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IMPACT OF OLDER ADULTS' SOCIAL STATUS AND THEIR LIFE SATISFACTION ON HEALTH CARE RESOURCES

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SUMMARY

Background: The article discusses the impact of the increasing numbers of the elderly on the social understanding of ageing (especially among physicians, therapists and caregivers). Statistics point to an urgent need to prepare the health care system for the greying population. In order to improve the quality of care for the elderly, their involvement in both treatment and therapy is essential. The misjudgments and discrimination that elderly people often have to endure puts successful ageing into question. The study was designed to investigate the quality of life among the elderly, with control groups of young and middle-aged adults.

Material/ Methods: The research involved 392 persons, divided into three age groups: early, middle, and late adulthood. All the participants were asked to fill in the Fragebogen zur Lebenszufriedenheit (FLZ, the Life Satisfaction Questionnaire).

Results: The general assessment of life satisfaction among the older respondents was significantly lower in comparison to the results obtained among the younger ones (≤ 35 years old). Nevertheless, when evaluated against the results obtained in the middle group, the difference was not that significant. Interestingly, more detailed analysis of the results revealed that the discrepancies in the assessment of the separate categories of life satisfaction were not very significant.

Conclusions: The preliminary findings prove that the satisfactory ageing popularized by the "new gerontology" is not merely a theoretical category, but a real life experience. The "greying" population makes it essential to involve the elderly in the process of improving the quality of care in later life.

Key words: ageing, quality of care, new gerontology

INTRODUCTION

An analysis of statistical yearbooks and demographic forecasts reveals a growing problem: the greying population (Hugman, 1999; CSDH, 2008). We are currently witnessing the highest proportion of seniors in history, and this number is expected to increase (Raeside & Khan, 2008; Xie, Xia & Liu, 2007; Joyce & Loe, 2010). The growth of the "grey" population is even more conspicuous in Europe. Kelly Joyce and Meika Loe (2010) analyzed the 25 countries with the highest number of citizens over 65. It turned out that as many as 23 of these countries were in Europe. Although Poland was not among them, the growth in the number of its senior citizens is very noticeable as well. The forecasts, similar to those for other regions, suggest further a strengthening of this tendency (see Table 1.).The fact of increasing longevity in society raises a number of questions concerning the nature and the mode in which the ageing process is going to take place (Jazwinski, 2000; Stuart-Hamilton, 2006; Carnes & Olshansky, 2007; Witiuk-Misztalska & Misztalski, 2009); how long the elderly are going to remain independent and fit (Stuart-Hamilton, 2006; Newman et al., 2011); when and to what extent they are going to need help and support (Laslett, 1997). In Poland, the urgency of these problems has also been discussed. The literature on the subject is not very extensive, but the monograph by Mossakowska, Broczek, and Witt (2007) or the interesting article published in *Acta Neuropsychologica* (Łuczywek et al. 2006) are certainly worth reading.

The social understanding of ageing is permeated with the demagogy of old age, despair, and the fear of disintegration. It thrives on medical arguments. The analysis of medical statistics reveals a growing tendency in the number of elderly people developing incurable illnesses that demand permanent care. The most common are:

- cancer;
- cardiological disorders (Kurpesa & Krzemińska-Pakuła, 2008);
- metabolic disorders (obesity; diabetes type 2);
- joint dysfunctions (hip in particular) resulting from arthritis, osteoporosis, or other muscle-bone conditions;

Table 1. Predicted changes in the age distribution of the Polish population, 2010 – 2035

Years	2010	2015	2020	2025	2030	2035
Total	38,092,000	38,016,000	37,830,000	37,438,000	36,796,000	35,993,000
0-17	7,107,000	6,918,000	6,959,000	6,816,000	6,253,000	5,632,000
18-44	15,294,000	15,005,000	14,072,000	12,823,000	11,624,000	10,834,000
45-59	8,211,000	7,473,000	7,195,000	7,765,000	8,622,000	8,719,000
60-64	2,327,000	2,691,000	2,650,000	2,190,000	2,102,000	2,450,000
65+	**5,153,000**	**5,929,000**	**6,954,000**	**7,844,000**	**8,195,000**	**8,358,000**

Source: Statistical Yearbook 2010

- visual and auditory impairments;
- Alzheimer's disease;
- depression and dementia (Salkeld, Cameron, Cumming, Easter, Seymour, Kurrle & Quine, 2000; Zboina, Kulik, Wiecheć & Koc-Kozłowiec 2002; CSDH, 2008; Kowalska & Cieślińska-Świder, 2010);
- Ageing also involves the neurodegenerative process of the brain that results in multiple functional disorders of a person, for instance a specific form of aphasia (Pąchalska, 1999) that is disruptive for his or her well-being (Olszewski & Tłokiński, 2004); or the cerebral gray matter (GM) volume decreases (Kaasinen, Maguire, Kurki, Brück & Rinne, 2005), leading to the decline of self-control and self-transcendence, which in turn limits the elderly's well-being.

Hence demographic predictions are being equipped with additional variables: health life expectancy (HLE) or disability-free life expectancy (DFLE). This is to help not only the senior citizens themselves but also their relatives, the pertinent institutions, and society in general (Wilcock, 2007) to prepare for the growth of the elderly population. The task at hand is not easy (Ambigga, Ramli, Suthahar, Tauhid, Clearihan & Browning, 2011) and creates numerous situations that demand a search for innovative approaches. Christine Bigby (2006), for instance, quotes the case of ageing among people with intellectual disability. They once had a higher age-specific mortality rate in comparison to the general population. In the first half of the 20th century, until 1930 to be exact, their average lifespan was 20 years. By 1993, it had increased by 50 years, and the majority of such intellectually challenged persons could become septuagenarians. The case of ageing among people with intellectual disability proves that old age and the modes of dealing with it pose new challenges and create new possibilities not only for these people, but also for their families, physicians, therapists, and the entire health care system (Moye, Armesto & Karel, 2005; Bigby, 2006).

CARE-SERVICES FOR LATER LIFE: CRITIQUES FROM THE PATIENT-CENTERED VIEW

The nature of help may either contribute to or interfere with the activation of residual or restored potentials. Thus the question of the quality of care for persons in later life remains relevant.

In general, the prevailing view is that the level of services for older people remains very low (Warnes, Warren & Nolan, 2000). Modern countries as a rule save money on their elder citizens. The right to rehabilitation, to obtain help in the place of residence, the right to health protection, and the right to protect their family life are grossly neglected. The difficult situation of the elderly (see: CSDH, 2008) is further exacerbated by the inefficiency of the institutions that are supposed to bring help, as well as welfare support and care for them. Negative attitudes on the part of physicians, therapists and caregivers limit the elders' opportunities for optimal care. The research conducted by Amy J.C. Cuddy, Michael Norton and Susan T. Fiske (2005) confirmed this thesis and documented the acute disregard

for elderly patients among medical staff. This conclusion was developed with the use of numerous publications, e.g. on frequent incorrect diagnoses or complete oversight of an important symptom among age-advanced patients (Derby 1991); on common misdiagnosis of depression among senior citizens (Lasser, Siegel, Dukoff & Sunderland, 1998); or on providing senior citizens with less detailed information on their health condition (Greene, Adelman, Charon & Friedmann, 1989). It seems to be only fair to state that the needs and the values of the elderly significantly diverge from those claimed by various decision-makers (the employees of welfare institutions, health care institutions, or the institutions paying financial benefits to the elderly; see Ameratunga & Brown, 2000).

Funding constitutes another important aspect of care for later life. They are directly correlated with the quality of the help provided and its ethical dimension. Frequently, specialists and institutions offering medical and psychological help and support to senior citizens are not sufficiently funded. This results in serious staff deficiency and a reluctant attitude towards their older clients/patients. In some countries, e.g. in Poland, the pathology of the system goes so deep that older people, in one author's view, are pushed to the:

> … very periphery of attention (how many geriatricians are currently being trained at Polish medical universities, and how many medical students express interest in studying this subject?); the very periphery of access (how many senior citizens become the patients of private hospitals and clinics?); the periphery of importance (how many senior citizens have heard "You are too old for this service, and besides what do you expect at your age?") (Kuchcińska, 2009, p. 179).

The Western system of welfare and health care is not much better. Barbara Ehrenreich (2006) impersonated an unqualified worker and got a job as an unskilled laborer in a nursing home. She worked on a closed ward for Alzheimer's disease patients. On one occasion, as a result of the absence of another employee, she was the sole member of staff on the whole ward and was fully responsible for what was happening to its residents: "… I fed the whole ward of Alzheimer's patients, cleaned after them, and even managed to bring a smile to several of the emotionless faces of the people under my care" (2006, p. 228). Following that experience, the journalist tracked down a report by the U.S. Department of Health and Welfare from July 2000 and learned that such a shortage of employees in the American welfare sector, particularly in profit-oriented nursing homes, was common. This leads to growing frustration among the staff and neglect of the patients. This is manifested by serious bedsores, undernourishment, dehydration, cardiac infarctions, and infections, all of which become common ailments among the residents.

Insufficient financial expenditures in aid sectors, especially in health care, have been changing the mentality of the people employed there. More and more frequently their reasoning and actions have been dominated by the shift from the

"responsibility" to "profitability" category. Alan Williams, a renowned British economist, revolutionized the philosophy of patient treatment and patient care by introducing the Quality Adjusted Life Year (QALY) calculation. This tool makes it possible to calculate the value of the help provided to a particular patient and compare it to help provided to other patients. It is based on the following rule: if a patient gains one year of healthy life as a result of treatment, he or she receives one point; and the score equals the number of years. However, if the help provided does not guarantee a full year of healthy life, a patient receives only a decimal value for one year, e.g. 0.6. Evaluating whose treatment constitutes a better investment when converted into QALYs is ethically highly questionable. Discrimination of patients based on their age constitutes a serious concern here (Nordenfelt, 1993; cf. Vaupel, 1997, cited by Carnes & Olshansky, 2007), since a chance of healthy life in top form among the elderly remains within the realm of wishful thinking rather than reality. In accordance with this statement, Karol Mausch and Ewa Ryś formulated this description of the social status of the elderly:

From the perspective of an older person, contemporary culture is not free from certain features of the culture of cynicism. Stigmatizing the existential issues of the elderly, while simultaneous pushing them to the sphere of cultural silence is the expression of branding those categories as inferior ones, which in turn creates the situations in which the age segregation is getting consolidated. An old person is forced to remain silent, shunted to the role of a child whose opinion and voice are not taken into consideration in the process of negotiating of social order (2007, p. 183).

MATERIAL AND METHODS

Participants

This research was conceived in response to a more comprehensive and urgent need to understand the quality of the aging process today. It was conducted on a group of 392 persons from three age groups: early adult (18-35 years), middle adult (36-55 years), and late adult (56-75 years). The research group consisted of 130 persons: 59 females and 71 males. The control group consisted of 119 young adults (66 females, 53 males) and 143 middle-aged adults (74 females, 69 males). A detailed description of the research sample is presented in table 2 below.

Procedure

The research consisted of two stages. The first stage was meeting the participants in order to inform them about this research on life satisfaction among people from different age groups. The participants were asked whether they would agree to take part in it. After giving their consent, those who were willing to take part in the research received the *Fragebogen zur Lebenszufriedenheit* (FLZ, The Life Satisfaction Questionnaire), created by Jochen Fahrenberg, Michael Myrtek, Jőrg Schumacher, and Elmar Brähler. The tool includes 10 scales that measure

Table 2. Description of the research sample

			Age			
Age bracket	Gender	Number	M	Min.	Max.	AV
Early adulthood	females	66	24.21	20	34	4.57
	males	53	26.79	16	35	4.79
Middle adulthood	females	74	45.85	36	55	6.49
	males	69	45.81	36	55	5.74
Late adulthood	females	59	60.58	56	83	5.24
	males	71	60.42	56	73	4.20

the life satisfaction in the following fields (1) health; (2) professional life; (3) financial situation; (4) leisure and hobbies; (5) marriage / partnership; (6) relationship to own children; (7) self-esteem; (8) sexuality; (9) social life; and (10) living situation. The FLZ questionnaire assesses the global life satisfaction of a person. The score is achieved by summing up the data from seven scales; the scales not taken into consideration at that point are: (2) professional life; (5) marriage / partnership; (6) relationship to own children (Zeidler, in press a,b). In addition, life satisfaction can be assessed separately in each of the 10 aspects of life. This gives a deeper and more reliable insight into the measured category. Statistical analyses were performed using STATISTICA version 9.0.

RESULTS

The results of the FLZ in the three research groups showed a difference in life satisfaction among participants in different age groups. Because of the uneven distribution of the representatives of particular groups, the generalized Tukey Test for numerically varying subgroups was employed. The results of the analyses on global life satisfaction assessments are presented in Table 3.

The calculations conducted during the test revealed that although the assessment of life satisfaction among the older respondents was significantly lower when compared with the results obtained among the younger adults , when evaluated against the results obtained in the middle group the difference was not significant. The persons between 36 and 55 years of age were only slightly more satisfied with their lives than the senior respondents. It is worth stressing that the latter represent the first stage of old age (to age 75), and the results for advanced old age may be different.

Further analyses were conducted on separate assessments of life satisfaction in ten measured aspects of life (health, professional life, financial situation, etc.). The generalized Tukey Test for numerically varying subgroups was also employed. The results for the relevance of differences between the mean scores of life satisfaction in the three age groups are presented in Table 4.

Table 3. HSD Test results on global life satisfaction assessment (N=392)

	Mean score			p		
	early adulthood (1)	middle adulthood (2)	late adulthood (3)	1:2	1:3	1:4
life satisfaction	240.85	221.50	218.25	**0.001***	0.766	**0.000***

*p values in **bold face type** are statistically significant (p<0.05)

Table 4. HSD Test results (N=392)

Scales	Mean score			p		
	early adulthood (1)	middle adulthood (2)	late adulthood (3)	1:2	2:3	3:1
professional life	33.964	34.230	33.581	0.977	0.837	0.952
marriage / partnership	40.041	35.514	37.266	**0.006***	0.496	0.175
relationship to own children	39.351	37.130	39.029	0.481	0.236	0.985
health	35.857	32.106	30.023	**0.001***	0.055	**0.000***
financial situation	29.305	26.929	27.543	0.147	0.870	0.347
leisure and hobbies	32.051	31.173	33.025	0.712	0.211	0.659
self-esteem	37.168	34.768	35.008	0.016	0.955	0.034
sexuality	36.239	32.695	30.159	**0.009***	0.099	**0.000***
social life	36.294	35.324	35.824	0.430	0.780	0.820
living situation	36.856	34.085	35.557	**0.005***	0.186	0.307

*p values in **bold face type** are statistically significant (p<0.05)

Further analysis of the results revealed that the oldest participants in the research gave the lowest assessment to life satisfaction in two domains: health and sexual activity. This tendency is only natural, and results from the changes that are taking place in the bodies and the environments of the elderly. Nevertheless, it is worth stressing that the results among the senior citizens were significantly different from the ones obtained among the youngest participants. When compared with the results obtained among the middle-aged group it is still different, but the discrepancy is not statistically significant. One can assume that deterioration of psycho-physical and sexual condition begins much earlier, and as such does not constitute an indicator of old age. Additionally, it turned out that senior citizens are not always the individuals with the lowest life satisfaction level. The respondents from the middle adulthood group, when compared with the older and younger groups, gave lower values for the level of life satisfaction in six of the ten categories: marriage / partnership, relationship to own children, financial

situation, leisure and hobbies, self-esteem, and living situation. It is worth noting that the level of life satisfaction in the categories of leisure and hobbies, relationship to own children, and social life was very similar among the representatives of the first and third age groups. This would mean that interpersonal relations and the mode in which the respondents spend their leisure time constitute a similar source of satisfaction in both age groups. Indirectly, it would counteract the stereotype of the lonely and sad old person. This claim needs to be treated with extreme caution, however, due to the aforementioned limitations regarding the representativeness of the sample for more advanced old age.

The last question examined was whether gender may be a source of variation in life satisfaction assessment. In order to calculate if there was any significant difference between female and male respondents in late adulthood, the t test was employed. The results are presented in the table below.

Table 5. Differences between mean scores of life satisfaction assessments between females and males in late adulthood (N=130)

Scales	Females			Males			Comparison				
	M	SD	N valid cases included	M	SD	N valid cases included	t	df	p	F	p variances
professional life	33.705	8.465	44	33.450	8.664	60	0.149	102	0.881	1.040	901
marriage / partnership	**33.286**	**8.993**	**28**	**40.200**	**6.314**	**35**	**-3.580**	**61**	**0.001**	**2.029**	**52***
relationship to own children	**40.481**	**6.163**	**52**	**37.549**	**7.875**	**51**	**2.106**	**101**	**0.038**	**1.633**	**84***
health	29.136	8.256	59	30.578	6.876	71	-1.087	128	0.279	1.442	143
financial situation	28.018	9.726	57	27.116	10.466	69	0.497	124	0.620	1.158	573
leisure and hobbies	32.655	9.304	55	33.431	8.750	65	-0.470	118	0.639	1.131	634
self-esteem	35.220	6.762	59	34.747	6.759	71	0.398	128	0.691	1.001	990
sexuality	**27.553**	**9.413**	**47**	**31.966**	**7.656**	**59**	**-2.662**	**104**	**0.009**	**1.511**	**136***
social life	36.848	5.813	59	34.873	5.757	71	1.938	128	0.055	1.019	933
living situation	35.339	5.984	59	35.662	6.454	71	-0.294	128	0.770	1.163	555
life satisfaction	216.000	38.745	59	219.380	41.243	71	-0.478	128	0.633	1.133	626

*p values in **bold face type** are statistically significant ($p<0.05$)

The difference between the means of the overall score from the FLZ questionnaire in the two analyzed groups was not significant. This indicates that both older women and older men have a similar, moderate view of life in this stage of the life cycle, and they assess life satisfaction in a comparable way as well. However, the analyses conducted on separate assessments of life satisfaction in the ten measured aspects of life showed few differences. The men turned out to be more satisfied in the field of their marriage/ partnership and sexuality in comparison to women. This result can be easily explained with the demographics of population aging. The unbalanced proportion between women and men limits the opportunity for need-fulfillment in the more numerous female group. It should be mentioned that these two life areas, though related, are not reducible one to the other, as shown by the comparisons of the numbers of valid cases included. The women assessed higher life satisfaction in their relationship to own children scale than did the men. This result remains in agreement with the patterns of attachment in adulthood.

Although interesting, the results reported here need to be treated as preliminary; they should be replicated on a numerically larger group. However, they remain a solid starting point for discussion on life satisfaction in late adulthood.

DISCUSSION

> How can we re-establish meaning for these people, or a sense of integrity? Or even a sense of satisfaction in life? What has being got to do with ageing? What is the experience of living for these people? What are their wishes, desires? What are the unfinished things of life? How can we help them to gain, or regain, a sense of integrity and control over their lives? (MacKinlay, 2004, p.16).

Recent publications have shown a new quality in the understanding of human aging that is included in the so-called “new gerontology” (Brooks, 2010). The proponents of this movement popularize the idea of satisfactory aging as the sole effective strategy to prevent rapid decline. Satisfactory aging “…is dependent upon individual choice, effort and behaviour, and can be achieved through the positive influence and adoption of several extrinsic factors, from psychosocial aspects to personal habits” (Rowe & Kahn, 1987, 1997, 1998, cited by Brooks, 2010, p. 65). Christine Bigby explains the importance of one’s awareness of the influence of one’s own aging as follows:

> Ageing is a process, not an event. Ageing occurs at a different rate with diverse manifestations for each individual and is strongly connected to earlier parts of the life course. Health, lifestyle, informal and formal supports from earlier years combined with genetic dispositions all influence the processes of ageing for an individual, its challenges and accompanying opportunities or vulnerabilities (Bigby, 2006, p. 19).

The results of the present study on life satisfaction among people from different stages of adulthood seem to support this positive view on the nature of human ageing. In general, they showed that the old may preserve a positive assessment of the majority of aspects of their lives. Life satisfaction is an important concept that describes the psychological mechanism that an active subject uses to localise himself or herself in the objective environment (Zeidler, in press a). Life satisfaction helps in preserving the internal locus of control and the motivation to act intentionally in an ever-changing environment. Thus it is an indication of and a condition for satisfactory ageing.

These results on the life satisfaction of older adults are contrary to prejudices, and make it possible to develop new and better attitudes towards the old and their needs. If they are accepted by specialists, they could also help in overcoming the situation where "...empowerment, participation and person-centred care pervade the health and social service policy and practice literatures" (Nolan, 2000, p. 55), but are still missing in real life. Thus the reorientation of professional ideologies and practices is necessary to improve both the quality of life and the quality of care for older people (Pachalska 2007).

In general care for older people is associated and very often limited to help and assistance. Such assistance is sometimes necessary, especially in situations of chronic illness or disability. However, it is connected with certain dangers (Ober-Łopatka, 2007). Assistance is provided in order to compensate for the deficiencies of senior citizens. In such conditions a caregiver will be always more involved than the person to whom this care is directed. This leads to submissiveness on the part of an elderly person who requires long-term assistance and support of others, and becomes more and more passive. In extremely unfavourable conditions, this process may even lead to helplessness on the part of the person subjected to this care, lowering her or his self-esteem, and deterioration of the quality of his or her life and finally apathy (Pachalska & Łukaszewska 2011).

In order to prevent this counter-productive result of assistance, one needs to create a situation in which role-reversal is possible, and the ailing and dependent side becomes the one that provides help (see: Barlow & Hainsworth, 2001, cited by Conners, 2008). A group of researchers – Julie H. Barlow, Georgina V. Bancroft, and Andy P. Turner, (2005) – have substantiated the theory that ailing persons who undertake the challenge of non-profit work become more active and self-disciplined in health-supporting activities and beyond. Working as Chronic Disease Self-Management Course (CDSMC) coaches, they are much trustworthier and more reliable in comparison to healthy persons when conveying information on effective methods of dealing with pain, most effective fitness activities and balanced diet, as well as efficient methods of fighting the symptoms of depression and communicating one's illness and the modes it is experienced to one's family and specialists, or how to solve problems or make changes in one's life (Brown & Pachalska 2003). Additionally, work that is to help others in coming to terms and active dealing with an ailment causes the volunteers with chronic conditions to gain a sense of value and experience the purpose of their actions,

thus regaining their self-confidence. Their own statements constitute the best illustration of this phenomenon:

> Just giving, really just giving other people the opportunity to move their illness forward in the way that I had that opportunity. It's a tremendous buzz when you see someone who on the first session is clearly, really struggling just to cope with surviving and on the last session goes out, you know, I won't say a completely different person, but, someone who, perhaps for the first time since they had the illness actually believes in themselves and believes that they have got some control over their destiny. [ID 7]" (Barlow, Bancroft & Turner, 2005, p. 131).
> I think it increases your confidence because when you're ill and you give up work, it eats away at your confidence and it helps to make you feel normal again, so you're back in the land of the living. You're not this strange being who has got an illness and doesn't seem to be on the same planet as everyone else. So it brings you back into society. I have a greater appreciation of the difficulties people go through. I think it's enriched my personality. I feel I inspire people as well and I feel I'm actually doing something to help people. It's very, very rewarding. [ID 1]" (Barlow, Bancroft & Turner, 2005, p. 131).

This project opens new perspectives for the old in the health care system and patient-oriented therapy. It makes it possible to replace an empty vision of older people with a dynamic one (Wilcock, 2007; see also: Warburton & Cordingley, 2004). The results of life satisfaction research reported here give positive encouragement to scientists searching for new solutions in adapting to the "grey" population phenomenon (Nagchoudhuri, Moore, McBride, Thirupathy, Morrow-Howell & Tang, 2007; Malanowski, Özcivelek & Cabrera, 2008; Okun, August, Rook & Newsom, 2010). They confirm the validity of the position of specialists who argue that "... individual therapists and the profession at large should support active ageing, both in their day-to-day practice and through political activism" (Wilcock, 2007, p.15). The involvement of the old in contributimh to others is an easy strategy for prolonging their high life satisfaction and good physical and mental health, but also for improving the health care system in general. It is a challenging activity, since it affects and changes not only a person, but also the whole context he or she inhabits (Warburton & Cordingley, 2004; Ober-Łopatka, 2007; Manheimer, 2008). The purpose of the activities undertaken with the person receiving assistance is to create conditions of life that will make this person feel accepted and understood, and enable them to use the recourses at their disposal and fulfill their own aspirations, hobbies and passions (Ober-Łopatka, 2007). This support provides him or her with "… the sense of control over his or her life, thus strengthening the belief in its stability" (Ober-Łopatka, 2007, p. 190). Thus it increases his or her life satisfaction (Zeidler, in press a,b).

CONCLUSIONS

The aim of this study was to prove that late adulthood does not mean merely physical and psychological decline. The ageing process may be related to high life satisfaction. Clinical practice (Music & Wilson, 2003; Wilcock, 2007) and observations (Brzezińska, Ober-Łopatka, Stec & Ziółkowska, 2007; see also: Levy, Ashman & Dror, 1999-2000; Haski-Leventhal, 2009) prove that the more seniors contribute to other people's lives, the better they adapt to their own age. Nevertheless, there are still numerous inconsistencies, ambiguities and misjudgements that may limit the optimal mode of experiencing one's ageing (Błachnio, in press). Following the preliminary results of quality of life among the old, specialists should change their attitude towards old patients /clients, and should take under consideration the reorganisation of the health care system so that it includes the elderly in the process of treatment and therapy and allows them to contribute to the process. This would create the conditions of life that will put the indicators of positive ageing within the older person's reach. The most important of those indicators are:

1. good physical and mental health and the ability to function independently;
2. having a positive life attitude;
3. productive, active participation in all aspects of economic, social and community life;
4. self-reliance/self-determination;
5. recognition as an actively contributing member of society;
6. a positive outlook on oneself and one's future;
7. mutually supportive social relationships and contacts;
8. financial security;
9. a safe and supportive environment/community to live and work;
10. the availability of adequate services and support.

These factors are deemed adequate to define positive and active ageing, also in Western culture (see: MacKinlay, 2004; Chong, Ng, Woo & Kwan, 2006; The National Seniors Council, 2010).

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