The Quality of Life of Older Adults Living in an Urban Environment: Professional and Lay Perspectives*

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RÉSUMÉ

Cette étude vise à identifier les facteurs reliés à la qualité de vie en milieu urbain chez les aînés et comparer les perspectives professionnelles et celles des personnes âgées en ce domaine. Les données ont été recueillies lors de groupes de discussion avec des aînés ($n = 8$) et des professionnels ($n = 3$). Les résultats révèlent une variété de thèmes, reflétant une gamme élargie de déterminants de la santé et de la qualité de vie et ce, chez les deux types de participants. Parmi les thèmes saillants figurent : la santé et l'indépendance, la sécurité financière, l'intégration sociale, les services de santé, les logements, l'accès aux services communautaires et le pouvoir décisionnel. Les commentaires desaînés et des professionels sont très convergents. Des questions spécifiques sont envoquées par chacun des deux types de participants. Les aînés ont discuté de façon beaucoup plus marquée des questions liées à la croissance et aux qualités personnelles de même qu'à la spiritualité. Les questions reliées à l'environnement ont fait l'objet de descriptions beaucoup plus étoffées chez les professionnels. En identifiant clairement une gamme de cibles d'action, ces résultats contribuent à enrichir les connaissances devant soutenir le développement d'interventions de promotion de la santé des aînés.

ABSTRACT

This study aimed to identify factors affecting older adults' quality of life in urban environments and to compare older adults' and professionals' perspectives on the issue. Eleven focus groups were conducted (eight involving older adults, three involving professionals), each discussing a wide range of issues related to determinants of health and quality of life. The most salient themes were health and independence, financial security, social integration, health care services, housing, accessibility of community services, and decision-making power. Older adults' and professionals' comments strongly converged, with specific issues also raised by each. Older adults provided the richest and most in-depth data on intrapersonal factors, such as personal growth, personal qualities, and spirituality. Professionals discussed community environment issues in greater depth. Health promotion interventions to maximize older adults' quality of life are needed. These results contribute to building a knowledge base to guide such efforts, by identifying a variety of possible intervention sectors for future programs.

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Introduction

The aging of the population is of great concern to health planners and practitioners (Ebrahim, 1997, 1999). Although increased longevity is generally considered to be a desirable goal and a sign of progress, it should not come at the cost of increased incapacity and a reduction in quality of life during people's final years. With many older adults currently suffering from incapacity and chronic illnesses, optimizing quality of life should be an important objective for a successful societal transition to an older population (Abeles, Gift, & Ory, 1994; Ebrahim, 1997; Keller & Fleury, 2000; Minkler, Schauffler, & Clements-Nolle, 2000). It is thus crucial to understand the factors that facilitate or impair older adults' quality of life, in order to identify vulnerable individuals and propose appropriate interventions.

The literature, particularly studies related to older adults, shows that this question has long held the attention of both social and medical researchers (Draper, 1997; Raphael, 2001). Despite the abundance of research in these fields, there is still no consensus about the definition of the concept, especially its dimensions and measurement (Fry, 2000a; Hunt, 1997; Jylhä, 1995). Furthermore, while existing tools have supported significant advances in clinical trials and research on social indicators, this work is of limited use to those health promotion planners and practitioners interested in identifying the intervention needed to improve quality of life of older populations.

Two major critiques of the quality-of-life literature are grounded in two central features of the health promotion and new public health movements (Schwab & Syme, 1997). First, the quality-of-life research is often focused on individuals' personal characteristics (Raphael et al., 1995; Raphael et al., 1999), which is somewhat at odds with the health promotion movement's wider vision of the determinants of health (Smedley & Syme, 2000). Furthermore, little consideration has been given to notions of personal control and opportunities for growth (Raphael et al., 1995; Raphael et al., 1999), which are central to a contemporary vision of health (World Health Organisation, Health and Welfare Canada, & the Canadian Public Health Association, 1986).

The second critique concerns the objective of participation inherent in health promotion research and intervention. So far, the scientific community's interest in quality of life has focused mainly on measurement (Jylhä, 1995). The primarily post-positivist research approaches have used measuring instruments with conceptual dimensions pre-defined by experts rather than by participants (Draper, 1997; Jylhä, 1995; Raphael, 2001). However, a perspective grounded in the alternative research approaches and methods advocated by the health promotion field would argue that quality of life is not a universal, abstract phenomenon, but rather a relative, contextual phenomenon laden with individual meaning (Eakin, Robertson, Poland, Coburn, & Edwards, 1996; Gendron, 2001). A research approach to investigate this phenomenon should thus be able to account for such complexity. As stated by Jylhä, "[T]here are innumerable elements out of which a (good) quality of life can be constructed, but in specific situations only certain things have real importance: . . . the thing is that there is no mechanical standardized way of finding out what those elements are" (Jylhä, p. 142).

Alternative methods, such as discussions and personal accounts, might be the most useful means of accessing issues that are meaningful for older adults.

Few quality-of-life studies have used an approach that privileges participants' voices and viewpoints. Fry (2000b) recently used a mixed methodology of questionnaires and semi-structured interviews to ask older adults about their perspectives on quality of life: their perceptions of factors that can positively or negatively contribute to quality of life, and their anxieties about – and their aspirations for – their current and future quality of life. While classic themes such as financial security and access to health services emerged as important factors affecting quality of life, additional issues arose, such as the right to privacy, personal control, and self-sufficiency in implementing late-life decisions. In another recent study, Raphael et al. (2001) used focus groups and interviews with informed older adults, service providers, and government representatives to identify nine key policy areas influencing older adults' quality of life: housing, acute illness care, long-term care, income security, transportation and mobility, promotion of healthy lifestyles,

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access to information, and acknowledgement of older adults' voices, including those from cultural communities.

Based on these considerations, our study aimed to identify the factors affecting quality of life for older adults in an urban environment, according to their perspectives. A secondary objective was to compare older adults' views with those of professionals involved with this clientele. Because decisions on priorities and resource allocation for the older adult population are often, if not always, heavily influenced by professionals' and experts' views, it is relevant to explore the extent to which their ideas on quality of life match those of older adults.

Methods

Research Context and Design

This study was part of a national participatory project on quality of life for older adults in Canada (Bryant et al., 2004). This paper reports on the Montreal project, led by a coordinating committee of older adults and researchers (the first and second authors) and supported by an advisory committee of local planners and practitioners. The leading partner was the Senior Citizens' Forum of Montreal, a social action group of older adults and organizations whose aims are to improve older adults' quality of life and contribute to society's well-being (www.fcam.qc.ca).

In line with the national research protocol and to facilitate comparisons with other sites, a focus-group methodology was selected (Krueger, 1994).

Participants and Recruitment Procedures

Older Adults

Older adult participants were recruited from seniors' groups and other Montreal community organizations serving older adults. Selected organizations ($n = 8$) were chosen to maximize the diversity of the participants based on their socio-economic status, health status, and cultural affiliations.

Recruitment began by contacting the leaders of these selected community organizations, all of whom agreed to participate. The directors or key informants from the organizations identified potential participants aged 55 and over among their memberships who might be interested in taking part in the study and invited them to participate in a focus group. Persons living in institutions were ineligible. One focus group of 8 to 10 participants was conducted for each organization, with a total of 72 older adults participating in eight focus groups. Written consent was obtained from participants at the beginning of each group.

Professionals

The Project Coordination and Advisory Committees created a list of 20 professionals involved with the planning or provision of services to older adults in Montreal. Care was taken to ensure representation from the intervention sectors concerned with older adults' quality of life, which included the community sector, public services sector, and municipal government departments. The project coordinator contacted potential participants, and all agreed to participate. Participants were assigned to one of three focus groups.

Focus-Group Procedures

All groups were conducted in French, with the exception of two focus groups of older adults, conducted in English and Spanish respectively. The same moderator led all the focus groups, except the Spanish group.

The older adults' focus groups lasted between 1 and 2 hours and took place on the premises of the participating community organizations. The professionals' focus groups were somewhat longer, between 2 hours and 2.5 hours in length, and were held at the Senior Citizens' Forum of Montreal.

In keeping with Krueger's (1994) approach, all the groups began with an introduction that familiarized participants with the topic and the ground rules of the focus group. The moderator then asked the initial uncued, open-ended questions, allowing participants to offer their personal opinions about the factors involved in quality of life for older adults and to have an interchange with other group members. After discussion, the moderator probed to elicit additional comments on themes already mentioned. An interview guide was used with questions on the following topics: factors related to good quality of life for older adults; elements negatively and positively affecting the quality of life of participants; existing and proposed measures to improve quality of life for older adults; and the role governments can play in the quality of life of older adults. Professionals were questioned on the same themes as were the older adults, except the questions were less personal, focusing on their organizations and the older adults whom they served. At the end of the meeting, all participants completed a short questionnaire documenting their basic personal characteristics.

Data Analysis

All focus groups were audiotaped. A research assistant took detailed field notes at each session,

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except that of the Spanish group. He later carefully listened to the audiotapes and coded each of the ideas expressed by participants into thematic categories. Data-analysis procedures followed Krueger's (1994) general principles; however, budgetary constraints limited the depth of analysis. As a result, the analysis was mostly descriptive, identifying the factors reported by the focus groups that negatively and positively influence quality of life for older adults. The research assistant also determined the relative importance accorded to each theme by participants by taking three factors into account: the number of focus groups that discussed a theme, the number of participants involved in the discussion of the theme, and the degree of consensus on that theme within the group.

The coding and analysis was validated at two levels. First, the principal researcher (the first author) conducted a detailed review of all the preliminary reports and audiotapes from the French and English groups. A Spanish-speaking collaborator followed the same validation process for the Spanish material. The second level of verification involved reviewing each preliminary report with focus-group participants at the corresponding community organization's location and allowing them to propose corrections. A synthesis report was then produced using the revised focus-group reports and the field notes (Richard, Laforest, Dufresne, & Sapinski, 2001).

Results

Participant Characteristics

Older Adults

The majority of participants (56%) were aged 70–79 (see Table 1). Nearly three-quarters of the participants were women. Most of them reported their financial situation to be sufficient or comfortable, with only 22 per cent describing themselves as poor or very poor. Health status was perceived as excellent or very good by a majority of participants (62%).

Professionals

Participants represented a diversity of organizations and professional disciplines. Slightly over one third came from the public services sector (health, education, transportation, police), another third from the community sector, and the rest worked for municipal governments (see Table 2). A majority of them devoted more than 40 per cent of their working time to issues related to older adults.

Factors Related to Quality of Life

Tables 3 and 4 summarize participants' perceptions about factors that positively or negatively affect the quality of life of older adults. Because the themes ranged from individual characteristics to macro-environmental features, we decided to use an organizing framework inclusive enough to handle such a broad spectrum of quality-of-life determinants. The ecological model of McLeroy et al. (McLeroy, Bibeau, Steckler, & Glanz, 1988) was chosen for this purpose. It emphasizes a variety of health determinants, including not only individual factors (intrapersonal factors such as attitudes and behaviours) but also, and primarily, factors related to individuals'

Table 1: Participant characteristics: Older adults (*N* = 72)

Characteristics	%
Age (*n* = 68)	
50–59 years	4.4
60–69 years	22.1
70–79 years	55.9
80–89 years	17.6
Gender (*n* = 72)	
Female	73.6
Male	26.4
Marital Status (*n* = 69)	
Married/common-law	33.3
Single (never married)	14.5
Divorced/separated	20.3
Widowed	31.9
Education (*n* = 68)	
Grade 5 or less	8.8
Grade 6–9	36.8
Commercial/science/classics program	13.2
University	30.9
Other	10.2
Self-Reported Economic Situation (*n* = 69)	
Comfortable	26.1
Sufficient income	52.2
Poor	15.9
Very poor	5.8
Self-Reported Health Condition (*n* = 60)	
Excellent	18.3
Very good	43.3
Average	35.0
Poor	3.3

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Table 2: Participant characteristics: Professionals (*N* = 20)

Characteristics	*N*
Organization (*n* = 20)	
Community organization	7
Public health sector organization	5
Municipal government	5
Public education sector organization	1
Public transportation sector organization	1
Police	1
Number of Years of Experience (*n* = 20)	
0–5 years	8
6–15 years	7
16 years and over	5
Proportion of Time Dedicated to Issues Involving Older Adults (*n* = 18)	
0–20%	4
21–40%	4
41–80%	3
81–100%	7
Primary Educational/Professional Background (*n* = 17)	
Psychology, social work, psycho-education	8
Physical education	3
Humanities, philosophy	3
Engineering	2
Management/business	1
Age (*n* = 20)	
25–34 years	2
35–44 years	9
45–54 years	4
55 years and over	5
Gender (*n* = 20)	
Male	8
Female	12

environments (interpersonal, organizational, community, and political factors).

Intrapersonal Factors

Three distinct clusters of themes were identified. The first consisted of two themes mentioned by participants in all groups: health and independence, and financial security. However, little discussion occurred on these themes because in most groups participants simply stated at the beginning that these were essential, self-evident prerequisites to a good quality of life.

A second cluster consisted of themes common to both types of participants, although discussed much more extensively by older adults. The first such theme was self-determination, described as the freedom to do whatever one likes and to make decisions for oneself, free of external constraints imposed by others, such as the state or an employer. Additional prominent themes included the importance of continued opportunities for personal growth and learning, as well the ability to pursue favourite activities. A third theme, primarily mentioned by older adults, suggested that a ''personal positive attitude towards life'' is linked to quality of life. This was defined as an openness towards and an interest in others, an acceptance of one's situation, and an active rather than a passive orientation to life. Negative self-perceptions and feelings of being useless were discussed by one group of professionals, who clearly related this to society's negative image of older adults: ''In the end, we become the older person that they suggest we are.''

The third cluster consisted of themes discussed exclusively by the older adults. In the majority of groups, quality of life was linked to specific personal characteristics; particularly, capacity for love, capacity for wonder, ability to live in the present and accept that one is aging, resourcefulness, and a sense of humour. Another element mentioned only by older adults related to the spiritual dimension, with religion, spirituality, and ''occasions to reflect on the meaning of life'' identified by several participants as essential to quality of life. Some clearly identified their traditional religious faith as important to quality of life: ''I have peace of mind . . . Because I'm a religious person.'' Others, like this man, defined their spirituality more broadly: ''I'm not really religious in the sense of belonging fully to a particular church, although I'm a Catholic. I find interest and solace in the general attitude to the development of the universe. In other words, I take a philosophical attitude. I read cosmologies of all different types, etc., and that opens my mind quite a bit in my old age.''

Later in the same group, another woman discussed her experience related to the previous comments: ''The other thing is the spirituality. I could not have done it without faith. I don't think I could be a survivor without faith. And I talk about spirituality, not religion, because sometimes religion doesn't provide the answers for everyone.''

Others also discussed how their faith and spirituality gave them the strength to cope with factors

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Table 3: Factors positively related to quality of life

Theme	No. of groups	
	Older adults ($N = 8$)	Professionals ($N = 3$)
Mentioned by Both Older Adults and Professionals		
Intrapersonal Factors		
Health and independence	8	3
Financial security	8	3
Self-determination	6	1
Opportunities for personal growth and learning	6	1
Personal activities / active lifestyle	6	1
Positive personal attitude	5	2
Life history	3	1
Interpersonal Factors		
Human contacts and social networks	7	3
Feeling useful/accepted; having a place in society	7	3
Social activities/involvement	7	1
Organizational Factors		
Quality and accessibility of health care services	6	2
Home-care services	5	1
Accessibility of medication	1	1
Community Factors		
Accessibility and proximity of services	6	3
Accessibility/quality housing	6	2
Accessibility/quality of public transportation	3	2
Safe environment	2	2
Political Factors		
Having decision-making power	5	2
Adequate income	3	1
Mentioned by Older Adults Only		
Intrapersonal Factors		
Personal qualities and capacities	5	
Spirituality/religion	4	
Luck	2	
Interpersonal Factors		
Balance and variety of activities	2	
Linguistic integration	2	
Organizational Factors		
Respect/consideration by health care workers	2	
Community Factors		
Availability of seniors' centres	7	
Easy access to services and resources	6	
Pleasant, healthy, and clean neighbourhood	5	
Mentioned by Professionals Only		
Interpersonal Factors		
Failures in the Health Care System Reform		1

Themes discussed by only one group of older adults: healthy society and social peace.
The importance of having intergenerational contacts was discussed by one group of professionals and by only one older adult participant.

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Table 4: Factors negatively related to quality of life

Theme	No. of groups	
	Older adults ($N = 8$)	Professionals ($N = 3$)
Mentioned by Both Older Adults and Professionals		
Intrapersonal Factors		
Financial problems/poverty	4	1
Negative personal attitude/self-perception	1	2
Interpersonal Factors		
Isolation, lack of social support	7	3
Negative attitude towards older adults	4	2
Difficulties in becoming socially involved	4	3
Violence/abuse	3	1
Organizational Factors		
Medication costs	6	1
Deterioration of the health system	4	2
Tendency towards over-medication	2	1
Community Factors		
Lack of affordable, quality housing	8	1
Poor quality of the regular/adapted transit system	4	3
Lack of access to adapted housing	3	1
Overloaded volunteer network	4	1
Difficulties in getting around the city (environmental barriers)	3	2
Automation of services	2	2
Climate of fear and insecurity	2	2
Political Factors		
Little decision-making power; feelings of powerlessness	5	1
Little or no consultation on important issues affecting populations	3	1
Mentioned by Older Adults Only		
Intrapersonal Factors		
Health problems and loss of independence	2	
Addictions	2	
Difficulties in adapting to retirement	2	
Political Factors		
Inadequate old age pension	7	
Questionable government financing priorities and actions	5	
High levels of taxation	4	
Government loss of power	3	
Abusive coercion by government	2	

(***continued***)

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Table 4 continued

Theme	No. of groups	
	Older adults ($N = 8$)	Professionals ($N = 3$)
Mentioned by Professionals Only		
Organizational Factors		
Lack of staff courtesy		1
Failures in the health care system reform		1
Community Factors		
Limited access to alternative community transportation services		2
Political Factors		
Sector-based vision of decision makers		2
Community sector over-controlled and insufficiently funded		1

Themes discussed by only one group of older adults: lack of spirituality, the need to move out of home, false negative image of the health system presented by the media, cold climate, tensions between anglophones and francophones, transfer of government responsibilities to families and group residences, too lengthy sponsorship period for immigrants.
Themes discussed by only one group of professionals and to a lesser degree (by only one participant): lack of information about available social and community resources, difficulties related to community coalitions (often seem detached from people's real concerns), natural disasters, adoption of projects that do not comply with municipal zoning bylaws, methods for awarding grants (depending on the current fashion), discriminatory hiring practices that exclude older adults from the workforce.

negatively affecting their quality of life, allowing them to experience quality of life in an inner sense when external, physical factors were more difficult.

Interpersonal Factors

Interpersonal factors clearly occupied a large part of the discussions and had the highest levels of consensus for both types of participants. The analysis revealed the importance of three levels of social integration. At the first level, both older adults and professionals emphasized the need for social relationships and the availability of help. Loneliness, isolation, and the loss of loved ones were spontaneously identified as major elements having a detrimental effect on quality of life. At the second level, both types of participants expressed the view that older adults need to feel socially integrated through participation in social activities and other forms of social involvement. The multiple benefits of participation in volunteer networks and activities were highlighted by many older adults in the majority of groups: ''It is another lifeline for me.'' One man reported, ''I'll tell you why my life is interesting. It's because since I've been retired, I've been involved in 10 times more volunteer work across generations, doing things I enjoy, instead of thinking about all my little aches and pains. And this is the joy of my retirement. If I had to stay at home like a lot of others and not go out, I'd be really unhappy.''

Older adults also insisted on the need to have access to varied activities and to maintain a balanced activity level, avoiding over-commitment and ''hyperactivity.'' Professionals contributed additional elements and discussed barriers limiting older adults' social involvement, such as the limited availability of interesting activities, the apathy of older adults themselves, and limited opportunities for volunteering, which were the result of fears that they could reduce the number of regular jobs. At the third level, older adults and professionals highlighted the need for older adults to feel useful and accepted and to have a place in society. In particular, many were concerned with the infantilization of older people, the lack of respect shown to them, and the feeling that older adults are a burden. One woman was disturbed by how ''older people are infantilized, to the point where they are addressed by the informal 'you' [in French], called by their first names.''

Another woman pointed out that in regular housing units, ''older people aren't treated in the same way. It's *just* an older person.'' Relating to this theme, older adults often mentioned a recent social debate on health care priorities (''a pacemaker for a senior of 85 years?'') as an example of how they feel excluded, a burden. Violence and abuse were also mentioned, although relatively marginally. Finally, the importance of having intergenerational contacts was discussed

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by one group of professionals, an idea briefly mentioned by only one older participant.

Organizational Factors
The health care system emerged as a major and general concern for both types of participants, who believed that several elements essential to quality of life in health care have deteriorated: the amount of resources; the accessibility and quality of services, including home-care services; and access to medication, since the implementation of a new government insurance plan. A tendency to over-medicate was highlighted by many older adults and professionals. Respect and consideration by health workers was a common concern about which older adults shared their experiences: ''[The doctor] doesn't even care to take off his coat when he comes to take my blood pressure.'' Professionals contributed specific comments related to Centres locaux de services communautaires (CLSCs[1]) and deplored their reduction of services, particularly in prevention.

At the macro-level, one group of professionals discussed at length Quebec's health reform failures. For example, they noted that the policy shift to ambulatory care has been characterized by a lack of coordination between hospitals and CLSCs. More generally, policies and procedures have not always responded to the needs of the older population.

Community Factors
Participants reached a high level of consensus on a variety of community factors. Older adults and professionals identified accessibility of services as a primary issue for older persons living in an urban area. One group of professionals felt the shift to a suburban model, characterized by superstores in commercial and industrial zones at the expense of small-scale neighbourhood retailers, was a key reason for decreased accessibility of services. Some older adults and professionals highlighted the automation of services, such as banking, as an example of decreasing accessibility of services for older adults. Second, participants were concerned about housing, focusing on the lack of affordable, quality housing in good locations and the difficulties associated with the conversion of existing housing into adapted units for older adults. Third, older adults and professionals considered public and adapted transportation to be essential to quality of life in an urban environment, and discussed factors such as accessibility, safety, and employees' lack of courtesy. Fourth, discussions centred on the need for safe neighbourhoods. Environmental obstacles in the city (e.g., poorly maintained sidewalks, and street/traffic designs poorly adapted to older adults) were viewed as significant barriers to older adults' quality of life. Other barriers included crime and the resulting fearfulness, though some professionals suggested that the importance given by the media to incidents involving older adults could exaggerate the risk of becoming a victim. A majority of the older adults' groups also identified the importance of residing in a ''pleasant, healthy, and clean neighbourhood.'' Finally, reflecting the recruitment mode, a majority of older adults in all groups strongly insisted on the benefits of participating in activities at seniors' centres.

Political Factors
At the political level, older adults and professionals both strongly emphasized that having a high quality of life depends on being listened to, being respected, and having decision-making power. Lack of citizen participation and influence in politics, especially for the older population, creates feelings of powerlessness about their ability to change things. Many felt this was related to lack of government consultation on important social issues.

Older adults also discussed at length a cluster of issues related to government financial priorities and actions. Unanimously condemning the inadequacy of old age pensions, many mentioned issues such as high taxation levels, a lack of commitment to the common good, a loss of power of the state vis à vis the private sector, and abusive government coercion (e.g., by imposing a lengthy period of sponsorship for older adult immigrants, judged to be too long by participants). Furthermore, two of the professionals' focus groups criticized the sector-based approach too often used by decision makers, which tends to separate older adults from the rest of population. Finally, they censured governments' treatment of the community sector.

Synthesis and Comparative Analysis

In general, a high level of convergence was found between older adults and professionals. At the intrapersonal level, the most convergent themes were health and autonomy, financial security, and having a positive attitude towards life. At the interpersonal level, social integration was the principal theme identified by both types of participants. The health care system was the key organizational factor, particularly the need for improved accessibility and quality. Also of concern were staff courtesy and respect, as well as access to medication. At the community level, there was consensus on access to services and resources, housing and transportation, and neighbourhood safety. Finally, at the political level, both types of participants emphasized

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the importance of older adults being heard and participating in decisions on issues that affect them.

Both older adults and professionals also had their own specific concerns. Unquestionably, the richest data on intra-personal factors was provided by older adults who discussed personal growth, personal qualities, and spirituality at length. While their views overlapped considerably with professionals' on community factors, older adults placed greater emphasis on the positive impact of community centres and organizations, in which most of them were involved. Their discourse on neighbourhood characteristics also referred to cleanliness and a pleasant character, elements not explicitly identified by professionals.

Professionals' more in-depth discussions on the community environment expanded on themes that were also mentioned, although at times more superficially, by older adults. They also felt very strongly about the need for a ''comprehensive vision,'' criticizing the present sector-based approach that tends to isolate the needs of older adults from those of the general population. Finally, by touching on macro-level factors involved in Quebec's health care reform, professionals extended the analysis and thus helped to provide a more complete picture of factors relating to health care.

Discussion

If optimizing the quality of life of older adults is a major objective for a better societal transition to an aging population (Ebrahim, 1997; Keller & Fleury, 2000), health promotion planners and practitioners need conceptual and methodological tools to better understand and act on the quality of life of this clientele. However, the current body of knowledge seems quite limited in this area (Fry, 2000a; Jylhä, 1995; Raphael, 2001). Instruments traditionally used by researchers for investigating quality of life have too often been based on a restrictive vision of the determinants of health. Furthermore, such tools are rarely inspired by a research approach that considers quality of life as a subjective and contextual phenomenon and focuses on particular, local experiences, as opposed to a traditional, post-positivist approach emphasizing abstract and universal definitions. New developments based on this emerging contemporary vision are gradually appearing in the literature (Fry, 2000b; Raphael, 2001; Raphael et al., 1999), and this study builds directly on such experiences.

A primary finding is the broad range of issues discussed by participants, fully covering all levels of an ecological model of health promotion (Green, Richard, & Potvin, 1996; McLeroy et al., 1988). The data showed that quality of life is not only related to health and psychological well-being, but is also the result of social, organizational, community, and political environments. Such findings certainly confirm the importance of an ecological approach to health promotion and quality of life, which has been championed by leaders in public health and health promotion (Evans, Barer, & Marmor, 1994; Smedley & Syme, 2000; World Health Organisation, Health and Welfare Canada, & the Canadian Public Health Association, 1986) over the past two decades.

Our results also converged with data from the few studies using a qualitative methodology to investigate quality of life issues for older adults. They corroborate Fry's (2000b) data on the need for personal control and self-sufficiency in decision making, although the issue of end-of-life decisions–prominent in Fry's data–was not mentioned by our participants. Second, and not surprisingly, our results (derived from a similar methodological approach) confirm data recently obtained by Raphael et al. (2001) on quality of life in another Canadian city. While their discussions with older adults and professionals focused more on government policy decisions, there was nevertheless a large degree of overlap between the determinants identified by both studies.

Another important finding relates to the comparison between professionals and older adults. In general, the content was quite congruent between the two types of participants. However, it is also important to highlight the specific concerns raised by each. Had only professionals been interviewed, the emphasis placed on spirituality, religion, and meaning of life by many older adult participants would have been completely missed. Similarly, while some issues (e.g., health) were raised by all groups of older adults, many other issues seemed to concern only a limited number of groups and participants (e.g., automation of services). Finally, the inclusion of professional participants allowed for a deeper discussion of issues that would perhaps have been more superficially discussed by the older adults. These divergences illustrate the contextual and relative nature of the concept of quality of life, which is consistent with the position advocated by many authors on the issue (Draper, 1997; Fry, 2000a; Jylhä, 1995; Raphael, 2001). On the whole, while our results confirmed the crucial importance of giving older adults a voice in quality of life studies for this population, they also demonstrated the value of mobilizing different stakeholder groups to obtain a richer and broader view of the phenomenon.

In terms of practical implications, the findings certainly suggest the need for a variety of health promotion interventions for older adults. Older adults are less frequently targeted by disease-prevention and health-promotion programs than are other age groups (Craig, 2000; Heidrich, 1998; Keller & Fleury, 2000). When such programs exist, they often use traditional approaches focusing on individual capabilities, rather than more innovative approaches that help create the environmental conditions favouring health and independence (Keller & Fleury, 2000; McKinlay, 1995). Given the body of knowledge that now exists on the determinants of health and quality of life for older adults (Glass & Balfour, 2003; Minkler et al., 2000), it is time for health promotion planners and practitioners to prepare for broader action. Our results confirm the diversity of potential determinants to be targeted by future activities. Next steps should include prioritizing areas for change, using, for example, consensus-building strategies such as Delphi or nominal groups. Another possible strategy, inspired by a recent B.C. study (Michalos, Humbley, Zumbo, & Hemingway, 2001), is to design a survey instrument to assess the various dimensions identified in this study and identify the factors most predictive of health and quality of life for a given population sample.

Several issues limit the interpretation of these findings. First, all older adult participants were recruited through community organizations or seniors' associations. Older adults unable or unwilling to attend group meetings or uninterested in belonging to such organizations might have had other perspectives on these issues. Second, although it was possible to identify certain issues important to older adults from minority cultural groups, the analysis did not allow the concerns of other groups – such as persons living in poverty–to be identified. Future research should aim at investigating the concerns of vulnerable populations such as these. Third, while the data collection strategy allowed for animated and dynamic exchanges among participants, it also occasionally limited full exploration of issues. It would be useful to include individual interviews in future studies.

Conclusion

Despite its limitations, this study provided a sizeable amount of information about the quality of life of older adults living in a large metropolitan area, from the perspectives of older adults and the professionals involved with this population. The portrait produced by this study includes a diversity of factors covering a wide range of the determinants of health and quality of life. Moreover, in contrast to traditional approaches used to investigate the quality of life of older adults, this study was based on a methodological approach that acknowledges the subjective and contextual nature of the phenomenon. Given that the population is aging, there is now a crucial need to develop health promotion interventions that will maximize the quality of life of older adults. The results of this study contribute to building the knowledge base that can guide these efforts.

Note

1 CLSCs are provincially funded local community health centres providing front-line services to the population as well as home-care services and case management for older persons with loss of autonomy.

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