality of Life (HRQoL) (Calidad de Vida asociada a la Salud). Sin embargo, a pesar de que la intención fue ampliar la definición de salud; se consiguió el efecto contrario, reducir el concepto de Calidad de Vida a salud. Desde ese momento, instrumentos que habían sido tradicionalmente utilizados para medir estado de salud se utilizan para medir Calidad de Vida (ej.: Nottingham Health Profile (NHP), the Sickness Impact Profile, or the Medical Outcome Study 36-Item Short Form Survey SF-36) y se crearon otros, que aunque solo miden frecuencia de síntomas de una determinada patología, incluyen Calidad de Vida en el nombre del instrumento (ej.: Adolescent Asthma Quality of Life Questionnaire, Alzheimer’s Carer’s Quality of Life Instrument, Attitudes to Randomised Clinical Trials Questionnaire, etc.).

En ambos casos, Calidad de Vida se está reduciendo a una sola dimensión de la vida: la salud, o incluso en algunos casos, peor aún, presencia versus ausencia de enfermedad (Fernández-Ballesteros y Santacreu, 2013).

En las áreas de psicología, socioeconomía y política, la simplificación o reducción del término ha tenido una dirección muy clara, hacia aspectos subjetivos de Calidad de Vida, como felicidad, bienestar subjetivo, positividad, etc. que nos lleva a introducir el siguiente apartado, en el que se explica el segundo de los errores que se ha cometido en torno a este concepto, el subjetivismo.

SUBJETIVISMO

La Calidad de Vida, además de reducirse a alguno de sus componentes, también se confunde con componentes únicamente subjetivos. Aunque en estos casos, a veces mantenga su carácter multidimensional, referido a diferentes aspectos de la vida, lo considera desde una perspectiva únicamente subjetiva. Como resultado, muchos instrumentos de evaluación de Calidad de Vida incluyen diferentes áreas, pero solo las tiene en cuenta como apreciaciones individuales, subjetivas y/o sobre el nivel de satisfacción respecto a las mismas (ej.: WHO-QOL, 1995) (Fernández-Ballesteros and Santacreu, 2013).

En el campo de la psicología, la Calidad de Vida se iguala a o se confunde con emociones positivas, como bienestar (well-being) y satisfacción con la vida, e incluso, características de personalidad, como optimismo. Es ejemplo de ello el inventario QoLI (Frisch, 1994, 2009), que incluye autoestima y creatividad como variables psicológicas relevantes para medir la Calidad de Vida.

Por último, desde una perspectiva socioeconómica, política y de desarrollo y progreso humano, algunos autores han igualado la Calidad de Vida a felicidad. Por ejemplo, Blanchflower and Oswald (2011) impulsan la utilización de índices de felicidad, como una expresión de la Calidad de Vida, como sustitución a medidas económicas objetivas.

Probablemente, esto haya sido consecuencia, por un lado, de un intento impetuoso por alejarse del uso exclusivo de indicadores objetivos que se hacía tradicionalmente para calificar la Calidad de Vida de las poblaciones. Y, por otro, por una cuestión puramente metodológica. La falta de correlación o la variada relación entre aspectos objetivos y subjetivos hace realmente difícil casar estos dos tipos de indicadores en un mismo modelo metodológicamente aceptable (Cummins, 2000; Fernández-Ballesteros & Maciá, 1996; Smith, 2000; Graham and Lora, 2010) unido a la utilización exclusiva de auto-informes como instrumento de recogida de información, que hace especialmente fácil obtener datos de naturaleza subjetiva (Fernández-Ballesteros, 2011).

Sin embargo, como destacan muchos autores y explica detalladamente Michalos (2002), esta reducción a lo subjetivo es problemática en muchos sentidos. De hecho, para entender su peligro solo hay que recordar el propósito para el que el concepto fue construido: trabajar en mejorarla. Como enfatiza Fernández-Ballesteros (2011) cuando se reduce la Calidad de Vida a indicadores subjetivos se corren varios riesgos. En primer

lugar, las personas proporcionan muy poca variabilidad en respuestas de satisfacción, la mayoría reportan estar satisfechos con la vida en general, o con diferentes aspectos de la vida como la salud o las relaciones sociales (Fernández-Ballesteros et al, 2012). No nos detendremos en explicar por qué ocurre esto, pero sí queremos resaltar el bajo poder discriminativo que tiene este tipo de ítems y lo poco útiles que pueden resultar para identificar aquellos elementos potencialmente mejorables, por la dificultad que supone tener una definición operacional de los mismos (Michalos, 2002).

En segundo lugar, cuando el objetivo es medir los efectos de programas de intervención, la utilización exclusiva de indicadores subjetivos puede ser engañosa y no dar cuenta de la producción de cambios reales en una determinada situación, si no solo de cambios en la forma en que la persona tiene de percibirla (Fernández-Ballesteros y Santacreu, 2013). Por ejemplo, una campaña política que promueve la mejora de la Calidad de Vida y la satisfacción de las personas mayores, puede llevar a que éstas reporten que están más satisfechos con su entorno después de la campaña, aunque en el entorno no haya habido cambios, sino solo un mensaje positivo de que va a haberlos. Esto ya era señalado por Sampson en 1981, que defendía que un concepto científico utilizado como un resultado social (como es la Calidad de Vida), no puede ser reducido o transformado a percepciones subjetivas si el objetivo es hacer cambios reales en la vida de las personas.

En tercer y último lugar, la necesidad de utilizar indicadores objetivos se hace más relevante cuando las personas evaluadas tienen alguna dificultad física o cognitiva, con limitaciones para comunicarse, como puede ocurrir en personas con demencia (Fernández-Ballesteros y Santacreu, 2010). Todo el mundo estaría de acuerdo en garantizar la mejor Calidad de Vida posible a las personas con demencia, identificando cuáles son las condiciones objetivas que mejor lo garantizan (ej.: atención y cuidado, instalaciones, su aseo, su funcionamiento físico,...), a pesar de que éstas no fueran capaces de reportar apreciaciones individuales o subjetivas sobre ello, ni qué consideran importante en sus vidas (Fernández-Ballesteros y Santacreu, 2012, 2014).

Para finalizar con este apartado y resumir lo que se concluye del mismo, citaremos a Wahl and Iwarsson (2007) que destacan la importancia de conocer el contexto objetivo de una persona (ambiental, red social,...), sus percepciones subjetivas y la relación entre ambas.

Intrumentos de evaluación de calidad de vida

Como era de prever, la falta de acuerdo en los elementos que definen la Calidad de Vida, también se pone de manifiesto en los instrumentos de evaluación que se utilizan para medirla. De hecho, como Netuveli y Blane (2008) destacan cada definición de Calidad de Vida lleva por necesidad asociado un instrumento de evaluación o la identificación de los indicadores necesarios para medirla. Y parece que en el desarrollo de instrumentos de evaluación para medir la Calidad de Vida es donde se han centrado los mayores esfuerzos.

Fernández-Ballesteros y Santacreu (2012) llevan a cabo una revisión de los instrumentos más utilizados para medir Calidad de Vida en población mayor. En primer lugar, revisaron cuáles debían ser los criterios para seleccionar uno concreto, entre la inmensa variedad que existe. Y, en segundo lugar, describieron algunos de los más utilizados en este sector de la población atendiendo a su contenido y a sus propiedades psicométricas. A continuación se resumen algunas de las ideas más importantes que se destacan en ese texto.

Dada la inmensa variedad de instrumentos de Calidad de Vida que han sido propuestos, tomar la decisión sobre qué instrumento utilizar para un determinado estudio resulta complicado. Para hacerlo, hay dos primeras preguntas importantes que uno debe hacerse: ¿cuál es el objetivo de evaluación? y ¿qué características tiene la población que va a ser evaluada? (Arnold, 1991). En tercer lugar, habrá que seleccionar, de entre los que mejor respondan a mis objetivos y a mi población target, aquellos que proporcionen las mejores características metodológicas y propiedades psicométricas.

Los 5 objetivos más comunes para evaluar Calidad de Vida son:

1. Comprender las causas y consecuencias de las diferencias individuales en la Calidad de Vida.
2. Evaluar el impacto de las intervenciones sociales y ambientales en la Calidad de Vida.
3. Estimar las necesidades de una población determinada.
4. Evaluar la eficiencia o la eficacia de las intervenciones de salud y/o la calidad del sistema de salud.
5. Mejorar las decisiones clínicas.

En cuanto a la población target, se han desarrollado algunos instrumentos para evaluar la Calidad de Vida en la población general (Ej.: Campbell, 1981); sin embargo, la creciente importancia en conocer las diferencias individuales atendiendo a la salud y/o a la edad, ha favorecido un crecimiento masivo de los instrumentos para medir Calidad de Vida en la vejez, y de entre éstos la mayoría asociados a la salud y/o a la presencia de una determinada enfermedad crónica. Por otra parte, no hay que olvidar, que esto último también se explica porque este concepto ha tenido su mayor impacto en el ámbito de la medicina (Figura 1).

En cuanto a la metodología, la primera pregunta que se nos plantea es ¿cuál es la mejor forma de obtener la información? La mayoría de instrumentos para medir la Calidad de Vida individual se basan en cuestionarios de auto-informe. Efectivamente, es la metodología más apropiada para obtener la percepción individual sobre diferentes componentes de la vida, apreciaciones subjetivas, satisfacción con la vida y niveles de felicidad; y, por ello, todos aquellos instrumentos que reducen Calidad de Vida a aspectos subjetivos utilizan auto-informe para medirla. Sin embargo, aunque el auto-informe también permite recoger datos objetivos, este tipo de indicadores pueden recopilarse mediante otros medios, como la observación directa y la valoración por parte de terceros (Ej.: familiares, médicos,...). Además, este tipo de datos también permite conjugar multi-métodos (auto-informe, valoración de terceros y/o observación) que ofrecen una imagen más completa de la Calidad de Vida de un individuo o población (Ej.: una persona puede informar de que ha sido diagnosticada de cáncer, esto puede ser confirmado por un familiar y observado por un médico).

Sin embargo, con frecuencia encontramos que los datos procedentes de diferentes fuentes de información no correlacionan. Fernández-Ballesteros, Zamarrón y Maciá (1997) encontraron que al medir Calidad de Vida ambiental mediante auto-informe y observación, la correlación entre ambas era muy baja. Por otro lado, Birren y Dieckmann (1991), destacaron la importancia de utilizar la información que proporciona un médico para ofrecer datos objetivos sobre salud, porque resultan más fiables que los reportados por los pacientes mediante auto-informe. Por el contrario, Lehr (1993) en el Bond Longitudinal Study (BOLSA), obtuvo que la salud subjetiva predecía mejor longevidad que la salud objetiva. De nuevo, la presentación de estos resultados contradictorios nos sugiere la necesidad de utilizar ambos tipos de indicadores, objetivos y subjetivos, para tener una fotografía completa de diferentes aspectos de la vida y de la relación entre sus componentes, que no son iguales en todas las muestras.

Finalmente, se pone de relieve que, como en la evaluación de cualquier otro constructo, para seleccionar un instrumento de evaluación de calidad se debe atender a sus propiedades psicométricas de validez, fiabilidad y sensibilidad al cambio. Para ello, se ofrece un cuadro en el que se recogen estas características de varios instrumentos habitualmente utilizados para medir Calidad de Vida (Fernández-Ballesteros y Santacreu, 2011).

Dada la estrecha relación entre los modelos y definiciones de Calidad de Vida y los instrumentos utilizados para medirla, en éstos últimos encontramos los mismos problemas que se dan en la conceptualización del término.

Como ya adelantábamos previamente, en el ámbito de la medicina, se pueden observar múltiples instrumentos de evaluación que se utilizan para medir Calidad de Vida y que reflejan una definición reduccionista o subjetivista de la misma. En la base de datos PROQOLID (<http://www.proqolid.org/>) podemos encontrar varios ejemplos de ello. Esta base, creada en 2002 por Mapi Research Trust (una organización sin ánimo de lucro que facilita el acceso a la información en el área de resultados centrados en el paciente) recoge y describe, hasta el momento, 878 instrumentos de evaluación, con el fin de facilitar la búsqueda del más adecuado para medir el impacto de enfermedades e intervenciones clínicas.

En esta recopilación encontramos que muchos instrumentos que tradicionalmente se han utilizado para medir salud, actualmente se describen como cuestionarios para medir Calidad de Vida o Calidad de Vida

asociada a la salud – aunque muchas veces no se hace esta especificación y los términos se usan indistintamente (Halvorsrud and Kalfoss, 2007). Algunos ejemplos son: Nottingham Health Profile, NHP; Sickness Impact Profile, SIP; Medical Outcome Study 36-Item Short Form Survey, SF-36. También, ha habido una proliferación de instrumentos destinados a medir Calidad de Vida asociada a la salud, en general (ej.: Multi-trait-multimethod analysis of health-related quality of life measure – HRQoL – Hadorn y Ron, 1991). Y cada vez son más frecuentes los instrumentos utilizados para medir el impacto que una enfermedad concreta tienen en la Calidad de Vida de las personas (ej.: Quality of life in Alzheimer Disease – QOLAS – Abert et al., 2000).

En esta primera parte del Capítulo I, se ha recogido una breve historia del concepto de Calidad de Vida, se ha detallado su definición en el contexto de la vejez y las polémicas que suscita el término, su uso y su evaluación. De ello podemos concluir, que la Calidad de Vida es un término que ya tiene 60 años de historia y cuyo uso, aunque polémico, tiene un crecimiento exponencial; esencialmente en el área de la salud y la medicina, pero también en ciencias sociales y políticas. La mayoría de autores que han teorizado sobre el término, lo consideran un concepto multidimensional, que debe incluir indicadores objetivos y subjetivos y que puede ser aplicable tanto a individuos como a poblaciones. Es un término de referencia para diseñar políticas sociales y valorar programas de intervención. Los instrumentos de evaluación que se utilizan para medirla, en su mayoría auto-informes, son variados, pero tienden a tener en cuenta solo aspectos subjetivos y cada vez se ajustan más a determinadas condiciones humanas, como la edad o una enfermedad concreta.

Parte I

Calidad de vida en la vejez

Capítulo 1
Historia del concepto, Características y Evaluación

Capítulo 2
Geropsychology in Spain

Capítulo 3
Quality of Life. Problematic issues

Capítulo 4
Aging and Quality of Life

GEROPSYCHOLOGY IN SPAIN

GeroPsych, 25 (3), 2012, 171–179

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Abstract

Spain, like other developed countries, has witnessed exponential growth in the number of older persons, and it has made great efforts to address this new social situation, gradually developing an extensive network for supporting not only dependent persons, but also healthy retired people with new demands. In order to better understand the situation with respect to aging, this chapter provides some demographic indicators illustrating the current structure of Spain's aging population. The second and third sections outline the main research areas in Spain and the resources available for older adults. With regard to research on aging, there has been a considerable increase in the number of both research projects and publications in the Spanish context, particularly from the 1980s to the present. Most of the studies are aimed at assessing the different characteristics and conditions of senior citizens. This is a good first step with a view toward identifying their demands, though more research is necessary for making crucial changes. On the subject of resources and services, Spain has developed a wide variety of resources designed to meet the needs of both independent and dependent older adults. Finally, it should always be borne in mind that social needs change over time, so that they must be continuously studied and reappraised – and our respective responses updated – in order to maintain standards of excellence.

Keywords: geropsychology in Spain, demographic changes, research on aging, programs and services for older adults.

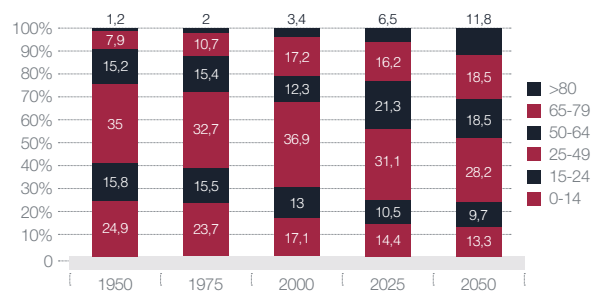
Introduction: Some Sociodemographics

The well-known phenomenon of the aging population within the European Union, caused mainly by massive demographic changes (dramatic decrease in fertility rates, major increase in life expectancy, high levels of migration) and its socioeconomic consequences (e.g., reduced numbers of people of working age vis-à-vis those of nonworking age, increase in care costs, etc.) have been described by several sociodemographic reports in recent years (Eurostat, 2007, 2011; Giannakouris, 2012). Spain, as an EU member, is no exception. In order to better understand its situation with respect to aging, this chapter provides some demographic indicators illustrating the current structure of Spain's aging population.

In comparison to other EU member states, Spain has experienced a faster aging process in its population for two main reasons. On the one hand, socioeconomic development slowed during the first half of the 20th century, and the so-called demographic revolution began only in the late 1970s. Spain doubled its life expectancy over the term of the 20th century, and the number of adults over 65 has doubled over the last 30

years. On the other hand, the fertility rate has decreased by more than half since 1975 (CSIC, 2010; Eurostat, 2012). Current data show that approximately 18% of the people living in Spain are over 65 years of age (8 million), 25% of whom are octogenarians. That is, there are six times more over-65s and 12 times more over-80s than there were in 1900 (Figure 1).

FIGURE 1 PERCENTAGE OF PEOPLE BY AGE FROM 1950 TO 2050 (CSIC, 2010).



Moreover, Spanish and European demographic predictions show that more than 30% of the population will be over 65 by 2050, and UN predictions mark the Spanish population to be the oldest in the world by the same year (CSIC, 2010).

Other relevant and related demographic data that help to explain the characteristics and structure of the Spanish older population can be summarized as follows: Life expectancy at birth (LE) is one of the highest in Europe, at 82.00 years for the general population (men = 78.9 and women = 84.9) (data from 2010), while disability-free life expectancy (DFLE) is 72.49 years (men = 71.27 and women = 73.75), so that there is an average of 8 years of “poor health” life to be reckoned with. Nevertheless, not only has LE increased, but so have healthy life years in older adults. From 1992 to 2009, LE and DFLE at age of 65 increased by approximately 2 years (Abellán & Ayala, 2012; Fernández-Ballesteros, Ruiz Torres, & Díez Nicolás, 1999; Giannakouris, 2008).

On the other hand, as the older population increases, the number of people of working age has decreased. Consequently, the number of people aged over 84 for every 100 people aged 45 to 65 (ratio of family support) has recently shown a progressive increase that is expected to continue, so that great efforts will need to be undertaken in order to control the impact of this factor on the social and health systems as well as on the increased number of families with insufficient resources to support such a large number of elderly people (Abellán & Ayala, 2012).

As for the health status of the elderly population, almost 40% of adults over the age of 65 report having good or very good health, versus approximately 86% of younger adults (Abellán & Ayala, 2012; INE, 2006). Fewer older women than men (33.1% and 48.5%, respectively) report having good or very good health (Abellán & Ayala, 2012; INE, 2006). In fact, older women have higher rates of disability, which implies more difficulties they have addressing activities of daily life (INE, 2008). Disability is also associated with low levels of education (86.7% of disabled older adults are illiterate or have only primary education) and with are institutionalized (Abellán & Ayala, 2012; EDAD, 2008). Finally, in 2010 the main causes of death were diseases of the circulatory system (31.2%), tumors (28.1%), and diseases of the respiratory system (10.5%) (INE, 2012). Mortality by neurodegenerative causes, such as Alzheimer’s disease, is also on the increase (Abellán & Ayala, 2012).

With regard to the social and health systems, Spain has a contributory public social security system (paid into by both employer and employee) that entitles one to a re-

tirement or disability pension (after a certain number of years of employment), free healthcare, and other social benefits. The pension or benefit one receives depends on the level of contributions paid during one’s working life. Since 1985 there have also been a number of non-contributory benefits for people who have never worked but meet certain conditions. In Spain the average pension is EUR 807.60, the minimum pension is EUR 357.70 (noncontributory), and 25% of pensioners have incomes of less than EUR 9,000 per year (data from 2011; Abellán & Ayala, 2012).

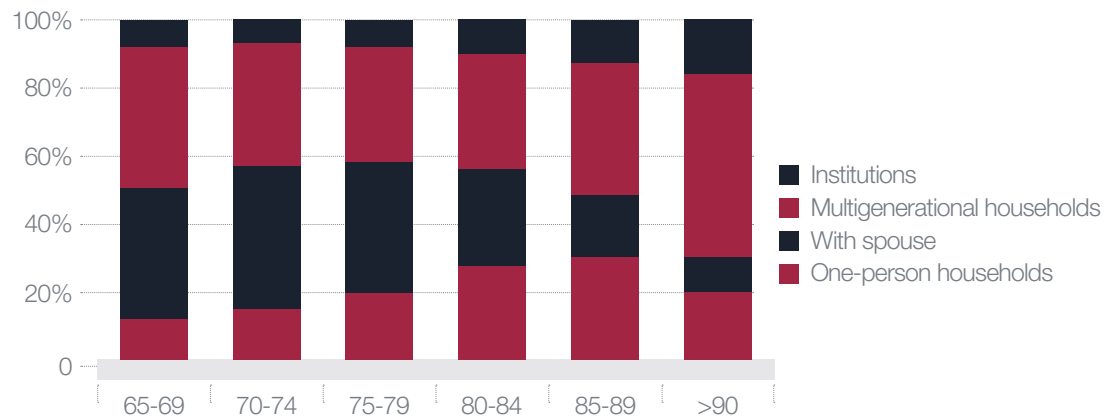
With regard to education, the number of people over the age of 65 with an education level of 2 or less (pre-primary, primary and lower secondary education level) according to the ISCED (International Standard Classification of Education) fell by 10% between 1992 and 2011, from 94.5% to 84.5%. Likewise, the number of people aged 55 to 65 with low educational attainment fell by 25% over the same period, from 91.4% to 66.3% (Eurostat, 2012¹).

With respect to social situation, Figure 2 shows the living arrangements by age range (INE, 2006). The number of people living with their spouse decreases with age (and there is a higher proportion of women living alone) (Abellán & Ayala, 2012). Moreover, the proportion of single households increases up to age 90, when it starts to decrease. The number of older adults living in multigenerational households and institutions increases with age. On the other hand, in Spain families are often the caretakers of older adults, and generally it is the wife (when it is a man who needs care) or the daughter (when it is a woman) who provide the care (Abellán & Ayala, 2012).

Finally, with regard to the socioeconomic and health characteristics of older adults in Spain, two principal challenges can be identified in the medium to long term: (1) promoting active aging and quality of life (QoL) in the population in order to avoid or reduce years of dependency as much as possible, with a special emphasis placed on the situation of women; (2) introducing socioeconomic and political measures with a view toward alleviating the heavy social burden on family members and society caused by the increasing numbers of older adults.

It should be stressed that the characteristics and needs of older adults change over time, so that data must be continually updated so as to address them and develop innovative and appropriate solutions. The following sections outline the main research areas in Spain and the resources available for older adults.

¹ Data extraction from: <http://epp.eurostat.ec.europa.eu/tgm/table.do?tab=table&init=1&plugin=1&language=en&pcode=tsdsc430>

FIGURE 2 WAYS OF LIVING OF THE POPULATION 65 AND OVER (INE 2006 – EQUIPO PORTAL MAYORES, 2009).


Research on Aging in Spain

Perhaps because its “demographic revolution” began later than in other European countries (in the late 1970s), research on aging in Spain also started later than elsewhere. Even though the Spanish Society of Geriatrics and Gerontology (Sociedad Española de Geriátría y Gerontología, SEGG) was founded in 1949, it was not until the 1980s that age, the aged, and aging became important social, economic, and political priorities in Spain (Giménez Toledo, Sevillano Bermejo, Pérez Díaz, Sancho Castiello, & Abellán García, 2008). At that time, the welfare state was being set up in Spain and population aging was accelerating strongly.

Before the late 1980s, Spanish publications in the field of gerontology were monopolized by pathological and abnormal aspects addressed not only from the geriatric perspective, but also from the psychosocial vantage point (Fernández-Ballesteros et al., 1999).

Recently, a bibliographical study on gerontology and geriatric research was carried out using the database from the Institute for Older Adults and Social Services & National Council of Research (IMSERSO-CSIC) Internet Site (Portal de Mayores)² (Giménez Toledo et al., 2008), which was created in 1997 and includes the most important scientific work in this field pub-

shed in Spain and by Spaniards since the 1970s. The report in question provides some relevant data that can be summarized as follows: From the 1980s to the present, publications of doctoral dissertations have increased eightfold and of scientific papers, threefold. Although scientific works on aging in Spain continue to lie largely within the medical and health sciences (37.7%), the number of publications regarding the social sciences (26.5%) and the psychological sciences (20.5%) has increased substantially. Finally, the fewest number of publications concern care and support (10.7%), experimental biology (4.2%) and other issues (0.4%). Hence, these data are similar to those found in other countries in Europe and worldwide (CSIC, 2010).

Psychology is the field that has seen the highest relative increase, especially in the areas of mental health (28.9%), assessment (14.6%), and lifestyles (11.5%), which represent over 55% of all psychology subcategories. Giménez Toledo et al. (2008) suggest that this growth may be due to the expansion of postgraduate study courses dealing with the subject of older adults – and indeed, 11 such courses are run in psychology faculties, 7 in faculties of health sciences, and 3 in centers or faculties of business studies, with others provided in different types of academic or research institutions.

² <http://www.imsersomayores.csic.es/documentacion/biblioteca/index.htm>

Pinquart, Fernández-Ballesteros, and Torpdahl (2007) asked key persons working in the geropsychology field from 30 countries of Europe to name the most important research topics in their respective countries. In Spain, “dementia” was considered the most important, followed by “cognitive development,” “caregiving,” “affective disorders,” “successful aging,” “prevention,” and “ageism.” This same author then created an electronic PsycInfo database computing the number of aging-related publications in the English language for each country (July, 2006). Spain was in eighth place among the European countries in terms of English publications (350 publications), preceded by Sweden, Germany, The Netherlands, Italy, Israel, France, and Finland.

From a sociopolitical point of view, Spain has supported European aging research, being the venue of international events such as the Second World Assembly on Ageing (Madrid, 2002) and recently participating in European research projects such as ERA-AGE, which started in 2004 (see PROGRESS from 2007 to 2013; CSIC, 2010). Finally, Spain is also a partner in the Joint Programming Initiative (JPI), whose goal is to develop a road map for research on aging in Europe³.

In summary, gerontological research has taken on a special relevance in Spain, to the extent that, as recent data show, 34% of the research fields were related to aging in 47 national research institutions, accounting for 4,294 research groups (CSIC, 2010). We look at this in more depth later on.

INSTITUTIONS AND RESOURCES

With regard to institutions and resources, it is important to distinguish between research centers and financial providers. Spanish institutions with major research production are universities (the three most important being the Complutense University (Madrid), the University of Barcelona, and the Autonomous University of Madrid), the Scientific Research Council (CSIC), and the Hospital Clínic (Barcelona). The main financial resources for aging research come from the Spanish state, from the EU, and from regional authorities. The Spanish state provides the largest amount of funding through the ministries, the Carlos III Health Institute, and the Health Research Funds. Next come the European financial agencies and, finally, the regional authorities (Table 1).

MAIN AREAS OF RESEARCH

Today, it is very difficult to draw a line between geropsychology and other areas of aging research. A report on the Spanish research on aging (CSIC, 2010) places “psychological sciences” in the seventh position among the 10 topics in which research groups working on aging are divided (Figure 3). But geropsychology concerns not only the psychological sciences, but also researchers on care, lifestyles, and environmental factors, not to mention neuroscience, where psychologists are making a substantial and active contribution. Therefore, despite the fact that aging research has been divided into various fields, psychologists are currently working in interdisciplinary groups together with engineers, physicians, neuroscientists, etc., the goal being to develop comprehensive knowledge, devices, medicines, cities, etc., that can help promote the best aging in the best conditions.

TABLE 1 MAIN RESEARCH INSTITUTIONS AND MAIN FINANCIAL AGENTS IN AGING RESEARCH IN SPAIN

Research institutions	Publication nº	Financial agents	Action no.
Complutense University of Madrid	487	Education and Science Ministry	52
University of Barcelona	370	Health Institute of Carlos III	37
Autonomous University of Madrid	279	European Union	37
Scientific Research Council (CSIC)	255	Health Ministry	21
Valencia University	200	Generalitat of Catalunya	12
Clinic Hospital of Barcelona	182	Science and Innovation Ministry	12
Granada University	179	European Fond of Regional development (FE- DER)	11
Autonomous University of Barcelona	177	Health Research Fund (FIS)	10
Oviedo University	171	Junta of Andalucía	10
Zaragoza University	130	University of Santiago de Compostela	107

Note: Modified from CSIC, 2010.

³ http://ec.europa.eu/research/era/areas/programming/joint_programming_en.htm

AN EXAMPLE: QUALITY OF LIFE

QoL is a concept widely used in gerontology which has become a goal common to many research areas; it is today also a political term (WHO, 2002). In the field of aging, it is considered the outcome of projects, programs, services, and policies, and is used to describe populations, contexts, and individuals. QoL is considered by most experts to be a multidimensional concept involving multiple domains (health, psychological, social, and environmental) and containing objective and subjective components (for a review, see Fernández-Ballesteros, 1993, 2011; Fernández-Ballesteros, Zamarrón, & Maciá, 1997). QoL is a good example of a geropsychology research aspect that satisfies the characteristics of aging research identified above, insofar as the assessment of QoL reflects population conditions (e.g., old age, healthy vs. disabled status, carers, community vs. institutionalized living) that must be taken into account since the needs of the elderly can change over time. Finally, QoL is an interdisciplinary concept involved in several aging research areas, such as health and medical sciences, social science, psychology, and the technological disciplines. This widespread use of the QoL concept means that it has various interpretations, but most experts consider it a multidimensional and multidomain concept (Fernández-Ballesteros, 2011) – even if there are some misunderstandings in its use (for a review, see Fernández-Ballesteros, 2011; Fernández-Ballesteros & Santacreu, 2012; Michalos, Ramsey, Eberts, & Kahlke, 2011). Nevertheless, here we consider an understanding of QoL in order to present some examples of current Spanish studies in the concept in relation to aging.

In Spain, the main goals of QoL research in the field of aging are as follows: (1) to develop a multidimensional concept of QoL (Fernández-Ballesteros, 1993; Fernández-Ballesteros & Maciá, 1993); (2) to construct a suitable questionnaire for assessing QoL in older adults living in different contexts (e.g., Fernández-Ballesteros & Zamarrón, 2007; González Sáenz de Tejada et al., 2011; Verdugo, Arias, Gómez, & Schalock, 2010); (3) to describe, compare, and predict QoL or QoL-associated variables in various contexts of older adults through descriptive and cross-sectional studies, attending to characteristics such as socioeconomic status and educational levels (e.g., Otero-Rodríguez et al., 2011), community vs. residential settings (e.g., Fernández-Ballesteros et al., 1996), or health and illness (e.g., Lopes et al., 2007); and (4) to improve QoL regarding different conditions assessed by pre-post studies, for example, improving QoL in impaired people and their caregivers (e.g., Pilotto et al., 2011;

Rodríguez-Rodríguez, Martel-Monagas, & López-Rodríguez, 2010; Serra Rexach et al., 2009). All of these issues have been explored by different research fields.

In the areas of psychology and the social and health sciences, the EVEN research group at the Autónoma University of Madrid has a long tradition in the area of QoL, having addressed most of the issues described above. Throughout the 1990s, this research group proposed a concept of QoL (Fernández-Ballesteros, 1993) and developed and tested the CUBRECAVI questionnaire (Quality of Life Brief Questionnaire; Fernández-Ballesteros & Zamarrón, 1996, 2007), combining the lay concept and the expert perspective defined above. This questionnaire is widely used in Spain (e.g., Calero & Navarro, 2011; Elouza, 2010; Olmos Zapata, Abad Mateos, & Pérez-Jara, 2010) and in Latin American countries (e.g., Duran, Orbegoz Valderrama, Uribe-Rodríguez, & Uribe Molina, 2008; Fernández Prado, Gandoy Crego, & Mayán Santos, 2007; Menéndez Montañés & Brochier Kist, 2011). Moreover, the EVEN group has carried out descriptive national and international studies of QoL. For example, Spanish community-dwelling older adults were compared with those in institutions (Fernández-Ballesteros et al., 1996), and Spanish community-dwelling adults aged over 60 (from the Valencia region) were compared with Mexican ones from Colima and Guadalajara (Fernández-Ballesteros, Arias-Merino, Santacreu, & Mendoza, 2012). Finally, the EVEN group also developed an assessment tool called SERA (Residential Settings Assessment Tool for Older Adults; Fernández-Ballesteros, 1996), based on the Multiphasic Environmental Assessment Procedure (Moos & Lemke, 1996), in order to assess QoL in residential settings in Spain and in several Latin American countries (Fernández-Ballesteros, Izal, & Montorio, 1998; Fernández-Ballesteros, Izal, Hernández, Montorio, & Llorente, 1991).

With regard to the contextual components of QoL, such as facilities, infrastructure, or care, many technological disciplines have contributed to developing measures for enhancing the environmental quality of older adults. For example, several systems have been designed for improving QoL in Alzheimer's disease patients and their families, including the international Smart Home for Elderly People (HOPE) project, in which the CETEMMSA Technological Centre (Barcelona) participated (Pilotto et al., 2011), or the Mnemosine system (Rodríguez-Rodríguez et al., 2010), aimed at increasing the QoL of both Alzheimer's patients and their caregivers as well as enhancing communication with neuropsychologists. Other initiatives include the

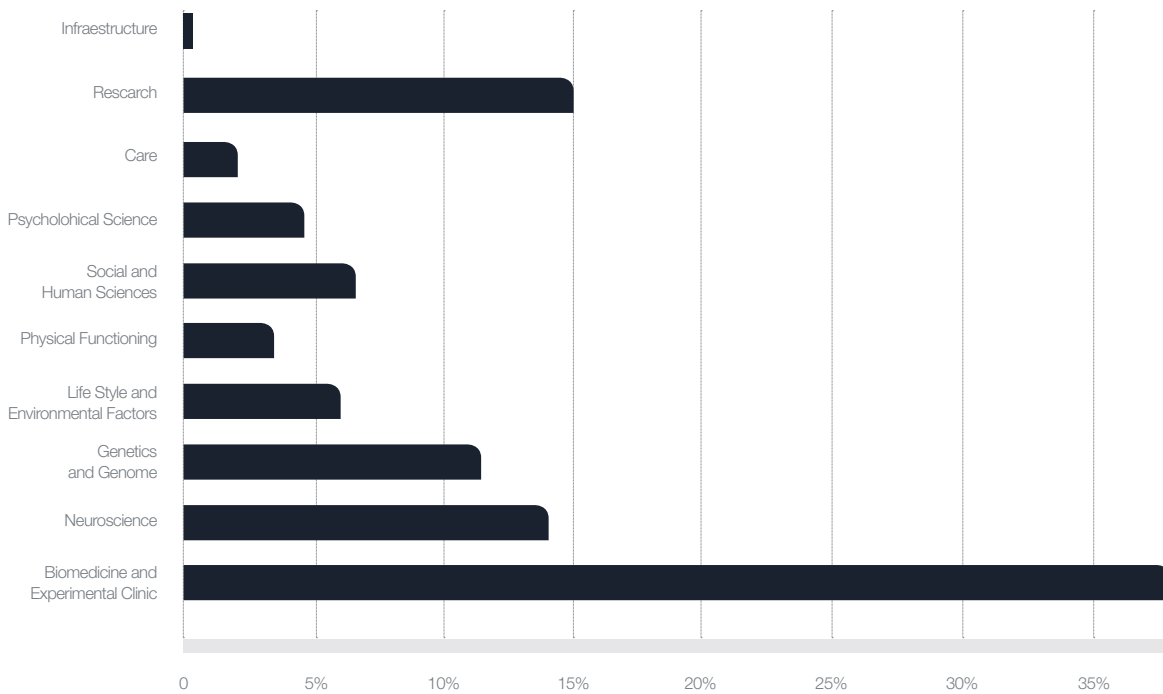
international Ambient Intelligence for Elderly (AmIE) project, the aim of which was to develop tools for the monitoring, control, and follow-up of older people through a system of alerts; and the Butler system, which is an e-health platform designed to improve the elderly population's QoL (Etchemendy et al., 2011).

Regarding medical and health sciences, the most widely used concept related to QoL is Health-Related QoL (HRQoL). Among the Spanish studies reviewed on the IMSERSO-CSIC internet site database and located through the "QoL" descriptor, the common goals are as follows: (1) to develop and/or validate Spanish versions of questionnaires considering different contexts and diseases; (2) to assess the impact of different diseases on QoL; and (albeit of less significance) (3) to assess the impact of treatments on QoL. For example, Lucas-Carrasco, Gómez-Benito, Rejas, and Brod (2011) carried out a validation study on the Dementia Quality of Life Questionnaire; Bernabeu-Wi-

ttel et al. (2010) studied HRQoL in polypathological patients; Miravittles, Naberan, Cantoni, and Azpeitia (2011) studied HRQoL in chronic obstructive pulmonary disease. Other illnesses that have been studied in relation to HRQoL include stroke (Marco et al., 2010), cancer (Guedea et al., 2009), and kidney problems (hemodialysis patients) (Lopes et al., 2007).

Although we have only described a small sample of studies here, we feel it is representative enough, and that it is possible to deduce from it that Spain has a long and comprehensive tradition of research on QoL in aging. Moreover, even though we have looked at only one aspect of aging research in Spain, by way of example, we could find similar situations in other areas, such as dementia, depression, active aging, and frailty.

FIGURE 3 MAIN FIELDS OF AGING RESEARCH IN SPAIN (CSIC, 2010).



Programs and Services for Older Adults

As several authors have pointed out, as people age their intervariability increases (e.g., Baltes & Baltes, 1990; Schaie, 2005). In fact, nowadays there are not only older adults who are dependent and need help, but also more older adults in good shape with much free time who look forward to doing and learning new things and who need resources to continue being active under good conditions for as long as possible. Currently, in Spain, there is a wide variety of resources designed to meet the needs of all different kinds of older adults (Table 2)⁴.

To help readers to understand the complex system of programs and services available for older adults in Spain, it is necessary to provide a brief explanation of this country's sociopolitical organization. Spain has a decentralized political system, with a central government and 15 regions (called Comunidades Autónomas, plus 2 autonomous cities). In most of these regions there are in turn provinces with provincial political systems (Diputaciones provinciales). Finally, there is the local authority in each city or town. Most of the public resources for older adults are assigned by the Spanish parliament to the regional governments, though the provincial and local authorities, being closer to the citizens' needs, also administer some resources for senior citizens. It should be mentioned that, at the central level, the Institute for Older Adults and Social Services (IMSERSO) has mainly a planning and coordination role, and also that there is a private network of services and resources.

The resources listed in Table 2 can also be divided according to those who receive them: institutionalized older adults or community dwellers.

In any case, as already mentioned, in addition to being responsible for the pensions system, the central government has the task of planning, programming, and coordinating senior-citizen services. But the IMSERSO also organizes holiday and hydrotherapy programs, which offer low prices in the off season; it provides support for older adults who wish to continue living alone – for instance, through the regionally based Tele-Asistencia program, whereby older adults and disabled people living alone and at risk can contact a specialized attention center by pressing a button on a necklace or bracelet that they wear all the time. It also offers services and programs to support caregivers, such as daycare centers, financial aid, or support groups, which help reduce the burden (and financial costs) of caregiving. And it organizes many other programs as well.

It is important to emphasize that while education, health, pensions, and assistance for dependent persons are universal pillars of the Spanish welfare state, there are other services that are free only to those with very low incomes.

TABLE 2 INSTITUTIONS THAT PROVIDE PROGRAMS AND SERVICES FOR OLDER ADULTS

Institution / Resource	Scope	Users	Aim
Residential settings	Public: regional	Private	Independent older adults Dependent older adults Mixed
Daycare centers	Public: regional, local Private	Dependent older adults	Its purpose is to improve or keep the level of autonomy of the elderly as well as to provide support and orientation to relatives or carers, promoting the position of older people in their family and social environment.
Senior centers and clubs	Public:Regions and local levels	Independent older adults	They are mainly places where old people can meet for social, leisure, and cultural activities. Depending on the center, they also offer: legal advice, psychological counseling, beauty services . . .
Community programs at home	Public: Regional level	Dependent older adults	Tele-assistance Homecare
CSSM	Public: local	All older adults	Centers that provide information, advice, and guidance on rights and social resources, manage and process applications of the social resources.
INSS (State level)	Public: State and regional	All older adults	Centers that provide information about economic benefits of social security and how to manage them.
IMSERSO programs	Public: State	Independent older adults Disabled persons	The competent organization of the social security system for the management of complementary services for old people and people in situations of dependence.
Other programs	Public: regional and local.	Older adults	Programs designed to provide a very specific service, such as holidays, helps caretaking, infrastructure changes, university programs, tele-assistance...
Health resources	Health centers Offices Hospital	Local Local Regional	Everybody Health care

Notes. INSS: information centers of the National Institute of Social Security. CSSM: centers of the local social services.

⁴ Further information can be found on the following webpage: <http://www.imsersomayores.csic.es/recursos/index.html> (in Spanish).

AN EXAMPLE: THE MADRID REGION

The city of Madrid is not only the capital of Spain, but also of the Madrid Region (Comunidad Autónoma de Madrid), which has the highest population density of all Spain's 17 Comunidades. Let us look at Madrid as a concrete example for all the institutions and resources listed in Table 2. Even though the other regions are provided with all the principal resources, in the smallest ones there is likely to be a smaller range and poorer access to them (though it should be mentioned that there are special programs for rural areas).

The Madrid Region has its own webpage⁶ with a special section devoted to senior citizens called "65 and +: For a Full and Active Life." The site offers information about public and private resources, cultural and leisure activities, health, volunteering, and other news and information of interest.

The resources available can be divided into three sections based on the different levels of dependency:

1. Resources and programs to help families with the caregiving task, such as daycare centers, weekend-care centers, financial aid, temporary stays in residences, workshops for caregivers to teach them how to look after their elderly relatives (and themselves), and Alzheimer's associations that lend support to families for dealing with the illness.
2. Resources and programs for enabling elders to remain living at home, including home-help for assistance with daily life activities, teleassistance programs, help with the geriatric preparation of one's home, intergenerational programs in which older people and college students help one another, and so on.
3. Resources and programs that offer a place to live with all services included. There are some 73 public and 420 private residential centers for older adults in the region. These resources are also available for people who are not dependent, but have nowhere else to live.

Some of these services include programs for promoting cognitive and physical activity, in order to help people to live independently for as long as possible.

On the other hand, there are programs that have nothing to do with dependent or disabled people, but are aimed at promoting active aging, such as senior citizens' centers or university courses. There are 30 senior citizens' clubs or centers in the Madrid region, as well as 5 public universities that offer study programs for persons over 65. The regional and municipal authorities also run many other programs, such as those offering cheap cinema tickets one day a week, cultural and hiking trips, holidays, or hydrotherapy courses.

WHAT IS THE ROLE OF PSYCHOLOGISTS IN SERVICES FOR OLDER ADULTS?

In Spain the realization has grown that the psychologist's role is important not only with regard to residents and/or patients, but also for caregivers, be they family members or residence staff and other professionals. In fact, we are seeing a progressive increase in the presence of psychologists in all types of institutions, especially in the private sector, which is also more well-developed (for example, in Madrid there are 420 private residences but only 73 public ones). Moreover, at least one executive member of the Spanish Association of Geriatrics and Gerontology is a psychologist, responsible for the social and behavioral sciences section. Finally, psychologists are also being hired as managers of institutions such as senior citizens' centers or residences.

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CONCLUSIONS: RESOURCES AND DEMANDS

Spain, like many other developed countries, is witnessing an exponential growth in the numbers of older persons. It has made great efforts to address this new social situation, gradually developing an extensive network for supporting not only dependent people, but also healthy retired people with new demands.

With regard to research on aging, there has been a considerable increase in the number of research projects and publications in the Spanish context. Most of the studies are aimed at assessing the different characteristics and conditions of senior citizens. This is a good first step with a view toward identifying their demands, though more research is necessary for making crucial changes.

On the subject of resources and services, Spain has developed a strong infrastructure for addressing many different kinds of demands.

On a final note, it should always be borne in mind that social needs change over time, so that they must be continuously studied and reappraised, and that our responses must constantly be updated in order to maintain standards of excellence.

Declaration of Conflicts of Interest

The authors declare that no conflicts of interest exist.

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Parte I

Calidad de vida en la vejez

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QUALITY OF LIFE. PROBLEMATIC ISSUES

Encyclopedia of Quality of Life and Well-Being Research, 2014, 5363-5371

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Introduction

Quality of Life (QoL) is a relatively new concept, having appeared only at the end of the 1960s; since then, its growth as a research issue has been exponential. QoL emerged from two different contexts: socio-political and biomedical. At that time, socio-economic measures were the main indicators for assessing the growth and development of populations and individuals. As Wilson (1968) stated, there were increasing signs of discontent with the continued use of traditional measures of economic, political, and social progress: per capita income and gross national product were not conceptually designed to measure changes in a global political and socio-economic environment that was pursuing a “new frontier”. Therefore, it was necessary to develop a set of social indicators for assessing the quality of life of a given population in relation to important policy decisions, hence the concept of social indicators as aggregate or representative welfare measures: individual status, individual equality, education, economic growth, technological change, agriculture, living conditions, and health and welfare.

Later, at the 1978 World Health Organization Conference, celebrated in Alma Ata, it was declared that health is a state of complete physical, mental and social wellbeing, not simply the absence of disease or infirmity (Declaration I), and that the promotion of the health of the people is essential to sustained economic and social development and contributes to a better quality of life (Declaration II) (World Health Organization, 1978).

On both fronts, QoL emerges as a new concept, superseding more traditional conceptualisations (welfare, wellbeing, health from the illness perspective), and linked to socio-political and health objectives. The past forty years have seen enormous growth in the importance of this concept. Indeed, while for 1969 we find just one citation in Medline, 3 in PsycLIT and 2 in Sociofile (Fernández-Ballesteros, 1998), thirty-five

years later, in 2004, there are 4,161 in Pubmed, 579 in PsycInfo and 241 in Sociological Abstracts (Fernández-Ballesteros, 2010). A review of definitions reveals that QoL is a multidimensional concept, made up of a set of subjective and objective components applying to both populations and individuals. Throughout the course of its tremendous growth in importance, QoL has continued to be, as Walker (2005a) describes it, ‘an amorphous, multilayered and complex concept with a range of components – objective, subjective, macrosocietal, micro-individual, positive and negative – which interact together’ (p. 3).

Our goal in this article is to provide a brief summary of the theoretical characteristics of QoL, with a view to highlighting some pending problematic issues.

Main characteristics of the QoL concept

WHAT ARE THE COMPONENTS OF QoL?

QoL is a multidimensional concept which, theoretically, involves as many components as life itself. Nevertheless, although authors stress its multidimensional nature, it is very difficult to find agreement among them about its ingredients (see Fernández-Ballesteros, 1998; Brown et al., 2004). The QoL components most frequently cited by both experts and by lay people, and mentioned in research reviews, would include the following:

- Ecological and environmental qualities. These can be assessed by measuring, for example, air and water conditions, energy resources, forestation, green zones and containers available in a city, and/or percentage of people who recycle.

- Economic resources are assessed by Gross Domestic Product, the budget available for a particular region, district or neighbourhood, and/or individual's income.
- Biomedical and Health aspects include epidemiological indices, such as mortality, morbidity, life expectancy or disability-free life expectancy. It is also important to measure health services available, health status, functional abilities, health self-perception and satisfaction, and physical activity.
- Socio-political and cultural variables at macro and aggregate levels. For example, security indices (prevalence of crime, suicide, public violence and family breakdown, etc.), policy and management aspects (such as, educational resources), social climate perception, social values, cultural images, etc.
- Psycho-social aspects at the individual level, which include social network and social support, frequency of relationships, satisfaction with those relationships, social leisure activities, etc.
- Finally, psycho-behavioural components, including subjective health, independence, leisure activity, working conditions, life satisfaction, well-being, mental health (depression/happiness, anxiety/relaxedness, dementia/preserved memory, etc.), appraisals of quality of life conditions, among others.

This list reflects the multidisciplinary of QoL, but – as we have emphasised elsewhere (Fernández-Ballesteros, Arias, Santacreu, & Rubalcava, 2012) – other authors have defined QoL as being equivalent to well-being (Campbell, 1981), to happiness in the social (Veenhoven, 1996) and economic domains (Ashkanasy, 2011), to life satisfaction in the psychology context (Palys and Little, 1983) or to health status in the bio-medical field (for example, Naughton and Wiklund, 1993). The World Health Organization (WHO; 1993, 1995) even reduced the WHOQOL (1995) instrument to the subjective appraisal of different components, thus transforming QoL into a subjective concept.

WHO IS THE SUBJECT OF QoL?

Life can also be analysed, following Bronfenbrenner (1977), at different levels. Thus, at a macro level, the subject of QoL can be the population; at the meso level, the unit can be a given context; finally, the individual would be the micro level. If at the macro level the assessment unit is the population, then measures are aggregated data. At the meso level the unit of as-

essment is a specific community. Finally, at the micro level, the observed unit is the individual, and measures may be aggregated or disaggregated (depending on the goal of the study)

In short, QoL conditions or components can refer to several subjects or units depending on the research discipline and its objectives. Sociologists and demographers are usually interested in populations and contexts, while health and psychology professionals are usually more interested in individuals.

WHAT IS THE NATURE OF QoL COMPONENTS?

Some life components are observable: for example, air pollution, per capita income, frequency of social relationships, social network size, number of illnesses in an individual or illness prevalence in a given population. However, other components cannot be observed because they depend on individuals' subjective appraisal, and these would include income satisfaction, health perception, or satisfaction with social relationships. This distinction is extremely important for QoL, since some authors appear to consider "quality" of life (as opposed to "quantity") as a purely "subjective" concept (see Bowling, 2005); however, according to the Collins dictionary definition, "quality" means "excellence", "calibre", "distinction", "grade". Throughout the history of the concept, this confusion has represented one of the major threats to QoL, and is among the common problematic issues we shall be discussing.

From the outset, authors have highlighted the importance of taking into account both objective and subjective components of QoL at the three different levels already described: macro, meso and micro (Brown et al., 2004; Fernández-Ballesteros, 1993, 2010; Lawton, 1991, 1996; Walker, 2005b). Let us look at the rationale supporting the use of objective and subjective components through examples. At the individual level, in assessing economic components of QoL, we can consider the person's income, but also his or her appraisal about the extent to which it is adequate. From an environmental perspective, QoL can be measured by acreage of green areas of a given community, and also by dwellers' satisfaction with that proportion or those areas (meso level). And as regards the socio-political perspective, QoL can be measured objectively by the amount of gender-equality legislation, and subjectively by collective perception of gender equality.

To organise the multidimensional, multilevel and "multi-nature" characteristics of the QoL concept, on the

basis of previous studies, Fernandez-Ballesteros (1993, 2010) has developed a classification system with two broad axes – population/contextual versus individual/personal, and objective versus subjective conditions – on which the different QoL components are situated (Table 1). Box 1 includes the macro and meso levels (population/contextual units) of these objective aggregate aspects of quality of life, such as demographics, environmental and physical conditions, social factors or health indicators. Box 2 includes conditions attributed to a given society as reported aggregate perceptions of a group of individuals, such as social stereotypes, values or collective self-efficacy, which could be considered as QoL-related conditions. Box 3 contains all personal or individual conditions cited by experts as ingredients of QoL that can be

considered objective disaggregate factors, such as demographic and economic characteristics of the individuals, environmental context, social and health conditions, physical fitness, etc. Finally, Box 4 includes subjective conditions cited as QoL factors, such as life satisfaction, well-being and any other subjective appraisal of external or personal factors, such as how the individual perceives both contextual and individual aspects of quality of life.

In summary, QoL can be defined as a multidimensional concept embracing both objective and subjective characteristics, and which refers to a given subject (a population, an individual or a group of individuals) with the goal of taking into account their “goodness”, excellence, calibre or distinction.

TABLE 1 QoL SUBJECTIVE AND OBJECTIVE COMPONENTS AT DIFFERENT LEVELS (FROM FERNÁNDEZ-BALLESTEROS, 1993, 2012)

Subject Nature	Population / Context	Individual
Objective	<ul style="list-style-type: none"> - Demographics (aging rates, density...) - Physical factors (latitude, residential facilities, protective assistance...) - Economic factors (pension system...) - Social factors (social networks, social services availability...). - Equality legislation. - Health factors (life expectancy, health security system...). - Disability/ability prevalence in old age. 	<ul style="list-style-type: none"> - Demographic characteristics (age, sex, education, SES...) - Physical conditions (home, residence, neighborhood...) - Economic factors (income...) - Social factors (family support, social network...) - Functional abilities and activity (ADL...) - Health conditions (medical records, prescriptions, days spent in hospital...) - Physical fitness (balance, strength, BMI)
Subjective	<ul style="list-style-type: none"> - Any collective or social perception such as stereotypes about aging, social values (individualism versus collectivism), aggregate well-being, subjective health. 	<ul style="list-style-type: none"> - Subjective conditions such as well-being, life-satisfaction, control perception, etc. - Any personal appraisal about his/her conditions in box 2. or about external conditions in box 1

Problematic issues

REDUCTIONISM AND CONFUSION

When a new scientific concept emerges it is because it has some advantage over those already existing. As mentioned in the introduction, proponents of the QoL concept in the socio-economic field are looking to re-appraise simple “welfare state” indicators, while in the biomedical context they seek to adapt the notion of “health” to a new multidimensional conceptualisation incorporating more complex events (physical, mental and social), at both the individual and population levels. Such arguments provide support for multidimensionality as an intrinsic characteristic of QoL, as described both by authors from all scientific domains and by lay people from a range of cultures and countries (Brown, et al., 2004; Bowling, 1995). The consensus is that it is not coherent to reduce QoL to its components or confuse it with them.

Nevertheless, although there is formal acceptance of multidimensionality, when instruments or indicators are developed, QoL is frequently reduced to some of its components. This reductionism or confusion is occurring within the biomedical, psychological, and socio-economic fields. Let us consider some evidence in support of these assertions.

Following Alma-Ata Declaration 1, which proposed a new definition of health, the bio-medical and health sciences adapted QoL to the health field through the term Health Related QoL (HRQoL). But although the purpose was to broaden the concept of health, many authors in the field have reduced the QoL concept to health, overlooking its multidimensional nature: they have changed the term but not the concept (for an update, see Kickbusch, 2003; Lawn, et al., 2008). Good examples of HRQoL measures would be traditional health (illness) status assessment tools such as the Nottingham Health Profile (NHP), the Sickness Impact Profile (SIP) or The Medical Outcome Study 36-Item Short Form Survey (SF-36).

This problematic conceptual issue can be clearly seen in www.proqolid.org, a database for QoL instruments, in which all the most well-known traditional health status instruments are classified as HRQoL, providing a good example of how QoL is being confused with or reduced to one of the components (see [Table 1](#), Box 3). The paradox seems to be that if health (in the sense of absence of illness) was the concept to overcome – since illness was considered as just one component of health (as in the WHO definition) as well as of life–, and the aim was to add other psychological and so-

cial aspects to that of health, why was this initial goal abandoned, with a return to the primitive concept of health?

Halvorsrud and Kalfoss (2007), in their review of 47 studies, concluded that “... almost two-thirds focused on QoL, where HRQoL was used as an overlapping term” (p.242). In sum, a review of the literature reveals that, into health context, QoL and HRQoL are both subject to some degree of reductionism to health status.

Within the psychological field, QoL is usually equated to or confounded with positive emotions, such as well-being or life satisfaction, or even with personality characteristics. In fact, there are many instruments used for measuring QoL that include general psychological characteristics; for example, one of these being the QOLI (Frisch, 1994), which among the QoL components incorporates Self-Esteem and Creativity. This was strongly criticised by Halvorsrud and Kalfoss (2007) in their review as well.

In seeking new measures for assessing economic, political, and social progress and human development, some authors from the socio-economic field have taken happiness to be interchangeable with QoL. For example, Blanchflower and Oswald (2011) propose using indices of happiness – as an expression of QoL– rather than economic measures.

In summary, although QoL emerges as a multidimensional concept, and is mostly considered as such, many authors violate this assumption on reducing it to one of its components (health, wellbeing/happiness) or confounding it with other concepts (personality characteristics). We would stress the importance of the multidimensionality of the concept by echoing the words of Birren and Dieckmann (1991): “QoL is not equivalent to quality of the environment, to quantity of material goods, to physical health status or to quality of health care, just as it is distinct from subjective constructs such as life satisfaction, morale or happiness”.

SUBJECTIVISATION

Not only has QoL been confounded with other concepts or reduced to one of its components, but a second important problematic issue emerges when QoL is conceived without taking into account both subjective and objective components. In fact, many instruments that assess several life components do so only in terms of individual, subjective appraisals and/or satisfaction, through questions such as “How satisfied are you with...?”, or “Please rate your... (physical environment, income, health, social relationships, etc.)”. If we consider [Table 1](#), such questions would be reducing all components to Box 4 or, at a population level, Box 2. A good example of this bias can be found in the WHOQOL (1995), an instrument that includes 6 domains: Physical health, Psychological health, Level of independence, Social relationships, Environment and Spirituality. The items vary according to the version, but all are designed to obtain the respondent's subjective appraisal of each domain, and none ask about objective aspects.

To put the danger of subjectivising QoL into context, it is important to remember that one of the goals of conceptualising and assessing QoL, at the individual or population level, is to work toward its improvement. As Fernández-Ballesteros (2010) stresses, if only subjective measures of QoL are taken into account, when policies or intervention are planned with the goal to improve QoL, then only changes ‘in people’s minds’, rather than in the real world, would be expected. Indeed, Sampson (1981) quite rightly argues that a scientific concept used as a social outcome (such as QoL), whether at the individual or population level, cannot be reduced or transformed into subjective appraisal if we are to make real changes and improvements in individual or social life.

An example might help to clarify the potential consequences of the subjectivisation of QoL at the individual level. Imagine a single man who is wheelchair-bound and living alone on the second floor without a lift. Obviously, the improvement of his QoL demands solutions that provide him with the best possible mobility and independence, so as to increase his scope for interpersonal relations and facilitate the fulfilment of his needs in general. His problem could be solved through the installation of a lift, the provision of social assistance, etc. There is no way to assess his QoL and to improve the situation simply by assessing his subjective appraisal of his QoL. Obviously, it is extremely important to know how he perceives the situation – which solution he thinks would be best, etc. But there

is also no doubt – as Wahl and Iwarsson (2007) argue – that we must take into account the objective context (environment, social network, etc.) as well as the person’s appraisal, and how person and environment fit together.

Furthermore, at a population level, numerous studies report how subjective and objective aspects of QoL are not strongly correlated (Fernández-Ballesteros and Maciá, 1993). Fernández-Ballesteros, Arias, Santacreu and Ruvalcaba (2012), comparing both population-based and individual QoL between Mexico and Spain in older adults, found that at the individual level (assessing QoL through the CUBRECAVI, which addresses both objective and subjective components; Fernández-Ballesteros and Zamarrón, 2007), Mexican elders reported significantly better subjective appraisals of different life aspects (environment, satisfaction, general QoL) than Spanish elders, who reported better appraisals of objective aspects related to environment, income and education. At the population level, all objective indicators of quality of life (e.g., Income per capita, Life Expectancy and many others) have higher values in Spain than in Mexico, whereas all subjective indicators (such as happiness or satisfaction) are higher in Mexico than in Spain.

In conclusion, the subjectivisation of QoL is due not only to the confounding of the concept with subjective (unobservable) concepts such as happiness, satisfaction or wellbeing, but also to the fact that when multidimensional domains are included they are assessed only via the individual’s subjective appraisal. Both objective and subjective conditions must be assessed in QoL studies, and taken into account in the design of data-collection instruments. Finally, when scientists and policymakers set out to improve QoL in a given population, a given individual or a group of individuals, QoL must not be reduced to subjective dimensions.

METHODOLOGICAL REDUCTIONISM

The self-report is the most efficient type of instrument, for both objective and subjective data collection; however, while objective information can be tested by means of other assessment devices, subjective information cannot (see Fernández-Ballesteros, 2003; Fernández-Ballesteros & Marquez, 2003). As stressed elsewhere (Fernández-Ballesteros, 2010), one of the consequences of the subjectivisation of QoL components is reductionism to just one method for assessing QoL: self-reports.

Although self-reports are efficient for the collection of data, they are threatened by several sources of error, notably social desirability, faking and impression management. Moreover, not only are self-reports threatened by error, but they also share sources of variance, being influenced by individual factors (such as optimism) and by cultural characteristics (such as individualism, see Fernández-Ballesteros et al., 2012). Therefore, where self-reports are used there is a need for research on these sources of errors and on common sources of variance, and sophisticated methods for test construction must be employed.

At our Gerontology Laboratory, several studies have been carried out on methods for collecting data about QoL. First of all, Fernández-Ballesteros and Zamarrón (1996) developed self-reports, observation codes and reports by relatives for assessing QoL. Through a series of studies, the CUBRECAVI (Brief Quality of Life Questionnaire, Fernández-Ballesteros, Maciá and Zamarrón, 1996, Fernández-Ballesteros and Zamarrón, 1996, 2007) was developed; it includes nine domains assessed by means of objective and subjective questions (Health, Functional abilities, Social integration, Activity and leisure, Life satisfaction, Social and health services, Environment quality, Education, and Income), plus a final question about one's appraisal of QoL.

Studies with the CUBRECAVI have also taken into account important aspects such as social desirability and faking (see Fernández-Ballesteros and Zamarrón, 1996). In this regard, recent data were obtained in our cross-cultural study of QoL among the elderly in Mexico and in Spain with a representative sample of Spanish and Mexican over-65s (Fernández-Ballesteros et al., 2012). The sample was divided up based on faking scores. In accordance with other studies, the results showed that 'high fakers' reported significantly more life satisfaction and objective, subjective and mental health than did 'low fakers'. These findings suggest the need to support self-report information with other

types of data, such as conditions observed by relatives (ADLs, social network, etc.); relatives and other people in the respondent's social circle can become informants, permitting the operational triangulation of QoL (Cook 1985) and the acquisition of more reliable, more objective information on QoL variables.

In summary, as concluded elsewhere (Fernández-Ballesteros, 2010), the self-report is undoubtedly an easy method for collecting data, and the only one possible when subjective components are being assessed. However, a conceptualisation of QoL that includes objective dimensions means that much more attention must be paid to well-known biases, and more stress should be placed on the use of triangulation and multi-method and multi-level analysis (Fernández-Ballesteros, 2010; Halvorsrud and Kalfoss, 2007).

Conclusions

Over the last forty years, QoL has broadly developed as a multidimensional, multi-nature, multi-level concept. However, throughout that time, three main problematic issues emerged: conceptual reductionism or confusion, subjectivisation, and methodological reductionism. In fact, although many authors highlight the importance of its multidimensionality, others are developing instruments which reduce QoL to one of its domains or confound it with them (health in the bio-medical context and happiness the socio-economic context); at the same time, some instruments reduce QoL to the individual's appraisal of these domains, converting it into a subjective concept or, worse still, reducing it to just one subjective condition (e.g., well-being, subjective health). Finally, another shortcoming in QoL research concerns its assessment by self-report only submitted to several uncontrolled bias.

We are in full agreement with Diener and Suh (1997), in that "...quality of life is a complex, multifaceted construct that requires multiple approaches from different theoretical angles. We encourage scientists from the various disciplines of social science to exploit the strengths of other's contributions in a collaborative effort. Instead of turf battles over who has the best indicator, each discipline needs to borrow insights about quality of life from the other fields" (p. 214). And we would add that, in any case, researchers must avoid any violation of the scientific logic of the QoL concept.

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Parte I

Calidad de vida en la vejez

Capítulo 1
Historia del concepto, Características y Evaluación

Capítulo 2
Geropsychology in Spain

Capítulo 3
Quality of Life. Problematic issues

Capítulo 4
Aging and Quality of Life

AGING AND QUALITY OF LIFE

International Encyclopedia of Rehabilitation, 2010

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Defining aging

Aging is commonly understood as the process of maturing or becoming older; in fact aging is a broad term which includes several processes:

1. Those changes happening along life,
2. Individual differences attributed to age and, finally,
3. The group of aged or older people (in comparison among those younger) (see Birren, 1996).

As authors have pointed out, across a life span there is a continuous balance among stability, gains and declines, especially after the individual reached the third decade of their life (e.g. Baltes, 1978). Within this balance, it is important to distinguish between bio-physical and psychosocial changes; across a life span, bio-physical systems are those that lose efficiency, psychological characteristics maintain stability, and show gains and declines depending not only on the biological organism but also on the socio-cultural context, and on the control individuals exert through his/her behaviours; in other words, as Bandura (1978, 1987) pointed out, the organism, the person and his/her behaviour and the socio-cultural context interact continuously.

From a bio-medical point of view, aging is associated with illness. We must be aware that some declines or losses across life span are due to illness (secondary aging) but are not, per se, due to age (primary aging). In fact through this chapter we are going to take into consideration that any human life condition is due to the transaction between bio-physical, behavioural and socio-environmental circumstances (see Fernández-Ballesteros, 2008). In fact, quality of life of an individual depends on all of these circumstances.

But aging can be considered not only from the perspective of the individual because aging is also a population phenomenon; nevertheless, must we take into consideration that in this article we considered the quality of life in old age at group or individual levels.

Defining Quality of Life in old age

It has been emphasized that Quality of Life (QoL) is an extremely complex, abstract, and scattered concept difficult to define and has a high impact on research and practice (Fernández-Ballesteros, 1997; Walker, 2005a, b). QoL is a key concept in environmental, social, medical and psychological sciences, as well as in public policy and in the minds of the population at large; nevertheless, there is no consensus regarding the definition of QoL (Fernández-Ballesteros, in press).

Moreover, when QoL is referring to old age it must be required to address the broad diversity of ways of aging; that is, from successful aging through usual aging to aging with disability (and dependency). Consequently, from the very beginning we have to take into consideration that QoL in old age cannot be reduced to QoL in clinical or health settings but must have a general (normal) vision.

QoL GENERAL DOMAINS OR CRITERIA

Following a step by step process (Fernández-Ballesteros, 1997), from a semantic point of view, the term “quality” refers to a set of attributes or characteristics of a given object (in this case, life), and “life” is a wide category which would include all living beings but here we are referring to human aging. Therefore we considered a human subject or group of human beings; consequently, we did not take into consideration the QoL at the population level. The QoL at population level were necessarily measured through social aggregates such as the GDP (Gross Domestic Product), unemployed or poverty rate, or other social indexes of crime, suicide, public violence, family disintegration. All these indicators were used as measures of social welfare and well-being. At population level, the indicators usually considered were bio-medical aggregate and epidemiological indices such as mortality, morbidity and/or life expectancy rates.

One of the characteristics commonly accepted of QoL is its dimensionality; in other words, QoL can be related with a set of conditions (ingredients, components, etc.) of a given individual or groups of individuals. Two main strategies have been followed to establish those conditions: with experts and lay definitions.

From an expert point of view, Lawton (1991) proposed a Four Sector model in which psychological well-being, perceived quality of life, behavioral competence and objective environment were present in the QoL of older individuals. Hughes (1990) enlarged those domains considering the followings: personal characteristics of the individual (functional activities, physical and mental health, dependency, etc.), physical environmental factors (facilities and amenities, comfort, security, etc.), socioenvironmental factors (levels of social and recreational activity, family and social network, etc.), socio-economic factors (income, socio-economic status, etc.), personal autonomy factors (ability to make choices, exercise control, etc.), personality factors (psychological well-being, morale, life satisfaction, happiness, etc.) and subjective satisfaction.

After reviewing several approaches (both theoretical and empirical) for understanding QoL Fernández-Ballesteros (in press) concluded that QoL integrates two broad dimensions: 1) personal or internal (e.g.: functional competence, health) versus socio-environmental or external conditions (e.g.: prosthetic helps) as well as 2) subjective (e.g. life satisfaction, subjective QoL) versus objective (e.g. income, physical environment) factors. All characteristics proposed by authors could be classified in these two dimensions but most importantly, the concept of QoL must integrate a set of both dimensions and never can be reduced to one them.

This view was accordance with Birren and Dieckmann (1991) when they established what is not quality of life: QoL is not equivalent of quality of the environment, is not equal to the quantity of material goods, is not equivalent to the physical health status, or to the quality of health care, just as it is distinct from subjective constructs such as life satisfaction, morale or happiness. Similarly, Browne, et al. (1994) stated: "Quality of Life (QoL) is (the product) of the dynamic interaction between external conditions of an individual's life and the internal perceptions of those conditions". In summary, we cannot reduce QoL concept to life's external conditions or to personal characteristics (even the perception of external conditions), or to subjective or objective view of them.

LAY CONCEPTS OF QoL

From a lay perspective, several authors have surveyed the conditions that older persons report to be important for their QoL. Brown and Flynn (2003) reviewed those components nominated by older people in selected studies, most of the population that was selected for these studies from several countries and world regions, identified the following factors as main aspects of QoL: good health, be independent, good pension/income, family and social relationships, be active, happiness, good living conditions and neighbourhood, opportunities for learning and development, religion. From this lay perspective, it was concluded that QoL of older persons was sharing a multidimensional concept of QoL, similar to experts.

DEBATES IN QoL

In spite of this multidimensional conceptualization, during the last decades, QoL has experienced two main problematic issues: reductionism and subjectivization. That is, several authors have proposed instruments or indexes which reduced QoL to one of its components and/or considered only the subjective appraisal of wellbeing (happiness, satisfaction, etc.) or one of those several components reducing to health. For example, QoL has been defined as equivalent to the well-being in the social domain, to the health status in the bio-medical field (also called Health-related QoL), and to life satisfaction or happiness not only within the psychology field but in many others.

Referring the field of health, since the World Health Organization enlarges the concept of health from the absence of illness to the physical, mental and social wellbeing, QoL has been converted into a parallel conceptualization of health developing hundreds of items as the Health Related Quality of Life (HRQoL) most of them traditional measures of health. Recently, Halvorsrud and Kalfoss (2007) revealed that from the very outset, HRQoL has been the most commonly used category at the individual level concluding that among the QoL studies reviewed: "almost two-thirds ...where HRQoL was used as an overlapping term".

The World Health Organization has not only changed the concept of health but has subjectivised the concept of QoL. So, under the assumption that "Quality" means "Subjective", WHO developed and spread out a measure of QoL WHO Quality of Life measure. Thus, the WHO QoL group (1995) defined QoL as "an individual's perception of their position in life in the context of the culture and value systems in which they live and in relationship to their goals, expectations and standards and concerns".

In summary, QoL focusing on health can be considered a predominant field on QoL, usually consisting of subjective appraisal of symptoms in specific pathologies and in the subjective appraisal functioning of the individual. Thus, in spite of the fact that QoL is a multidimensional concept that arises from several disciplines (biology, medicine, psychology and sociology), from a bio-medical perspective, authors propose a reductionistic definition without balance between personal (internal) and external conditions, or subjective and objective characteristics. This criticism is in many of QoL perspectives from social sciences or from psychology (Walker, 2005 a,b).

Regarding these criticisms, Fernández-Ballesteros (in press) concluded that two characteristics are embedded in the field of QoL. One is a reductionistic conception of QoL expressed by the HRQOL exponential growth of interest of QoL as an isomorphic concept of health within the medical context; the other is a subjectivization of the concept which must be called "Subjective Quality of Life" (SQOL) when several dimensions of QoL were reduced to the subject's appraisal of these dimensions.

QoL is a scientific concept used as an outcome of interventions and policies (among them, bio-medical interventions) when goals are the improvement of societal or individual living conditions. As Sampson (1981) pointed out, when bio-psycho-social changes were expected as outcomes of interventions (both at individual and population levels), these output cannot be reduced or transformed into their corresponding individuals' subjective appraisal. It is concluded that the focus from social or health policies must be assessed through objective and subjective outcomes of a given individual, group or a population or context. For example, on the field of aging, when policies are developed through social or health interventions at the individual or group level (as well as community or population levels), QoL must be operationalized through a set of expected outcomes: physical abilities and physical and mental health, social participation, etc., but also through other objective outcomes such as health and social services availability, better pensions, better physical environment, etc. QoL cannot be reduced to the subjective appraisal of those external life conditions.

The argument that QoL could be reduced to the subjective appraisal of one or several life circumstances could have perverse repercussions; that is, try to move up an individual's subjective appraisal changing his/her opinion but not improving their objective

insufficient life conditions. In the next section several instruments developed in order to assess QoL in old age are going to be described, and in Table 1 and 2 components and characteristics of those selected instruments for assessing QoL can be found.

Instruments assessing QoL

GENERAL CHARACTERISTICS

Since there is not a commonly accepted definition of QoL, during the last thirty years dozens of QoL instruments assessing different components have been developed. Before presenting selected measures, let us introduce those proposed criteria for selecting the appropriated QoL measure.

Arnold (1991) pointed out that, in order to take decisions about QoL instruments, two main aspects have to take into consideration: the assessment purposes and the target concerned. Moreover, a third aspect that must be take into consideration for select a QoL measure is the instrument basic method.

Usually, QoL assessment is conducted for five purposes:

1. To understand the causes and consequences of assessing individual differences in QoL.
2. To assess the impact of social and environmental interventions in QoL.
3. To estimate the needs of a given population.
4. To evaluate the efficiency or effectiveness of health interventions and/or the quality of the health care system.
5. To improve clinical decisions.

Regarding the target population, although several efforts have been made in order to assess QoL in the general population (for example, Campbell, 1981), a review of QoL instruments indicates that age and health differences are the two most important target circumstances for selecting a QoL instrument. That is, a significant number of QoL instruments have been developed for the elderly, and among them the majority of QoL instruments for older people were health-related measures taking into consideration that the concept of QoL has had its greatest impact in medicine.

Finally, as was emphasized by Campbell (1981), although there are methods of rating available by other measures, the most common method for assessing QoL is self-report. Obviously, self-report is the most direct measure for assessing subjective appraisal for any of the conditions present in QoL; therefore, those instruments reducing QoL to subjective components (happiness, life satisfaction, health perception, etc.) are using self-report. At the same time, self-reports are also used for collecting objective conditions of health. Moreover, other sources of data can be used as external/objective variables as components of life in order to have a more complete picture; for example, rating-by-others. Moreover, in order to improve multi-method validity, some instruments include both types of procedure for collecting data: self-reports as well as rating-by-other scales. Hadorn and Hays (1991) tested the construct validity of two methods for assessing HRQoL through Multitrait-Multimethod (MTMM), although the authors conclude that the construct validity of self-reported HRQoL was supported, substantial method variance and little valid trait variance was observed for the HRQoL preferences. Therefore, the assumption that different methods are assessing the same component of QoL is not supported.

For example, assessing environmental conditions, Fernández-Ballesteros, Zamarrón & Maciá (1997) used both observational procedures and self-report evaluation in order to assess environment quality but they obtain low correlations among rating-scales and self-report about objective (external) characteristics. Also, rating scales have been proposed by Birren & Dieckmann (1991) emphasizing that, for assessing health status, physicians' ratings must complement self-report measures because they are better measures for health (The fact that we are defending the utilization of subjective as well as objective measures (in health as well as in other domains), in QoL assessment, does not mean that both can have different predictive values. For example, the Bonn Longitudinal Study (BOLSA), Lehr (1993), found that subjective health was a better predictor of longevity than objective health.).

As in the measurement of other constructs, QoL instruments must present certain psychometric properties: reliability (internal consistency and test-retest correlations), validity (criterion-related and construct validity) and sensitivity to change are the most important aspects reported in QoL measurement (Messik, 1995). Finally, since most of the instruments are self-reports, it must take into consideration the variance due to method as a common source of error. As has been pointed out by Fernández-Ballesteros and Zamarrón (1996), faking is a source of error of QoL self-report measures:

those people high in faking reported better health, better environmental quality, and higher satisfaction than those low in faking.

Linked to health-related QoL assessment, instruments developed in a specific language/culture have been translated and/or adapted to other languages and contexts. As Anderson et al. (1993) point out: "it is difficult, if not impossible to make definitive statements about cross-cultural equivalence of measures". A review of the cross-cultural QoL literature points to the existence of two main problems: inappropriate translation/adaptation methods and the lack of investigation into psychometric properties in the new culture. The conclusion from the analysis of the most widely-used QoL instruments was that "none of the instruments reviewed were judged to have data available for all aspects of measurement equivalence considered. Too often, health-related QoL measures have simply been translated into another language linguistically, and immediately used in research with the assumption that the essential properties of the original instrument have been preserved" (Anderson et al., 1993). As is well known, psychometric properties in the 'original' (domain) version are not guaranteed in the new target version. Now the situation is much more positive: there are QoL instruments, such as WHOQoL, carefully adapted to several cultures/languages (Skevington, 2002). Skevington, Sartorius, Amit and the WHOQoL group (2004) report data of this instrument in 40 countries and many languages.

Moreover, international guidelines have been developed for test translation/adaptation (Hambleton, 1994). These guidelines have been extended to the field of aging by Fernández-Ballesteros, Hambleton & Van Vijver (1999) and are a step forward in the right direction to improve cross-cultural research in QoL.

In conclusion, in order to make decisions about instruments, the complexity of the QoL construct requires taking into consideration the objective of the study, the characteristic of the sample to be assessed, and the possibility to use multiple methods already adapted to the country/language.

GENERAL INSTRUMENTS OF QoL FOR ASSESSING OLD AGE

Table 1 shows a list of selected QoL instruments usually developed for the elderly. Those instruments are classified on base of the target population, the procedure used and their psychometric properties. In Table 2, the same instruments are examined through the domains included on base of our theoretical classification described in Section 2.

TABLE 1 QUALITY OF LIFE MEASURES: PSYCHOMETRIC PROPERTIES.

Measure	Population	Administration	Reliability	Validity
Elderly community reactions to the nursing home (Biedwenharn & Baslin, 1991)	Institutionalized residents	Interviewer and self-administered	Limited	Limited
Evaluating the efficacy of physical activity for influencing quality of life outcomes in older adults (Stewart & King, 1991)	Elderly	Interviewer	Limited	Limited
Initial psychometric evaluation of a quality well-being measure: The Integration Inventory (Ruffining-Rahal, 1991)	Elderly	Interviewer	Limited	Limited
Multitrait-multimethod analysis of health-related quality of life measures (HRQOL; Hadorn & Ron, 1991)	General population and the elderly	Interviewer	Limited	Limited
Older American resources and services instrument (OARS; Duke University, 1978)	Elderly	Most experience obtained from interviewer	Extensive data available	Extensive data available
Nottingham health profile (PSN)(NHP; Hunt et al. 1981)	Health related	Interviewer and self-administered	Extensive data available	Extensive data available
Quality of life in elderly, chronically ill outpatients (Pearlman & Uhlman, 1991)	Elderly and chronically ill	Interviewer	Extensive data available	Extensive data available
Sickness Impact Profile (SIP; Bergner et al., 1981)	Extensive use in many populations, including chronically ill	Interviewer and self-administered	Extensive data available	Extensive data available
Subjective well-being instrument for the chronically ill (Gill, 1984)	Chronically ill	Interviewer	Limited	Limited
Quality of Well-Being Scale QWE (Kaplan & Bush, 1982)	Numerous populations, including chronically ill and frail elderly	Interviewer	Extensive data available	Extensive data available
Schedule for evaluation of individual QoL (SEIQoL; McGee et al., 1991)	Elderly	Interviewer	Limited	Limited
Elderly Cruz Roja Quality of Life (Guillén et al. 1990)	Elderly	Interviewer	None	None
CUBRECAVI (Fernández-Ballesteros & Zamarrón, 1997)	Elderly	Interviewer	Limited	Limited
FUMAT (Verdugo et al., 2009)	Experts	Self-administration	Limited	Limited
The Medical Outcome Study 36-Item Short Form Survey (SF-36; Ware and Sherbourne, 1992)	General population	Interviewer and self-administered	Extensive data available	Extensive data available
German Chronic Respiratory Questionnaire (CRQ; Puhan, 2005)	People with COPD	Interviewer and self-administered	Limited	Limited
WHOQOL (WHO, 1993)	General population	Interviewer and self-administered	Limited	Limited
EQUAL (Walker, 2005)	Elderly			
Quality of Life inventory (QOLI; Frisch 1994)	General population	Self-administered	Limited	Limited
Quality of Life in Alzheimers' Disease (QO-LAS, Albert, S.M, et al., 2000)	Patients with dementia	Interviewer	Limited	Limited
Alzheimers' Disease Related Quality of life (ADRQL, Rabins, et al., 2000)	Experts	Self-administered	None	None

In order to select an instrument to measure QoL, it is not only important to focus on what domains it includes, but also in which are its psychometric properties. Since, it would be impossible here to review each instrument, information about psychometric properties of each instrument are provided.

QoL is a multidimensional construct, so internal consistency is not applicable to the complete QoL instrument but to its subscales. Rand Health Status Measure-36 (MOS-36, Ware et al. 1989) is a good example of internal-consistency reliability coefficients. They range from moderate to high (from .67 to .90) in its different subscales.

In QoL there are domains which are very constant such as culture or financial resources, and domains which are more variable, including pain (Fernández-Ballesteros, 1992). This is known through the process of test-retest, which means assessment through the administration of a given instrument (or subscale) at two points in time. For example, test-retest reliability for the six Nottingham Health Profile (NHP; Hunt et al. 1981) domains ranged from 0.77 (energy subscale) to 0.85 (physical mobility and sleep subscales).

Criterion validity is a very frequently used both in concurrent or predictive format. For example, the Sickness Impact Profile (SIP; Bergner et al., 1981), which is used in rheumatoid arthritis and hip replacement, has a total score that correlates above 0.80 with specific measures of patients' functioning assessed concurrently (Anderson, Aaronson & Wilkin, 1993). However, these high correlations are strongly associated with the nature of the construct assessed for a given domain. In fact, if SIP emotional domains are correlated with another instrument assessing the same variables (e.g., anxiety or depression) correlations are only moderate. Also, Otero-Rodríguez et al. (2010) reported that among the older adults from the general population, two year changes in the SF-36 (as measure of HRQOL) predict mortality in the subsequent 4 years.

As we have already said, QoL is a multidimensional construct with different domains; therefore, construct validity is one of the most important procedures. For example, as mentioned above, in our QoL questionnaire validation studies, for different samples and different sources of data, we obtained a very close factorial structure (Fernández-Ballesteros y Maciá, 1996; Fernández-Ballesteros, Zamarrón y Maciá, 1997).

Finally, several authors emphasize the importance of QoL sensitivity measure for the changes in programs, treatment and over time (e.g., Kaplan & Bush, 1982).

Ruiz & Baca (1993) assessed the Quality of Life Questionnaire ("Cuestionario de Calidad de Vida", CCV) sensitivity to change by comparing treated and non-treated insomnia subjects. Significant differences ($p < .001$) between pre- and post-treatment scores, in the predicted direction, were found both in CCV total score and in all domain scores (Social Support, General Satisfaction, Physical/ Psychological Well-being, and Absence of Work Overload/Free Time).

As an example of general instruments of QoL, let us briefly introduce one of the most widely used: the World Health Organization Quality Of Life measure. The WHO-QOL (WHO, 1993, see also, Skevington, et al. 2004) is a general QOL instrument administered through the individual's self-report or through interview. WHOQOL has been developed cross-culturally and systematically and it has different forms for different purposes. It includes subjective overall QOL and health (4 items), and the individual's appraisal on the six domains of quality of life (Physical health/Energy and fatigue, Psychological Bodily image and appearance, Level of Independence/Mobility, Social/Personal relationships, Environment and Spirituality/Religion/Personal beliefs), and twenty-four facets covered within each domain. Since four items are included for each facet, it a total of 100 items. There is a WHOQOL- Bref reduce to one from each of the 24 facets. All items are rated on a five point scale (1-5). WHOQOL (both 100 and Bref) has demonstrated to have discriminant validity, content validity, test-retest reliability and sensitivity to change.

SPECIFIC INSTRUMENTS WITHIN REHABILITATION SETTINGS

Rehabilitation studies are developed within the bio-medical domain; thus, the assessment of QoL is referring health related quality of life instruments. Usually, those instruments on the field of rehabilitation have the purpose for evaluating a given intervention; therefore, the most important psychometric characteristic of them must be sensitivity. Table 1 showed selected QoL instruments usually used for rehabilitation listed on the basis of the target population, the basic administration procedure and their psychometric properties. Table 2 shows the same instruments analyzed through the domains included.

Several instruments developed in rehabilitation settings (independently of the type of rehabilitation) consider QoL as a subjective construct and mainly related to health; therefore, most of those instruments conceptualize QoL as the subjective appraisal of the individual within life domains such as health, mental and emotional, and social functioning. Few of them take into consideration other objective aspects of health.

TABLE 2 DOMAINS ASSESSED IN SELECTED QOL INSTRUMENTS

	Individual													Contextual		
	Physical functioning	Emotional functioning	Cognitive functioning	Social functioning	Life satisfaction	Health perception	Functional skills	Economic status	Cultural status	Recreation	Sexual functioning	Self-Esteem	Risk factors	Energy and Vitality	Physical environment	Services
Elderly community reactions to the nursing home	X	X				X								X		
Evaluating the efficacy of physical activity for influencing quality of life outcomes in older adults	X	X	X	X	X	X				X		X		X		
Initial psychometric evaluation of a quality well-being measure: The Integration Inventory		X		X	X	X	X					X		X		
HRQOL	X			X	X	X	X							X		
OARS	X	X	X	X		X		X		X						
NHP	X	X		X		X	X			X	X			X		X
Quality of life in elderly, chronically ill outpatients	X	X	X	X	X	X	X	X								
SIP	X	X	X	X		X		X		X				X		
Subjective well-being instrument for the chronically ill		X												X		
QWE	X			X												
Reintegration to normal living index	X							X								
SEIQoL	X	X		X	X	X	X	X	X	X			X	X		
Elderly Cruz Roja Quality of Life	X					X	X		X							
CUBRECAVI	X	X	X	X	X	X	X	X		X				X	X	X
FUMAT	X	X		X	X	X	X		X				X		X	X
MOS-SF-36	X	X	X	X		X	X							X		
CRQ		X				X										
LAWTON (1983)						X									X	
WHOQOL																
EQUAL	X		X	X	X										X	X
QOLI			X	X		X		X				X				
QOLAS	X		X	X			X									
ADRQL		X	X	X						X						

On the field of aging and rehabilitation, several types of instruments have been proposed; thus, as Stewart and King (1994) have pointed out, special problems of some subgroups of older populations, such as cognitive difficulties or sensory limitations, may impede the use of self-report and, therefore, affect the choices regarding which would be the optimal method. To solve this problem, several methods are available, including performance-based testing, medical exams, clinical analysis and expert observations.

Lucke et al., (2004) assess quality of life in individuals with spinal cord injuries following rehabilitation, emphasizing the importance of environmental factors in QoL. These authors report several Swedish studies, where environmental barriers were less of a concern than in many other countries, researchers found no differences among perceptions of QoL in people with severely limited mobility, compared to those in the general population (Siösteen, 1990; Stensman, R., 1994).

Lawton (1991, 1994), an expert both in QoL and dementia, emphasized that people with the diagnosis of dementia were unable to accurately express their internal state. Nevertheless, he maintains it is possible to assess QoL in dementia patients even when the patients cannot report their evaluations. In summary, on the field of aging and QoL on rehabilitation settings, three major approaches can be found:

1. The assessment of several domains through self-reports.
2. Rating-by-others approach.
3. Environmental observations from experts.

As an example of QoL instruments developed on the field of aging and rehabilitation, let us introduce one of the most popular: the Quality of Life in Alzheimers' Disease (QOLAS, Albert et al., 2000). The QOLAS is a dementia QoL instrument, administered to the Alzheimer's patient and his/her care provider, which includes both qualitative and quantitative data. Respondents are interviewed and asked to identify what is important for their QoL. Two issues from each of the following domains are identified: Physical, Psychological, Social/family, Usual activities, and Cognitive functioning. Patients then are asked to rate how much of a problem s/he is currently feeling for each of the 10 issues on a 5-point scale (0 = no problem; 5 = it could not be worse). Scores range from 0 to 50 in which higher scores reflect poorer QoL. A limitation of the QOLAS is that psychometric properties have been obtained from a small sample of patients (only 22 dementia patient-ca-

re-providers dyads were assessed). Care providers and patients were interviewed separately. Internal consistency reliability measured by coefficient alpha was .78 for patients and caregivers. Construct validity was indicated by significant higher patient-reported QoL from a subgroup of patients with less disability in Activities of Daily Living as compared to patients with more disability. Agreement between patient-reported QoL scores and scores on a generic measure of QoL ranged from low to medium (kappa ranged .09 to .67, Mdn = .45). For caregiver-reported QoL, kappa values ranged from low to high (range .09 to .82, Mdn = .47).

In summary, it seems that in the rehabilitation field there is more interest for the objective aspects of QoL, especially when the people are unable to self-report or have physical difficulties.

Concluding remarks

Quality of Life is an important field for aging as well as for rehabilitation. In both fields, QoL is considered a multidimensional construct composed by several domains referring to the individual and his/her context. In spite of this fact, two main problematic issues have emerged: from a bio-medical perspective QoL is mainly reduced to health, and several health measures have been taken as QoL measures. When several domains were considered, QoL was reduced to the individual's subjective appraisal of those domains. This panorama determines the existence of a variety of self-report methods assessing QoL combined with a minority of rating-by-other scales. With some exceptions, QoL measures can be placed in an immature state. Our proposal here is to emphasize the multidimensionality of QoL and the strong need to use both subjective and objective components of those dimensions.

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Parte II

Cambio sociodemográfico y Envejecimiento Activo.

Contribución Científica para Políticas Públicas Previsoras (CASOENAC)

Capítulo 5

Proyecto CASOENAC

Capítulo 6

Quality of Life in Mexico and in Spain

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Multidimensional - Multisystems - Multinature indicators of Quality of Life

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PROYECTO CASOENAC

Origen y consolidación del proyecto CASOENAC

El proyecto CASOENAC (Cambio Sociodemográfico y Envejecimiento Activo) fue una iniciativa política del gobierno del estado de Colima (México) a través de la Secretaría de Salud. Su objetivo general era generar un sistema de servicios de bienestar biopsicosociales de calidad para las personas mayores de esta región de México. El estado de Colima ha sido pionero en el desarrollo y aplicación de programas políticos de distinta índole para mejorar el desarrollo de su territorio y el de sus ciudadanos, funcionando como modelo de referencia para el resto de los estados mexicanos. Esto ha sido posible gracias a las características de las que goza este estado, que se posiciona entre uno de los mejores de México. Su nivel económico, su reducido tamaño territorial y su bajo número de habitantes, en comparación con otros estados mexicanos, le sitúa en unas condiciones idóneas para la aplicación de este tipo de planes estratégicos.

En la **tabla 1** se exponen algunos datos socioeconómicos que reflejan la situación privilegiada de Colima, recogidos de la página web del Instituto Nacional de Estadística y Geografía (INEGI) de México (<http://www.inegi.org.mx/>). En esta tabla, se compara Colima con otros dos estados: Jalisco (que también fue incluido en el estudio) y Estado de México, capital del país. Se incluyeron además los datos del conjunto de los

Estados Mexicanos, para poder tener una referencia normativa del país.

Observamos que el PIB de Colima está en la media del país, pero se encuentra por encima de los otros dos estados. Aunque su densidad de población es parecida a la de Jalisco y superior a la de los Estados Mexicanos en su conjunto, es muy inferior a la del Estado de México y, en valor absoluto, su población es significativamente más reducida que la de los otros dos estados; representa el 0,6% de la población total. Los datos demográficos son semejantes en los tres estados analizados y a la media del país; por eso, también sirve de referencia para la generalización de resultados tras la implantación de nuevas políticas. Sin embargo, atendiendo a los datos económicos observamos que Colima es un estado privilegiado. Tiene el PIB más alto, la tasa de paro más baja y el menor número de personas sin derecho a sanidad pública. También tiene el mayor número de personas mayores de 65 años con participación económica. Finalmente, hay que destacar que Colima representa uno de los estados más seguros de México, con menor tasa de delitos. En resumen, Colima cuenta con una distribución demográfica parecida a la del resto del país, pero con una población significativamente más reducida y con mejores condiciones económicas y de seguridad.

TABLA 1 DATOS OS DE COLIMA, JALISCO ESTADO DE MÉXICO Y EL CONJUNTO DE ESTADOS MEXICANOS EN 2011.

	Colima	Jalisco	México	Estados Mexicanos
PIB (2008-2012)	3,9	3,5	3,4	3,9
Población total (2010)	650.555	3,5	15.175.862	112.336.538
Extensión (Km2)	5.627	78.588	22.351	1.964.375
Densidad de Población (2010)	115,61	93,53	678,98	57,30
Tasa de Crecimiento (2010)	1,80	1,50	1,40	1,40
Tasa de natalidad (2010)	16,7	17,9	17,4	-
Tasa de mortalidad (2010)	5,0	5,1	4,2	-
Esperanza de vida al nacimiento, 2010	75,80	75,60	76,00	-
Población sin derecho a servicios de salud, 2010	112.776	2.536.651	6.128.990	38.020.372
Participación económica de la población de 65 y más años, 2010	26,39	24,26	23,83	26,01
Tasa de desocupación de la población total, 2010	3,22	4,01	5,07	4,54
Delitos registrados en averiguaciones previas del fuero común, 2010	8.408	84.842	268.419	1.716.115
Inversión pública ejercida en desarrollo social (Miles de pesos), 2010	5.797.439	-	18.841.627	164.248.572

Sin embargo, el breve análisis realizado sobre las condiciones sociodemográficas de Colima no es suficiente para explicar y comprender el origen de este proyecto. Para ello, es necesario aludir a la biografía de su impulsor: Volker Lehr. Lehr es un alemán afincado en Colima que trabajaba como asesor político del gobierno de este estado. Su madre era Ursula Lehr, una prestigiosa investigadora en el área del envejecimiento y política alemana que, entre otras cosas, fundó el Instituto Alemán de Investigación sobre Envejecimiento en la Universidad de Heidelberg (Alemania). Así pues, la preocupación heredada sobre la vejez de Volker Lehr, su posición política y el eminente cambio sociodemográfico de México hacia el envejecimiento de su población impulsaron su liderazgo en este proyecto.

La filosofía subyacente a este proyecto era basar la propuesta política en aportaciones científicas y programas políticos que ya hubieran tenido éxito en el pasado. Para ello, Lehr solicitó la colaboración de científicos expertos en la aplicación de estrategias políticas en materia de envejecimiento. Por comprensible conveniencia, Lehr contactó, en primer lugar, con el profesor Andreas Kruse, actual director del Instituto Gerontológico de la Universidad de Heidelberg y asesor político en diferentes estatutos gubernamentales de su país. Éste, a su vez, propuso a la profesora Rocío Fernández-Ballesteros de la Universidad Autónoma de Madrid, que por su colaboración en el II Plan de Acción Internacional sobre el Envejecimiento (Madrid, 2002) y ser una experta en evaluación y envejecimiento, la hacía una candidata idónea para contar con su participación.

A nivel internacional, este proyecto también contó con la participación de la Fundación Academia Europea de Yuste. Su colaboración fue esencial por su experiencia en poner en común temas científicos, políticos y sociales y su capacidad para darles visibilidad a nivel europeo.

Por último, a nivel nacional, Lehr contó con la colaboración de un equipo multidisciplinar de la Universidad de Colima y con un grupo de la Universidad de Guadalajara liderado por la doctora Elva-Dolores Arias, quien ya había hecho colaboraciones en proyectos científico-políticos en el sistema de salud mexicano. Así pues, este proyecto finalmente resultó una fusión político-científica, de la Secretaría de Salud del Gobierno de Colima, dos entidades nacionales –las Universidades de Guadalajara y Colima– y tres socios europeos: la Universidad Autónoma de Madrid (IP: Prof. Rocío Fernández-Ballesteros), la Fundación Academia Europea de Yuste (IP: Miguel Martín Ramos) y la Universidad de Heidelberg (IP: Prof. An-

dreas Kruse). El respaldo multidisciplinar de esta propuesta finalmente consiguió financiación económica por parte del CONACYT y de la Comunidad Europea a través de su Fondo Común FONCICYT. La subvención económica fue de \$14.405.600,00 (898.407,19€) y el coste total del proyecto ascendió a \$21.549.600,00 (1.343.943,72€). La duración del proyecto fue de 22 meses, en los cuales 32 personas fueron contratadas a tiempo completo para la coordinación, supervisión y divulgación del mismo.

Una vez conformado el grupo de trabajo y conseguida la financiación, se establecieron tres reuniones de una semana de duración en las que representantes de todos los consorcios se congregaron en el estado de Colima (Colima y Manzanillo) y Jalisco (Guadalajara). La primera se realizó en diciembre de 2009 y tuvo tres objetivos: 1) una presentación de los componentes del consorcio y sus líneas de investigación en los países de origen; 2) establecer los estudios a realizar por cada uno de los asesores científicos europeos, así como su colaboración con las universidades nacionales y 3) establecer los tiempos a seguir, presupuestos y demás tareas administrativas y organizativas. La segunda reunión se realizó en septiembre de 2010. En ella se discutió sobre los resultados preliminares de los estudios ya finalizados, de los estudios y análisis que quedaban por realizar y de la elaboración de los informes que se debían entregar para la finalización del proyecto. En la tercera y última reunión, celebrada en junio de 2011, se presentaron los resultados de todos los estudios realizados, así como las conclusiones y las recomendaciones derivadas de ellos.

En la primera reunión, resultó una tarea ardua y complicada consumir acuerdos con respecto a los estudios que iba a desarrollar cada parte del consorcio, decidir quién iba a participar en cada uno de ellos y qué financiación iba a recibir cada grupo. Este proceso requirió una semana de largas reuniones, en las que se mezclaban tres lenguas simultáneamente (español, inglés y alemán) e intereses muy diversos de tipo político, científico y económico.

Finalmente, se estableció que la Universidad Autónoma de Madrid liderara cuatro estudios:

- El entorno y las personas mayores. Satisfacción residencial y espacios públicos. Este estudio fue coordinado por el profesor José Antonio Corraliza de la Universidad Autónoma de Madrid que trabajó en colaboración con la profesora Elva Dolores Arias de la Universidad de Guadalajara. El objetivo de este estudio fue identificar qué elementos de los

que componen la satisfacción residencial (vivienda, barrio y vecindad) resultaban más satisfactorios y deficitarios según los ciudadanos colimenses. Con los resultados, que indicaban que la mayor insatisfacción se encontrar con los elementos del barrio (calles, plazas, parques, etc.), se elaboró una propuesta de los elementos que debían ser modificados para mejorar la movilidad y accesibilidad de las personas mayores a todos ellos.

- Los muy mayores 80+. La coordinación y ejecución de este estudio fue liderada por la Dr. María Ángeles Molina. El estudio tenía como objetivo caracterizar el envejecimiento de los muy mayores de Colima y derivar las recomendaciones oportunas a partir de sus resultados. Para ello, se administró el mismo protocolo multidimensional de Evaluación del Envejecimiento que se había aplicado en un estudio previo del grupo EVEN realizado en España, llamado “90 y +” (Molina y Fernández-Ballesteros, 2012).

- Estereotipos e imágenes de profesionales sobre la vejez. El responsable de este estudio fue el profesor Antonio Bustillo de la Universidad Nacional de Educación a Distancia (UNED). El objetivo de este estudio fue observar como los estereotipos sobre la vejez mantenidos por profesionales que atendían a adultos mayores en centros de mayores y residencias de Colima influían en el comportamiento y el bienestar de sus usuarios y residentes, respectivamente. (Bustillos y Fernández-Ballesteros, 2012, 2013).

- Calidad de Vida: un estudio comparativo entre Colima, Jalisco (México) y Alicante (España). Éste constituye la parte empírica de esta tesis doctoral. Fue un estudio coordinado por la profesora Rocío Fernández-Ballesteros y yo misma, de la Universidad Autónoma de Madrid, en colaboración con Elva-Dolores Arias y Neyda Rubalcaba de la Universidad de Guadalajara. Su desarrollo se describe con detalle a continuación.

Calidad de vida: un estudio comparativo entre Colima, Jalisco (México) y Alicante (España)

En el marco completo del proyecto CASOENAC, el objetivo de este estudio concreto fue realizar un diagnóstico de la Calidad de Vida de las personas mayores en Colima. Con este objetivo, en la primera reunión del proyecto CASOENAC, las dos universidades implicadas se coordinaron para establecer los aspectos relativos a la preparación del mismo: selección de la muestra, instrumento de evaluación, fechas de evaluación. Los resultados de este estudio quedan plasmados en dos artículos. En el primero, titulado “Quality of Life in Mexico and in Spain” y publicado como capítulo de libro en “The Global Dynamics of Ageing” editado por Jason J. Powell y Sheying Chen, se presentan los resultados descriptivos de ambos países y su comparación. En el segundo estudio, titulado “Multidimensional/ Multisystems/ Multinature indicators of Quality of

Life: Cross-cultural evidence from Mexico and Spain” y publicado en la revista científica “Social Indicators Research”, se presenta un modelo basado en ecuaciones estructurales que avala empíricamente el modelo teórico de Calidad de Vida presentado.

En ambos textos se detalla información sobre la muestra, el instrumento y el procedimiento; sin embargo, el espacio limitado no permite explicar en detalle todos los elementos relevantes del estudio realizado. A continuación exponemos una explicación de todos ellos.

Metodo

PARTICIPANTES

El objetivo principal para el consorcio político del proyecto CASOENAC era elaborar un estudio que identificara el estado de la Calidad de Vida de sus habitantes mayores y la derivación de recomendaciones para mejorarla. Para identificar el estado de la Calidad de Vida de los habitantes mayores de Colima se consideró esencial tener otras muestras de referencia que permitieran hacer comparaciones. Para ello, se seleccionó otra muestra Mexicana del Estado de Guadalajara y una muestra Española de la Provincia de Alicante.

Muestra mexicana

Las muestras mexicanas, se obtuvieron de dos poblaciones de personas mayores de 60 años de los Estados de Colima y Jalisco. Se hizo el cálculo de la muestra en el programa Stat Calc con un nivel de confianza de 95%, el parámetro de referencia fue un estudio previo de Calidad de Vida en Guadalajara (Arias-Merino, 2008). Se hizo un muestreo aleatorio y proporcional por sexo de los estados de Colima (municipios de Colima, Tecmán y Manzanillo) y Jalisco (municipios de Guadalajara, Zapopan, Tlaquepaque, Tonalá, Tlajomulco de Zúñiga y El Salto que corresponden a la Zona Metropolitana de Guadalajara). Para ello, se determinaron aleatoriamente las Áreas Geo-Estadísticas Básicas (AGEB's), propuestas por el Instituto Nacional de Estadística y Geografía Mexicano (INEGI), según su concentración de personas mayores, y se determinó la cuota por AGEB (proporcional por sexo y por población), la cuota mínima requerida fue de $n=30$. La muestra final estuvo conformada por 600 participantes en el estado de Colima y 599 en Jalisco.

Se incluyó en el estudio a personas mayores de 60 años, residentes en la comunidad y que aceptaron participar a través de un consentimiento informado. No se incluyeron a personas institucionalizadas. Las entrevistas se llevaron a cabo del 26 al 30 de junio en Jalisco y del 9 al 12 julio de 2010 en Colima.

Muestra española

Se seleccionó la provincia de Alicante por dos razones. En primer lugar, esta región española es geográficamente parecida a Colima porque ocupa una zona costera y tiene condiciones climáticas similares. En segundo lugar, la distribución de las características poblacionales de la comunidad levantina son similares a las de la población española y, por tanto, la generalización de los datos a la población general podía estar más ajustada.

La muestra española, fue extraída de una población de personas mayores de 60 años de la provincia de Alicante. El procedimiento de extracción fue polietápico, estratificado por conglomerados, con selección de unidades primarias de muestreo (municipios) y de las unidades secundarias (secciones) de forma aleatoria proporcional, y de las unidades últimas (individuos) por rutas aleatorias de sexo y edad.

Los estratos se formaron por el tamaño del hábitat dividido en 9 categorías: menos de 2.000 habitantes, de 2.000 a 5.000 habitantes, de 5.000 a 10.000 habitantes, de 10.000 a 20.000 habitantes, de 20.000 a 30.000 habitantes, de 30.000 a 50.000 habitantes, de 50.000 a 100.000 habitantes, de 100.000 a 200.000 habitantes y de 200.000 a 500.000 habitantes. La muestra final estuvo compuesta por 600 personas. Los datos fueron recogidos durante el mes de abril de 2010.

INSTRUMENTO DE EVALUACIÓN

Selección del instrumento de evaluación

Para evaluar la Calidad de Vida se propuso al consorcio utilizar el Cuestionario Breve de Calidad de Vida (CUBRECAVI) (Fernández-Ballesteros y Zamarrón, 1997, 2007). El grupo EVEN y, en concreto, las Profesoras Rocío Fernández-Ballesteros y M^a Dolores Zamarrón desarrollaron el Instrumento CUBRECAVI en 1996 y lo actualizaron en 2007. El concepto de Calidad de Vida que subyace a este instrumento es el que se defiende en esta tesis doctoral: Multidimensional, con indicadores objetivos y subjetivos. Es un instrumento muy utilizado en el contexto de las personas mayores tanto en España como en países Latinoamericanos y sus propiedades psicométricas se han replicado en diferentes muestras y países hispanohablantes (Fernández-Ballesteros y Zamarrón, 2007). Estas condiciones facilitaron el acuerdo del consorcio en seleccionar este instrumento de evaluación. La existencia de un estudio piloto de Calidad de Vida realizado por la Universidad de Guadalajara (Arias-Merino, 2008) alertó de que había algunas expresiones lingüísticas que en México no se entendían y en base a ello, se hicieron algunas adaptaciones lingüísticas con el objetivo de eliminar la terminología de los ítems conflictivos y encontrar términos entendibles por ambos países.

Descripción del instrumento

El cuestionario CUBRECAVI está formado por 21 elementos que, a su vez, se agrupan en 9 áreas (Salud, Integración social, Habilidades funcionales, Actividad y Ocio, Calidad ambiental, Satisfacción con la Vida, Servicios sociales y sanitarios, Nivel de Educación e Ingresos). Cada elemento está formado por una o varias preguntas. Además, se añade un área para indagar el propio concepto de Calidad de Vida del sujeto y una pregunta sobre la valoración subjetiva y global de Calidad de Vida (En el [Anexo 1](#) se puede encontrar el instrumento aplicado).

La Calidad de Vida que trata de evaluar el CUBRECAVI es multidimensional y, por tanto, no presenta una sola puntuación sino puntuaciones parciales por áreas. A continuación se describe brevemente cada escala.

- **Salud (subjetiva, objetiva y psíquica).** La salud subjetiva representa el nivel de satisfacción que el sujeto manifiesta con respecto a su estado de salud. La salud objetiva indaga acerca de la ocurrencia y frecuencia de una serie de síntomas físicos. Por último, la salud psíquica pregunta por la ocurrencia y frecuencia de alteraciones psicológicas como depresión, pérdida de memoria y desorientación.
- **Integración social.** Indaga sobre la frecuencia y satisfacción de las relaciones sociales tanto con las personas con las que convive como con las que no vive.
- **Habilidades funcionales.** Realiza una valoración general de cómo la persona puede valerse por sí misma y evalúa la dificultad que tiene para hacer algunas actividades de la vida diaria.
- **Actividad y Ocio.** Pregunta por la frecuencia e intensidad con la que la persona realiza actividad física. Además, indaga sobre la frecuencia con que se realizan una serie de actividades de ocio y productivas. Y, finalmente, se hace una pregunta sobre su satisfacción con la forma de ocupar el tiempo.
- **Calidad ambiental.** Se obtiene información sobre la satisfacción general que la persona tiene con su vivienda, en general, y por sus distintos elementos, en particular.
- **Satisfacción con la Vida.** Se compone de una sola pregunta sobre su nivel general de satisfacción con la vida.

- **Servicios sociales y sanitarios.** Examina la frecuencia con que las personas utilizan estos servicios así como la satisfacción que tienen con los mismos.

- **Nivel de Educación.** Se pregunta por el máximo nivel de estudios alcanzados.

- **Nivel de Ingresos.** Recaba información sobre los ingresos mensuales totales que se reciben en el hogar.

Para una descripción más exhaustiva de cada una de las áreas ver Fernández-Ballesteros y Zamarrón, 2007.

El CUBRECAVI, muestra una consistencia entre moderada y alta para todas sus escalas, excepto para “Integración social” que muestra una consistencia baja. El análisis factorial del instrumento encuentra una estructura factorial consistente con la teóricamente planteada y plasmada en él (Fernández-Ballesteros y Zamarrón, 2007).

Adaptación del instrumento

Como ya se ha explicado previamente, el instrumento no se aplicó en su versión original publicada, sino una versión adaptada que se presenta en el [Anexo 1](#) y que hemos denominado CUBRECAVI-R.

En esta versión revisada se realizaron dos tipos de modificaciones: adición de ítems por área y adaptaciones lingüísticas y culturales. Todos ellos están recogidos en el [Anexo 2](#).

Con respecto al primer tipo de cambios, adición de ítems, se variaron tres escalas (Salud, Integración Social y Actividad y Ocio). Por ejemplo, en la escala de salud objetiva, se añadió el síntoma “dolor de cabeza”, que no estaba en la versión publicada. En relación a las adaptaciones lingüísticas, se hicieron cambios en cinco escalas (Salud, Habilidades funcionales, Actividad y Ocio, Educación y Nivel educativo). Por ejemplo, se tuvo que añadir al síntoma “picores” la palabra “picazón”, para que el ítem fuera entendido en México. También, se modificaron algunos ejemplos que definían determinadas actividades o habilidades funcionales.

PROCEDIMIENTO

Entrenamiento de evaluadores

La recogida de los datos en México y en España se realizó mediante la contratación de dos empresas: Inmaye Marketing S.C. e INTERCAMPO, respectivamente. Tanto la Universidad de Guadalajara como la Universidad Autónoma de Madrid, coordinaron la capacitación y entrenamiento de los entrevistadores de sus respectivos países para asegurar la adecuada aplicación del instrumento.

En el caso de España, nos desplazamos a la oficina de Alicante de INTERCAMPO. El procedimiento seguido para el entrenamiento fue el siguiente. Primero, se leyó el cuestionario en voz alta para asegurarnos que se entendían todas las preguntas y que no había errores. También se contestaron las dudas que surgieron en algunos ítems. Después, se realizaron dos ensayos de entrevista con dos personas mayores de 60 años que fueron remuneradas por participar en tal fin. Éstas fueron entrevistadas por dos entrevistadoras cada una y sirvieron de modelo al resto de sus compañeras. Durante el ensayo, se especificaron algunos aspectos sobre cómo dar las alternativas de respuesta y cómo evitar condicionar la respuesta de los participantes. Aunque ocurre en sectores de población más joven, por nuestra experiencia y participación como entrevistadoras en estudios con personas mayores, sabemos que es más probable que algunas personas mayores y muy mayores, estén poco acostumbrados a este tipo de formato de entrevista cerrado y les resulte complicado dar una respuesta concreta; así pues, es más frecuente que el entrevistador caiga en el error de dar la puntuación que él/ella considera como conclusión de la respuesta cualitativa del entrevistado. En México, se realizó un entrenamiento homólogo.

Con esta formación, facilitamos una homogeneización en la recogida de datos en ambos países.

La aplicación del CUBRECAVI se realizó en forma de entrevista estructurada individual, en el domicilio del entrevistado. Cada entrevista tenía una duración aproximada de 40 minutos.

En este capítulo, se ha recogido el origen y la historia del proyecto CASOENAC, se han detallado los objetivos del sub-proyecto de "Calidad de Vida: Un Estudio Comparativo entre Colima, Jalisco (México) y Alicante (España)", y se ha descrito su desarrollo y metodología. A continuación, se presentan los resultados obtenidos de este estudio recogidos en dos artículos. El primero recoge los resultados descriptivos y comparativos de la Calidad de Vida en México y España. En el segundo, se presenta un modelo de Calidad de Vida a partir de los datos encontrados, que justifica la utilización de múltiples dimensiones de la vida con indicadores objetivos y subjetivos para evaluar adecuadamente este constructo.



Parte II

Cambio sociodemográfico y Envejecimiento Activo.

Contribución Científica para Políticas Públicas Previsoras (CASOENAC)

Capítulo 5
Proyecto CASOENAC

Capítulo 6
Quality of Life in Mexico and in Spain

Capítulo 7
Multidimensional - Multisystems - Multinature indicators of Quality of Life

QUALITY OF LIFE IN MEXICO AND IN SPAIN

The Global Dynamics of Aging. Nova Science Publisher, 2012, 3-23

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Abstract

The term Quality of Life (QoL) is a new scientific concept broadly-used in the field of public policy; therefore, it has become a key goal in social welfare for the elderly at Local, National, Regional, and International levels. In the field of social and health services, an elder's QoL is considered as an outcome of projects, programs, or policies, and it is also used for describing contexts, places and individuals. With the purpose of describing people, older than 60, living in Mexico (Colima State) in comparison to those living abroad, in Spain (Alicante Province), and, in order to make recommendations for enlarging and increasing the number of well-being among this population target in Colima, a cross-cultural study of QoL was performed. With this objective, the CUBRECAVI (Brief Questionnaire of Quality of Life for the Elderly, Fernández- Ballesteros and Zamarrón, 1996, 2007) -a multidimensional instrument widely used across Latin American countries and in Spain- was administered to two representative samples of individuals older than 60 in Mexico and in Spain. Also, in order to take into consideration the contextual (macro) level, QoL population indicators from Mexico and from Spain were examined. The results are presented and discussed taking into consideration both subjective and objective measures, as well as contextual and personal factors.

In conclusion, although both objective macro (population/contextual) and micro (personal) level factors and indicators of QoL are higher in Spain than in Mexico, subjective appraisal of the quality of life and life satisfaction are higher in Mexico than in Spain. Since, this research project might serves as a support for several political recommendations for improving life conditions among the elderly in Colima (Mexico), its results also underline the importance of taking into consideration a multidimensional concept of QoL including objective and subjective personal and contextual measures and indicators.

Introduction

Quality of Life (QoL) is a relatively new concept which emerged as a scientific label at the end of the sixties and its traces can be found throughout several scientific data bases. The importance, multicontextuality, and growth of QoL literature was assessed by looking at the number of citations in several data bases (Urban, Biosis, Medline PsycLit and Sociofile; see Fernández-Ballesteros 1998, 2011a). From these studies, it can be concluded that at the beginning of the seventies, there were no more than one hundred references to QoL, but forty years later, Sociofile (sociological scientific literature data base) increased the citations in this field from 11 to almost 300; PsycInfo (the well-known source of psychological publications) runs from 8 to close to 600, and finally, publication sources in the field of medicine and health such as Pubmed, increased citations of QoL and aging from 100 to more than 5000 (Fernández-Ballesteros, 1998, 2011a.). It can be concluded that, in the field of aging,

QoL is a keyword used as a scientific concept and which spreads out in biomedical and health, socio-political and psychosocial disciplines.

As pointed out elsewhere (Fernández-Ballesteros, 2011a), from a semantic point of view, "quality" corresponds to "fineness or grade of excellence," as specified in the entry in Webster's (Webster's Dictionary, 1986); "life" is a broad category that includes all living beings (as distinct from inorganic objects), but more specifically, QoL refers to human life. Therefore, briefly, QoL is concerned with the positive characteristics of human life.

After reviewing a variety of models of QoL, Brown, Bowling and Flynn (2004) distinguished several types of QoL components: objective social indicators (e.g.: income, living conditions, etc.); subjective measures (e.g. satisfaction, happiness, etc.); social indexes (e.g.: crime

rates, living conditions, etc.); satisfaction of human need measures (e.g.: self-esteem, self-actualization, etc.); psychological and personality characteristics (subjective well-being, life satisfaction, happiness, sense of coherence); health and functioning (e.g.: generic health measures, specific health problems); social health, social networks and support (e.g.: social interaction frequency, social satisfaction); social cohesion and social capital (e.g.: access to leisure, transports facilities, etc.), and environmental contexts ecologically (e.g.: physical and/or neighborhood resources, etc.).

Although this heterogeneous set of factors are expressing a multidimensional conceptualization of a diverse nature (objective and subjective), and present at different levels (contextual vs. individual), other authors have defined QoL equivalent to well-being (Campbell, 1981), or to happiness (Veenhoven, 1999) in the social domain, to health status in the bio-medical field (which uses the Health-related QoL concept – for example, Naughton and Wiklund, 1993), and to life satisfaction in the psychology domain (Palys and Little, 1983). Even, there are authors, such as WHO quality of life group (1993, 1995), which had considered QoL as a multidimensional construct (with a diversity of components such as health, social relationships, environment, finances), but reduced its measure to the subjective appraisal of those different components, therefore, transforming QoL into a subjective concept.

Many authors agree that QoL is in a pre-scientific state, considering it as an “abstract”, “soft”, “amorphous” concept (Birren and Dieckmann, 1991 pp. 344-345), as one that “has no fixed boundaries” (Hughes, 1990, p 47), that “has been exceedingly difficult to define (it) precisely” (Andersen, Davidson and Ganz, 1994, p.367) or that is “difficult to operationalize” (Lawton, 1991), and even as one whose “meaning is dependent of the user of the term” (Fowlie and Berkeley, 1987; p.226), or it is “in the eye of the beholder” (Ziller, 1974). Walker (2005) summarizes these opinions stating that “QoL is a rather amorphous, multilayered and complex concept with a range of components –objective, subjective, macrosocietal, micro-individual, positive and negative– which interact together” (p. 3).

In fact, as Fernandez-Ballesteros (2011a) emphasized, there is much more consensus in what QoL is not as Birren and Dieckmann (1991) stated: QoL is not equivalent to quality of the environment, to quantity of material goods, to physical health status or to quality of health care, just as it is distinct from subjective constructs such as life satisfaction, morale or happiness (Campbell, 1981; Georg and Bearon, 1980; Naughton and Wiklund, 1993). As also Browne,

et al. (1994) pointed out: “Quality of Life (QoL) is (the product) of the dynamic interaction between external conditions of an individual's life and the internal perceptions of those conditions” (p.235). Thus, the concept cannot be reduced to life's external conditions or to personal or individual characteristics, or even to one's perception of external conditions; nor, indeed, to any objective or subjective component of external or personal conditions. We totally agree with with Diener and Suh (1997) who emphasized that “...quality of life is a complex, multifaceted construct that requires multiple approaches from different theoretical angles. We encourage scientists from the various disciplines of social science to exploit the strengths of other's contributions in a collaborative effort. Instead of turf battles over who has the best indicator, each discipline needs to borrow insights about quality of life from the other fields” (p. 214).

In sum, taking an integrative approach, taking into consideration the diversity of factors involved in human life, we agree that QoL is a multidimensional concept integrating both objective and subjective conditions and which can be considered at different multilevels, from populations to individuals.

On the basis of several theoretical and empirical works, Fernández-Ballesteros and her associates (1993, 1996, 1998, for a review see Fernández-Ballesteros, 2011a) arrived at a simple and parsimonious classification system of the most general (commonly accepted), multidimensional components of QoL in old age, classifying them into two broad multi-level multi-dimension axes: population (or contextual) versus individual (or personal) units of analysis, and objective versus subjective nature of those multi-dimensional components analyzed (see Fernández-Ballesteros, 1993, 2011a, b).

Figure 1 shows some examples of the commonest multidimensional ingredients of QoL in old age, indicating the unit level, that is, whether they refer to population/contextual (aggregate indicators) or to the individuals, and whether the conditions examined are objective or subjective in its nature (see: Fernández-Ballesteros, 2011a).

Box 1 includes all population/contextual and objective aspects of the quality of life, such as environmental and physical factors (latitude, climate, residential facilities, etc.), economic factors (rent per capita, pension systems, micro-credit facilities, etc.), social factors (adult education, social networks, social services availability, etc.) and health factors (life expectancy, disability free life expectancy, health services, etc.).

Box 2 lists conditions attributed to a given society as reported perceptions of a group of individuals, social stereotypes about ageing or collective self-efficacy, aggregate well-being or subjective health which could be considered as QoL-related conditions.

Box 3 contains all personal or individual conditions cited by experts as ingredients of QoL that can be considered objective, such as demographic factors (age, gender, marital status), economic factors (income, economic resources), social factors (family or social support), functional abilities (Activities of Daily Living, ADL, or Instrumental Activities of Daily Living, IADL), health conditions (medical records, prescriptions, days in hospital, etc.) or physical fitness (balance, strength, BMI, etc.).

Finally, Box 4 deals with subjective conditions cited as QoL factors, such as life satisfaction, well-being or perception of control, together with any other subjective appraisal of external or personal factors, such as how the individual perceives both contextual and individual aspects of the quality of life (e.g., satisfaction with health services or satisfaction with personal health conditions).

Let us give some examples of measures of QoL. Following our argument, from the population perspective, QoL would refer globally to a given universe, covering a territory and/or society or a given context. A good

example of multidimensional population measurement is The Economist QoL Index (The Economist, 2005). This index was developed in an effort to remedy the shortcomings of Life Satisfaction Survey measures, which, it was argued, reduced QoL to happiness, life satisfaction or other subjective conditions (that is, a portion of subjective life). A set of QoL multidimensional domains and indicators were selected: material well-being (GDP per capita); health (Life Expectancy at birth), political stability and security (The Economist measure), family life (divorce rates), community life (church or union participation) climate and geography (latitude), job security (unemployment rate), political freedom (average index of civil and political liberties), and gender equality (average ratio of men/women salaries). All these domains and indicators can be placed in Box 1 and 2.

From an individual perspective, many instruments have been developed (for a review see Fernández-Ballesteros, Maciá and Zamarrón 1996). Among them all, the WHOQOL (1993, 1995) has been the one with the most extended use in Latin America. Although it has six multidimensional domains (physical health, psychological, independence, social relationships, environment and spirituality) all those domains are assessed through the person's appraisal; therefore it is measuring the subjective appraisal covering only subjective aspects of QoL (that is reducing QoL to components in Box 4).

FIGURE 1 CLASSIFICATION SYSTEM FOR MOST COMMON FACTORS OF QOL IN OLD AGE (FROM FERNÁNDEZ-BALLESTEROS, 1993)

Nature	Unit	Population / Context	Individual
Objective		<ul style="list-style-type: none"> - Demographics (aging rates, density...) - Physical factors (latitude, residential facilities, protective assistance...) - Economic factors (pension system...) - Social factors (social networks, social services availability...). - Equality legislation. - Health factors (life expectancy, health security system...). - Disability/ability prevalence in old age. 	<ul style="list-style-type: none"> - Demographic characteristics (age, sex, education, SES...) - Physical conditions (home, residence, neighborhood...) - Economic factors (income...) - Social factors (family support, social network...) - Functional abilities and activity (ADL...) - Health conditions (medical records, prescriptions, days spent in hospital...) - Physical fitness (balance, strength, BMI)
Subjective		<ul style="list-style-type: none"> - Any collective or social perception such as stereotypes about aging, social values (individualism versus collectivism), aggregate well-being, subjective health. 	<ul style="list-style-type: none"> - Subjective conditions such as well-being, life-satisfaction, control perception, etc. - Any personal appraisal about his/her conditions in box 2. or about external conditions in box 1

The CUBRECAVI ("Short Quality of Life Questionnaire," Fernández-Ballesteros and Zamarrón, 1996, 2007), which is also widely used in several Latin American countries is based on a multidimensional concept of QoL containing both subjective and objective components. It includes nine domains assessed through objective and subjective questions: Physical and mental health (objective and subjective health); Social integration (social network size and social satisfaction); Functional abilities; Activity and leisure; Life satisfaction; Social and health services (availability and satisfaction); Environmental quality (subjective appraisal of physical characteristics); Education; and Income.

The CUBRECAVI shows a high internal consistency and an internal validity of its domains, and a high sensitivity to intervention. Furthermore, its raw scores can be converted into norms (available by age group and by living conditions).

Finally, the CUBRECAVI allows the weighing of individual preferences and also asks about the individual's overall appraisal of his/her quality of life. In sum, all domains can be placed in Boxes 3 and 4.

Summarizing, there is a consensus that QoL in old age can refer to different "units" (from contexts or populations to individuals) and embracing health, functional status and activity levels, social, economic, and environmental components assessed, most of them, objectively and subjectively, as well as subjective conditions such as perceptions, evaluations, and satisfaction, at context and individual levels which can be classified into the 4 different quadrants on the proposed classification system in order to assess the Quality of Life in Mexico and Spain within the CASOENAC Project complementing the CUBRECAVI, as an individual set of measures, with other indicators of QoL of both contexts.

CASOENAC project

CASOENAC (Socio-demographic Change and Active Aging: Scientific Contribution to Public Policies) emerged as a European Union-Mexican States Agreement of collaboration under a Consortium of the Health Department of the State of Colima, the University of Colima, and the University of Guadalajara (Mexico), the Autonomous University of Madrid and the Academia de Yuste (Spain), and the University of Heidelberg (Germany).

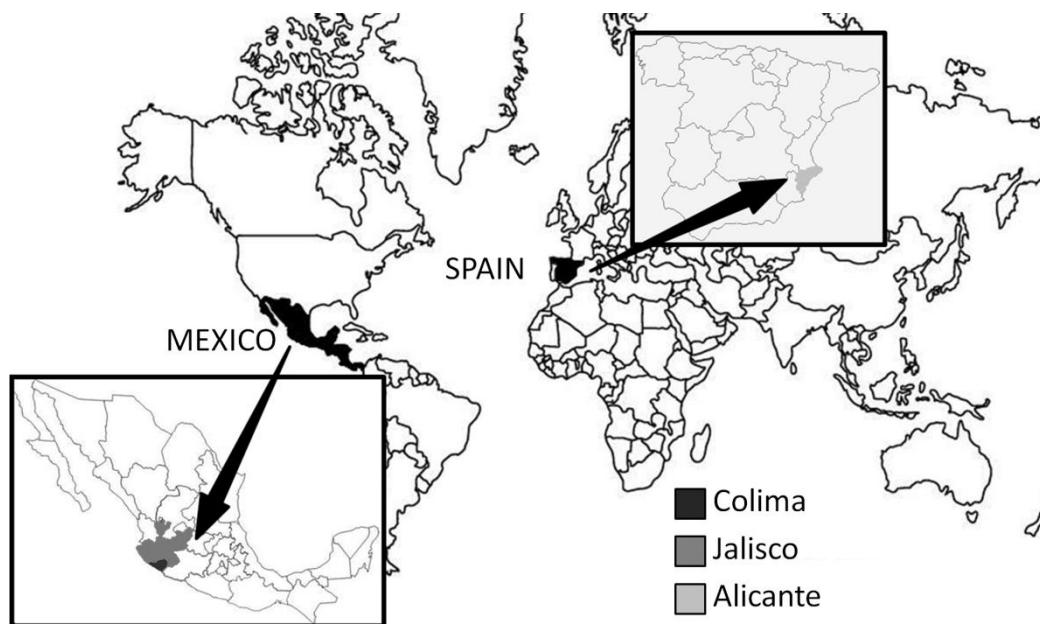
The general objective of this Project was: "to develop gerontological knowledge in order to provide high quality bio-psycho-social services to the Colima State elderly people". The Subproject on Quality of Life was developed by the University of Guadalajara and the under the following specific objective: "to assess the Quality of Life of the elderly making Regional and European comparisons". This article reports the results obtained trying to measure population and individual QoL.

Method

THE CONTEXT

In order to compare people from two different countries, before examining the individual's QoL, it is important first to examine indicators at population levels. Geographically, the two contexts (region and province respectively) assessed in this study are shown in Figure 2. The main target population in this study was Colima State, therefore, the Spanish sample was selected in Alicante, a province with some similarities to Colima, taking into account some geographical characteristics of both territories: both are located under the ocean,

FIGURE1 GEOGRAPHICAL LOCATION FROM WHERE THE SAMPLE HAS BEEN COLLECTED



they have broad touristic resources, they have comparable comparisons with their respective countries.

Since it is highly difficult to have disaggregated data for Colima and Alicante, we are going to examine the Mexico and Spain population QoL indicators through several sources of data. First of all, taking the Economist QoL Index data for 100 Countries around the world, using a 10 point Scale, Mexico scored 6.766 being in the 32nd place, and Spain scored 7.727 being in the 10th position. Secondly, we have also collected some population statistics from three different data bases: The World Health Report (WHO, 2000), United Nations Development Programme (2000), Word Values Survey (2005, 2007).

In [table 1](#), not only objective aspects are shown (i.e. GDP, Life expectancy, Adult literacy rates) but also subjective ones (i.e. Life satisfaction, subjective health, happiness).

[Table 1](#) shows that even though all objective measures are better in Spain than in México (i.e. the Disability Free Life Expectancy is longer in Spain than in Mexico), Mexican people report better scores in the subjective appraisal of QoL (i.e. Mexicans report more happiness than Spanish people).

Finally, it would be important to deduce whether age is influencing those subjective aspects of QoL in each country. So, data collected from the Word Values Survey show to what extent as age increases, “happiness” and “subjective health” decrease, but this happens significantly in both Mexico and Spain ([Table 2](#)).

According to the data collected from this study (Word Values Survey, 2005, 2007) and taking into account only people who were over 65, we found that although differences between Spain and Mexico in “subjective health” were not significant, the Mexicans reported significantly better “Happiness” than Spaniards ([Table 3](#)), as we have pointed out before taking into consideration the general population.

The data reported illustrates once again the importance of considering objective aspects of QoL and not only subjective conditions. In this Project, if we had considered only subjective characteristics we would not have developed any proposal to improve QoL of older Mexican’s from Colima.

TABLA 1 POPULATION DATA OF SUBJECTIVE AND OBJETIVE FACTORS OF QOL

Variable / Country	México	España
OBJETIVE FACTORS of QoL		
GPD per capita	7.704	16.212
Life expectancy at birth	72,3	78,1
Males, Life expectancy at birth	71,0	75,3
Females, Life expectancy at birth	77,1	82,1
DFLE Total at birth	65,0	72,8
Males, DFLE at birth	64,4	69,8
Males , DFLE at 60	14,7	16,8
Females, DFLE at birth	67,6	75,7
Females, DFLE at 60	16,8	20,1
Males, Expectation of disability at birth (years)	8,6	5,5
Females, Expectation of disability at birth (years)	9,6	6,4
Males, % years with disability	9,6	7,3
Females, % years with disability	12,4	7,7
Adults literacy rate	90,8	97,4
SUBJETIVE FACTORS of QoL		
Life Satisfaction	7,41	7,13
Positive affect	2,68	1,59
Negative affect	1,30	0,89
Affect balance (Positive-Negative)	1,38	0,70
Subjective health	2,36	2,35
Happiness	3,49	3,05
Disability Free Life Expectancy (DFLE)		

⋮ The World Health Report (WHO, 2000), United Nations Development Programme (2000) and Word Values Survey (2005, 2007).

TABLE 2 ANOVA TO GAUGE THE DIFFERENCES BETWEEN AGE GROUPS IN TWO VARIABLES: "SUBJECTIVE HEALTH" AND "HAPPINESS".

Country			M	SD	F	Sig. (2-tailed)
MEXICO	Subjective health*	15-24	3,08	,696	23,516	,000
		25-34	2,96	,748		
		35-44	2,81	,790		
		45-54	2,81	,808		
		45-54	2,51	,845		
		65+	2,36	,855		
	Happiness*	15-24	3,54	,625	7,937	,000
		25-34	3,59	,595		
		35-44	3,51	,644		
		45-54	3,49	,694		
		45-54	3,30	,799		
		65+	3,29	,731		
SPAIN	Subjective health*	15-24	3,39	,571	77,647	,000
		25-34	3,25	,604		
		35-44	3,14	,559		
		45-54	2,98	,567		
		45-54	2,81	,607		
		65+	2,35	,736		
	Happiness*	15-24	3,18	,547	10,141	,000
		25-34	3,16	,493		
		35-44	3,08	,380		
		45-54	3,04	,426		
		45-54	2,99	,526		
		65+	2,90	,510		

TABLE 3 INDEPENDENT-SAMPLE T TO GAUGE THE DIFFERENCES BETWEEN MEXICO AND SPAIN IN TWO VARIABLES: "SUBJECTIVE HEALTH" AND "HAPPINESS"

People 65+	Country	N	Mean	Std. Deviation	t	Sig. (2-tailed)
Subjective health	Mexico	129	2,36	,855	,133	,894
	Spain	249	2,35	,736		
Happiness	Mexico	131	3,25	,778	4,761	,000*
	Spain	250	2,89	,523		

THE PARTICIPANTS

The sample was recruited from people aged over 60 who live in the Alicante region (Spain), Jalisco¹ and Colima States (Mexico). The sample has been collected by the random routes sampling method.

The total sample consisted of 1817 participants 60 years of age and older (Mexico n = 1199, Spain n = 618). The mean age is 70.19 years (SD = 7.97) in Mexico and is 71.81 years (SD = 9.97) in Spain (p <.001). In both countries, the proportion of women was higher than men (54.6% and 53.1%). Regarding marital status, in Mexico there were 49.2% married and 34.4% widowed, while in Spain most of the participants were married 65.5% and 27.8% were widowed (Table 4).

The number of people living at home was also significantly higher in Mexico (Mean=3.4; SD = 2.3) than in Spain (Mean= 2.19; SD = 0.99). The current employment situation was also different in both countries. In Spain, most were pensioned or retired (65.4%), in Mexico they were only 26.3%, while 23.6% were currently working and 15.1% were unemployed, compared with 4.5% and 2.8 % respectively in Spain. The majority of the elderly in Spain had worked as employees (80.7%), compared with 44.8% of Mexicans, as 27.9% were self-employed.

TABLE 4 SOCIO-DEMOGRAPHIC DATA OF THE PARTICIPANTS

Variable	Mexico (n= 1199)	Spain (n= 618)	p-value
Age, years (Mean ± SD)	70.19 ± 7.90	71.81 ± 7.97	
60 – 64	29.4 (352)	22.3 (138)	
65 – 69	22.4 (269)	22.8 (141)	.000 ^a
70 – 74	21.0 (252)	22.0 (136)	.016 ^b
75 – 79	11.8 (142)	13.9 (86)	
80 +	15.3 (184)	18.9 (117)	
Gender, % (n)			
Women	54.6 (655)	53.2 (329)	.572 ^b
Men	45.4 (544)	46.8 (289)	
Marital status, % (n)			
Single	6.6 (79)	4.4 (27)	
Married	49.2 (590)	65.5 (405)	.000 ^b
Widow/er	34.4 (413)	27.8 (172)	
Divorced	4.0 (48)	1.3 (8)	
Separated	5.8 (69)	1.0 (6)	
Number of people who live with (Mean ± SD)	3.40 ± 2.34	2.19 ± 0.99	.000 ^a
Employment situation			
Currently working	23.6 (283)	4.5 (28)	
Retired / Pensioner / Disabled	26.3 (315)	65.4 (404)	.000 ^b
Unemployed	15.1 (181)	2.8 (17)	
Housewife	35.0 (420)	27.3 (169)	
Way of working (present or past)			
Self-employee	27.9 (335)	19.3 (119)	
Employee	44.8 (537)	80.7 (498)	.000 ^b
Not applicable	27.3 (327)	0.0	

^a = t test for independent samples, ^b = Chi-square test.

¹ Since CASOENAC had the objective not only to make comparisons between Colima and Spain, but among Colima and another Mexican State, Jalisco, two representative samples from Colima and Jalisco States were recruited. Since minor differences between Colima and Jalisco were found, here we are only referring to differences between Mexico (both States) and Spain.

INSTRUMENT AND PROCEDURES

CUBRECAVI ("Short Quality of Life Questionnaire," Fernández-Ballesteros and Zamarrón, 1996, 2007) was the instrument selected to assess QoL in this study. It includes nine domains assessed through objective and subjective questions. The first domain is "Physical and mental health". It assesses subjective health by asking: "In general, how do you rate your health state?" and objective aspects by asking about the frequency of 22 different pains and physical symptoms (i.e. headache, pain in legs, urinary incontinence, etc.) and mental symptoms (i.e. memory problems, being lost, etc.).

The second domain is "Social integration". It is assessed objectively by asking the frequency about family members and friends contact (i.e. children, grandchildren, neighbors ...) and subjectively by asking to what extent the individual is satisfied with each relationship he/she has. "Functional abilities" is the third domain asking about various difficulties in performing daily life activities. The fourth domain, "Activity and leisure" includes objective data asking about the frequency of doing physical activity or sport, as well as to what extent leisure activities are performed (i.e. going to the cinema, doing errands, taking care of their grandchildren...). Also, subjective data is collected by asking for the individual's satisfaction in spending his/her time. "Life satisfaction" is assessed through a subjective scale asking about the general appraisal of life.

The sixth domain is "Social and health services" consisting of two items, one related to the frequency of attending these services (objective) and the other one related to the satisfaction with them (subjective). "Environmental quality" assesses the frequency of some environmental elements (i.e. noise, amenities, luminosity...) and the general satisfaction with them. "Education" and "Income" are both objective scales, by asking for the number of years they received a formal education and the total monthly income received in home. Finally, the CUBRECAVI includes a question asking about his/her appraisal about his/her QoL.

An adaptation of the instrument has been done, adding some little changes adapting some idioms for the application in the Mexican sample. From the data of this sample, psychometric analysis (internal consistency and construct validity of its domains) was performed following the analysis done by Fernández-Ballesteros and Zamarrón (1996, 2007 and See: Fernández-Ballesteros, Arias-Merino, Santacreu and Mendoza-Ruvalcaba, 2011).

Reliability analysis has been assessed by internal consistency; Cronbach's alpha levels run from medium ("Physical and mental health" scale's $\alpha=.67$) to high ("Functional abilities" scale's $\alpha=.84$), only one scale ("Social integration") yielded a low alpha coefficient ($\alpha=.45$). These results are similar to that found by the original CUBRECAVI ("Social integration" scale's $\alpha=.31$, "Physical and mental health" scale's $\alpha=.70$ and "Functional abilities" scale's $\alpha=.92$). Construct validity was tested by an Exploratory Factor analysis (using principal component and Varimax rotation). The variance explained by the seven factors yielded was 62.16% and 65.44% by Mexico and Spain respectively.

The factors obtained were congruent with the theoretical ones raised in both samples. The variance explained is lower than the one explained in the original CUBRECAVI (78.2%), but the factor structure is similar to the one found by Fernández-Ballesteros and Zamarrón (1996, 2007).

Last, but not least, factor convergence analysis showed that the seven factors found in each country were convergent between them (all values equal to or greater than 0.9), which means that QoL structure is closely similar in Spain and Mexico. Nevertheless, in spite of this factorial congruence among countries, there are two indicators that are loading differently in Spain and in Mexico. Thus, Life satisfaction and Subjective appraisal of quality of life are loading in the same factor in the Mexico sample, but in the Spanish sample, Life satisfaction is loading in the Health factor and Appraisal of the quality of life is loading in Education and Income.

Finally, the CUBRECAVI was administered following the Manual by trained interviewers individually in the subject's home.

Results

HEALTH

A comparison among subjective, objective and mental health between Mexico and Spain is shown in Table 5 and graphically in Figure 3. Regarding subjective health, no statistically significant differences between the two countries were found; satisfaction with their current health is between a little and fairly good.

Regarding objective health, no significant differences were also not found. Participants from both countries reported similar presence of symptoms and pain (between sometimes and never). It was found that, on average, they were suffering from 5 symptoms or pain. In Mexico, the most reported symptoms were: stan-

ding to urinate and / or night urination (61.8%), bone, spine or joints pain (59.3%), weakness of legs (48%), fatigue for no apparent reason (48%) and headache (50.5%). In Spain, the most common were: bone pain, spine or joints (77.2%), standing to urinate and / or night urination (61.8%), weakness of legs (55.2%), gasses (55.2%) and sleep disorders (50.3%).

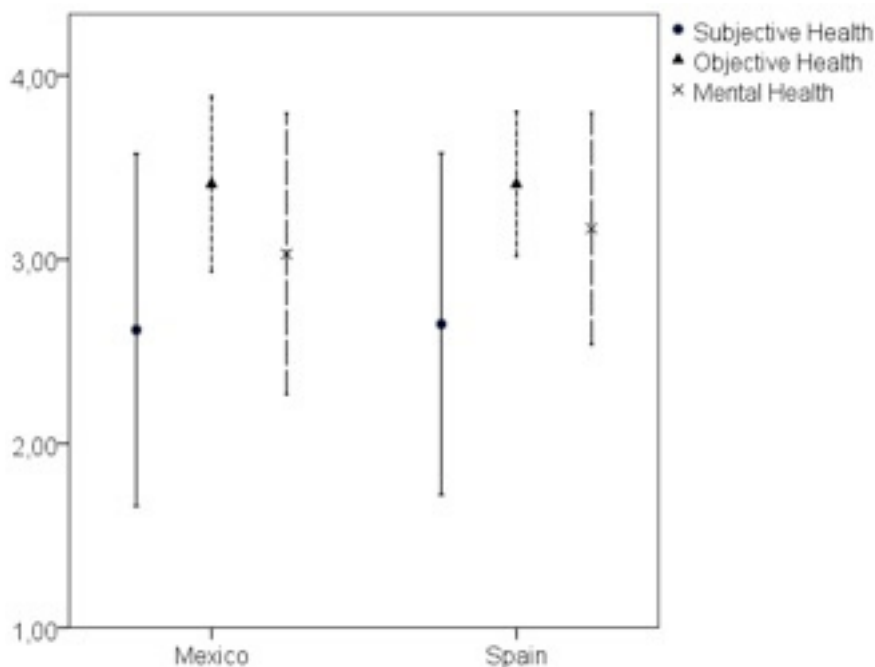
Regarding mental health, significant differences were found between the two countries ($p \leq .000$, $t = -4129$, $df = 1479$). The Spanish elderly reported better mental health than the Mexicans.

TABLE 5 HEALTH COMPARISON BETWEEN MEXICO AND SPAIN

Variable	Mexico, (n= 1199) Mean ± SD	Spain, (n= 618) Mean ± SD	p-value ^a
Subjective health*	2.61 ± 0.95	2.64 ± 0.92	.496
Objective health**	3.40 ± 0.47	3.40 ± 0.39	.986
Mental health**	3.02 ± 0.76	3.16 ± 0.63	.000

^a: t test for independent samples, SD= Standard deviation; *Score from "nothing"=1 to "very much"=4; **Score from "often"=1 to "never"=4.

FIGURE 3 HEALTH COMPARISON BETWEEN MEXICO AND SPAIN.



FUNCTIONAL ABILITIES

Concerning functional abilities, the Spanish elderly reported significantly less difficulty in performing daily living activities than the Mexican elderly do ($p \leq .000$, $t = -6084$, $df = 1408$; see Table 6). Specifically, the Mexican elderly had greater difficulties when taking care of their physical appearance, household activities, walking, and in performing outdoor tasks. Self-perception of functionality was also different between the

two countries (Table 7), being more positive in Spain, where 83.1% and 43.9% of the participants considered that they were able to perform daily life activities very good (39.3%) and good (43.9%) in comparison with 73.3% compared of Mexican participants (very good 38% and good 35.3%). Also, Mexicans significantly reported more difficulties when performing ADL in comparisons with Spaniards.

TABLE 6 FUNCTIONAL ABILITIES

Variable	Mexico, (n= 1199) Mean ± SD	Spain, (n= 618) Mean ± SD	p-value ^a
Activities of daily living*	3.41 ± 0.78	3.63 ± 0.67	.000
Taking care of their physical appearance*	3.63 ± 0.80	3.79 ± 0.57	.000
Doing household activities*	3.48 ± 0.86	3.58 ± 0.78	.014
Walking*	3.28 ± 0.98	3.61 ± 0.80	.000
Performing outdoor tasks*	3.38 ± 0.95	3.63 ± 0.78	.000

^a= t test for independent samples, SD= Standard deviation; *Score from "not at all difficult"=4 to "very difficult"=1.

TABLE 7 CONSIDERS THAT HE/SHE CAN MANAGE FOR THEMSELVES IN PERCENTAGE

Variable	Mexico, (n= 1199) Mean ± SD	Spain, (n= 618) Mean ± SD	p-value ^a
Very well	38.0 (455)	39.3 (243)	.000
Well	35.3 (423)	43.9 (271)	
Some	23.3 (279)	13.1 (81)	
Bad	3.4 (41)	3.7 (23)	

^a= Chi-square test.

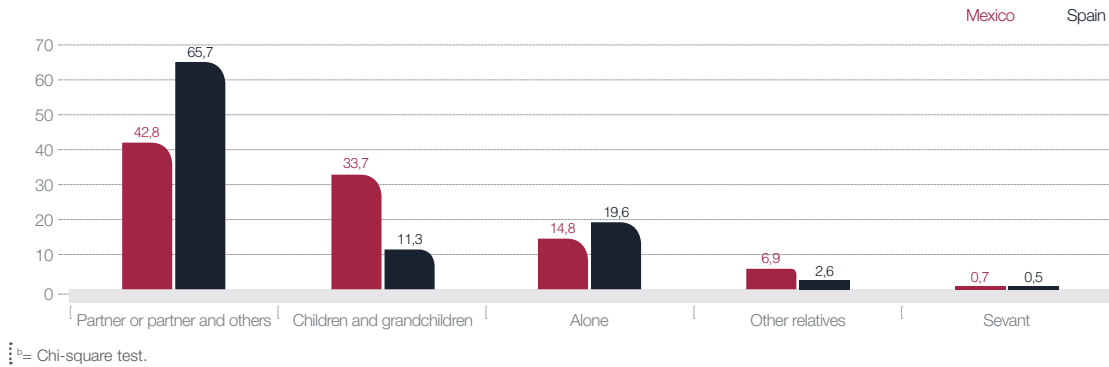
SOCIAL INTEGRATION

Family networks were different between both of the countries ($p \leq .000$), as shown in Figure 4. In Spain, most of the participants reported living with his/her partner (65.7%), while in Mexico there were only 42.8%, but 33.7% lived with their children and/or grandchildren, compared with only 11.3% of the Spanish. It was also found that a higher proportion of the elderly lived alone in Spain (19.6%) than in Mexico (14.8%). In both countries, most of the participants said they were satisfied with the relationship they had with the people they lived with (90.8% Mexico, Spain 98.8%, $p = .000$).

Regarding the frequency of family relationships not living in the home, or how often they met other people not living with them, the Spanish elderly interact more frequently with their children ($p \leq .000$, $t = -10,562$,

$df = 1461$), grandchildren ($p \leq .000$, $t = -8801$, $df = 1317$), neighbors ($p \leq .000$, $t = -10,074$, $df = 1466$) and friends ($p \leq .000$, $t = -7551$, $df = 1403$) compared to the Mexican elderly. No differences were found regarding the frequency of relationship with other family members. In addition, when they were asked about satisfaction regarding these relationships, the Spanish elders expressed greater satisfaction than the Mexicans in their relationship with their spouse ($p = .000$, $t = -5937$, $df = 948$), children ($p = .000$, $t = -5397$, $df = 1637$), grandchildren ($p \leq .000$, $t = -5333$, $df = 1558$), other family members ($p = .000$, $t = -8447$, $df = 1692$), neighbors ($p \leq .000$, $t = 10976$, $df = 1560$) and friends ($p = .000$, $t = -11.495$, $df = 1390$).

FIGURE 4 FORMS OF COHABITATION (WITH WHOM IS LIVING WITH).

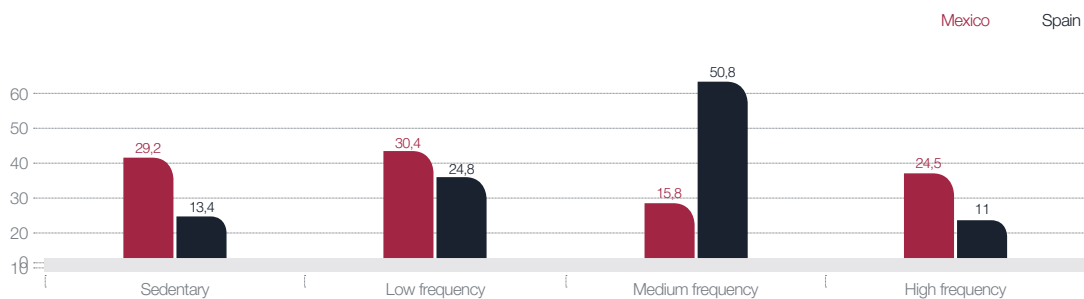


ACTIVITY AND LEISURE

As shown in Figure 5, the physical activity performed by the participants of both countries was significantly different ($p=.000$). It was found that Mexicans, in comparison with the Spanish, were significantly more sedentary (29.2% vs. 13.4%) when performing exercises of low intensity and less frequency (30.4% vs. 24.8%). However, a significant number of Spaniards performed physical exercises of high frequency and intensity (24.5% vs. 11%). It should be highlighted that most of the Spanish elderly (50.8%) reported to perform a medium physical exercise frequency and intensity compared to 15.8% of the Mexican elderly.

Additionally, the Spanish participants reported doing more frequently leisure activities ($p\leq.000$, $t=-3851$, $df=1815$) and productive activities ($p\leq.000$, $t=-8479$, $df=1428$) compared to the Mexicans. In both countries, the leisure activities that were reported as being more frequently performed were: watching TV (67.8% vs. 93.5%), listening to the radio (45.1% vs. 48.4%) and reading books, newspapers or magazines (38.5% vs. 38.3%). Likewise, the productive activities that were performed more often were: shopping (Mexico 43.4% Spain 74.8%) and management or payments (40.5% vs. 64.2%). No significant differences were found regarding satisfaction; that is, participants expressed the same satisfaction with the way they spend their time ($p = .798$, $p = .257$, $df = 1815$), 77.3% were very satisfied in Mexico and 83.5% in Spain.

FIGURE 5 PHYSICAL ACTIVITY PERFORMED DURING THE LAST YEAR.



ENVIRONMENTAL QUALITY

Regarding satisfaction with housing, participants from both countries reported being satisfied to the same extent ($p=.101$, $t=-1642$, $df=1291$), proportionally, 83.2% of Mexicans and 96.6% of Spanish expressed satisfaction with their home ($p\leq.000$). Specifically, the Spaniards reported a greater satisfaction than Mexicans regarding: noise/silence ($p\leq.000$, $t = -10541$, $df=1771$), temperature ($p\leq.000$, $t=- 20386$, $df=1612$), lighting ($p\leq.000$, $t=-12000$, $df=1727$), housekeeping ($p\leq.000$, $t=-11445$, $df=1622$), furniture ($p\leq.000$, $t=- 9918$, $df=1814$) and comfort ($p\leq.000$, $t=-10047$, $df=1792$) in their home.

LIFE SATISFACTION

Mexican participants reported greater life satisfaction than Spaniards ($p=.004$, $t=2854$, $df=1408$). Specifically, 35.4% of the Mexicans experienced high satisfaction compared with 21% of the Spaniards. Most of the latter (60%) reported fair satisfaction, in contrast to 40.8% of Mexicans. Some satisfaction was reported by 21.7% of the Mexican elderly and 16% of the Spanish, while 2.1% and 2.9% (respectively) reported no satisfaction with life.

EDUCATION

Educational levels were lower in participants from Mexico than from Spain, the former had an average of 5.06 (SD = 4.73) years of education compared with 5.96 (SD = 4.37) of the latter ($p\leq.000$, $t=-3884$, $df=1800$). Specifically, it was found that 17.7% of Mexican elderly were illiterate compared with only 5.3% of the Spanish, 37.9% vs. 44.5% were literate, and 18.1% vs. 33% had completed primary education ($p \leq .000$).

INCOME

In this scale, it must be pointed out that 209 Mexicans and 81 Spaniards did not answer this question. In Spain, people reported significantly more income than in Mexico. In a 9 point answer scale (from 0 to 8), Mexico's average income is 2.23 (SD = 2.39) while the Spanish one is 3.30 (SD = 1.42).

Table 8 shows that more than 50% of a Mexican's income is concentrated in the first three points of the scale, while a Spaniard's income is concentrated between points 3 and 5.

TABLE 8 INCOME

Variable	Mexico, (n= 1199) Mean ± SD	Spain, (n= 618) Mean ± SD	p-value ^a
Less than \$1,500	23.4	Less than 300 €	0.6
From \$1,5001 to \$2,500	19.5	From 301 to 450 €	5.0
From \$2,501 to \$3,500	12.1	From 451 to 600 €	19.7
From \$3,501 to \$4,500	8.8	From 601 to 900 €	29.3
From\$4,501 to \$5,500	4.5	From 901 to 1200 €	17.0
From \$5,501 to \$6,500	3.3	From 1201 to 1600 €	8.4
From \$6,501 to \$7,500	3.4	From1601 to 2100 €	4.2
From \$7,501 to \$8,500	1.8	From 2101 to 2700 €	1.8
More than \$8,501	5.8	More than 2700 €	0.8
Did not know/ did not answer	17.4	Did not know/ did not answer	13.1
Total	100	Total	100

TABLE 9 USE AND SATISFACTION ON SOCIAL AND HEALTH SERVICES

Variable	Mexico, (n= 1199) Mean ± SD	Spain, (n= 618) Mean ± SD	p-value ^a
Frequency of use:			
Frequently	34.0 (407)	50.3 (311)	.000
Occasionally	46.3 (555)	47.9 (296)	
Never	19.7 (236)	1.8 (11)	
Level of satisfaction:			
Very satisfied	31.9 (342)	36.0 (221)	.000
Fairly	28.5 (306)	52.3 (321)	
Few	23.6 (253)	9.3 (57)	
Nothing	16.0 (171)	2.4 (15)	

^a= Chi-square test.

HEALTH AND SOCIAL SERVICES

The Spanish elderly reported a significantly higher use of health and social services - 50.3% reported to use them frequently compared with 34% of Mexicans. In contrast, only 1.8% of Spanish and 19.7% of Mexicans reported not to use them.

The satisfaction with services was higher with the Spanish elderly, 36% and 52.3% who said they were very and fairly satisfied, compared with 31.9% and 28.5% of Mexican elderly, respectively. A greater proportion of Mexican elderly (16%) than Spanish (2.4%) reported being dissatisfied.

APPRAISAL OF QUALITY OF LIFE

Finally, it was found that the Mexican elderly value their own quality of life significantly higher than the Spanish ($p \leq .000$, $t = 4775$, $df = 1550$). Mexican participants assessed themselves as high 10.9%, medium 63.7% and low 25.4%, compared with 8.9%, 79.6% and 11.5% (respectively) of the Spanish.

Discussion

First of all, it must be emphasized that, after a theoretical review, we have taken an integrative approach to QoL, trying to embrace a broad, multidimensional and multilevel concept of QoL. In other words, we consider QoL as a multidimensional concept integrating both objective and subjective conditions and which can be considered at different multilevels from populations to individuals.

Regarding QoL at a population level, results shows that even though all of the objective measures are better in Spain than in Mexico, Mexican people report better scores in the subjective appraisal of QoL (i.e.

Mexicans report more happiness than Spanish people). But, when we tried to investigate whether age is influencing the subjective appraisal, data from the Word Values Survey, showed that as age increases, “happiness” and “subjective health” decrease, significantly, in Mexico and in Spain. Finally, when we considered people over 65, we found that while differences between Spain and Mexico in “Subjective health” were not significant, Mexicans reported significantly higher “Happiness” than Spaniards (Table 3), as we have previously pointed out, before taking into consideration the general population of both countries.

Taking into consideration individual QoL assessed through the CUBRECAVI, no significant differences between Mexicans and Spaniards were found regarding subjective and objective health, but Spaniards reported better mental health than the Mexicans did. Also, Spaniards significantly reported to have less difficulty than Mexicans in their Activity Daily Life as well as being able to perform those activities better. Social integration in Spain and Mexico significantly differ, mainly because of the structure of the household; more Spaniards significantly live alone, or live with their partners, while more Mexicans live with their children and grandchildren. Nevertheless, both Mexicans and Spaniards are satisfied with the people with whom they live. According to that, the Spaniards reported significantly more frequent meetings of family members who do not live at home and friends than the Mexicans did. Also, the Spaniards significantly reported to be more satisfied with family and social relationships than the Mexicans did. Regarding Physical activity, the Spaniards perform significantly more frequent physical activities and sports and they are significantly more involved in leisure and productive activities than the Mexicans. No significant differences were found regarding appraisal about environmental quality among the Mexicans and Spaniards. Spaniards significantly reported higher use of health and social services and were more satisfied about services than

Mexicans. This could be in accordance with the fact that in Spain, there is a universal public health system and a low percentage of Mexicans have such a system. Mexicans and Spaniards also significantly differ in their income and education which is in accordance with differences at the population level.

In spite of the fact that most of the domains of QoL support older Spaniards having a higher QoL than Mexicans, Mexicans significantly reported a higher Life satisfaction and, at the end, a higher appraisal of Quality of Life. In other words, it seems that the subjective appraisal about satisfaction with life and about quality of life are independent of the other factors, while in Spain they are highly related to them (both objective and subjective quality of life domains) (see, Fernández-Ballesteros, Arias, Santacreu y Ruvalcaba, 2011). This intriguing result is in accordance with the already mentioned Method Section: factor analysis yielded an independent factor of subjective appraisal of life and quality of life in Mexico, while in Spain, life satisfaction is related to health and quality of life is related to income and education. It is interesting to emphasize that Spain is fulfilling the assumption that education and income are behind QoL (Blanchflower and Oswald, 2011) but Mexico is fulfilling the QoL independence (Ashcanasy, 2011, Diener, Diener and Diener, 1995).

The issue about the international comparison in quality of life is discussed throughout literature; let us introduce some arguments claimed by the authors. First of all, after examining data coming from international studies on subjective happiness (well-being, happiness, satisfaction and quality of life are taken almost as interchangeable terms), Blanchflower and Oswald (2011) conclude that a stable pattern has been replicated in several countries, but it is not supported by our results, as our results do not support : 1) Age distribution is U-shaped, that is, happy people are, among other conditions, disproportionately, young or old (not the middle-aged). This pattern is not supported in our study; from context data, age is negatively associated to happiness. As Pinquart (2001) pointed out from meta-analysis studies, a positive mood is negatively associated with age, in the same way that from our population data, happiness is decreasing as age is increasing both in Mexico and in Spain. 2) The profile of happy countries are, among other conditions, disproportionately rich and educated bringing data from the International Social Survey Programme or ISSP; the happiest countries are, in this order: Ireland (coefficient 0.2196), Switzerland (0.1677), and Mexico (0.1559), the United States (0.0939), Great Britain (0.0844), and New Zealand (0.0754). Nevertheless, there are contradictory results coming from other studies (Diener et al.,

1995; The Economist, 2005; Vennhofen, 1999) which not support this profile. In our study, at a contextual level, people in Mexico yielded higher scores of happiness than in Spain, both for the total population and also for those older people. In the same line, at an individual level, Mexicans reported a higher appraisal of Life satisfaction and Quality of Life than the Spaniards did, but both at contextual and individual levels, Spaniards have a higher education and a higher income than Mexicans have.

Some authors interpret results about QoL as well-being and happiness, taking into consideration a cultural construct: individualism (other authors, such as Triandis 1995, include a bipolar dimension individualism versus collectivism). Veenhoven (1999) compares 43 nations in the early 1990's. Individualization is measured by three aspects: 1) moral appreciation of individualism, 2) opportunity to choose, and 3) capability to choose. Next, overall individualization is measured by means of an expert-estimate. Quality-of-life in nations is measured by the citizen's subjective appreciation of life, as assessed by the question of happiness on the World Values Study. She calculated this index in 48 nations in 1990. The more individualistic (1-10) countries were USA (10), followed by Canada, New Zealand, The Netherlands, and Switzerland (9). The less individualistic countries were China (2) and Nigeria (3). Taking into consideration this conceptualization, the Mexican individualism score was 5 yielding a happiness score of 2.95, while for Spain the individualistic score was 6 with a happiness score of 3.04. In sum, these interesting results from Veenhoven, from an "individualistic" position, do not highlight the differences found between Mexico and Spain in QoL.

In summary, although both objective macro (contextual) and micro (personal) level factors and indicators of QoL are quite higher in Spain than in Mexico, subjective appraisal of the quality of life and life satisfaction are higher in Mexico than in Spain. Much more research must be conducted in order to clarify the meaning of these positive concepts, including the quality of life, satisfaction, happiness or well-being, when they are used in any cross-cultural research and more sophisticated analysis must be conducted in order to make progress in this field.

In synthesis, both objective and subjective conditions assessed at different levels must be requested when QoL studies are conducted. When scientists, or policy makers, wish to improve the way of living of a certain population, in no way can QoL be reduced only to subjective dimensions.

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Parte II

Cambio sociodemográfico y Envejecimiento Activo.

Contribución Científica para Políticas Públicas Previsoras (CASOENAC)

Capítulo 5
Proyecto CASOENAC

Capítulo 6
Quality of Life in Mexico and in Spain

Capítulo 7
Multidimensional - Multisystems - Multinature indicators of Quality of Life

MULTIDIMENSIONAL - MULTISYSTEMS - MULTINATURE INDICATORS OF QUALITY OF LIFE

Social Indicators Research, In press

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Abstract

The aim of this study is to provide cross-cultural empirical support that endorses the scientific nature of Quality of Life (QoL), which a review of definitions reveals as a nomothetic and multidimensional concept (personal and environmental circumstances), made up of a set of subjective and objective indicators. Although this is commonly accepted, many instruments and authors reduce it to subjective and personal conditions.

Bearing in mind the aim described, multi-group Structural Equation Modelling (SEM) analysis was applied to two representative samples made up of 1217 participants aged over 60 from Mexico and Spain, recruited both at random (through the random route procedure), who completed the CUBRECAVI (Brief Questionnaire of Quality of Life). In this model two third-order latent variables are considered for QoL: personal and external factors, both made up of objective and subjective indicators. As predicted, the results permit us to state that the structural model is invariant across the two countries – that is, although the QoL construct has the same meaning in the two countries, the importance of the indicators (factor loadings) and the relationships between them are not equivalent.

Introduction

QoL emerges as a new concept at the end of the 1960s, in two different scientific contexts: sociopolitical and biomedical, superseding more traditional social indicators of conceptualisations (welfare, wellbeing, health from the illness perceptive), and linked to socio-political and health objectives [1-4]. Over the past fifty years this concept has shown enormous growth in the scientific literature [1, 2, 5, 6], becoming a key concept in environmental, social, medical and psychological sciences, as well as in public policy and in the minds of the population at large. Despite all of these advances, however, there is no consensus regarding the definition of QoL [2, 5, 7, 8], which has been described as “a rather amorphous, multilayered and complex concept with a range of components –objective, subjective, macrosocietal, micro-individual, positive and negative– which interact together” (Walker, 2005, pp. 3)[7].

The aim of the present study is to provide empirical support that endorses the scientific nature of the QoL concept, which a review of definitions reveals as a nomothetic and multidimensional concept, made up of a set of subjective and objective components of personal and

external domains [2, 4, 5, 7, 9, 10]. Although this concept can be applied to both populations and individuals, our study addresses only the individual point of view, including personal and environmental circumstances as well. This goal of developing a comprehensive model of QoL has been mentioned as a priority aspect of future research on quality of life in old age [11].

As a multidimensional concept, theoretically, QoL involves as many components as life itself. Although it is difficult to find a consensus on the ingredients of QoL [1, 12], those most frequently cited by both experts and lay people, and mentioned in research reviews, would include the following: ecological and environmental comfort, economic resources, biomedical and subjective health, socio-political and cultural variables, and psycho-social and psycho-behavioural aspects [4, 5, 7, 13-15]. These can be divided in two groups, those referring to personal circumstances, such as health and functional ability (personal “ingredients”), and those referring to one’s environment, such as income, environmental facilities and social relationships (external “ingredients”).

Furthermore, the nature of QoL components can be analysed from an objective perspective or from directly observable data (for example, income, social network size or number of illnesses) and from a subjective perspective – that is, individuals' appraisals of given components (for example, income satisfaction, health perception or satisfaction with social relationships). According to the Tesch-Romer (2012) “the distinction between objective and subjective quality of life implies that the two concepts are not congruent and, hence, nor redundant” (pp.3)[6]; a combination of high and low levels of both types of indicators may result in a general QoL index [16]. That is, many authors defend the idea that objective and subjective approaches are not interchangeable, but rather complement one another (e.g., Fernandez-Ballesteros, 1998, 2010; Michalos, Ramser, Eberts and Kahke, 2011; Wettergren, Kettis-Lindblad, Sprangers, and Ring, 2009)[1, 2, 14, 17].

But although this assumption has been endorsed by several authors, others argue the opposite. Thus, as Fernandez-Ballesteros (1997, 2011) pointed out, throughout the history of the concept, QoL has been subject to two threats. First, subjectivisation, which has involved reducing the concept to the individual's appraisals of different life aspects (e.g., Bowling, 2004; Skevington, 2002; World Health Organisation, 1993) [12, 18, 19]. For example, some authors have reduced QoL to well-being (e.g., Campbell, 1981) [20], to happiness in the social area (e.g., Veenhoven, 1996) [21] or to life satisfaction in the psychology context (e.g., Palys and Little, 1983) [22]. This may indeed be due to considering “quality” of life as opposed to “quantity” (as a purely “subjective” concept); however, according to the Collins dictionary definition, “quality” has several meanings: “excellence”, “calibre”, “distinction”, “grade”, which are scarcely subjective in nature. And the second of these “threats” is Reductionism, which consists in reducing the concept to one of its components, thus violating the principle of multidimensionality. Generally, QoL has been reduced to health status in the bio-medical field (e.g., Naughton and Wiklund, 1993) [23], and to economic data (e.g., Ashkanasy, 2011) [24]. Even though several authors maintain the multidimensional nature of QoL, they subjectivise the concept by asking individuals to rate their level of satisfaction with health, income, social relationships, and so on [19]. Other authors consider that QoL is an idiographic concept which must be defined by each individual (e.g., O'Boyle, 1997) [25]. Finally, some authors give equivalence to individual-micro-subjective, on the one hand, and to population-macro-objective on the other [13], when one can in fact obtain subjective and objective data at the macro level (aggregate data – e.g., stereotypes) and the micro level (individual data – e.g., life satisfaction).

In order to organise multidimensional, multilevel and “multi-nature” characteristics of the QoL concept, on the basis of previous studies, Fernandez-Ballesteros (1998, 2011) has developed a classification system with two broad axes – population versus individual based on the systemic level and objective versus subjective nature – on which the different QoL components are placed [1, 2]. In the first square, we find objective aggregate aspects of quality of life, such as demographics, environmental and physical conditions, social factors or health indicators. The second square includes subjective characteristics attributed to a given society as aggregate perceptions reported by a group of individuals, such as social stereotypes, values or collective self-efficacy, which could be considered as QoL-related conditions. The third square contains all personal or individual conditions cited as “ingredients” of QoL that can be considered objective factors, such as demographic and economic characteristics of the individual, environmental context, social and health circumstances, or individual physical fitness. Finally, the fourth square includes subjective conditions cited as QoL factors, such as life satisfaction, well-being and any other subjective appraisal of external or personal factors, such as how the individual perceives both context and individual aspects of life.

In the field, most energy is spent on measuring QoL; therefore, the definition of quality of life, by necessity, has to be considered together with its measurement indicators or instruments (Netuveli and Blane, 2008). With this goal, Fernandez-Ballesteros and Zamarron (1997, 2007) developed the ‘Brief Questionnaire of Quality of Life’ (CUBRECAVI) [26], which is based on the QoL concept described above. Thus, the questionnaire provides a multidimensional measure of different life ingredients referring to personal and contextual circumstances of the individuals, measured by objective and subjective items. The CUBRECAVI has shown high internal consistency, internal validity of its domains and high sensitivity to intervention in Spain and Latin-American countries [26]. Our goal in this article is to provide empirical data in support of the QoL model behind, based on structural equation modelling (SEM) statistical analysis, which captures the multidimensionality and “multi-nature” of the QoL concept at the individual level, in both personal and external circumstances. With this aim, we test the cross-cultural nature of the model, applying it in two representative samples of people aged over 60 in two different countries, Mexico and Spain. The hypothesis is that despite the existence of the same QoL model in the two countries, the factor score weights are different for each country, as the characteristics of the countries and subjective perceptions of what is important for QoL were found different in previous studies[27].

CASOENAC project

CASOENAC (Socio-demographic Change and Active Aging: Scientific Contribution to Public Policies) emerged as a European Union-Mexican States collaboration agreement supported by a Consortium of the Health Department of the State of Colima, the University of Colima and the University of Guadalajara (Mexico), the Autónoma University of Madrid (Spain), the University of Heidelberg (Germany) and the Academia de Yuste (Spain).

Although the general objective of this project was: “To develop gerontological knowledge in order to provide high quality bio-psycho-social services to older adults in Colima State”, a subproject on Quality of Life was developed by the University of Guadalajara and the Autonomía University of Madrid according to the following specific objective: “To assess the Quality of Life of the elderly, making Regional and European comparisons”. That is, since it was expected that although a nomothetic model of QoL equivalence in both countries exists, significant differences will be found.

Reliability was assessed through internal consistency, Cronbach’s alpha levels ranging from moderate (“Physical and mental health” scale, $\alpha=.67$) to high (“Functional abilities” scale, $\alpha=.84$); only one scale (“Social integration”) yielded a low alpha coefficient ($\alpha=.45$). These results are similar to those yielded by the original CUBRECAVI (“Social integration” scale, $\alpha=.31$, “Physical and mental health” scale, $\alpha=.70$, and “Functional abilities” scale, $\alpha=.92$).

Method

PARTICIPANTS

The sample was made up of 1217 participants (599 from Mexico: Colima; and 618 from Spain: Alicante), recruited as a random sample (through the random route procedure), aged over 60 years, and representative by age and gender of their respective population context. The main socio-demographic characteristics of the samples are shown in Table 1.

TABLE 1 SOCIO-DEMOGRAPHIC INFORMATION OF PARTICIPANTS

Variable	Mexico (n= 1199)	Spain (n= 618)
Age, years (Mean ± SD)	70.19 ± 7.90	71.81 ± 7.97
Gender, % (n)		
Women	54.6 (655)	53.2 (329)
Men	45.4 (544)	46.8 (289)
Marital status, % (n)		
Single	6.6 (79)	4.4 (27)
Married	49.2 (590)	65.5 (405)
Widow/er	34.4 (413)	27.8 (172)
Divorced	4.0 (48)	1.3 (8)
Separated	5.8 (69)	1.0 (6)
Number of people who live with (Mean ± SD)	3.40 ± 2.34	2.19 ± 0.99
Employment situation		
Currently working	23.6 (283)	4.5 (28)
Retired / Pensioner / Disabled	26.3 (315)	65.4 (404)
Unemployed	15.1 (181)	2.8 (17)
Housewife	35.0 (420)	27.3 (169)
Way of working (present or past)		
Self-employee	27.9 (335)	19.3 (119)
Employee	44.8 (537)	80.7 (498)
Not applicable	27.3 (327)	0.0

INSTRUMENTS, VARIABLES AND PROCEDURES

In this study, the CUBRECAVI (“Brief Quality of Life Questionnaire,” Fernandez-Ballesteros and Zamarron, 1996, 2007) was the instrument selected to assess QoL [26]. It is a multi-scale questionnaire, which includes eight domains assessed through objective and subjective items (Table 2), as well as an idiographic question asking respondents to rank the importance of the domains. The questionnaire was administered by trained interviewers in line with the CUBRECAVI Instruction Manual, individually in participants’ home, with an estimated duration of 20 minutes per interview. For these two samples, the statistical properties emerged as sound [27, 28]

STATISTICAL ANALYSIS

In order to test our hypotheses, a multi-group SEM employing AMOS 21 was performed. Multi-group SEM is appropriate because it allows the comparison of the latent variable means and the relationships among the variables across different groups [29], which is particularly appropriate for cross-cultural data [30]. We analysed the covariance matrix using the maximum likelihood method of estimation. In this model, two third-order latent variables are considered for Quality of Life: personal factors and external factors. The personal Quality of Life factor was made up of two latent variables: Health and Functional abilities, both latent variables comprising one objective factor and one subjective factor. The external Quality of Life factor was made up of three latent variables: Social relationships, Environmental satisfaction and Socio-economic status (SES). Social relationships comprised one objective and one subjective factor; Environmental satisfaction was made up of two subjective factors; and SES comprised three objective indicators (see Table 2 and Figure 1).

In order to build the model, five domains from the complete questionnaire were selected on the basis of theoretical and statistical reasons. On the one hand, to fulfil the theoretical requirements we selected the domains most frequently cited as QoL ingredients [1, 31], namely: health, functional abilities, social relationships, environmental appraisal and socio-economic status (SES). On the other hand, in order to meet the statistical requirements, we took into account the following constraints: 1) selecting the same number of items for each dimension so as not to artificially overestimate the weight of any factor (Table 2) because, as the number of indicators increases, there is greater potential for shared secondary influences and cross-loadings among the indicators [32]; 2) selecting no more than three items per factor, so as not to falsely overestimate model fit by SEM statistical analysis [33]; and 3) selecting the three items that best represent each first-order latent variable.

TABLE 2 CUBRECAVI STRUCTURE. VARIABLE SELECTION FOR SEM MODEL.

		INDICATORS: item selection.				
		N	items			
Nomotheitic	Health	O	Frequency of symptoms (26)	3	Difficulty breathing or feeling of lack of air Palpitations Pain or tightness in the chest	sal9 sal10 sal11
		S	Satisfaction with health (1)	1	How satisfied are you with your general health?	
		O	Difficulties to functioning (4)	3	How often do you keep in touch with... • Family (those not living with you)? • Neighbours? • Friends?	hab- func3 hab- func4
	S	Satisfaction with functioning (1)	1	How satisfied are you with the people you live with?	hab- func5	
	Social relationships	O	Frequency of social relationships (6)	3	How often do you keep in touch with... • Family (those not living with you)? • Neighbours? • Friends?	vive3 vive4 vive5
		S	Satisfaction with social relationships (6)	1	How satisfied are you with the people you live with?	
		O	Frequency of activities (12) and sport (1)			
	Activity and leisure	S	Satisfaction with how you occupy your time (1)			
		O	Frequency of visiting service (1)			
	Social and health services	S	Satisfaction with services (1)			
		S	Life Satisfaction (1)			
	Environmental quality	S	Elements (6) and general (1) satisfaction	4	How satisfied are you with • Housekeeping • Furniture • Facilities How satisfied are you with your environment in general?	amb4 amb5 amb6
	SES	O	Education (2)		Educational level Years of education	P16 P17
		O	Income (1)	3	Monthly income	SD8
	Idiographic		Individual ranking of importance of domains			

O: Objective
S: Subjective

Results

CONVERGENT VALIDITY

Convergent Validity is calculated to see how an indicator shares in a single construct. An indicator is said to converge if its factor loading value is high and significant, and it has a standardised factor loading estimate greater than 0.5. The construct validity is determined by the average AVE (Average Variance Extracted) value. Reliability and convergent validity statistics were calculated for all the first-order latent variables (Table 3).

MEASUREMENT MODEL

After checking the reliability and construct validity of the first-order latent variables, in a second step we carried out a Confirmatory Factor Analysis. Various indexes have been suggested for checking the fit of the models, given the sensitivity of the Chi-square statis-

tic to sample size and deviation from normality of the data. Following Hu and Bentler's (1999) recommendation for the combination of fit indexes, CFA and RMSEA indexes were employed in order to test the fit of the model to the data: RMSEA, for which values below .06 are indicators of good fit, and CFI and NFI, which must yield values of over .95 to indicate good fit [34]. The analyses indicate a good fit of the model to the data $\chi^2 = 357.43$, $p < .0001$, $\chi^2/DF = 2.52$, CFI = .972, NFI = .955, RMSEA = .035. Standardised estimations of the model are shown in Figure 1. For reasons of clarity, neither regression errors nor the corresponding observable variables for first-order latent variables are shown (see Table 3).

TABLE 3 RELIABILITY, CONSTRUCT VALIDITY AND STANDARDISED REGRESSION WEIGHTS OF FIRST-ORDER LATENT VARIABLES

	Item	β s	Cronbach α	Jöreskog Rho	AVE
Objective health	sal9	.69			
	sal10	.84	.79	.79	.56
	sal11	.76			
Objective functional skills	habfunc3	.71			
	habfunc4	.80	.80	.81	.58
	habfunc5	.79			
Objective social relationships	vive3	.87			
	vive4	.93	.67	.75	.56
	vive5	.39			
Environmental elements	amb4	.56			
	amb5	.80	.75	.75	.51
	amb6	.79			
SES	P16	.91			
	P17	.43	.53	.83	.64
	SD8	.94			

TABLE 4 GOODNESS-OF-FIT STATISTICS FOR MULTIPLE-GROUP ANALYSIS

Goodness-of-fit statistics	χ^2	p	χ^2/DF	CFI	RMSEA	RMSEA 90% CI
Single group solution						
Mexican	246.20	.001	1.73	.974	.035	.028-.042
Spaniard	307.66	.001	2.17	.960	.043	.037-.050
Measurement Invariance Mexican						
Equal form (configural)	547.85	.001	1.93	.967	.028	.024-.031
Equal factor loadings (weak)	697.29	.001	2.34	.951	.033	.030-.036
Equal indicator intercepts (strong)	1094.218	.001	3.45	.904	.045	.042-.048

⋮ Note: CFI (Comparative Fit Index), RMSEA (Root Mean Square Error of Approximation).

METRIC INVARIANCE ACROSS GROUPS

In a third step, and following Byrne's recommendation (2001), we performed a Confirmatory Factor Analysis for the Mexican and Spanish samples separately [35]. This analysis indicates the correspondence among the observed variables and the latent constructs, which are the hypothesised unobserved causes of the measured indicators [29, 30], see Table 4.

Finally, multiple group analysis was carried out between the Mexican and Spanish samples in order to check for strong factor invariance. Strong factor invariance confirms that the measurement instruments, which were intended to be identical in the two countries, were in fact equivalent. Two preconditions are necessary in order to test for strong factorial invariance: configural and weak factorial invariance [30, 36, 37]. The first condition, or configural invariance, implies equal forms of the measures across groups,

which can be established when the number of factors and pattern of indicator-factor loadings do not differ between groups. Weak factorial invariance can be established when the factor loadings are equal across groups.

Following the recommendation of Chen (2007, pp. 501) for testing multiple group analysis when sample sizes are greater than N = 300 and equal across the groups, for testing loading invariance, a change of $\geq .010$ in CFI, supplemented by a change of $\geq .015$ in RMSEA, would indicate non-invariance [38].

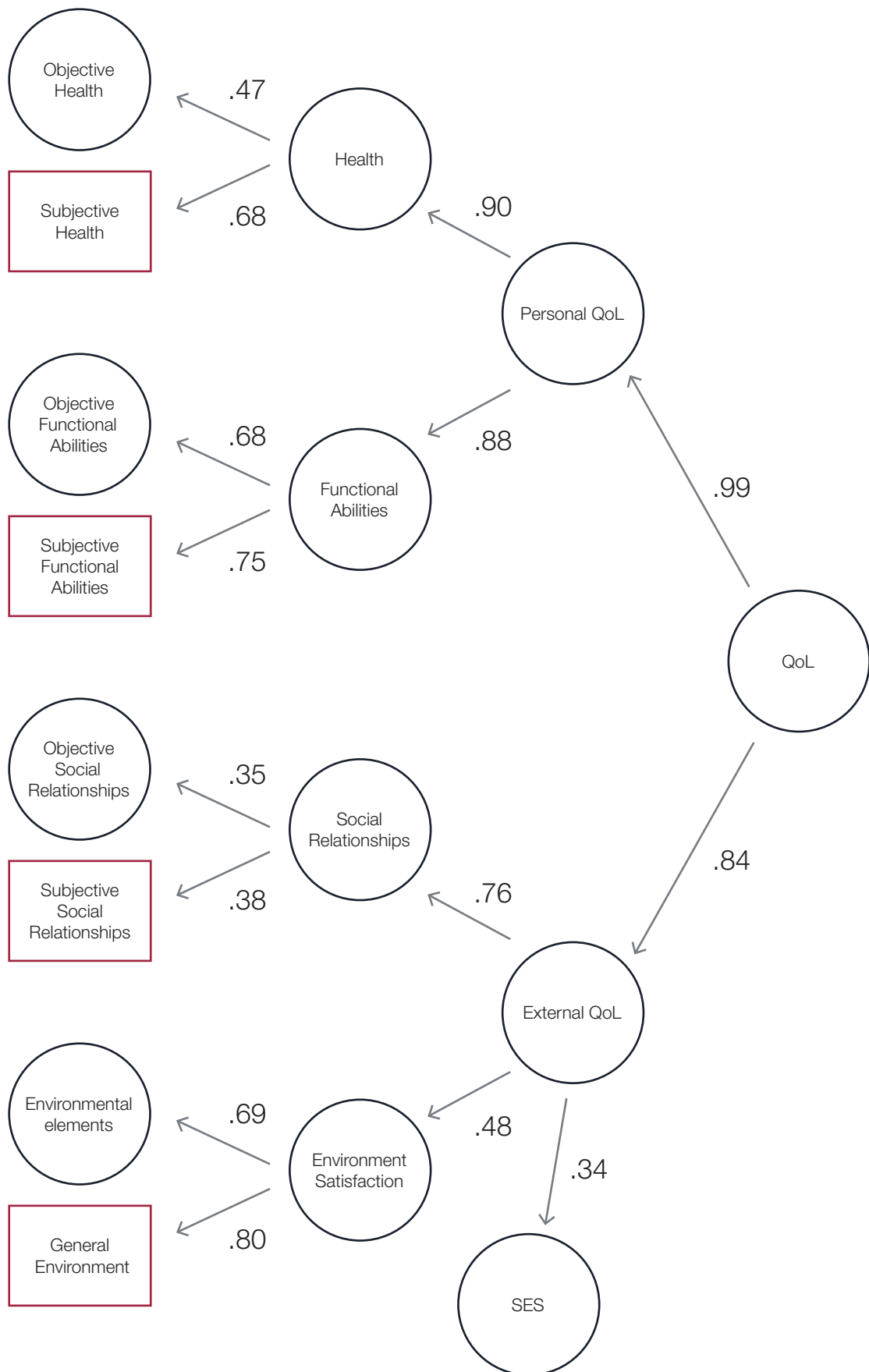
Table 4 shows the statistics of the base model and of the multiple group analysis that permit us to state that the structural model is invariant across the two countries. Finally, Table 5 shows significant differences between both samples.

TABLE 5 DIFFERENCES IN STANDARDIZED REGRESSIONS WEIGHTS BETWEEN SAMPLES

			Mexico	Spain	Z
Personal QoL	→	QoL	.99	.81	26.44**
External QoL	→	QoL	.38	.99	39.09**
Health	→	Personal QoL	.93	.93	0.00
Functional Abilities	→	Personal QoL	.86	.87	.69
Environment	→	External QoL	.64	.16	10.38**
Relationships	→	External QoL	.70	.99	30.96**
SES	→	External QoL	.30	.24	1.13
Objective health	→	Health	.50	.45	.13
Subjective health	→	Health	.63	.71	3.82**
Objective functional abilities	→	Functional abilities	.48	.82	11.03**
Subjective functional abilities	→	Functional abilities	.63	.84	8.35**
Objective social relationships	→	Social relationships	.40	.15	4.74**
Subjective social relationships	→	Social relationships	.58	.08	10.13**
Environmental Elements	→	Environment	.68	.55	3.67**
General environment	→	Environment	.77	.97	18.65**

p < **

FIGURE 1



Discussion

The present research tested a QoL model in Spain and Mexico through two representative samples of people aged over 60. The aim of the study was to provide cross-cultural empirical support for the QoL model measured by subjective and objective indicators of personal and external life aspects, considering both types of indicators as important in the context of aging. This theoretical model has been posited by Fernandez-Ballesteros (1998, 2011) and supported by several other authors [1, 2, 11, 14]. As far as we know, there is no other study that provides empirically support for this dual-axis classification system (personal/external and subjective/objective), but there are elements that are shared with the proposals of other authors, as detailed below.

Once we had checked for acceptable reliability and construct validity of the first-order latent variables of the model (Table 3), Confirmatory Factor Analysis was performed on both samples, together and separately. Using the accepted statistical criteria [38], the results (model fit) showed that the QoL construct exists with the same meaning in the two countries. Nevertheless, and as might have been expected, the importance of the indicators (factor loadings) and the relationships between them are not equivalent (Figure 1, Table 4). On the whole, though, it would seem that, in line with previous findings, there is correspondence of the QoL concept between cultures and individuals [18].

QoL CONSTITUENTS

There is controversy about which elements should be part of QoL. Although, as has pointed out, QoL could theoretically include as many elements as there are in life itself, this conceptualisation is unfeasible from an empirical point of view [2]. In this study, the inclusion of life elements in the model is not exhaustive, since the focus of the research is the objective and subjective nature of the QoL concept. However, we selected five of the most commonly accepted domains of QoL in older people, taking into account personal (Health and Functional abilities) and external (Social relationships, Environment and SES) circumstances, as cited by researchers and lay people [11, 39, 40], and which are included in most QoL assessment instruments and QoL models [3]. However, there are some important ones missing, such as participation or productive and leisure activities, and which have been found to be strongly associated with life satisfaction [41, 42]. These variables, in spite of their being assessed by CUBRECAVI, could not be included in the model, because they were significantly correlated with SES, AVDs and Health, as has

been reported in other studies [6]. Thus, level of activity correlates with those who have higher income, better health and better functioning.

We also examined the way in which variables should be organised in the model. Several authors have distinguished between internal and external factors by which QoL could be influenced [8]. This is why we considered two different possibilities for organizing the QoL model. On the one hand, the first model tested whether QoL was directly made up of the five factors selected: Health, Functional abilities, Social relationships, Environment and SES. Thus, we obtained five second-order latent variables for QoL. On the other hand, the second model regroups the five life elements in two third-order latent variables: personal and external QoL. The latter model, which is actually the one reported here, fitted the best, showing that in explanations of QoL it is necessary to draw a distinction between those variables that depend on the characteristics of the person (Health and Functional abilities) and those that depend on the characteristics of his/her environment (Social relationships, Environment and SES). This distinction is also quite commonly made in public health research [8]. Here, the empirical problem with including Productive and leisure activities in the model becomes evident once again. Despite its being considered a relevant contributor to QoL, it falls in between personal elements of life such as good health and functioning, and external elements of life such as income [42].

Once the model structure had been selected, following model fit statistical indexes, we tested whether the model was shared by the two countries. Although we find that the two countries shared the structure of the QoL model (configural, see Table 4), the relationships between variables and the levels of importance assigned to each dimension differ between the countries (weak invariance, Table 4). These results are in accordance with those reported by Walker and Lowenstein (2009), who found that the relations between variables varied across persons and cultures [11]. Nevertheless, this does not mean that the indicators we use to measure QoL in different countries should be different or idiographic. Even so, it would seem relevant to know what it is important in each country in order to identify targets in the design of intervention programmes for improving QoL [5, 6][5, 6, 43][5, 6, 43], which is, after all, the ultimate aim of the development of the QoL concept and its assessment tools.

In spite of the differences between countries, there is some correspondence between them (Table 5). The

relationship between Health ($\beta_{\text{Mexico}}=.93$; $\beta_{\text{Spain}}=.93$) and Functional abilities ($\beta_{\text{Mexico}}=.86$; $\beta_{\text{Spain}}=.87$) with Personal QoL is the same in the two countries. Likewise, the factor weight of Objective Health in Health is equivalent across the two ($\beta_{\text{Mexico}}=.50$; $\beta_{\text{Spain}}=.45$). Thus, we found that for Personal QoL, Health and Functional abilities are of considerable importance in both countries. These results are congruent with those that indicate Health and Functional abilities as the most important for explaining QoL in people in general and older adults in particular [39, 44]. Some authors state that the lack of any life element (e.g., a good job, high income or good health) makes it more relevant for the person [13]. Thus, it would appear that the probable lack of health or worry about its failing makes Health a highly relevant element in older people's lives. Indeed, some results suggest that the impact of health on overall quality of life increases with age [45].

Regarding SES (income and education), it appears to be less important in explaining External QoL in both countries ($\beta_{\text{Mexico}}=.30$; $\beta_{\text{Spain}}=.24$). Generally, income and education yield controversial results when used as independent variables to explain variability in quality of life, happiness and life satisfaction [42, 46]. While some studies report that income and QoL are positively related [47, 48], other studies refer to the complex relationship between income, happiness and QoL [49]. On the other hand, it is important to note that SES (income and education) is not at the same level as Health, Social relationships or Functional ability. While the former is a life-long variable, the latter are cross-sectional ones. Many authors have stated that variance in QoL can be explained by the differential influence of life-long variables (e.g., SES) and cross-sectional ones (e.g., the onset of a disease) on QoL throughout life and across individuals and cultures [15, 24, 50]. In our sample, it seems that life-long variables have less influence than current ones, which is in line with the results from other studies [51, 52]; although in order not to overestimate its weight the number of indicators of cross-sectional variables were equalised.

All other factor loadings vary significantly across countries; hence, relationships among variables are not equivalent between them. Several hypotheses have been proposed to explain these differences across cultures and individuals. Bowling et al. (2003) attribute them, for example, to low levels of a particular component (poor health, low income, short social support), to people's values and aspirations, or to living circumstances [39]. As mentioned above, the differential influence of life-long variables and cross-sectional ones is also a factor to take into account [15, 24, 50].

In congruence with the above result, we find that the dynamic property attributed to the QoL concept refers not to the fact that the construct's composition changes with the ageing process or/and cross-culturally (Bowling, 2004), but that domains' importance (factor loadings) and the relations between them are what actually change across living conditions. In fact, and in spite of the differences between countries, what we found to be one of the strengths of this study is that empirical data are supporting a cross-cultural individual model of QoL underlying several dimensions of personal and external life events, measured by objective and subjective indicators. Therefore, these results lend empirical support to the argument that reductionism to one life component or dimension (subjective appraisal) makes no sense for the QoL concept, as Fernandez-Ballesteros (2010) and Fernandez-Ballesteros and Santacreu (2011, 2013) pointed out [2-4].

SUBJECTIVE AND OBJECTIVE INDICATORS

As set out in the introduction, the use of both subjective and objective indicators for explaining QoL has at best been neglected, and at worst has yielded controversy. Some authors highlight the importance of subjective perspectives in which QoL is defined by self-appraisal of different life dimensions [12, 44, 47]. For example, Bowling et al. (2004) reported that subjective self-assessment of well-being and health are more powerful for explaining variations in QoL ratings than objective indicators (income or socio-demographic changes)[53]. On the other hand, Pinqart and Sorensen (2000) argued that the results from life satisfaction studies and subjective estimations of life situation yielded inconsistent information, and were not to be well recommended for making comparisons across different groups by themselves [54]. Kahneman and Krueger (2006) agreed that subjective appraisals of life satisfaction were strongly influenced by current mood, memory and context [55]. An intermediate position would be that subjective perceptions and objective qualifications are not equally correlated in all samples; in fact, it is found "...positive subjective evaluations expressed by many older people living in objectively adverse conditions..." [11]. Consequently, we agree that the two types of indicators are complementary and necessary in producing a comprehensive summary of people's QoL [6, 11, 17]. Moreover this aspect is extremely relevant when we want to obtain a reliable, bias-free measure of QoL. We should not lose sight of the purpose for which the QoL concept was developed, that is, as an outcome of projects, programmes, services or policies. Thus, social policies must take into consideration objective components when the purpose is to measure QoL in a certain so-

cial group. The subjectivization of QoL could contribute to the delusion of a part of reality. In other words, if evaluation policies assess only subjective appraisals of QoL, this would be the only target for change, neglecting objective life conditions who claim improvement.

Thus, our model includes Objective and Subjective indicators to define each dimension (personal and external QoL). Here, in line with Bowling's (2004) results, the QoL construct is better explained by subjective general questions about health, functional abilities, social relationships and environment satisfaction than by their respective objective indicators (Figure 1) [12]. However, the empirical model does not dismiss the importance of objective indicators as components of QoL. Therefore these results are in agreement with the assumption that both types of indicators are important for the measurement of QoL.

Besides pointing out the strengths of this study, we also acknowledge some limitations. Regarding the data collection methodology, only self-reports were used, and these are well-known to be affected by biases [56]. For this reason, randomised controlled objective variables would be necessary to determine whether the hypothesised relationships hold. Indeed, the CUBRECAVI incorporates subjective and objective factors distinguishing the nature of a certain condition; for example, subjective health is the appraisal of health, whereas objective health refers to number of illnesses diagnosed.

Regarding the assessment instrument, it has several limitations. First, there are not subjective and objective questions for all events – there are some objective items that do not have a subjective counterpart (e.g., education and income), while there are others that are objective with no corresponding objective item (e.g., environment). In this sense, we consider that security is an important domain of environmental QoL, which is missing and should be important to be added in the future. Second, there are two items about General QoL and Life Satisfaction that could not be used in the model because there was almost null variability; the answers, provided on a 3-point Likert-type scale, showed that most of the sample appeared to be satisfied with life and have good quality of life. This lack of variability is probably due to the small number of response options. However, similar findings emerged in other studies, in which older people usually reported being satisfied with life, as they are able to adapt to their declining health and compensate for it [44].

Even though the results lend support to the model, further research is needed, with a threefold aim: 1) to improve the conceptual and theoretical validity of the QoL constituents – that is, to check whether this dual information from objective and subjective indicators is replicated for other life dimensions; 2) to obtain more empirical support with samples of older adults from different countries; it is important to know whether this cross-cultural model can be extended to other countries with different languages and cultural characteristics; and 3) to analyse in more depth the relationships between variables. Having tested the nomothetic concept of QoL, more studies are necessary to provide information about the different relationships between variables, which is what is actually important for identifying targets with a view to improving QoL.

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Parte III

Discusión y Conclusiones

Discusión y Conclusiones

En este apartado se discute de forma general los diferentes aspectos que han sido tratados en el compendio de artículos presentados. Primero, se analizan las conclusiones principales que se derivan del primer grupo de artículos de carácter teórico. En segundo lugar, se discuten los resultados y se exponen las principales conclusiones que se derivan del trabajo empírico. Finalmente, se destacan algunas limitaciones del trabajo realizado y se exponen las líneas de investigación que se consideran relevantes para el futuro en el ámbito de la Calidad de Vida.

Los tres trabajos teóricos han sido el resultado del extenso esfuerzo que hemos realizado por difundir y defender un concepto de Calidad de Vida científico que respete las propiedades que lo caracterizan así como el objetivo para el que fue creado. Los tres reflejan la importancia que tiene el concepto de Calidad de Vida a nivel socio-político y científico, destacando su relevante presencia en el área de la vejez y el envejecimiento. El primero, enmarca el área de la investigación de la Calidad de Vida en la gerontología española. El segundo, se centra en la definición del concepto y sus problemáticas. Y, el tercero, se centra en los instrumentos de evaluación que se utilizan para medirla y valora sus características.

La conclusión esencial que emana de ellos es que, a nivel teórico y transversal, la Calidad de Vida es un constructo multidimensional integrado por varios dominios referentes al individuo y a su contexto, representados por indicadores objetivos y subjetivos (Fernández-Ballesteros, 2011; Michalos et al., 2012; Walker, 2005a). Sin embargo, aunque a este nivel, abstracto, nadie pone en duda dichas características de la Calidad de Vida, a nivel práctico, estos mismos autores lideran la denuncia del mal uso que se hace de este concepto, que con frecuencia resulta reduccionista y subjetivista.

A pesar de las sucesivas críticas, la incorrecta utilización de este constructo parece estar lejos de extinguirse, es más, sigue creciendo en ciertos ámbitos, como el de la salud y algunas ciencias sociales. Desde una perspectiva biomédica, la reducción de la Calidad de Vida a la salud es cada vez más frecuente y están emergiendo numerosos instrumentos de evaluación específicos a cada tipo de enfermedad o, incluso, son utilizadas medidas de auto-informe que tradicionalmente se utilizaban para medir salud (por ejemplo, el Sickness Index Profile-SIP de Bergner et al. 1976). Por su parte, en las ciencias sociales prevalece la subjetivación del concepto, reduciendo sus indicadores a valoraciones subjetivas de los individuos sobre

determinadas condiciones o, aún peor, equiparando Calidad de Vida a otros constructos psicológicos tales como la satisfacción con la vida o el bienestar subjetivo (Fernández-Ballesteros y Santacreu, 2012).

Estos trabajos dedicados a la definición teórica del constructo de Calidad de Vida, que pudieran resultar, en cierto modo, reiterativos tanto en nuestro equipo de investigación (Fernández-Ballesteros y Macía, 1993; Fernández-Ballesteros, 1997, 2004, 2011) como en el de otros autores que insisten de forma similar (ej.: Michalos, 2010; Walker y Lowenstein, 2009; Tesch-Roemer, 2012) resultan pertinentes por el peligro que la Calidad de Vida corre de convertirse en un mantra, que invoque un ideal utópico de vida, al que solo se aluda en discursos políticos, justificaciones de proyectos científicos, o como objetivo general de programas de intervención social y/o de la salud; sin que ello se traduzca en un impacto real que mejore la vida de las personas. Por ello son tan necesarias las revisiones teóricas que denuncian el mal uso del concepto y reclaman la necesidad de ser pulcro, cuidadoso, exacto con su utilización y medición (Tesch-Roemer, 2012).

El segundo conjunto de artículos fruto del proyecto político-científico internacional en el que se enmarca la tesis, tuvo un doble objetivo. A nivel político, el estudio pretendía identificar el nivel de Calidad de Vida existente en la población colimense mayor de 60 años (México), y compararla con la española, con el fin de implantar políticas para su mejora. A nivel científico, se pretendía avalar empíricamente las propiedades del término de Calidad de Vida en la vejez que se ha postulado desde una perspectiva teórica atendiendo tanto a modelos científicos, como a las características que las personas mayores consideran importantes para su propia Calidad de Vida (Bowling et al, 2003; Fernández-Ballesteros y Macía, 1993) y estudiar su carácter transcultural.

De los resultados obtenidos, encontramos especialmente relevantes la discusión de dos temas: 1) el paralelismo existente entre el modelo empírico aportado y el modelo popular en que las personas mayores informan de los aspectos que resultan importantes para su propia Calidad de Vida; y 2) la falta de relación entre algunos indicadores objetivos y subjetivos.

Atendiendo al primer punto, los resultados expuestos en Santacreu, Fernández-Ballesteros y Bustillos (In press) avalan empíricamente la definición teórica de Calidad de Vida a nivel individual como concepto

multidimensional, representado por factores de tipo externo e interno y mediante indicadores objetivos y subjetivos. En cuanto a la valoración que los propios individuos hacen de las dimensiones que son importantes para su propia Calidad de Vida (Anexo 3); encontramos que ambos países coincidían en que los factores más importantes eran: la salud, las relaciones familiares y sociales, valerse por sí mismo y mantenerse activo; en ese orden. Aunque relegado a la quinta posición, “tener una buena pensión y renta” también se citaba como elemento importante.

Este resultado es diferente a lo encontrado en estudios previos en los que los ingresos se encontraban en una segunda o tercera posición (Fernández-Ballesteros y Zamarrón, 1997, 2007; Fernández-Ballesteros y Maciá, 1993; Martínez-Martin et al., 2012). Sin embargo, en el modelo presentado en Santacreu et al. (2013) los indicadores socio-económicos, entre ellos ingresos, también obtenían el menor peso sobre la variable latente Calidad de Vida externa y, asimismo sobre la general.

A diferencia de lo que se había encontrado hasta ahora, la variable “ingresos” aparecía como menos importante que “valerse por sí mismo” y “mantenerse activo”. Este descenso en el rango de importancia que se le otorga a los recursos económicos en ambos países resulta altamente sorprendente si prestamos atención a las condiciones de renta y pensiones tan diferentes que presentan México y España. En España, los mayores tienen una renta asegurada y la mayoría perciben unos ingresos situados en los valores intermedios de esta escala del CUBRECAVI. Mientras que en México, tal pensión no está asegurada y la mayoría tienen un nivel de ingresos situado en los valores bajos de la misma escala. Asimismo, resulta llamativo, que esta diferencia en aspectos objetivos tenga tan poco impacto en la percepción general de la satisfacción con la vida y la Calidad de Vida de ambas muestras (Fernández-Ballesteros et al., 2012). Este hecho se ha identificado en numerosos estudios (Kruger y Engelbrecht, 2010).

En cuanto a la falta de relación entre algunos indicadores objetivos y subjetivos de Calidad de Vida; parece que a pesar de que en el modelo presentado ambos aparecen como relevantes y asociados por constructo (por ejemplo, indicadores de salud objetiva y subjetiva componen la variable latente salud), a nivel general no resulta ser así. En los resultados obtenidos en Fernández-Ballesteros et al. (2012) observamos una falta de relación entre algunos componentes

objetivos y subjetivos que representan la Calidad de Vida, tanto a nivel poblacional como individual. Como tendencia general, encontramos que mientras en México los indicadores objetivos señalan peor Calidad de Vida que en España, cuando se analizan los indicadores subjetivos ocurre lo contrario, y México resulta tener mejor Calidad de Vida que España. Esto mismo sucede a nivel poblacional, cuando se analizan las cifras de bases datos internacionales y públicas.

La discordancia entre los indicadores objetivos y subjetivos de la Calidad de Vida, ya ha sido descrita por otros autores (Cummins, 2000; Hagerty et al., 2001). Para tratar de explicar este fenómeno, diferentes autores han propuesto algunas hipótesis. Por ejemplo, Cummins (2000) propone la teoría de la homeostasis del bienestar, por la cual las personas tienden a mantener sentimientos positivos sobre sí mismos y sus vidas, a pesar de vivir en condiciones ambientales adversas. Muchos estudios realizados muestran como las personas mantienen niveles medio-altos de satisfacción o bienestar subjetivo y son prácticamente inexistentes las puntuaciones menores de 40 en escalas de satisfacción general con rango 0-100. Ocurre también en nuestra muestra, donde más del 75% reporta estar muy o bastante satisfecho con la vida. Con ello, no quiere decirse que los indicadores objetivos y subjetivos sean totalmente independientes, sino que su relación no es lineal. De estos resultados deducen que siempre que las condiciones ambientales permitan la adaptación por parte de las personas, habrá poca o ninguna relación entre el bienestar objetivo y el subjetivo. Sin embargo, una vez que se supere el umbral de la adaptación y las circunstancias objetivas sean tan difíciles que no permitan la adaptación, la Calidad de Vida subjetiva también disminuirá y la relación entre indicadores objetivos y subjetivos será más fuerte. Finalmente, Cummins señala que la cultura de un país y los valores de cada individuo influirán en su umbral de adaptación. En ninguna de las muestras que hemos evaluado en este estudio, las condiciones objetivas parecen ser altamente adversas.

En este sentido, Triandis (1995) y Veenhoven (1999) señalan la dimensión individualismo-colectivismo, como una variable cultural relevante para explicar las diferencias en las apreciaciones subjetivas que hace un individuo sobre su vida. Como discutimos en Fernández-Ballesteros et al. (2012), no parece ésta una variable que pueda explicar el caso que compara España y México, puesto que su puntuación en individualismo es muy similar.

Hagarty et al. (2001) explica que la variabilidad de los indicadores subjetivos es dependiente de múltiples dimensiones como la regulación emocional, distintas variables de personalidad (ej. extraversión, optimismo), los procesos cognitivos (ej.: la disonancia cognitiva) y distorsiones de respuesta propias de los auto-informes (ej.: la deseabilidad social, la sinceridad), todos ellos difícilmente controlables de forma objetiva.

Nuestros resultados, no permiten identificar qué explica la falta de correlación entre lo objetivo y lo subjetivo; sin embargo, sí que destacan la importancia de dos aspectos importantes identificados por varios autores (Tesch-Roemer, 2012; Walker & Lowenstein, 2009; Wettergren et al., 2009). Por un lado, los indicadores subjetivos y objetivos parecen ser componentes necesarios y complementarios de la Calidad de Vida que nos informan de naturalezas diferentes de la vida, que parece que atienden a reglas distintas; Camfield y Skevington (2008) hablan metafóricamente de dos termómetros que miden dos procesos que ocurren en un mismo cuerpo, a una misma persona. Por otro lado, nuestro modelo avala la importancia de incluir ambos tipos de indicadores para cada dominio incluido en la Calidad de Vida (salud, relaciones sociales, ambiente,...), como destacaba Hagerty et al. (2001).

Por ello, consideramos importante subrayar las dramáticas consecuencias que tendría analizar la Calidad de Vida si solo se tuviera en cuenta un tipo de indicadores: objetivos o subjetivos (Hagerty et al., 2001). En el caso de nuestra muestra, y atendiendo a los datos subjetivos obtenidos en México se podría descartar una intervención para mejorar la Calidad de Vida, porque los ciudadanos informan sentirse felices y satisfechos con su vida, en general, y con diferentes aspectos de la misma, en particular; a pesar de informar de otros muchos aspectos objetivos potencialmente mejorables como los servicios sociales, el sistema de pensiones o el nivel educativo. Ocurre lo contrario en la muestra española, en la que a pesar de gozar de unas “buenas” (mejores que en México) condiciones objetivas de vida, se informa de un menor nivel de satisfacción. Lo paradójico de la cuestión, es que a pesar de que todos los aspectos objetivos se valoraron peor que en España, la muestra mexicana informa de mayor Calidad de Vida general y satisfacción que la española. Parece que estos resultados aluden a las formas de valoración sobre aspectos propios implicando juicios de comparación con los otros, diferencias entre expectativas y resultados amén de variables de personalidad (Wrosch et al., 2003; Camfield y Skevington, 2008). Desde el punto de vista de la

atribución social, podría también justificarse por un juicio sobre la obligación de la sociedad de resolver los problemas del individuo, como así se interpreta por algunos sociólogos que atribuyen una posición pasiva frente a un estado de bienestar que todo resuelve (Díez Nicolás, 20011; Tesch-Roemer, 2012).

En conclusión, el CUBRECAVI y la identificación de indicadores poblacionales, permitieron la evaluación de la Calidad de Vida considerando su carácter multidimensional, su naturaleza objetiva y subjetiva y sus diferentes niveles de estudio (poblacional e individual), haciendo referencia tanto a los aspectos del individuo como a los de su entorno. Como resultado se obtuvo un diagnóstico diferencial de la Calidad de Vida de las personas mayores en ambos países. A nivel político, el impacto práctico de este trabajo fue la posibilidad de guiar el desarrollo de las propuestas políticas que debían hacerse para mejorar la Calidad de Vida de las personas mayores de 60 años en el estado de Colima, identificando los elementos diana que debían ser intervenidos para poder conseguirlo. Lo cual constituía uno de los objetivos principales del proyecto político de CASOENAC (Fernández-Ballesteros et al., 2011). Se elaboraron propuestas para cada uno de los elementos para los cuales el estado de Colima resultaba peor valorado que el estado de Jalisco y que España. Además, se insistió en cuidar aquellos elementos que resultaban satisfactorios en esta población para procurar potenciarlos. Las propuestas concretas se recogieron en un documento interno del proyecto que serviría de guía al Gobierno de Colima para elaborar sus políticas sociales en materia de envejecimiento y promoción de su Calidad de Vida.

El desarrollo de este estudio ha llevado consigo una serie de limitaciones, en relación a la metodología y al instrumento utilizado para medir la Calidad de Vida. En cuanto al instrumento CUBRECAVI, aunque, por lo general, ha presentado buenas propiedades psicométricas tanto en nuestra muestra, como en muestras anteriores (Fernández-Ballesteros y Zamarrón, 1997, 2007), existen varios aspectos que deberían ser modificados para mejorar su calidad. Siguiendo la recomendación del modelo presentado (Santacreu et al., In press) y la propuesta de Hagerty et al. (2001) para la elaboración de un buen indicador de Calidad de Vida, es necesario incluir indicadores objetivos y subjetivos por cada una de las áreas evaluadas. Aunque para la mayoría de dominios se incluyen ambos tipos de indicadores (salud, relaciones sociales, servicios sociales y de salud, actividad física y de ocio); faltan in-

dicadores objetivos para el área de calidad ambiental (características de la vivienda y el barrio) y no existen indicadores subjetivos para el nivel económico y educativo, como la satisfacción con los mismos.

Por otro lado, la escala de relaciones sociales presentó consistencia interna media. Ocurre también en otros instrumentos que miden relaciones sociales (Antonucci et al., 2004); y es que, aunque parece que las relaciones sociales favorecen un buen envejecimiento y Calidad de Vida, no se conocen bien los parámetros que contribuyen a ello, frecuencia, variedad, el hecho de vivir solo o acompañado, o sentirse satisfecho con todo ello. Existen relaciones poco claras entre la frecuencia de relaciones sociales y la satisfacción con las mismas, y se sabe poco sobre cómo eso influye en la forma de envejecer. Por ejemplo, los resultados no son concluyentes acerca de cómo las relaciones sociales favorecen o no la salud, el buen envejecimiento y, en definitiva, la Calidad de Vida (Marquez et al., 2014). Así que, aunque parece que vivir con la pareja, una frecuente relación con amigos y estar satisfecho con ello contribuye a la Calidad de Vida, no se sabe en qué medida no tenerlo, contribuye a lo contrario y, por tanto, resulta complicado operativizar la dimensión “relaciones sociales” y elaborar una escala que evalúe los parámetros pertinentes (Marquez et al., 2014).

Otra de las limitaciones de esta investigación fue la imposibilidad de poder estudiar en qué medida se incorporaron las recomendaciones realizadas a las nuevas políticas implantadas y, sobre todo, qué impacto tuvieron sobre la Calidad de Vida de las personas mayores colimenses. Por desgracia, este hecho resulta muy común en estudios poblaciones con objetivos socio-políticos, en los que con frecuencia se realizan estudios para identificar los déficits de una población, pero no se evalúa el impacto de los programas aplicados y, por tanto, es difícil constatar la eficacia y efectividad de los cambios propuestos. Derivado de este hecho, hay que destacar, por un lado, la importancia de realizar investigación interventivo-valorativa sensible a detectar los cambios que se producen tras una intervención (Fernández-Ballesteros, 1992). Por otro, la necesidad de seguir estudiando en qué medida el CUBRECAVI como instrumento de medida de la Calidad de Vida general, es sensible a la detección de cambios, una vez aplicada una intervención; aunque ya ha sido utilizado como medida dependiente de intervenciones mostrando cambios positivos en el sentido esperado (Fernández-Ballesteros y Zamarrón, 1997, 2007), los estudios son limitados y escasos.

Los resultados presentados van en la línea de investigación que Walker y Lowenstein (2009) proponen como prioritarias en el estudio de la Calidad de Vida en mayores; atendiendo esencialmente, al estudio teórico y metodológico del constructo. Sin embargo, como se ha identificado tanto en el cómputo de artículos presentados como en la discusión general realizada, en el estudio de la Calidad de Vida todavía existen muchas lagunas y cuestiones por resolver. A continuación, proponemos las futuras líneas de investigación que, a raíz de los resultados presentados consideramos importantes. En primer lugar, mejorar la validez conceptual y teórica de los componentes de Calidad de Vida, es decir, comprobar si este doble sistema de indicadores objetivos y subjetivos se replica en otros dominios que componen la Calidad de Vida. En segundo lugar, estudiar si este modelo propuesto se replica en otras muestras de personas mayores de diferentes países, con distintas lenguas y características culturales. Tercero, analizar más detenidamente las relaciones entre variables; después de haber avalado el concepto nomotético de la Calidad de Vida, es necesario investigar cómo se relacionan las diferentes variables, y ver cómo identificar aquellos elementos target sobre los que es prioritario intervenir para mejorar la Calidad de Vida de las personas mayores. Para ello, es imprescindible realizar estudios longitudinales que nos permitan identificar cambios a lo largo del envejecimiento y realizar estudios de valoración de programas que pretendan mejorar la Calidad de Vida.

En conclusión y tras haber realizado este último trabajo de reflexión sobre el conjunto de resultados encontrado, haber identificado las principales limitaciones y describir las líneas de investigación futuras de la investigación en Calidad de Vida, queremos destacar que -desde nuestro punto de vista- este trabajo tiene implicaciones importantes para la comunidad científica puesto que supone un aval empírico que justifique el modelo teórico que se defiende; pero también para la sociedad en general, quien finalmente percibe, o al menos debiera percibir, los resultados de programas e intervenciones que pretenden mejorar su Calidad de Vida.

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ANEXOS

Anexo 1

Anexo 2

Anexo 3

ANEXOS

Anexo 1

Anexo 2

Anexo 3

Anexo 1

CUBRECAVI-R

Proyecto CASOENAC

PAIS:

CÓDIGO:

EDAD: ____ años y ____ meses FECHA NACIMIENTO: ____ - ____ -19 ____

SEXO: Mujer VarónESTADO CIVIL: Soltero Casado Separado Divorciado ViudoESTADO LABORAL: Trabaja Retirado /Pensionado Incapacitado Desempleado, ha trabajado anteriormente Ama de casaTRABAJAR/ HA TRABAJADO POR: Cuenta propia Asalariado No se aplica

¿CUÁL ES SU PROFESIÓN? _____

1. SALUD.

1.1. Salud subjetiva

1.1.2. ¿Se siente Vd. satisfecho con su salud actual?

Mucho	Bastante	Algo	Nada
4	3	2	1

1.2. Salud objetiva

1.2.1. ¿Número de enfermedades diagnosticadas?

1.2.1. En las últimas semanas, ¿ha tenido usted alguno de los siguientes dolores o síntomas?

Dolor o síntoma	Nunca	Algunas veces	Bastantes veces	Muchas veces
1. Dolor de huesos, de columna o de las articulaciones	4	3	2	1
2. Mareos o vahídos	4	3	2	1
3. Tos, catarro o gripe	4	3	2	1
4. Tobillos hinchados	4	3	2	1
5. Cansancio sin razón aparente	4	3	2	1
6. Dificultad para dormir	4	3	2	1
7. Flojedad de piernas	4	3	2	1
8. Dificultad para respirar o sensación de falta de aire	4	3	2	1
9. Palpitaciones	4	3	2	1
10. Dolor u opresión en el pecho	4	3	2	1
11. Manos o pies fríos	4	3	2	1
12. Adormilado durante el día	4	3	2	1
13. Boca seca	4	3	2	1
14. Sensación de náuseas o ganas de vomitar	4	3	2	1
15. Gases	4	3	2	1
16. Levantarse a orinar por las noches	4	3	2	1
17. Escapársele la orina	4	3	2	1
18. Zumbido de oídos	4	3	2	1
19. Hormigueos en los brazos o en las piernas	4	3	2	1
20. Picores en el cuerpo	4	3	2	1
21. Sofocos	4	3	2	1
22. Llorar con facilidad	4	3	2	1
23. Dolor de cabeza	4	3	2	1
24. Tensión alta	4	3	2	1

1.3. Salud psíquica

1.3.1. ¿Podría decirme con qué frecuencia le ocurren a usted las cosas siguientes?

Trastornos	Nunca	Casi nunca	A veces	Frecuentemente
1. ¿Sentirse deprimido, triste, indefenso, desesperado, nervioso o angustiado?	4	3	2	1
2. Tener problemas de memoria, olvidar el día de la semana, lo que ha estado haciendo o donde puso sus objetos personales	4	3	2	1
3. Desorientarse o perderse en algún lugar	4	3	2	1

2. INTEGRACIÓN SOCIAL.

2.1. ¿Con quién y con cuántas personas vive usted?

¿Quién?	Solo	Con su pareja	Hijos	Nietos	Otros familiares	Otras personas	Servicio doméstico	Residencia Habitación Compartida	Residencia Habitación Individual
¿Cuántos? Nº									

2.2. ¿En qué medida está Ud. Satisfecho con la/s persona/s con la/s que vive o solo?

Nada	Algo	Bastante	Mucho	No procede
1	2	3	4	9

2.3. ¿Con que frecuencia suele usted verse (para hablar o tomar algo) con las siguientes personas?

Personas, si procede	Todos o casi todos los días	Al menos 1 vez a la semana	Al menos 1 vez al mes	Menos de 1 vez al mes	Nunca	No tengo
1. Hijos/as que no viven con usted en la misma casa	4	3	2	1	0	9
2. Nietos/as que no viven con usted en la misma casa	4	3	2	1	0	9
3. Familiares que no viven con usted en la misma casa	4	3	2	1	0	9
4. Vecinos	4	3	2	1	0	9
5. Amigos que no sean vecinos	4	3	2	1	0	9

2.4 ¿En qué medida está usted satisfecho de la relación que mantiene con las personas allegadas a usted?

Personas, si proceden	Nada	Algo	Bastante	Mucho
1. Su cónyuge	1	2	3	4
2. Sus hijos	1	2	3	4
3. Sus nietos	1	2	3	4
4. Otros familiares	1	2	3	4
5. Vecinos	1	2	3	4
6. Amigos no vecinos	1	2	3	4

3. HABILIDADES FUNCIONALES

3.1. ¿Cómo considera Vd. que puede valerse por sí mismo?

Muy bien	Bien	Regular	Mal
4	3	2	1

3.2. ¿En que medida tiene usted dificultades para realizar las siguientes actividades?

Actividades	Ninguna	Alguna	Bastante	Mucha	No lo hace (no aplica)
1. Cuidar de su aspecto físico (peinarse, lavarse, vestirse, ducharse)	4	3	2	1	9
2. Realizar tareas del hogar	4	3	2	1	9
3. Caminar	4	3	2	1	9
4. Realizar tareas fuera de casa	4	3	2	1	9

4. ACTIVIDAD Y OCIO

4.1. Ejercicio Físico

¿Cómo describiría su actividad física en su vida diaria durante el último año?

4.2.1	Actividad sedentaria	No realiza ningún ejercicio físico regular.		
4.2.2	Actividad física escasa y no regular:	Algunas veces pasea, realiza tareas domésticas ligeras, jardinería normal esporádica.		
4.2.3	Ejercicio físico regular ligero (caminar, jardinería normal, deporte de baja intensidad, etc.)	De 1 a 2 horas semana	Entre 2 y 3 horas semana	Más de 3 horas semana
4.2.4	Ejercicio físico regular moderado (nadar, gimnasia de mantenimiento, etc.)	De 1 a 2 horas semana	Entre 2 y 3 horas semana	Más de 3 horas semana
4.2.5	Ejercicio físico regular intenso (correr, tenis, entrenamiento físico fuerte)	De 1 a 2 horas semana	Entre 2 y 3 horas semana	Más de 3 horas semana

		A diario	Semanal	Mensual	Nunca
2.1.1. ACTIVIDADES DE OCIO	Leer libros, periódicos o revistas	4	3	2	1
	Ir a algún espectáculo (cine, teatro, festivales, etc.)	4	3	2	1
	Realizar actividades como crucigramas, sudoku, jugar al ajedrez, etc.	4	3	2	1
	Celebraciones familiares, fiestas, ...	4	3	2	1
	Buscar información, chatear, etc. en Internet	4	3	2	1
	Ver la televisión	4	3	2	1
	Escuchar la radio	4	3	2	1
	Viajar, hacer excursiones	4	3	2	1
2.1.2 ACTIVIDADES PRODUCTIVAS	Cuidar niños	4	3	2	1
	Cuidar familiares enfermos	4	3	2	1
	Hacer manualidades (coser, bricolaje, punto, etc.)	4	3	2	1
	Hacer recados, gestiones	4	3	2	1
	Ir de compras o a la compra	4	3	2	1
	Trabajo de voluntariado	4	3	2	1
	Trabajo remunerado	4	3	2	1

4.2. ¿Con qué frecuencia, durante el último año, ha realizado usted las siguientes actividades?

2.3. ¿En general está usted satisfecho con la forma en que ocupa el tiempo?

Nada	Algo	Bastante	Mucho
1	2	3	4

5. CALIDAD AMBIENTAL

5.1. ¿En qué medida su casa/ residencia...?

Aspectos	Nada	Algo	Bastante	Mucho
1. es silenciosa	1	2	3	4
2. mantiene una temperatura agradable	1	2	3	4
3. es luminosa	1	2	3	4
4. está ordenada y limpia	1	2	3	4
5. el mobiliario está en buen estado	1	2	3	4
6. dispone de comodidades (lavavajillas, lavadora, microondas, aire acondicionado, calefacción, etc.)	1	2	3	4

5.2. ¿Qué grado de satisfacción tiene usted con la vivienda/residencia en general?

Nada	Algo	Bastante	Mucho
1	2	3	4

6. SATISFACCIÓN CON LA VIDA

6.1. ¿En qué medida está Ud. satisfecho, en términos generales, con la vida?

Nada	Algo	Bastante	Mucho
1	2	3	4

7. EDUCACIÓN

7.1. ¿Podría decirme el nivel máximo de estudios terminados alcanzados por usted?

Ingresos mensuales en Euros	Puntuación
Menos de estudios primarios, no sabe leer	0
Menos de estudios primarios, sabe leer	1
Estudios primarios completos	2
Formación profesional 1er. Grado	3
Formación profesional 2do. Grado	4
Bachiller elemental, EGB	5
Bachiller superior, BUP, COU	6
Estudios de grado medio	7
Universitarios o Superiores	8
NS/NC	9

8. INGRESOS

8.1. ¿Podría decirme los ingresos mensuales, que por todos los conceptos, entran en su hogar?

Ingresos mensuales en Euros	Puntuación
Hasta 300	0
De 301 a 450	1
De 451 a 600	2
De 601 a 900	3
De 901 a 1200	4
De 1201 a 1600	5
De 1601 a 2100	6
De 2101 a 2700	7
Más de 2700	8
NS/NC	9

9. SERVICIOS SOCIALES Y SANITARIOS

9.1. ¿Con qué frecuencia utiliza usted los servicios sociales que le ofrece la comunidad/residencia (polideportivos, centros de mayores,)?

Muchas veces	Bastantes veces	Algunas veces	Nunca
1	2	3	4

9.2. ¿Con qué frecuencia utiliza usted los servicios sanitarios que le ofrece la comunidad/residencia (ambulatorio, hospital, atención domiciliaria)?

Muchas veces	Bastantes veces	Algunas veces	Nunca
1	2	3	4

9.3. ¿En qué medida está usted satisfecho con los servicios sociales que utiliza?

Mucho	Bastante	Algo	Nada
4	3	2	1

9.4. ¿En qué medida está usted satisfecho con los servicios sanitarios que utiliza?

Mucho	Bastante	Algo	Nada
4	3	2	1

10. IMPORTANCIA DE LOS COMPONENTES CALIDAD DE VIDA

- 10.1. Como usted sabe, hoy en día un objetivo importante es lograr una mayor calidad de vida. ¿Podría decirme qué importancia concede usted a cada uno de los aspectos que le voy a indicar para su calidad de vida, indicando cuál es el primero, el segundo, el tercero, el cuarto, el quinto, y el sexto más importante?

Aspectos	1°.	2°.	3°.	4°.	5°.	6°.
1. Tener buena salud						
2. Mantener buenas relaciones con la familiar y sociales						
3. Poder valerse por sí mismo						
4. Mantenerse activo						
5. Tener una vivienda buena y cómoda						
6. Sentirse satisfecho con la vida						
7. Tener oportunidades de aprender y conocer nuevas cosas						
8. Tener una buena pensión o renta						
9. Tener buenos servicios sociales y sanitarios						
Otras, ¿Cuáles)						
Ninguna						
NS/NC						

- 10.2. ¿Cómo valora Vd. su propia Calidad de Vida?

Baja	Media-baja	Media-alta	Alta
1	2	3	4

ANEXOS

Anexo 1

Anexo 2

Anexo 3

Anexo 2

CUBRECAVI –R. Cambios realizados respecto a la versión original publicada en TEA.

ADICIÓN DE ÍTEMS

En cuanto al área de “Salud”, solo se ha llevado a cabo un cambio en relación al número de síntomas físicos por los que se pregunta. Se ha añadido “Dolor de cabeza”.

En la escala de “Integración social”, se ha modificado la pregunta sobre convivencia. En el CUBRECAVI original solo existen dos opciones de respuesta vivir “solo” o “acompañado”. En esta revisión se especifica con quién vive: pareja, hijos, nietos, servicio, etc.

En la escala de “Actividad y ocio” se llevaron a cabo dos tipos de cambios. En relación a la pregunta de frecuencia de actividad física, se cambió la escala de respuesta de 5 puntos a 7. Esta recodificación de la escala de respuesta tiene en cuenta tanto la frecuencia como la intensidad del ejercicio físico que se realiza. En cuanto a la frecuencia de actividades de ocio y productivas se han añadido algunas como: “buscar información, chatear, etc. en Internet”, “viajar, hacer excursiones”, “realizar actividades como crucigramas, sudoku, jugar al ajedrez, etc.”, “trabajo de voluntariado”,...

En el resto de las escalas no se realizó ningún cambio.

ADAPTACIONES DE LENGUAJE

A continuación se presentan varias tablas especificando el tipo de adaptaciones lingüísticas o culturales que se ha realizado en el CUBRECAVI-R aplicado en México. En estas tablas, se encuentra la información que se modifica del ítem de España tachado y lo que se añade para México subrayado, con el fin de identificar fácilmente las diferencias.

De nuevo, una de las escalas que ha sufrido cambios ha sido “Salud objetiva”. A este nivel, algunas palabras que describían los síntomas han tenido que ser eliminadas o ligeramente modificadas para poder ser entendidas por la muestra de México. A continuación se especifican los cambios:

Dolor o síntoma
2. Mareos o vahídos
7. Flojedad <u>Debilidad</u> de piernas
16. Levantarse <u>y/o</u> orinar por las noches
20. Picores <u>Picazón</u> en el cuerpo
21. Sofocos <u>Ahogos</u>

En la escala de “Actividades de la Vida Diaria” (AVDs). Se modificaron algunas expresiones y se ejemplificaron algunos ítems, como se muestra a continuación.

Actividades
1. Cuidar de su aspecto físico (peinarse, lavarse, vestirse, ducharse, <u>bañarse</u>)
2. Realizar tareas del hogar
3. Caminar
4. Realizar tareas fuera de casa (<u>compras, pagos, salir de paseo</u>)

En la escala de “Actividad y ocio”, en el ítem referente a las “Actividades productivas”, también se modificaron los ejemplos propuestos para cada actividad, puesto que el tipo de tareas que se asociaban a ellas eran diferentes.

ACTIVIDADES PRODUCTIVAS
Cuidar personas, niños o familiares
Hacer manualidades (<u>coser, pintar, bordar, ganchillo, punto, etc.</u>)
Hacer recados o gestiones, <u>pagos (luz, agua, teléfono).</u>
Ir de compras o a la compra
Trabajo de voluntariado

En la escala “Calidad ambiental”, sólo fue modificado el último ítem en relación a la satisfacción con las comodidades de la vivienda, que se eliminó la palabra “electrodomésticos”.

En cuanto al nivel máximo de estudios alcanzado, se equipararon los nombres entre España y México de la siguiente manera:

GRADO ALCANZADO España	GRADO ALCANZADO México
Menos de estudios primarios, no sabe leer	Menos de estudios primarios (no sabe leer)
Menos de estudios primarios, sabe leer	Primaria no concluida (sabe leer)
Estudios primarios completos	Primaria concluida
Formación profesional 1er. Grado	Secundaria no concluida
Formación profesional 2do. Grado	Secundaria concluida
Bachiller elemental, EGB	Bachillerato no concluido
Bachiller superior, BUP, COU	Bachillerato concluido
Estudios de grado medio	Licenciatura no concluida
Universitarios o Superiores	Licenciatura concluida
NS/NC	NS/NC

La equivalencia monetaria de Ingresos mensuales se realizó de la siguiente manera:

Ingresos mensuales en Euros	Ingresos mensuales en Pesos
Hasta 300€	Menos de \$1,500.00
De 301€ a 450€	De \$1,501.00 a \$2,500.00
De 451€ a 600 €	De \$2,501.00 a \$3,500.00
De 601€ a 900 €	De \$3,501.00 a \$4,500.00
De 901€ a 1200 €	De \$4,501.00 a \$5,500.00
De 1201€ a 1600 €	De \$5, 501.00 a \$6,500.00
De 1601€ a 2100 €	De \$6,501.00 a \$7,500.00
De 2101€ a 2700 €	De \$7,501.00 a \$ 8,500.00
Más de 2700 €	Más de \$8,500.0
NS/NC	NS/NC

ANEXOS

Anexo 1

Anexo 2

Anexo 3

Anexo 3

Componentes de la Calidad de Vida desde el punto de vista de las personas mayores

ESPAÑA

	1	2	3	Total
Tener buena salud	439 71.0%	113 18.3%	41 6.6%	593 95.9%
Poder valerme por mi mismo	80 12.9%	191 30.9	152 24.6%	423 68.4%
Mantener buenas relaciones familiares y sociales	45 7.3%	169 27.3%	158 25.6%	372 60.2%
Mantenerme activo	17 2.8%	33 5.3%	115 18.6%	165 26.7%
Tener una buena pensión o jubilación	20 3.2%	65 10.5%	67 10.8%	152 24.5%
Tener buenos servicios sociales y sanitarios	7 1.1%	18 2.9%	30 4.9%	55 8.9%
Sentirme satisfecho con la vida	4 0.6%	15 2.4%	25 4.0%	44 7%
Tener una vivienda buena y cómoda	4 0.6%	13 2.1%	25 4.0%	42 6.7%
Tener oportunidades de aprender y conocer nuevas cosas	1 0.2%	4 0.6%	9 1.5%	14 2.3%

MEXICO

	1	2	3	Total
Tener buena salud	933 77.8%	151 12.6%	49 4.1%	1133 94,5
Mantener buenas relaciones familiares y sociales	85 7.1%	472 39,4%	143 11,9%	700 58,4
Poder valerme por mi mismo	60 5.0%	257 21.4%	361 30.1%	678 56,5
Mantenerme activo	16 1.3%	69 5.8%	154 12.8%	239 19,9
Tener una buena pensión o jubilación	31 2.6%	52 4.3%	122 10.2%	205 17,1
Tener una vivienda buena y cómoda	26 2.2%	84 7.0%	123 10.3%	233 19,5
Sentirme satisfecho con la vida	16 1.3%	38 3.2%	122 10.2%	176 14,7
Tener buenos servicios sociales y sanitarios	18 1.5%	35 2.9%	73 6.1%	126 10,5
Tener oportunidades de aprender y conocer nuevas cosas	4 0.3%	18 1.5%	39 3.3%	61 5,1

