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Quality of life and active and successful ageing – an outline

Introduction

The issues of quality of life and active and successful ageing, discussed across a wide range of scientific disciplines, are highly fragmented and lack a shared discourse on the welfare and well-being of individuals and groups, including on the rules defining the scope of those categories. Consequently, the potential for knowledge accumulation is significantly reduced (Zalega, 2015: 153).

The European Statistical System applies the quality measurement concept based on the guidelines contained in J.E. Stiglitz report. It assumes that a statistical measurement of quality of life should cover two dimensions: objective conditions (welfare), including such domains as material living standards, health, social connections, quality of infrastructure and natural environment in the place of living, and the subjective dimension (well-being). Measurement of well-being, in addition to satisfaction with life as a whole, should also encompass satisfaction with various aspects of life (Report by the Commission on the Measurement of Economic Performance and Social Progress, 2009, http://www.stiglitz-sen-fitoussi.fr/en/index.htm, accessed on: 03.03.2015).

B. Christoph and H.H. Noll argue that life satisfaction is the most common indicator to measure overall subjective well-being. It corresponds to individual cognitive assessments of the general life situation in the context of one's aspirations, expectations and values (Christoph and Noll, 2003: 523). It thus may be concluded that life satisfaction is an element of well-being as a broader concept embedded in the context of one's functioning. Life satisfaction can, therefore, be understood as a reflective

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assessment of one's own life as a whole or its individual domains (or a sum of assessments of individual domains).

In well-being analyses, the terms: happiness and life satisfaction are often used. However, it is difficult to make a clear distinction between them, largely because of the problems with their precise definition – they are commonly used and their understanding is intuitive. Undoubtedly, life satisfaction is a gradable notion, with its level being dependent not only on one's objectively assessed life situation but also on one's psychological characteristics, for instance the level of pessimism – optimism (Rokicka and Petelewicz, 2014: 149–150).

It can be argued that examination of subjective quality covers a relatively wide range of indicators describing the multidimensionality of well-being, including: individual satisfaction with different domains of life, the desire, or will, to live, and the overall assessment of life. In the case of objective quality of life, the methodology used refers to indicators taking into account material conditions of life, namely disposable income, size of dwelling, real property and durable goods owned. A complete picture of quality of life is, on the other hand, obtained when both its subjective and objective dimensions are studied.This article is a review. It was written based on an overview of interdisciplinary literature. The purpose of the study is to clarify the essence and the key determinants of quality of life as well as the concepts of successful and active ageing. The structure of the article is as follows. After a brief introduction, the focus is on the interdisciplinary understanding of quality of life. Quality of life is explained in sociological, psychological, economic, social and medical terms. Afterwards, the crucial factors determining quality of life are analysed. Further, the concepts of successful ageing and post-retirement activity that are inextricably linked to the quality of everyone's life are discussed. Finally, major conclusions end this study.

Quality of life – definitions and interdisciplinary approaches

The term *quality of life* appeared for the first time after World War II in the United States and was associated solely with material well-being. It was not until the interest in values related to Fromm's "to be" instead of "to have" developed that it was extended to new areas of human functioning. That change was accompanied by the interest in subjective criteria of quality of life at the expense of objective conditions of existence (Wnuk and Marcinkowski, 2012: 23).

Quality of life is associated with a positive and successful life. The terms related to quality of life are: happiness, life satisfaction, standard of living, well-being. In the literature, the concept of quality of life has many meanings, multiple dimensions and a subjective aspect in addition to the objective one. The multiplicity of definitions of quality of life probably stems from the fact that quality of life is an interdisciplinary notion studied by researchers active in medicine, psychology, sociology, philosophy and social economics.

An important step in the development of quality-of-life research was the adoption of a definition of health in the preamble of the Constitution of the World Health Organization (Constitution of the World Health Organization Conference, 1946; World Health Organization, 1948). According to this definition, health is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". That document also states that "the health of all peoples is fundamental to the attainment of peace and security" and that access to the highest standards of medical treatment is a fundamental human right (Constitution of the World Health Organization, 2005). This WHO position called to mind that health is not only a state of biochemical and bodily equilibrium but is also subject to emotional, environmental and social factors.

On the basis of various definitions, the category of quality of life includes certain permanent elements such as objective, social, and subjective factors. Objective factors most often reflect material well-being, social factors are measured by means of social services and available infrastructure, and subjective factors cover some ephemeral characteristics, for example individuals' mental sensations, satisfaction, contentment and happiness.

One of the first definitions provided in 1972 by N.C. Dalkey and D.L. Rourke states that quality of life consists of life satisfaction and happiness (Dalkey and Rourke, 1972). In turn, A. Campbell claimed that quality of life covered the degree of satisfaction in predetermined domains of life: marriage, family life, health, neighbours, friends, household chores, professional work, living in a given country, place of residence, leisure, housing conditions, education, and standard of living (Campbell, Converse and Rogers, 1976). In 1978, J.C. Flanagan pointed out that the predetermined spheres of life might carry different meanings for the people surveyed. Therefore, for the purposes of evaluating the level of satisfaction with particular areas of life, he suggested using a weighting factor to assess how important the spheres of life were to the respondents. He considered that quality of life so assessed would become more subjective (Flanagan, 1982: 56–59). According to G.W. Torrance, quality of life as a broad concept should recognise all aspects of individual existence (Torrance, 1987: 6–11).

The sense of quality of life varies with the stage of human development throughout life. In old age, an individual has some goals to achieve, some life roles to fulfil, some dreams, but also lives in a community, here and now, while having a unique, specific body of experience (Baumann, 2006: 166). This means that quality of life will be understood in various terms by people at various stages of psychosocial development.

Undoubtedly, quality of life determines the prospects for successful ageing and old age, departing from an approach solely focused on handicaps, difficulties and a rich variety of problems associated with this stage of human life. By gaining knowledge about not only its objective underlying factors but also sociological and psychological aspects, we deepen our understanding of old age and its positive determinants.

In sociological terms, quality of life most often reflects the way and degree of satisfaction of diverse human needs, including the perception of the standard of living (Albrecht and Fitzpatrick, 1994: 17–18). Social needs take precedence over material needs. In this context, Gałęski distinguishes the notion of standard of living referring to the degree of satisfaction of needs and quality of life as the ways of catering for needs.

In psychological literature, the term "quality of life" is sometimes used interchangeably with well-being and life satisfaction, and quality of life is oftentimes defined by self-assessments of one's own life. While making such assessments, people evaluate their lives at two levels: emotional (affective) and cognitive. These two aspects may be understood as two sides of happiness, or life satisfaction (Veenhoven, 1991: 22–23), or happiness may be treated as an emotional state whereas life satisfaction as a cognitive assessment of one's life (Zalewska, 2003: 25–26). It can, therefore, be said that, in psychological definitions, quality of life is frequently determined by individuals' satisfaction with the optimum quality of their lives. Satisfaction may be a generally assessed reflection on one's life and on its individual areas: work, family life, health, and relationships with other people. Quality of life is also defined as the ability to implement plans, the degree of satisfaction of material and non-material needs of individuals, families and communities, a positive overall assessment of functioning, the difference between hopes and expectations on the one hand and current experiences on the other (Woynarowska, 2007: 41).

Thus far, social sciences have failed to develop a universal definition of quality of life. This concept encompasses mutually interacting objective and subjective factors. It is simultaneously assumed that the former are major determinants of the subjective dimension of quality of life, also referred to as a sense of quality of life, a sense derived from self-evaluation of the various spheres and the entirety of life. According to B. Suchodolski, quality-of-life research should focus on attempts to answer the question: "what should I be like?". He notes that the origins of the notion can be traced back to the deliberations of E. Fromm, a representative of the "Critical School". In his analyses, he contrasted two types of individual life motivations: the desire to be, understood as an autotelic goal, and the desire to have, determining the quality of human existence (Suchodolski, 1990: 23). According to T. Tomaszewski, quality of life can be equated with the quality of the world and of man. Then, quality of life is "(…) a set of elements existing in different proportions and intensities, consisting of: the wealth of experience, level of consciousness, level of activity, creativity, and participation in social life" (Tomaszewski, 1976: 204).

The sense of quality of life is a subject of phenomenological approaches that concentrate on experiencing, feeling and evaluating everyday life. In social sciences, this subjective dimension of quality of life is generally identified with human psychological functioning that is sometimes analysed on the basis of hedonistic or eudemonistic way of understanding happiness. In the first case, quality of life is associated with mental well-being the level of which is determined by the balance of positive and negative emotions experienced in a certain period and by a cognitive assessment of

one's life (Kowalik, 2007). On the other hand, in eudemonistic approaches relying on the assumption that, in a happy life, sensual pleasure and emotional experience become less relevant in the face of the essential goal of self-realisation, quality of life means a life of true fulfilment, exploitation of development potential, and satisfaction with good life in line with recognised values (Daszykowska, 2010: 68). It can be noticed here that the subjective dimension of quality of life clearly refers to the mental and spiritual dimensions of health, dimensions that – as already mentioned – are significant for the sense of well-being in the ageing and old-age periods.

In economic sciences, quality of life as an economic concept emerged in the second half of the 19th century. Contemporary economic literature distinguishes three extreme views of this category:

1) traditional, treating quality of life as material possessions;
2) extremely spiritualistic, emphasising a spiritual (non-material) dimension of quality of life (e.g. in deep ecology);
3) a combination of approaches emphasising a comprehensive (multifaceted) and functional understanding of quality of life as abolition of constraints and attainment of freedom (the right choices).

The first view includes various liberal and non-liberal (e.g. socialist, Catholic) concepts within mainstream contemporary economics (from the neoclassical to socialist concept). The second group consists of ecological, religious and social visions of anti-globalists. The third group encompasses neo-liberal concepts and A. Sen's approach.

A. Sen propounds a new approach to quality of life that, as he believes, lies in existence rather than in possession of goods. Quality of life can be assessed as the capabilities of using one's possessions to lead a decent life, termed "functionings" by Sen. From the point of view of that theory, the capability of possessing or using a good matters more than the good itself or the use of it. One of major goods is freedom. Goods should enable functionings, that is being, and they should be judged from this perspective – the perspective of human existence (Sompolska-Rzechuła, 2013: 135).

A. Sen's broad view of quality of life allows (Zalega, 2016: 71):

– socio-economic development and quality of life to be analysed in both economically developed and backward countries,
– a new look to be taken at quality of life and its essence to be better understood,
– new strategies to be developed that will lead to a satisfactory quality of life.

In medical sciences, the notion of quality of life emerged along the lines of the search for diagnostic tools for evaluation of the functioning of patients suffering from certain diseases and evaluation of functional effects of applied treatment.

In the implementation of new criteria for treatment evaluation, a milestone in the quality-of-life assessment was reached with "The Rosser Index Matrix" developed in 1972 by R.M. Rosser (Rosser and Watts, 1972: 361–368). It was a descriptive method combining two indicators: limited life activity (mobility) and experienced suffering (pain). "The Rosser Index Matrix" combines a subjective measure of dis-

ability ranging from 1 (for non-disability) to 8 (for gross disability) with a subjective measure of the pain experienced.

In 1977, the WHO began to establish structures in order to implement a universal vision of health as a global policy in collaboration with national governments. According to the WHO, quality of life is individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, standards and concerns (World Health Organization. Report of WHOQOL Focus Group Work, 1993). On the basis of this definition, in 1994, quality-of-life experts from 15 centres in various countries devised and published an instrument for measuring quality of life – the WHOQOL-100 (World Health Organization Quality of Life) questionnaire (The WHQOL Group, 1995: 1403–1409). In its operationalisation, clinical, psychological and social aspects of health are taken into account; health is construed as well-being in the area of the physical, mental and social functioning of the human being. It is also assumed that experiencing this well-being is conditioned by the environmental context of human daily life. These scales belong to a group of general and global tools. They are designed to examine the quality of life of both ill and healthy people, allowing for comparative studies of these populations.

Summing up the above reflections on quality of life, it can be stated that the literature distinguishes its two types: subjective and objective. An argument supporting such an approach to studying quality of life is provided by the research subject, namely the human being and human communities rather than "population". Quality of life is then understood as the level and the interrelation of two aspects of human existence: the capacity for one's full development and life satisfaction. In other words, quality of life perceived subjectively is the result of internal processes of evaluating different spheres of life and life as a whole. Quality of life in the objective sense is a set of living conditions, objective attributes of the world of nature, objects and culture, and objectively assessed human attributes related to the living standard and social position (Sęk, 2007).

Determinants of quality of life

A key problem in the study of life satisfaction is the search for determinants that affect the level of life satisfaction. The first (bottom-up) model assumes that the level of life satisfaction depends on exogenous factors (living conditions and life events). However, studies clearly show a weak and rather short-term impact of these factors on life satisfaction (Zalewska, 2003: 25). The second (top-down) model assumes that the level of life satisfaction is primarily influenced by personality traits – relatively permanent human characteristics predisposing towards a positive or negative interpretation of various events and experiences and towards creation of different situations. An attempt to integrate the above assumptions is reflected as a model presuming that life satisfaction depends on exogenous determinants, person-

ality characteristics, and interactions between them (Furnham, 1991: 235–239). The same external factors may thus carry different meanings for different people, hence their impact on life satisfaction is modified by personality traits of an individual. The fourth proposed model (Headey and Wearing, 1991: 56–59) implies that the level of life satisfaction is determined by an individual's resources (demographics, personality traits, relationships with others) and life events. This model emphasises transactional relationships between studied variables: "one's characteristics, resources affect life satisfaction, the way in which events are experienced and interpreted, and life events affect life satisfaction and can modify one's resources" (Zalewska, 2003: 28).

Surely, a vital factor in quality of life is health. Health-related quality of life (HRQOL) was introduced in medical sciences in 1990 by H. Schipper and his colleagues, who defined it as the functional effect of an illness and its consequent therapy upon a patient, as subjectively or objectively perceived by a patient. HRQL covers 4 areas (Schipper, 1990: 171–185):

1) physical condition and fitness,
2) mental state,
3) social situation and economic conditions,
4) somatic sensations.

At present, the thesis concerning a close link between the health status and the overall well-being perceived by an individual is widely acknowledged in the related literature (Gopalakrishnan and Blane, 2008: 113–126). Many researchers regard the health status as a significant correlative of well-being, and the World Health Organization (WHO) assumes that it is an inherent and very important component of well-being. There are many studies documenting the relationship between physical health and mental well-being. In performing meta-analyses based on numerous studies conducted mainly on the elderly, M.A. Okun, W.A. Stock, M.J. Harring and R.A. Witter obtained correlations between the two variables ranging from 0.04 to 0.75. The average correlation coefficient was 0.35, and the number of studies in which no significant association was found was negligible (Okun, Stock, Harring and Witter, 1984: 111–132).

Life satisfaction in old age is a major problem, because people experience many distressing situations in the last phase of their lives. The loss of a beloved partner, the loss of health, withdrawal from professional life, less intensive social life, and the realisation of reduced physical and mental aptitude may be a source of numerous painful experiences. The contemporary world does not value old age, it does not value the wisdom and experience of seniors. What matters today is health, beauty and youth, and knowledge is passed on through multimedia rather than by older generations. On the other hand, older people get some perspective on life, achieve serenity, and often state that they feel happy. This is very important since the feeling of life satisfaction is connected with good mood and positive emotions. When a person is happy and cheerful, this has a number of specific consequences in his or her daily function-

ing (http://www.psychologia.edu.pl/obserwatorium-psychologiczne/1650-czy-optymizm-jest-dla-ciebie-dobry.html, accessed on: 02.03.2016):

1. Brains of happy people work more efficiently and productively. The body produces more adrenaline that enhances vigilance and attention, improves memory and comprehension, and speeds up decision making and problem solving.
2. Happy people are less likely to fall ill. A positive mood increases the concentration of immunoglobulins and boosts the activity of histamine, the hormone that mobilises the immune system. It also increases the blood content and the effectiveness of leukocytes, the body's defence cells.
3. People who are satisfied with their lives cope with stress more easily. Optimists perceive difficult situations as a challenge, not as a threat that paralyses them. In addition, a good mood reduces the blood concentration of hormones associated with response to stress. Therefore, cheerful people, after distress, recover their equilibrium faster.
4. Happy people bear the pain better. Well-being intensifies the production of endorphins, the so-called happiness hormones that act like natural anaesthetics and mood improvers.
5. A cheerful mood makes a person more energetic, more active, and facilitates the development of close, friendly relationships with others.

Without a doubt, married people achieve higher levels of well-being, optimism and life satisfaction, are more resilient, happier, more open to others and less likely to experience solitude compared to widowed, single, divorced and separated persons. This is, among others, because spouses are usually a source of broad support for each other, thus are able to cope with stressful situations better.

Friendship has a considerable influence on seniors' quality of life and health, through the related pleasure of being with others and through positive emotions developed when seniors know and feel that others accept their actions, attitudes, views, aspirations, axiological orientations – generally, their way of experiencing themselves and the world. Such social connections evoke the sense of belonging and understanding in older people. All these positive emotions stimulate the smooth functioning of the immune system (Ryff and Singer, 1998). Some researchers reveal that friendships with non-relatives have a greater impact on self-assessed quality of life in old age than family relationships. G.R. Lee and C.L. Shehan (1989) argue that the reason is that relationships with friends are voluntary, whereas contacts with family are often forced ones. Relationships with family affect quality of life positively when the relationships between adult children and older parents are characterised by love and acceptance, with no feeling of dependence (George, 2006: 327). It can, therefore, be said that support from family and friends is a strong predictor of subjective quality of life in old age.

From the perspective of environmental factors, social support is a major determinant of the quality of life of older people. It is defined in several ways: as an individual perception of the support network that an individual has, as an effect or outcome of

supportive social exchange, or as a specific type of support provided to an individual (Johnson, 1992). It is also understood as a sense of satisfaction of one's social needs through interactions with significant others – it strengthens the sense of belonging, security, approval; as aid in directing activities, advice, support received when one is a member of a particular group, leading to the reinforcement of self-esteem. Social support is also defined as the type of interaction undertaken by one or two parties in a problematic situation, whereby emotional or instrumental information is exchanged. It can also be treated as resources provided to individuals by others in their environment (Rodin and Salovey, 1997) or as a message that informs individuals that they are loved, appreciated, considered worthy and that they are participants in the interpersonal communication and mutual responsibilities systems (Fengler, 2000: 164).

A vital factor contributing to the development of support networks for the elderly is to overcome stereotypes about old age that exist in public awareness. A stereotype is a cognitive structure consisting of three elements: knowledge, beliefs and expectations of an observer on a given social group. An additional element that integrates these three cognitive segments is affect, meaning the emotional undertone that is oriented towards the object observed and that is crucial for the understanding of how a stereotype works (Mackie, Hamilton, Susskind and Rosselli, 1999). The old-age stereotype existing in a society is a reflection of the situation of seniors living in that society. This reception may be positive when it highlights the life experience and wisdom of old people, the need for respect and proper care for them. However, it can also be negative if a society is mainly focused on production and judges people on the basis of whether they participate in production or not. That being the case, seniors are seen as useless, and their experiences are said to be obsolete and worthless (Gaweł and Urlińska, 2016: 114–115).

Studies in many countries suggest that the impact of social interactions and relationships on the quality of life and health of older people cannot be overestimated. Psychological analyses reveal a meaningful role played by good and close relationships with "significant others" in coping with stress in life and confirm that stressful events deplete psychological resources such as self-esteem, the sense of control and meaningfulness of life, while social support makes it possible for these sudden deficiencies to be replenished (Krause, 2006).

For many years, such studies have been carried out by the Centre for Public Opinion Research, TNS OBOP, as part of the *Social Diagnosis*, and by the European Social Survey. The regularity of these surveys not only allows the current situation to be described but also a studied phenomenon to be monitored over the years. The conclusion of the studies is optimistic. It turns out that several years after the launch of systemic changes, Poles are much better off than they were in the People's Republic of Poland, and their life satisfaction is growing year by year as proved by empirical evidence. According to TNS Polska, nearly half of people aged 65+ were satisfied with their lives in 2014, with two fifths having ambivalent feelings and more than one in ten declaring dissatisfaction (TNS Polska, 2014).

Similar data on the psychological condition of Poles are provided by CBOS surveys. They reveal that in 2014, more than 2/3 of respondents were satisfied with their lives, of which almost one in five (19%) felt very satisfied and less than half (47%) rather satisfied. Life dissatisfaction was reported by four out of a hundred respondents (4%), while moderate satisfaction was declared by 29% of those interviewed. For Poles, children, marriage and social relationships are the source of greatest satisfaction. Half of those living in couples (50%) are very satisfied with their relationships and, counting in those who are rather satisfied, more than three quarters (77%) state that they are satisfied with their marriage. Relationships with friends are positively assessed by more than four fifths of respondents (81%), yet their feelings are more moderate than in the case of family relationships – they tend to be rather, not very, satisfied (44% and 37%, respectively). Respondents also have similar feelings about their place of residence – 36% are very satisfied with it, and 43% – moderately satisfied. More than half of respondents report satisfaction with their work (59%), health (58%), education, qualifications (53%) and material living conditions – housing, furnishings, etc. (51%). Only two fifths of Poles (40%) voice satisfaction with their prospects for the future, with nearly one third (30%) having ambivalent feelings about it and over one fifth (21%) perceiving the future pessimistically. Traditionally, Poles are least satisfied with their financial situation and income. Currently, one in four respondents (25%) is content, while the others express dissatisfaction with their financial situation (38%) or perceive it as average (36%) (CBOS, 2014).

Successful ageing

Quality of life is inextricably linked with the concept of successful ageing. The concept was popularised in 1961 by R.J. Havighurst through his article published in that year in the first edition of *The Gerontologist* (Snyder, Lopez and Pedrtotti, 2011). According to Havighurst, two complementary conditions are decisive for successful ageing. He defined them metaphorically as "adding years to life" and "adding life to years". This means that successful ageing is experienced by people who live longer than others, i.e. are characterised by absolute longevity and feel life satisfaction in old age (Havighurst, 1981: 92–94). Similar aspects are highlighted by E. Palomore's definition stating that the specificity of successful ageing includes optimum survivability, good health and life satisfaction (Palomore, 1995: 914–915). C.D. Ryff construes successful ageing as a form of human functioning that results in the optimum development of an adult throughout his or her life (Ryff, 1982: 209–214).

In the European culture, the myth of an old man is derived from the theory of "disengagement" promoted after World War II, which treats seniors as inactive and expecting the help from others (Kryszkiewicz, 2006: 281–282). This approach was reflected in the term *ageism*. However, as gerontological research shows, it is an active way of spending time that allows seniors to achieve life satisfaction (Eriksson

and Wolf, 2005: 76–77). While activity is both a social and mental need of people of all ages, in the case of the elderly it is important to emphasise two conditions that must be fulfilled, namely pursuing an activity that a person really enjoys and his or her aptitude in this respect. The active ageing model is also supported by the World Health Organization (WHO), which treats older people's social activity and continuous learning as a precondition for good quality of life and successful ageing.

The model of successful ageing was first suggested by J.W. Rowe and R.L. Kahn, who define this concept as avoiding illness and disability. The definition conceived by those authors focuses on physiological deficits as barriers to successful ageing. In their opinion, successful ageing is a combination of three factors that should accompany ageing (Rowe and Kahn, 1987: 143–149):

1) a low probability of disease and disability,
2) sufficient ability to learn and take up physical activity,
3) active participation in society.

In turn, successful ageing according to R.D. Hill means a human making use of available resources to optimise the ageing experience. The resources that can be used to get older in a positive way include (Hill, 2009: 42):

- inherent mental predispositions that are, nonetheless, largely influenced by the will or state of mind;
- environmental conditions (medical procedures, access to health and care services, housing, work, various occupations, etc.);
- individual characteristics – personality, attitudes, beliefs.

Within his concept of positive ageing, R.D. Hill proposes seven strategies, each requiring the taking up of predefined actions. Positive ageing strategies include: finding the meaning in old age, learning independently of age, using the past to develop wisdom, fostering long-term interpersonal relationships, supporting personal development through giving and receiving help, forgiving oneself and others, having a grateful attitude to life (Hill, 2009: 16).

Contemporary definitions of successful ageing are focused not only on physical and mental health and functional capacity but also on aspects of social functioning. However, these definitions, despite a broader view of positive ageing, still do not apply to impaired people who lead an active life and live independently with the sense of good quality of life in spite of complex medical problems. In 2009, Y. Young, K.D. Frick and E.A. Phelan put forward a new definition of successful ageing. According to them, successful ageing can be experienced by people with coexisting diseases and limited functional capacity if they have developed compensatory psychological and/or social mechanisms (Young, Frick and Phelan, 2009: 87–92). For those authors, the fundamental premises were the individual variation of the ageing process and different pathways that could lead to successful ageing. Among compensation mechanisms, they list: emotional vitality, flexibility, optimism, spiritual life, and social ties. These have a significant positive effect on quality of life and, consequently,

on positive ageing even in the face of diseases and impairments (Kędziora-Kornatowska, Kornatowski and Grześk, 2010: 39).

In systematising the literature definitions of successful ageing, A. Bowling distinguished five groups, each with its dominant category. These are: the area of social functioning, life satisfaction, mental resources, biomedical view, and popular perception of successful ageing (Bowling, 2007: 293–300).

What positively ageing individuals have in common is that they also focus on positive aspects of life rather than on the problems and difficulties of advanced age. According to G. Vaillant, positive ageing must always reflect the crucial response to change, disease and environmental imbalance; positive ageing does not involve solely avoiding a loss of health and definitely not avoiding death (Vaillant, 2002: 161).

Activity as an element of the quality of seniors' life

Activity is a lifelong process characteristic of all children, adolescents and adults of working and post-working ages. According to L. Kozaczuk, it is "a constant and personalised effort that determines proper development and enables a creative and harmonious life". Activity is also a factor that significantly influences human ageing and the attitude toward one's old age, whereas the lack of it results in deterioration of physical and mental condition. Furthermore, older people's activity is the potential to be tapped by both individuals and the whole society (Kucharska, 2012: 129–130).

Older people's activity, above all, satisfies the desire to be useful and needed, gives a sense of fulfilment, independence, enables the transmission of life wisdom and gained experience. Upon retiring, the elderly also find new forms of leisure pursuits allowing them to actively and successfully live at old age, making activity not only a privilege of youth.

The concept of "active ageing" first appeared in the early 1960s and has evolved gradually over the past years. According to the OECD definition coined in 1998, active ageing is the ability of people to lead a productive life in the social and economic areas despite older age. This means that they can make flexible choices in managing their time throughout their lifetime. For the labour market, active ageing involves convincing people that they should work longer and adapting the working environment to seniors' needs. In the social security area, active ageing means that pension systems must allow part-time work and gradual retirement. In the field of health care, active ageing requires a radical change of current health practices at the individual and institutional levels (Orzechowska, 1999: 13).

In 2002, the World Health Organization (WHO) presented a multidimensional concept of active ageing, defining it as the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age. This definition implies that activity should not be associated solely with professional

work or physical condition but that it refers to all areas of life: social, economic, cultural, spiritual, and civic (Jurek, 2012: 9).

According to the *Encyclopedia of Aging*, activation of old people is understood as a set of diverse actions designed to slow down, delay, and mitigate the ageing processes and to teach them how to become an old person. What is most important for seniors is that they should not give up and be passive but should continue to live actively instead. An active attitude in this period is the only way to continue to enjoy life and even minor activities (*Diagnosis of the Elderly's Situation…*, 2016: 8).

Within the whole range of individual resources, seniors' health and quality of life particularly depends on their broadly defined activity considered as an essential component of their lifestyles (LaLonde, 1974). Based on the literature, it is reasonable to claim that activity is a central integrator of health and quality of life in old age. This involves both physical activity, which, at this stage of life, has a beneficial effect on the biological capacity of an ageing body, mitigates many diseases of the elderly and improves the psychosocial functioning (Marchewka, 2012), as well as mental activation of seniors and their participation in social life.

Among the theories explaining the adaptation to old age, the theory of activity developed by R.S. Cavan, E.W. Burgess, R.J. Havighursta and H. Goldhamer (1949) deserves attention. It assumes that activity is a condition for positive adaptation to the ageing processes and that social, physical and intellectual activity helps to improve the quality of one's life. This means that a normal ageing process allows for functioning at the same level as previously. For this reason, optimally ageing people remain active in social life. Well-being is essentially conditional upon varied forms of activity that are to compensate for the lack of professional work. It can, therefore, be said that the active style of ageing is characteristic of people who seek to function optimally and try to cope with the challenges they face.

The related literature also distinguishes three types of seniors' activity: formal, informal and solitary. The first type consists in participation in various social associations, politics, work for the local environment, voluntary work, etc. Informal activity involves contacts with family, friends, acquaintances and neighbours. This classification also includes solitary activity that generally encompasses watching TV, reading books and newspapers, developing personal interests and hobbies.

As rightly noted by I. Stuart-Hamilton, those active at older age are more mentally fit and live longer, endure failures better, are less likely to experience helplessness and loneliness. Commitment to a task enhances seniors' optimism deriving from the sense of control, which obviously may be an illusion but does not change the fact that it is connected with the hope of success. Moreover, it appears that older people who engage in many activities and perform different social roles have higher mental well-being indicators than those with limited activity. However, active individuals find it more difficult to cope with situations where they cease to play their social or professional roles (upon retirement or due to poor health). This difficulty is explained by a stronger integration of the social identity of persons with multiple roles and by

a stronger emotional response when this identity is disturbed by the loss of its important elements (Stuart-Hamilton, 2006).

A progressing ageing process points to the continuity of human development throughout life. What happens in old age, which is long given the number of years and varied in terms of the direction and scope of changes, covers positive and negative aspects of this period. These include satisfaction with retirement, with family life, and a greater ability to evaluate different situations, which in turn compensate for coexisting health problems or internal anxiety.

In the context of activity, senior's education and health monitoring are significant. Education should promote a healthy lifestyle, a higher ability to monitor one's health and emotions, without neglecting the first worrying symptoms of disease. In the lifestyle theory, it is important that educational activity serves to acquire knowledge necessary to sustain mental aptitude in order to understand oneself and others and integrate experiences for building up life wisdom. The role of maintaining cognitive activity and mental ability is indicated. All forms of activity requiring intellectual effort and sustaining well-being slow down the pace of memory and learning skills deterioration.

With the EU programmes such as Lifelong Learning and its Grundtvig component, and Erasmus+ since 2014, many educational programmes have been successfully addressed to seniors (old age education). However, as noted by Z. Szarota (2014: 14–17), there are no offers for the oldest old people, the so-called people of the fourth age. In the near future, it might be possible to develop, based on the skills acquired by seniors in institutions intended for the "young old", and implement modern communication tools in educational practice and conduct an educational dialogue using e-learning solutions, blogs, e-magazines, repositories of works created by seniors themselves. Digital skills will become essential in a world where e-services will be developing.

Despite some limitations, today's reality provides more and more opportunities for older people to further develop, acquire new knowledge and actively spend their free time. Leading a good life at old age can enable the fulfilment of ambitions, offer a sense of fulfilment and self-confidence. An opportunity for more interesting, and thus healthier, old age lies first and foremost in interactions with others, openness to the world and achievement of dreams. Year by year, more formal and informal institutions are emerging that help in successful and active ageing, such as: Universities of the Third Age, Senior Clubs, Prayer Clubs, and Day Care Homes. Furthermore, the forms of recreational activity such as sanatorium stays or tourist trips deserve attention (Kurowska, 2007: 273–274; Kurowska, 2008: 28–29).

However, it is important to note that older people today and in the near future are far different from seniors living years ago. The following aspects are primarily indicated (Golinowska, 2012: 138–145):

– better education and greater mobility of seniors,

- *rejuvenation of old age*, reflected as the change of the elderly's attitude towards themselves, the adoption of new consumption patterns, and a new lifestyle,
- life in better conditions,
- greater availability of information,
- retirement when one is still relatively physically and intellectually fit,
- heterogeneity of the senior population,
- evolution of old-age patterns in the public perception – from negative stereotypes to diversity.

In April 2014, the Active Ageing Index was published as a result of research into active ageing in 28 European countries. Seniors' activity was assessed in four areas:

1) employment (in the age categories of 55–59; 60–64; 65–69; 70–74);
2) participation in society (volunteering, care provided to children, grandchildren, older adults, political participation);
3) independent, healthy and secure living (financial independence, physical activity, access to health services, lifelong learning, housing security);
4) enabling environment for the use of broadly understood resources (potential) of an ageing population (life expectancy, healthy life expectancy, mental well-being, use of ICT, social connectedness, formal educational attainment).

In the overall ranking, Poland (28.1%) was in the penultimate 27th position. Only Greece (27.6%) was worse, having been downgraded by three positions as compared to the 2012 ranking. Sweden (44.9%) was the first, Denmark (40.3%) the second, and the Netherlands (40.0%) the third. The UK (39.7%), Finland (39.0%) and Ireland (38.6%) follow (Active Ageing Index, 2014, 2015: 18). It should be noted that the difference between the first and the second country in the ranking is relatively large, amounting to 4.6 percentage points. This considerable discrepancy is mainly caused by the very high employment rate of elderly people in Sweden. The penultimate position of Poland among all EU countries (EU average is 33.9%) means that public bodies and social organisations dealing with seniors' problems do not work properly. Certainly, this result is a consequence of many factors. One of them is undoubtedly the fact that the Polish society predominantly holds the traditional view of old age as a time of rest and withdrawal.

The analysis of the individual domains covered in the ranking shows that the strongest emphasis was placed on seniors' social participation and potential to be exploited. Obviously, these are intended to serve seniors, their sense of belonging in the society, security, prevention of social exclusion, yet the priority is given rather to seniors' activity contributing to their independence and economic productivity. Such perception of active ageing is due to the rapidly growing population of elderly people and ageing-related expenditure. The Active Ageing Index (AAI) is a tool for measuring seniors' untapped potential for active and healthy ageing in different countries. It measures the already mentioned level of independence, professional activity, social participation, and capacity for active ageing.

With regard to Poland, the social participation indicator is the lowest. In this area, Poland (12.1%) was ranked last among 28 countries, just behind Estonia (12.8%), Romania (12.7%) and Bulgaria (12.5%). The highest indicators were noted for Ireland (24.1%) and Italy (24.1%). The situation is slightly better for the employment rate in the various age groups. In this case, Poland (22.4%) occupies the 20th position, ahead of Slovakia (21.9%), Luxembourg (21.9%), Belgium (21.0%) and Greece (20.4%). In terms of enabling environment for active ageing, Poland (47.9%) took the 22nd place, leaving behind Estonia (47.5%), Slovakia (47.1%), Hungary (46.9%), Greece (45.5%), Lithuania (45.3%) and Romania (40.9%). Sweden (69.2%) and Denmark (65.1%) were the leaders in this part of the ranking. Taking into account the indicator of independent and healthy living, Poland (64.9%) ranked 24th, ahead of Greece (64.9%), Bulgaria (62.7%), Romania (61.8%) and Lithuania (58.7%). The security of older people is much better in Denmark (79.0%), Finland (79.0%) and the Netherlands (78.9%) (Active Ageing Index, 2014, 2015: 21).

The analysis of the relationship between the Active Ageing Index (AAI) and the proportion of people aged 65+ in the EU countries demonstrates that there is no correlation between the share of seniors in the population and their activity. It is not true whatsoever that the older the population, the more intense the activity of seniors. This lack of link is a consequence of intensive movements of people that followed the enlargement of the EU in 2004 and later (Jurek, 2015: 50). Those migrations significantly altered the demographic structures of individual EU countries. In the immigration countries (old EU countries), population ageing was slowed down or, in extreme cases, (temporarily) reversed, while in the emigrant countries (new EU countries), it was intensified. As a result, there emerged a landscape of countries with relatively high old age rates and only slight activity of seniors (e.g. Hungary, Bulgaria, Latvia) and, on the other hand, countries with relatively low old age rates and intense activity of seniors (e.g. Ireland, Luxembourg, Cyprus).

Conclusion

In the related literature, old age is increasingly recognised as a development phase where all areas evolve and transform: from medical and biological through social and economic to family-related and personal, individual areas. Living to "old age" is no longer a privilege of the chosen few but is enjoyed by more and more people. As rightly noted by E.H. Erikson, late adulthood is a phase of life faced with developmental tasks no less significant than in the previous periods, meaning that old age must be treated on a par with other development stages (Erikson, 2004: 19).

Seniors often emphasise that it is at this stage of life that they have more time to pass their experience, knowledge, traditions and customs on to younger generations. Their grandchildren teach them new linguistic forms, computer and Internet skills. This makes it easier for older people to know and understand the ever-changing world

that surrounds them. It is often on family that the elderly focus their emotional life, and it is family that motivates them to remain active.

The adoption of a healthy lifestyle inhibits the development of certain diseases, and social and medical progress can increase the number of frail older people by further prolonging their lives. Hence, a change of priorities is clearly visible: a longer life span is an already achieved goal; the focus now is on quality of life at every stage.

Quality of life of the elderly is primarily determined by age, health, income, educational attainment, marital status and piousness. What is also important is seniors' activity after they retire, in particular participation in courses organised by Universities of the Third Age.

Quality of life is inextricably linked with the concept of successful ageing. In the related literature, researchers accuse one another of inconsistencies in the application of some variables. These variables are sometimes treated as predictors of successful ageing, whereas in other cases they are construed as ones constituting this process (Scheidt, Humpherys and Yorgason, 1999: 277–282). This may be illustrated by the example of independence, which is a characteristic of a particular individual and may take certain forms (financial independence – financial security; mobility independence – physical fitness). Therefore, the fact that someone strives to be independent suggests, to some extent, that they may age successfully in the future. Possible controversies in the perception of independence ensue from the perception of successful ageing.

The theory of active ageing, in turn, promotes the image of an older person who is vigorous and socially involved despite the years passed. The essence of this theory is a positive relationship between activity and life satisfaction. It argues that high quality of life in old age requires the continuation of social roles performed in earlier adulthood or their replacement with substitutive roles (Powell, 2006: 49). It may thus be stated that the concept of active ageing has been recognised as a paradigm in the European social policy. The implementation of this idea, on the other hand, requires it to be put into practice at the local, regional and national levels.

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Summary

Quality of life and active and successful ageing – an outline

The observed demographic changes involving mainly the progressive ageing of the Polish population are leading to the increased market importance of the senior segment. Therefore, a stronger emphasis is put in on quality of life and its related concepts of successful and active ageing that have been recognised as a paradigm in modern social policy. This is justified by the fact that quality of life is consistent with the core values ensuing from human rights, such as independence, participation, dignity, security and self-realisation.

The purpose of this study is to clarify the essence and the key determinants of quality of life, as well as the concepts of successful and active ageing. The structure of this article is as follows. After a brief introduction, the focus is on the interdisciplinary understanding of quality of life. Quality of life is explained in sociological, psychological, economic, social and medical terms. Afterwards, the crucial factors determining quality of life are analysed. Further, the concepts of successful ageing and post-retirement activity that are inextricably linked to the quality of everyone's life are discussed.

Keywords: old age, seniors, quality of life, successful ageing, active ageing.

JEL Code: A12; D1; D07.