As fit as butchers’ dogs?'
A report on healthy lifestyle choice and older people
Age Concern

Age Concern England (ACE) is a national voluntary organisation aiming to improve opportunities and quality of life of people over 50. We work through campaigning, policy development, research, information provision, publishing, training, grant-making and international and European work.

ACE is part of Age Concern, a federation of approximately four hundred independent charities working with and for older people. They share the name Age Concern and are committed to a common purpose and shared values. Age Concern England, as the national Member, supports and works with local Age Concerns, and, as the National Council on Ageing, brings them together with other national bodies, including charities, professional bodies and representational groups with an interest in older people and ageing issues. The ACE Policy Unit has five core functions. These are building and managing an evidence base; informing and educating; policy analysis and development; influencing policy; and influencing practice and the development of products and services.

Ageing Well UK

The Ageing Well UK programme is a health promotion initiative that enables older people to take control of their own health and promote healthy lifestyles to their peers. The programme recruits and trains volunteers who are 50 years or over to become Senior Health Mentors. The volunteers then make contact with isolated people and community groups, providing vital links to health services and opportunities in local communities.

Ageing Well projects focus on providing advice on a range of issues, including diet/nutrition, physical activity and falls prevention, offering services within the context of positive and holistic health.

National Consumer Council

The National Consumer Council (NCC) makes a practical difference to the lives of consumers around the UK, using its insight into consumer needs to advocate change. We work with public service providers, businesses and regulators, and our relationship with the Department of Trade and Industry — our main funder — gives us a strong connection within government. We conduct rigorous research and policy analysis to investigate key consumer issues, and use this to influence organisations and people that make change happen.

Acknowledgments

We would like to thank the older people who took part in workshops and groups. We greatly appreciated the enthusiastic efforts of all participants in the study. All names used in this report have been changed but the case studies are real.

We would also like to thank and acknowledge Monique Rotik, Liz Britton and Sonia Taylor of Opinion Leader Research for conducting the research.
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Executive Summary

Age Concern England (ACE) and the National Consumer Council (NCC) commissioned Opinion Leader Research to undertake research with older people to explore the subject of choosing a healthy lifestyle. Two half-day workshops and four in-depth interviews with groups of three were conducted with people over 60 years of age in a northern and a southern location in England during July and August 2005.

The research aimed to explore:

■ Older people’s knowledge and awareness of healthy lifestyle information;
■ The factors which drive and underpin older people’s health behaviour; and
■ Barriers and enabling factors to older people leading a healthy lifestyle.

This report discusses the research findings and implications in terms of the public policy work of ACE and NCC and the ‘health literacy’ agenda.

Main findings

Awareness about and interest in general health guidelines is high among older people, who view health holistically and have an intuitive understanding of the relationship between mental well-being and physical health. In definitions of a healthy lifestyle, research participants included a positive frame of mind, balanced diet, keeping active, mental stimulation and social contact.

In terms of attitudes towards health, a positive outlook and philosophy, or ‘zest for life’, are seen as essential, both in terms of physical and mental well being. Interaction with others is seen as key to maintaining a positive outlook. There is a perceived link between happiness and health, which results in many older people doing what is enjoyable rather than what is healthy. Equally some feel that their age is testimony to having had good health and so feel no need to make any changes. People who lead more healthy lifestyles are more likely to feel responsibility for their own health status, whereas those who have fewer healthy habits are more likely to demonstrate greater apathy.

Information about health is obtained both passively and actively through a variety of sources. Popular media, such as lifestyle programmes on TV, magazines and newspapers are the main sources of health information for most people. Health messages, especially when viewed over time, can become confusing and inconsistent. Older people are not always clear on the detail of health guidelines or the reasons why the guidelines are being promoted.

Attitudes to health often change in later life and, for some, this can result in changes in health behaviour. Retirement often brings on a re-evaluation of lifestyle. Some older people go through an ‘epiphany’ in later life, usually prompted by a health scare or concern over ill health. Advice from health professionals can result in changes in health behaviour for some, but others struggle to incorporate advice into their daily lives. Older people take decisions about
their health and leading healthy lifestyles based on what they feel is right for them as an individual. Guidelines are not followed ‘by the book’.

There are a number of practical and attitudinal barriers to older people living healthy lifestyles. These include apathy and lack of motivation, habits and routines, fatalism, attitudes to ageing, health problems and/or disabilities, problems of affordability, dependency, depression, lack of self-confidence, access difficulties, low ‘health literacy’ and lack of cultural capital. These factors may be inter-related and are experienced differently by different people.

Enabling factors include supportive and positive contact with others which is critical for both physical and mental health. Friends and family provide ‘life-lines’, support and encouragement, and can be sources of health information. They can prevent lonely and bereaved older people from drifting into bad health habits and poor mental health. Those who have a social network are more likely to engage in exercise and to remain active.

Older people feel that better transport, facilities and guidance would help them to lead healthier lifestyles. Much of what older people think will help them may already be available in some localities. Better publicity of available facilities and support could provide ‘routes in’ for older people.

The findings suggested that some groups of older people would require more intervention than others, particularly those who present attitudinal barriers to adopting a healthier lifestyle. Vulnerable groups are principally older men who live alone and older people who live in care homes. Older men can be ill-equipped to cope if they lose partners in later life. People who live in care homes are dependent on the home for access to the basic provisions of healthy lifestyles, such as food, opportunities to socialise and exercise. For many who live in care homes, attitudinal factors are additional barriers to choosing healthy options.

In terms of choices over adopting ‘healthy’ or ‘less healthy’ lifestyles, four main type groups emerged from the research. These are based on factors which affect whether a person is ‘able’ and / or ‘willing’ to take up and maintain lifestyles which are good for health. Factors affecting someone’s ability to adopt healthy habits are more often practical issues such as health literacy, ill-health and/or disability and access to services. Factors affecting willingness concern attitudinal issues such as philosophy on life such as ‘zest for life’, attitude to ageing, apathy, fatalism and resistance to change. The four type groups are:

**Group 1**: Able and willing to be healthy

**Group 2**: Able but unwilling to be healthy

**Group 3**: Unable but willing to be healthy

**Group 4**: Unable and unwilling to be healthy
Recommendations

1. Health Literacy

The Department of Health:

■ Should ensure that the importance of health literacy and its impact on health outcomes is recognised throughout the healthcare system, and that quality measures and standards for health literacy are created to help make this an integral part of healthcare;

■ Oversee the development of a health literacy skills index to identify the key components and levels of functional health literacy; and

■ Measure levels of health literacy among the general population to identify groups with low health literacy to inform the development of a targeted strategy for maximising the impact of health literacy interventions.

Healthcare professionals should:

■ Recognise the importance of widespread variations between different population groups in health literacy levels and needs, and develop tailored health literacy interventions, as appropriate.

Those involved in promoting the physical and mental health and well-being of older people should:

■ Recognise the importance of health literacy interventions in improving the health and quality of life of older people; and

■ Receive appropriate training in assessing and improving the functional health literacy of older people to enable them to make healthy choices.

2. Communicating health messages

■ The Department of Health’s proposals to market ‘health’ should be informed by older people’s views on health messages and the information they would like to receive.

■ The Department of Health’s Food and Health Action Plan should be updated to incorporate information about and access to healthy food in later life.

■ Age Concern’s Ageing Well Programme should review the way in which it communicates health messages in the light of the views that older people expressed in this research.

■ Organisations which provide information and advice to older people should consider the implications of the outcome of this research on both the content and style of information older people would like to receive about health. They should review their current information and develop new materials accordingly.

■ The Link Age Plus pilots should test out how they can incorporate information on health and healthy lifestyles for older people backed up by support to take action.
3. Target groups for interventions

- The Commission for Social Care Inspection should consider how its review of the framework for regulation and inspection can be used to support care homes in promoting the health of residents.

- Care home managers should review their opportunities for promoting health and the ways in which they can offer and increase choices available to older people about healthy lifestyles.

- The Social Exclusion Unit should work with the Department of Health to address the practical barriers faced by some older people in following a healthy lifestyle. Primary Care Trusts in the most deprived areas should initiate pilot health promotion programmes targeted at the most vulnerable groups, working with established groups of older people to tap into local knowledge and resources.

- The Department of Health should ensure that the roll-out of the programme for Health Trainers specifically includes and addresses the needs of older people highlighted in this report.

- Primary Care Trusts should consider commissioning voluntary and community sector groups to deliver parts of their Health Trainer programmes.

- The Ageing Well UK network should work with the Men’s Health Forum to pilot further ways of working with older men to raise awareness of health issues and to promote appealing approaches to increasing healthy lifestyles.

- Health promotion campaigns, facilities and organised activities for older people should place an emphasis on social stimulation and company rather than on health benefits alone.

4. Timing of interventions

- Employers and trade unions should work together to commission or provide pre-retirement planning for all employees, taking account of the holistic views of health expressed by older people and their preferences for receiving health messages.

- Health professionals and others involved in promoting the physical and mental wellbeing of older people should be supported in giving advice on healthy lifestyles through training and development programmes. The creation of ‘care pathways’ for the care and treatment of specific diseases or illnesses should include opportunities for health promotion information and advice.
5. Mental well-being and quality of life

■ The Department of Health’s delivery of its priority of promoting healthy and active life amongst older people should include the goal of improving and sustaining mental health and well-being.

■ The implementation of the National Mental Health Promotion Strategy should recognise the holistic view which older people hold of health.

■ Primary Care Trusts, Local Authorities and voluntary organisations in contact with older people should prioritise action and resources to promote good mental health in later life and to prevent and/or treat depression.

6. Joined-up solutions

■ The Cabinet Sub-Committee on Ageing Policy should consider the areas in which older people will need informed choice and support in order to make changes to their lifestyles to improve health.

■ Local Authorities and their partners should build on the key findings of this report in developing their strategic approach to the promotion of health amongst older people. Local Area Agreements should be used to develop services and support which will enable older people, including those who are most vulnerable, to take steps towards improving their health.

■ The Audit Commission should consider the messages from older people about their views of health in developing its measures of performance against CPA targets.
1. Introduction

Our population is ageing – falling birth rates and an increase in average life expectancy mean that already one in six people in the population is aged 65 or over. In the next 30 years this will rise to over a quarter. While overall life expectancy has increased, improvements in healthy life expectancy have not kept pace. Between 1981 and 2001 the number of years a man could expect to live in poor health increased from 6.5 to 8.7. Women can expect to live longer in poor health than men – in the same period the expected time in poor health for women rose from 10.1 years to 11.6\(^2\).

At the same time health inequalities have continued to widen. In spite of improvements in death rates from some major diseases, the latest data show that the gap between England as a whole and the 20% of Local Authorities with the lowest life expectancy has increased by 2% for men and 5% for women\(^3\).

Government policy on improving the health of the population has focused on individuals choosing healthy lifestyles, with additional support for those least able or likely to take up these options. From the Wanless Review of public health\(^4\), which emphasized the action needed to achieve a ‘fully engaged scenario’ in which all sections of the population are supported and encouraged to take action to improve and maintain their health, to the Government’s White Paper on Public Health\(^5\) the theme of health as a consumer commodity, for which demand can be created, has prevailed.

In spite of our ageing society, older people have not been at the centre of policies to improve health. The delivery plan for the public health white paper identifies older people as a priority only in respect of promoting healthy and active life; the actions in relation to mental health or food and health take little account of later life.

Health promotion is important at all stages of life, but there is a gap in understanding of older people’s views in relation to healthy lifestyle choices. Building people’s knowledge and ability to manage their own health and well-being is one of the most important ways of encouraging and enabling people to make more healthy choices. It is also crucial in tackling health inequalities. Variations in peoples’ skills to obtain, understand, and interpret information about health can have implications for equity in healthcare and lead to unacceptable differences in health outcomes. Older people are more likely to be in poor health, and often perform at lower literacy levels than other age groups.

There is a need to explore the specific issues for older people in ‘choosing health’ and what kinds of supporting mechanisms are needed to enable more older people to choose health, including building health literacy skills.
The Government’s strategy for an ageing population recognises that maintaining health is a dominant concern for older people. It is equally clear that this is key to retaining a good quality of life as well as determining the use that is likely to be made of the NHS.

This report presents findings from deliberative qualitative research commissioned by Age Concern England (ACE) and the National Consumer Council (NCC). The aims of the research were:

- To explore older people’s knowledge, attitudes and preferences regarding choice of healthy lifestyle and managing their health
- To discover any barriers that are likely to prevent older people (or particular groups of older people) from taking up healthy lifestyles and managing their health
- To gather older people’s views on how to overcome any barriers
- To inform policy development regarding health promotion for older people
- To contribute to the debate on health literacy.
2. Methodology

The objective in this research was not just to understand health behaviour, but also to engage older people actively in how best to encourage and enable people in their age group to adopt positive health behaviour. The sample included a diverse group of people over 60 years of age, and used a deliberative approach, encouraging participants to develop their own solutions and ideas to issues raised in the research. As such, the approach was both exploratory and deliberative.

The approach was designed with three primary outcomes in mind:

- To understand current behaviour
- To discover the drivers of this behaviour
- To deliberate and develop possible solutions.

Half-day workshops were conducted in locations in the north and south of England. Participants were drawn from diverse backgrounds, and recruitment criteria specifically included:

- Those who defined themselves as having more healthy and less healthy lifestyles
- Mixed genders
- Mix of socioeconomic groups
- Age segments 60-69, 70-79, 80-89, 90+
- Those living independently and those in supported accommodation
- Mix of ethnic groups
- Those with physical disabilities or chronic health conditions
- People from inner city, urban-suburban and rural areas.

The workshops were extended sessions lasting over a half day, and each included a total of 20 people. They took a participative approach using projective and enabling techniques to uncover underlying issues and barriers, and actively engaged older people in developing solutions.
In addition, ‘trio’ interviews were conducted with groups of three people in northern and southern locations in England in order to explore significant factors affecting perceptions of health and uptake of healthy lifestyles, and in order to include more vulnerable and socially excluded groups. These groups comprised:

- Women with hearing and visual impairments
- Men with hearing and visual impairments
- Women with low literacy levels
- Men with low literacy levels
- Recently bereaved or divorced men
- Women living in care homes.

A total of 58 people aged 60 years and over participated in this research.
3. Findings

3.1 Developing a definition of health

- Awareness about general health guidelines is high among older people
- Older people view health holistically and have an intuitive understanding of the relationship between mental well-being and physical health.
- Older people defined a healthy lifestyle as one which included:
  - Positive frame of mind
  - Balanced diet
  - Keeping active
  - Mental stimulation
  - Social contact

Older people are generally knowledgeable about what is required to maintain health. General health guidelines are quite well understood and were mentioned by almost all of those who took part in the research without any prompting. Participants understood what was prohibited by health guidelines and what was recommended to help to maintain good health.

When asked what constitutes a healthy lifestyle, diet was mentioned first of all, followed by exercise. Participants were aware of health messages around fruit and vegetables, and in particular, the ‘five-a-day’ message. A diet which is high in salt, fat or sugar was thought to be damaging to health. There was general awareness of health messages about eating fish frequently instead of meat, which was felt to be less healthy.

Older people were aware of messages on exercise, but were slightly less confident about specific guidelines. Older people understood that exercise could be incidental and could be done through everyday tasks, such as gardening, housework and shopping.

There was little difference in the level of knowledge between people who had adopted healthy lifestyles and those who had not, although the ‘healthier’ older people were more likely to have actively sought information.
Examples of Famous More Healthy and Less Healthy People

We asked participants to tell us which people in the public eye they considered to be healthy and which they considered to be less healthy, and talk about the reasons for their choice. There was a great deal of similarity in the responses across the workshops and groups. People considered to be healthy included Madonna, Cliff Richard and sports men and women. Those considered to be less healthy were generally people who were thought to overindulge. Examples included Jo Brand, Bernard Manning and Johnny Vegas. Participants made a direct link between being significantly overweight and not leading a healthy lifestyle.

Politicians featured heavily in the less healthy group as participants thought their lifestyles are characterised by high levels of stress, irregular diet, high levels of alcohol consumption and little or no exercise. John Prescott and Kenneth Clarke were top of mind for almost all of those who took part.

‘Healthy Lifestyle’

We asked older people to come up with their definition of a healthy lifestyle, to agree what would constitute a healthy lifestyle from their point of view, rather than simply recalling health messages. Responses were broadly in line with general health guidelines as these were seen as sensible and credible health advice. However, it was striking that mental well-being, happiness and company were given as much priority as diet and exercise.

“For me it means healthy diet, and health in terms of fitness. Nothing in extreme, I have two bottles of wine in the course of a week or a few beers but it also means having a good social life. It’s not only a healthy body but it’s a mental thing as well. You have to have a healthy mental attitude so it’s mental health and physical health”.

[Male trio, sight and hearing impairments, southern England]

Keeping the mind active and stimulated was also considered to be key to health. Many participants saw the brain as a muscle which needs exercise. Maintaining an active mind and keeping an interest in life and the world around them helps to ward off low moods and contributes to a positive outlook. Taking part in bingo, doing crosswords, taking an interest in current affairs, painting, playing a musical instrument and reading were all thought to help contribute to a healthy lifestyle.

Participants thought that a healthy diet should be varied and well balanced, including fruit, vegetables and fish, and should be low in fat, salt and additives. It was thought that fresh, home cooked food is best.

Keeping active was emphasised more than ‘doing exercise’. Participants felt that it was important to get out of the house each day and to avoid being sedentary. Getting out each day was thought to be good for the mind as well as good in terms of physical exercise for the body. Even going for a walk to the local shops could include opportunities to talk to others and to ‘chat over the fence’ with neighbours. Contact with others was felt to be fundamental to keeping the mind healthy, which, in turn, encouraged older people to make an effort to keep the body healthy too.
Participants made the link between physical and mental well-being intuitively, without being aware of information sources that advised them that this would be beneficial.

In summary older people defined a healthy lifestyle as one which included:

- Positive frame of mind
- Balanced diet
- Keeping active
- Mental stimulation
- Contact with others.

3.2 Attitudes, values and beliefs on healthy lifestyles

- Older people feel that a positive outlook and philosophy, or ‘zest for life’, is a key driver of health, both in terms of physical and mental well being
- Interaction with others is key to maintaining a positive outlook
- Many older people favour doing what is enjoyable rather than what is healthy, because of the perceived link between happiness and health
- Some older people feel that they do not need to change their lifestyle and that their age is testimony to that
- Those who are more healthy are more likely to demonstrate attitudes in line with taking responsibility for their health status. Those who are less healthy demonstrate greater apathy.

Philosophy on life

Participants talked about philosophy on life a great deal and thought that this had an impact on whether or not people lived a healthy lifestyle. They talked about the health benefits of being happy, having a good sense of humour and good friends. A positive attitude and outlook were considered to be important to health in terms of diet and exercise and essential to maintaining mental well being.

The workshops and interviews indicated that those who have a positive outlook on life were also the most likely to take responsibility for their own health, and to take active steps to lead a healthy lifestyle. They were also more likely to have contact with others, including relatives and friends.
In contrast, those who were less healthy were more likely to have a less optimistic outlook on life and to suffer from bouts of depression or times of feeling low. This group also had less contact with others and demonstrated apathetic attitudes to their own health.

Attitudes to age and ageing were also considered to have an impact on health behaviour. Many participants were keen to emphasise that age is an attitude of mind and that believing yourself to be ‘old’ contributes to a negative outlook on life and can result in apathy about health. This group enjoy later life and do not feel a longing to be younger.

**Ken** is 92 and has lived in sheltered accommodation for two years. He is on his own after his wife died 8 years ago. Ken has not lost his ‘zest for life’ and tries to eat well and keep active.

“In the morning I have a normal breakfast. The first thing I have is a cup of hot water. I have cereal one morning, I have toast another morning, I have a bacon sandwich the next, and I drink orange juice. I go out about quarter to ten in the morning and I go for a walk about three miles, come back, make my lunch, then have half an hour rest. If the weather’s nice I go out and have another walk. I eat lots of fruit. Now I don’t eat very much at teatime because it upsets me. I feel all right and I think age is in the mind. And if you can keep active and keep a good diet I think it is beneficial.”

“Getting older doesn’t bother me. I don’t wish I was any younger”.

**[Male, sight and hearing impairment trio, southern England]**

This ‘zest for life’ seems to be key to well-being in later life. Participants felt that some older people get to a point when they ‘give up on life’, perhaps because of bereavement, isolation, or depression.

“I think loneliness takes you into depression”.

**[Less healthy group, northern workshop]**

This raises the question of which comes first: state of mind, or state of health? Addressing issues such as depression and isolation may be a route in to empowering older people to improve their own health.

**Social capital**

Outlook on life was also seen to be crucial in terms of interaction with others. Some participants emphasised the importance of friendships and getting out of the house to meet with others. Those who have ‘given up on life’ are perceived to be less likely to mix with others and make the effort to leave their home.

“If you are going to stay indoors and just sit, then, I think you will pop off a lot quicker”.

**[More healthy group, southern workshop]**
A number of those who demonstrated healthy lifestyle behaviour and a positive outlook reported having ‘faith’ and being involved in their places of worship, such as churches and temples. Faith in large part contributed to or helped them maintain their outlook on life, as well as providing them with a social and support network.

“Well no man is an island we all need people and friends and I’m very fortunate because I’m a member of our local chapel and we’ve got a wonderful fellowship there and it’s just very uplifting”.

[More healthy group, southern workshop]

Other participants explained how helping others has clear benefits for them as well as the people they help. For example, Barbara, who is a very resilient and optimistic person, helps out in her local community, and is involved in hosting coffee mornings, outings and a rangeof other activities.

“If you look to how you can help them instead of how they can help you, you will get a much better relationship with people because everybody needs help in one way or another and love and comfort. We can’t live alone, we are not individuals, we are part of a large family and we have the responsibility to look after one and another.”

[More healthy group, southern workshop]

After Michael’s wife died, he decided to get involved with his local Age Concern office to keep himself occupied. He now gives help and advice to other older people on Pension Credit applications, benefits and other financial matters. Michael reported that his Age Concern activity ensures that he gets out of the house at least 3 times a week during the day time and provides him with a sense of purpose.

Outlook and attitude of mind appeared to be independent of socio economic classification or cultural considerations such as ethnicity.

Health and happiness

The importance of maintaining a positive outlook means that, for many, enjoying themselves in later life is a top priority. This leads some older people to take decisions to continue with behaviours and habits which go against health advice. Many participants reported making a choice between what they know to be good for them and what they enjoy doing.

As outlined above, participants see mental well-being and ‘happiness’ as being inextricably connected to health. Many felt that, should they deprive themselves of the routines that make them happy, this could have a worse impact on their health than these routines in themselves would cause. For instance, George goes to his local club (a working men’s social club) most nights and has 2-4 pints and several cigarettes, he eats the foods he enjoys which does not include what he refers to as “rabbit food”.

“Well I can’t stand rabbit food me. I think it’s horrible.”

[Less healthy group, northern workshop]
He explains that he enjoys his life as it is, and particularly the social contact with others at the club. George has weighed up cutting down on drinking and smoking in favour of a healthier lifestyle but has decided that his happiness is more important.

“I don’t eat properly, I don’t do enough exercise, I smoke too much, but I’m happy so I’m not bothered”

[Less healthy group, northern workshop]

Similarly, many participants have opted to allow themselves the ‘treats’ that they enjoy, regardless of the fact that this might be against health advice. Having ‘a few treats’ is thought to be harmless and any potential ‘risk’ is balanced by the happiness these treats bring. There is a feeling that ‘we deserve a few treats at our age’.

Some participants reported that due to confusion in health messages over what they should eat, particularly with regards to dairy products, eating whatever they want in moderation ensures that they are not doing much more, or much less, than the guidelines advise.

Life experience, genetics and fatalism

Having lived to at least 60 or more years (and many of the sample were over 75 years of age and still active), some felt that there was little need to start leading a more healthy lifestyle now. Some of those who have had no significant health problems thought that they did not need to change their lifestyle, and that health advice did not apply to them as they felt quite well.

Those who led less healthy lifestyles, but felt fit and were still active, thought that they had a ‘good constitution’, resulting from genetic heritage, and were resilient to health problems. One participant described himself and his family as “Fit as butchers’ dogs”.

“Maybe I’m a bit of a fatalist. It hasn’t affected me so sod it.”

[Less healthy group, southern workshop]

Responsibility

Those who led more healthy lifestyles talked about taking responsibility for their own health. They argued that individuals should take responsibility for their own health which includes taking reasonable steps to preserve health and to prevent illness.

“So make sure that you use your muscles, the old saying is true, if you don’t use it, you lose it and that all ties in actually with keeping fit. I think we’ve got a duty to ourselves and those who care for us to look after our body and you know, do what we can ourselves before we call on others to help.”

[More healthy group, southern workshop]

Those in the less healthy group, while aware of the measures they are advised to take through health guidelines talked less of a duty to themselves. Indeed, they expressed a much greater need for help and support to lead a healthy life.
All participants demonstrated a respect for the advice of health professionals and felt that they ought to follow advice given by their GP and practice nurses. Many older people were proactive in seeking advice from health professionals and were likely to act upon it. Some reported taking themselves for an annual health check without being prompted by their local surgery.

“I think that if you take your car to have an MOT, why shouldn’t you do it with your own body?”

[Male trio, sight and hearing impairments, southern workshop]

3.3 Information Sources

- Information about health is obtained both passively and actively through a variety of sources.
- Popular media, such as lifestyle programmes on TV, magazines and newspapers are the main sources of health information for most people.
- Health messages, especially over time, can become confusing and inconsistent.
- Older people are not always clear on the detail of health guidelines or the reasons why the guidelines are being promoted.

We have looked at what is important to older people in terms of their own health, and what they perceive as healthy behaviours. But where do older people get health information from, and what information sources do they trust?

Knowing what action to take in order to lead a more healthy lifestyle was widely regarded as a matter of common sense. However, older people draw on a wide variety of information sources on health and healthy lifestyles.

Information about healthy lifestyles is generally acquired passively through popular media. Magazines aimed at women (which also fall into the hands of men), news stories, and newspaper supplements are key information sources on health. An increasing interest in food has meant that older people are interested in what they ought to be eating and why. Information on diets and recipes from TV lifestyle programmes and cookery programmes were therefore mentioned as useful sources of information on health. Participants felt that these programmes communicate health messages in a way which is much more about lifestyles and taking an interest in oneself than about health in itself. They are therefore considered to be more entertaining and interesting.

Initiatives by food retailers have also played a part in providing information. In supermarkets, five-a-day symbols on everything from juice cartons to ready meals have promoted the guideline to “eat at least five portions of fruit and vegetables each day”.

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Local GP surgeries were also cited as a source of information on health and healthy lifestyles, with information being offered from GPs or practice nurses in response to a health problem or an annual ‘check-up’.

“With our practice nurse, I suppose we are very lucky. You go like for your cholesterol test or whatever and she’ll tell you should maybe cut your cheese and eggs down. And keep up your fruit and she always mentions exercise as well.”

[Less healthy group, northern workshop]

Although health information is largely received passively or inadvertently, some participants reported actively seeking information. Some reported actively seeking preventative health information from health professionals and also seeking out health information in the media, for example, purposefully buying the newspaper with the best health/lifestyle supplement.

Health information is also communicated through word of mouth, and by friends and family. Participants found the subject of healthy lifestyles absorbing and, in some cases, fascinating. Older people reported a keen interest in healthy lifestyle information and expressed an appetite for more.

Though awareness of general health guidelines was high, there were significant gaps in participants’ knowledge of the benefits of following health advice, and a lack of clarity about points of detail in general health guidelines. For instance, most people were aware of the advice to eat five portions of fruit and vegetables per day, but were unsure of what constitutes a portion. In addition, although most participants were aware of advice to eat a low fat diet, few understood what saturated fat is and which foods were low in saturated fat.

Older people know more about what they should be doing than why they should be doing it. While they were aware that eating fish is a ‘good thing’, they are not clear on what the health benefits would be for them. Older people would welcome health promotion strategies that communicate the benefits of acting on health advice, rather than just repeat what to do and what to avoid.

Confusion / Inconsistencies

Although general knowledge of key health messages is high, health promotion messages were also perceived to be inconsistent and, at times, conflicting. New scientific evidence had meant that some of the health behaviours once considered to be positive were later discounted. For instance, advice on butter versus margarine was thought to have been inconsistent to the point where some participants were not clear on which is currently best for them.

Although the consensus was very strong in all groups about the damage to health from smoking, participants could recall a time when there was no concern about the links between smoking and cancer and heart disease. Participants even recalled being encouraged to smoke. Some reported that they were told to smoke when they were in the army, as it was ‘good for nerves’. They also told how smoking was considered the social norm and that people who did not smoke were considered unusual.
“During the war, when we were in the army, we were given cigarettes, issued them free. And more or less told - go and smoke.”

[Less healthy group, southern workshop]

Messages from sources other than government advice have also caused confusion. For example the advertising slogan ‘Go to work on an egg’, an advertising campaign in the 1970s by the British Egg Marketing Board was remembered as a health message rather than as commercial marketing. It would seem that because health information comes from a variety of sources, older people are in danger of interpreting messages from ‘unofficial’ sources as health guidelines. Currently advertisements marketing food and drinks which contain ‘friendly bacteria’, and products which claim to lower cholesterol levels, are similarly perceived as authoritative advice.

3.4 The impact of ageing on health behaviour

- For many people attitudes to health change in later life.
- For some, this can result in changes in health behaviour.
- Some older people go through an ‘epiphany’ in later life, usually prompted by a health scare or concern over ill health.
- Advice from health professionals can result in changes in health behaviour for some, but others struggle to incorporate advice into lifestyle.
- Older people take decisions about their health and lifestyles based on what they feel is right for them as an individual. Guidelines are not followed ‘by the book’.

Change in health behaviour with age

Some older people reported a change in their attitudes towards healthy lifestyles and in their health behaviour as they got older. In the main, changes in attitudes and behaviour were the result of a growing sense of their own mortality.

“Some sort of fear, you get old, you get scared that the bones are going to seize up and you’re not going to be able to do things and get around”.

[More healthy group, southern workshop]

“When the years clock up you have to think about these things. When you’re young, it doesn’t bother you really all that much”.

[More healthy group, southern workshop]
“When I was 50 or 60, I suddenly was listening to healthy things more than I was before”.  

[Female trio, hearing and sight impairments, northern England]

For some participants, the cavalier attitude of their youth, which meant eating whatever they liked, drinking and smoking, and putting more strain and exertion on their body, was replaced by more attention to moderation, giving up smoking, and even cutting out alcohol altogether.

“As I’ve got older I’ve cut out drinking too much and cigarettes, they just got by the wayside anything like that, and I feel much better for it and better off in my pocket too”.  

[Male trio, sight and hearing impairments, southern England]

However, changes in attitudes towards health lifestyles do not necessarily equate to a change in health behaviour. Some participants reported that they had become more concerned about their health as they have got older, and even become more aware of healthy living messages but had not changed their behaviour as a consequence.

A few reported going through an ‘epiphany’ in later life, which had radically changed both their outlook and attitude to health and their health behaviour. This was largely triggered by a health scare, or hearing about the health scares of other people who were similar age and lead a similar lifestyle.

In some cases, the epiphany comes with a determination to live as long a life as they can. Decisions to lead a more healthy lifestyle in these cases were directly related to a desire to live longer.

“They used to say three score years and ten, now people are living long after and that’s what I’m aiming to do”.  

[Male trio, sight and hearing impairments, southern England]

John lives on his own in a sheltered housing estate. He enjoys living in sheltered housing as the estate has a real community spirit and there are always opportunities to socialise with others, while retaining independence.

Six years ago, John suffered a heart attack. He used to be a heavy drinker, smoker and the staples of his diet were meat and fried food. He was shocked by his heart attack and was determined to make the best of his later life and to be in the best possible health. He decided to take action to be healthier and ward off the possibility of future heart attacks. John has always cooked for himself and finds cooking enjoyable. Rather than eating foods high in fat, he now grills meat and fish and ensures that he eats plenty of fruit and vegetables each day. He has never really enjoyed ‘exercise’ and so wouldn’t be interested in going to a gym, swimming or classes but he has a dog which he walks twice a day.
Making decisions about healthier lifestyles

Guidelines do not necessarily define older peoples’ approach to leading a healthy lifestyle. Some participants reported that they have come to understand their own body and what suits them as an individual. Certain foods, types and levels of exercise, whilst thought to be generally good for most people, may not be good on an individual level as they ‘disagree’ with them. The overall view was that with age comes an understanding of what is good and bad for them personally.

Often good intentions to lead a healthier lifestyle do not last. Some participants reported having adopted ‘healthy eating’ or taking up exercise of some sort and not ‘keeping it up’. It would seem that boredom with the new healthy regime was a primary reason for this, along with not seeing any immediate benefits. Some participants reported not feeling any different in the short term and so finding little incentive to maintain the healthier behaviour.

R1: “Well I mean if I was reading something that said you should try and do this, I would do it for a while and then I might think, oh I’m not going to bother anymore. I think sometimes you expect the results from something to be quicker and if you’re not getting them you think, oh well no this is not working”.

R2: “Yeah that’s what happens or you think, oh well I’m not going do this it’s not doing anything for me”.

R1: “I know, I’m very impatient, I don’t know about you? I want it to be done yesterday.”

[Female Trio, hearing and sight impairments, northern workshop]

3.5 Barriers to healthy lifestyles

- There are a number of practical and attitudinal barriers to older people living healthy lifestyles
- These include apathy and lack of motivation, habits and routines, fatalism, attitudes to ageing, health problems and/or disabilities, problems of affordability, dependency, depression, lack of self-confidence, access difficulties, low health literacy and lack of cultural capital
- These may be related to each other and are experienced differently by different people

Factors impacting on behaviour can be practical and / or attitudinal. Barriers are subjectively experienced and therefore have more or less of an impact depending on the individual. That is, what may be a significant barrier for one person may be relatively easily overcome by another. In addition, attitudinal barriers may be outweighed by practical barriers and vice versa. For example, a resilient attitude may defy practical barriers such as ill health or disability.
Attitudinal barriers

Motivation levels and apathy
A key attitudinal barrier is apathy. Some older people appeared to lack motivation to make changes to their lifestyle and were indifferent about their health. Changes may be seen as a big step which they were not inclined to take. In particular, healthy meals were described as requiring too much effort to prepare and tidy up after.

“We all agreed that we don’t eat healthy because it’s a bit of a bind cooking a meal for yourself”

[Less healthy group, northern workshop]

In many cases (though by no means all), it is clear that this apparent ‘apathy’, which resembles laziness in some, is a result of feelings of worthlessness and having ‘given up on life’. It would seem that this behaviour could be altered with a sense of purpose, which for many may be linked to the availability of social support.

Confidence
Some older people spoke about feeling less confident in older age. This could be less confidence to do new things or change habits. Or it could be less confidence in a social context; older people might feel less comfortable going out on their own or meeting people.

“I tell you what I find now I don’t mix as easy as I used to. So to go anywhere on my own, it’s hard to join in.”

[Male hearing and visual impairment trio, northern England]

Habits and routines
For some though, indifference towards healthy lifestyles is linked to habitual behaviour. Older people can be resistant to changing habits and commented that it was hard to “change the habit of a lifetime”. Of those who had been relatively inactive for most of their life, some found it very difficult to adopt new behaviours.

Fatalism
Fatalistic attitudes were common amongst the research participants. These could act as a significant barrier to older people adopting healthy lifestyles in later life as there was a sense that they do not have control over how long they live. As such, changing behaviour was considered to be inconsequential. In addition, some felt that they had ‘cheated fate’ by living to this age. They saw no reason to alter health behaviour at that stage of life.

Practical barriers
Practical barriers are readily reported by older people which suggests they are ‘top of mind’ when considering healthy lifestyle choices.
Health problems and/or disability

For this group ill health and having a disability were crucial barriers in terms of doing exercise. Participants reported that doing exercise and being active had become more difficult with age. Some described how physical activity made them tired and so infringed on their typical daily activities.

With formal, as opposed to incidental exercise, there was a perception that a certain level of basic fitness was needed in order to take on a more strenuous exercise regime. If they felt very unfit, taking up exercise was seen as too physically demanding or painful for some.

Having poor health or a disability can severely restrict the amount of exercise that can be undertaken. This was true for older people with minor health problems and/or disabilities through to those who were very ill and presented more debilitating disabilities.

“I wouldn’t be able to bend and I’ve got problems with me knee and it wouldn’t be for me. But I would, if I was healthier, I’d love nothing more I’d love to do exercise.”

[Male, literacy trio, southern England]

Dependence on others

Those who were dependent on others for care perceived themselves to have little power over much of their lifestyles and the extent to which these lifestyles were healthy. Dependence on care can determine what and when older people eat. Those who were dependent were not able to shop or cook for themselves and so had little or no control over how healthy their food was. Similarly they had little or no control over when they ate.

Dependence on care can also determine how active an older person can be. This meant that they were not in control of how often and how much exercise they took.

Perhaps most importantly for those receiving care, dependency affected their social activity. Those who received personal care funded by their local authority felt that they had to accommodate the schedule of their carer, which can infringe on their social activity. Social activities are also often a source of physical activity or mental stimulation. Therefore, if dependency infringes on them it also affects levels of physical or mental activity.

Depression

Depression is another barrier to older people living more healthy lifestyles. Although related to attitudinal barriers, perhaps causally, depression is a common, treatable illness in a significant proportion of older people and therefore is seen as a practical barrier. Many of the participants spontaneously mentioned depression as central in the ability to live a healthy lifestyle. It was thought to lessen or eliminate motivation to lead a healthy lifestyle.

“People with depression…can’t make themselves do anything.”

[Less healthy group, southern workshop]
Flora described how her friend’s depression has an impact on both of them. She explained that her friend is often depressed and has no motivation. She sleeps a lot and does not go out as much as she used to. This is a ‘pain’ for Flora as her friend often cancels plans they had made which leaves Flora to go on her own or miss out. Flora advises her friend to see her GP and get a prescription for anti-depressants. Flora is concerned about her friend and really hopes she does not become depressed too in the future.

Health literacy

Health literacy is the extent to which people are able to obtain, understand and act on information in ways that are health enhancing. As noted earlier, older people felt well informed and ‘health literate’. In some cases, this could lead to complacency as they felt they were well informed and made decisions on their health based on what they thought they knew. Older people may not actively seek more information and can too readily accept messages relayed in popular media, lifestyle programmes and advertising, attributing this information with more authority and expertise than it may have. There was evidence from both the workshops and groups that this could produce ‘health myths’ and confusion.

There is a need for clear information from an authoritative source or sources upon which older people could base their decisions about healthy lifestyles.

Location

Location is important in terms of services on offer to older people – be they social clubs, or exercise classes. Those in rural areas reported fewer opportunities than those in urban areas. Location could also determine the amount of incidental exercise an older person may take. Living within walking distance of local amenities offers the choice of getting exercise in the form of walking, but living too far away means that transport is needed.

“To go to real shops it’s too far away, you need the car to get there.”

[More healthy group, southern workshop]

Cultural capital

‘Cultural capital’ refers to the entrenched norms and values which are not necessarily related to socio-economic status. It had an impact on the extent to which older people wish to and actually feel they can change health behaviour. It is about much more than knowing how to change. For some people with a lack of ‘cultural capital’, adopting new health habits could be so outside their cultural experience as to feel impossible. Cultural capital was closely related to health literacy as it dictated both how health messages were received and the desire to seek out and have an interest in health information.
3.6 Enabling factors

- Supportive and positive contact with others is critical for both physical and mental health.
- Friends and family provide ‘life-lines’, support and encouragement and can be sources of health information. They can prevent lonely and bereaved older people from drifting into bad health habits and poor mental health.
- Those who have a social network are more likely to engage in exercise and to remain active.
- Older people feel that better transport, facilities and guidance would help them to lead healthier lifestyles.
- Much of what older people think will help them already exists, or has been done before.
- There is scope for better publicity of available facilities and support and to provide ‘routes in’ for older people.
- Some groups of older people will require more intervention than others, particularly those who present attitudinal barriers.

A key part of the research was encouraging older people to develop their own ideas and solutions. This chapter sets out the ideas developed by research participants, drawing on attitudes, behaviours and barriers to enable people to make healthier choices in later life.

Social Capital

Friends, family and social networks have a huge impact on the health behaviour of older people for a variety of reasons.

Grandchildren can have an impact on older people both in terms of keeping them active and in giving them a role and sense of purpose. Some participants reported getting great pleasure from spending time looking after grandchildren to help out their children. Anne lives with her teenage granddaughter and takes a major role in her up-bringing. Occasionally, she finds looking after her granddaughter tiring but she emphasises that being around a teenager ‘keeps her going’, both mentally and physically.

Having ‘grown-up’ children around can be a great source of support, providing company, advice and a regular ‘life-line’ on the telephone. Many participants spoke of how much they appreciated regular phone calls and visits, especially if they were living alone. For some, this was the key factor in avoiding sinking into depression and inactivity after they lost their partner.
“I lost my partner about ten months ago but I haven’t been lonely because my two daughters…can’t do enough for me and they’re there all the time”

[More healthy group, southern workshop]

Family also played a role in ensuring that older people ate well, by inviting them to eat at their house, by bringing food around, by going food shopping together or simply by repeatedly encouraging them to eat regular and home cooked meals.

Friends also played a huge part in helping older people to lead healthy lifestyles. Many participants reported doing exercise with other people that they would not do on their own. In some cases, this can mean that exercise is only sustained when it is also a social activity.

“I used to go swimming regularly and…my friend dropped off and I don’t like going on my own”

[Hearing/visual impairment trio, northern England]

For those living in residential care, building social networks in their care homes were crucial to their happiness within the home and their state of mind.

“I’m quite happy with my friends. I’m very pleased with all the people that are here. Without them, I don’t think I could exist”.

[Female trio, care home]

Some older people derived a sense of well-being from helping and being useful to others. Being involved in the local community had benefits for both parties, providing a sense of purpose for the community spirited, as well as helping them to keep active, and helping those who may have become ‘stuck in a rut’ by lifting in them out of depression.

What older people think would help them lead a more healthy lifestyle

Improving access

Those who had physical disabilities, and those who found it difficult to travel on their own pointed to the need for better transport and help getting to and from facilities. Participants felt that more could be done to ensure that older people had the freedom to travel within their area and get out more.

Some participants mentioned facilities that they once used which were forced to close due to a lack of funding.
“But transport’s always a big issue isn’t it, I mean some areas don’t have a bus even that runs through … but you still have a lot of people who are either elderly or disabled, with no way to get to where they need to go. And it’s frustrating you might want to go somewhere but you just can’t get”

[Less healthy group, northern workshop]

More guidance

Despite feeling fairly knowledgeable about healthy living and the steps that are necessary to take if a healthy lifestyle is to be achieved, many participants pointed to a need for more information and advice, and in particular, from health professionals.

Guidelines and available facilities may not be enough to change behaviour. Some, especially those in the less healthy group and those who had attitudinal barriers, would require active intervention as they were less likely to proactively take steps to take responsibility for their own health behaviours. Many participants pointed to the need for encouragement and a ‘push’ to make the effort to lead healthier lifestyles and to get involved in local activities. The benefit of getting involved and getting out more was not questioned at all but many felt that in order for older people to make the leap, they would require a push in the right direction.

Some participants also pointed to the need to ‘start earlier’ and to receive health advice before retirement. It was felt that good health behaviour should be encouraged before later life to lessen the extent of radical change that some felt the guidelines required of them.

More facilities

There was a call for local, affordable, well-publicised facilities. Many wanted to attend lunch clubs, or attend day centres or get involved in their local community but simply did not know how to. It was thought that facilities, and any publicity for these facilities, should emphasise social elements and enjoyment, rather than exercise or learning.

“The PCT [primary care trust] put money in to the healthy living centres, which they started up, which were good and there were gyms that, elderly or young people, anybody can use, and they were free. But the trouble is they only gave like a year’s money for them, they got them introduced and now that money is running out and now there’s nobody to continue them. So you start with it, it’s good and everybody gets involved and the healthy living picks up, and then the money’s not there to keep them going. So then they’ve closed and then there’s nowhere for people to go again. And it does it all the time, it’s happening all the time.”

[Less healthy group, northern workshop]
Overview

Much of what participants suggested would enable them to lead a healthier lifestyle exists already. Clearly this depends on where they live and what is available locally. However, it would seem that their ideas are not new and many are currently available. Participants’ views suggest that provision for older people is patchy and inconsistent. Information about what is already available is not reaching all of those who would be interested. In addition, there is evidence to suggest that older people do not always take the first step to seek support or to find out about what might be available to them.

3.7 Vulnerable groups

- Vulnerable groups are principally older men who live alone and older people who live in care homes.
- Older men can be ill-equipped to cope if they lose partners in later life.
- People who live in care homes are dependent on the home for access to the basic provisions of healthy lifestyles, such as food, opportunities to socialise and exercise.
- For many who live in care homes, attitudinal factors are additional barriers to choosing healthy options.

It is clear that some groups are more vulnerable and are likely to require more intervention and support than others. These groups will find it more difficult to lead a healthier lifestyle, or to maintain health behaviour that may once have been their routine.

Men who live alone

There is a gender difference in both willingness and ability to lead a healthy lifestyle. Men who live on their own as a result of bereavement or divorce reported finding being in the home more difficult. Many older men reported feeling overwhelmed by household chores, shopping and cooking in the absence of their wife. Before retirement, they had gone out to work while, in the main, their wife had taken a more active role in the home. After retirement, wives continued in this domestic role, despite their husband being at home. As a result, some older men simply did not know how to look after themselves.

R1: “See with a woman, she does the housework and everything herself so basically her world does not change a great deal [without her husband]”

R2: “There’s less work for her to do, she hasn’t the ironing for the husband and his meals and everything. With a man he’s got to do the housework, his got to cook his own dinner, he’s got to wash his shirts, iron them. It’s a completely different world that you walk into.”
**R1:** Yeah I think for an elderly man who is living by himself, especially who never really has done any cooking – whenever I try to do anything it’s tasteless, I don’t know how to season food, you know and OK it’s food, you eat it because you’ve got to eat but it really isn’t very tasty. So rather like Bernard I also entirely exist on the package foods.

[Trio, bereaved men]

Women were seen to take a role in ‘propping men up’, taking the lead in the home and telling men what they ought to do, when and how they ought to do it. After losing their wife, some older men reported literally sitting around the house all day, uncertain of what to do next. Clearly lack of company and purpose is also a factor here, where some men simply did not see the point in carrying on as they once did, now they were on their own.

Women were considered by male participants to have more ‘get up and go’ and to be more able to get on with life on their own than men. They were considered to be more resilient and generally more determined to get on with life, in spite of bereavement.

“I did sit at home and mope for a couple of years, you know, so I think women have, yeah, maybe that mental drive maybe more than I have”

[Less healthy group, southern workshop]

“I think widows cope better than widowers”

[Trio, bereaved men]

Some male participants also remarked that women ‘age better’ than men, and therefore find it easier to carry on as they always have.

“But I think women are better at it than men, I hate to admit it but they are, they don’t seem to age as quick being that they seem to keep more mobile, let’s put it that way, than men. Men seem to lose the ability quicker than women.”

[Less healthy group, southern workshop]

Bereavement impacts on social activity. In the group with bereaved men there was discussion about social life dwindling with the loss of a partner:

“What I’ve found in the last few years is I’m not a couple any more, so you don’t get invited out.”

[Trio, bereaved men]

“I used to love entertaining all the time. But since my wife passed away, I’m not particularly interested to be honest with you. I seem to have lost…the interest. Just happy to get through each day.”

[Trio, bereaved men]
These men felt more isolated and got ‘out and about less’. This impacted on their level of physical activity.

“The only person that used to be able to make me walk was my wife… She was very good for me because she chased me out. She’s not here anymore so I don’t have to do it.”

[Trio, bereaved men]

Older people living in care homes

Overall, it would seem that people living in care homes had less control over what they ate and had less autonomy over their lifestyle generally. However, the level of autonomy people living in care homes had over their lifestyle and health behaviour depends both on the home they were in, and, like other older people, their attitude to their own health.

Participants in our research spoke highly of their care home and felt that options were available to them if they wanted to choose healthier habits. The main barriers they reported appeared to be their own attitude to health and their own habits. They reported that whilst there was help and encouragement to do exercise, even for the most disabled, few were interested in taking it up.

R1: Two or three times a week, people come in to give us exercise…But there aren’t enough people taking part

Moderator: Why is that, do you think?

R1: Boredom, I think.

R2: Boredom, laziness. I don’t know really why.

[Female trio, care home]

In addition, whilst a healthy diet was available to them, they simply did not have the appetite to eat the food that was put in front of them.

It appears that people in care homes, though they may have company, are susceptible to depression and ‘low moods’. The women who took part in the research described having been depressed at some point, but also explained that the strength of their friendship with others there made living in a care home bearable, and sometimes even enjoyable. None wished to be in a care home, and reported that initially, being there was the main driver for their depression.

“Sometimes you get a bit depressed. You felt like why should you be in a place like this when you had a lovely home.”

[Female trio, care home]
“I wondered, I couldn’t help it because I had such a wonderful life, I wondered what did I do wrong to be in a home.”

[Female trio, care home]

3.8 Older people health behaviour typologies

The health behaviour of participants can be summarised by four emerging type groups. These are based on both practical and subjective factors which impact upon healthy lifestyle behaviour.

Practical factors include:

■ Health literacy
■ Dependency
■ Ill health and/or disability
■ Bereavement
■ Social capital (isolation/ lack of support)

Subjective factors are based on attitudes and characteristics and include:

■ Apathy
■ Fatalism
■ Outlook on life
■ Resistance to changing habits
■ Cultural capital

These factors are related to each other and are inter-linked. It may be in some cases that an attitudinal factor is symptomatic of a practical factor, and vice versa. For instance, apathy and fatalism may come about as a consequence of bereavement; levels of social capital may come about as a consequence of outlook on life, just as much as outlook on life can be determined by social capital.

Type groups are not fixed so movement between them is possible. Some participants reported factors in their past circumstances that would have put them into a different category than they occupied at the time of this research. It should therefore be possible provide appropriate support for people in all groups.
The four type groups are:

**Group 1:** Able and willing to be healthy

**Group 2:** Able but unwilling to be healthy

**Group 3:** Unable but willing to be healthy

**Group 4:** Unable and unwilling to be healthy

Within each type group there are different degrees of willingness and ability. For instance, an older person who falls into the ‘unable but willing group’ may present more substantial practical factors than attitudinal.

The following ‘case-studies’ are illustrative of each of the type groups.

**Group 1: Able and willing to be healthy**

Maisie’s story is illustrative of older people who do not have any physical health problems and/or disabilities and who have a positive outlook on life and who demonstrate positive attitudes to health. Maisie is ‘health literate’ in as much as she seeks, understands and acts on health advice and general health messages.

Maisie is 75 and lives alone in a village. She is really determined to look after herself in her older age. She thinks she is lucky to be healthy and wants to stay this way by leading a healthy lifestyle. This means that she is careful in what she eats and tries to have a low calorie diet with plenty of fruit and vegetables, and lots of fish. She ensures that she takes regular exercise – she goes to keep fit classes and swimming every week. Maisie also stays active by regularly volunteering at her local church. She believes that if you help other people this makes you feel better and it keeps you going both physically and mentally. She doesn’t smoke or drink at all.
Group 2: Able but unwilling to be healthy

Donald’s case-study shows the impact of attitude and outlook. While he does not present any practical barriers to leading a healthy lifestyle, he is apathetic about changing his lifestyle and is happy with his current routine. He is ‘stuck in his ways’ in as much as he can’t imagine living any other way. Donald presents some health literacy issues as his lack of ‘cultural capital’ impacts on the extent to which he absorbs health messages. Donald would not seek health information and tries to stay away from his GP.

Donald is 68 and lives in the suburbs of a large city. He is married and has two grown-up daughters who live nearby. He worked as a coach driver before retiring 3 years ago. He loves ‘good old-fashioned food’ and likes nothing better than mince and dumplings. He hates salad and ‘modern food’ like pasta. Donald is overweight and uses a walking stick, but he is able to get about on his own. Donald smokes 20 cigarettes a day and has smoked for most of his life. He goes to the pub every evening to meet friends and he “wouldn’t change it for the world.” He enjoys life and doesn’t want to change. He just can’t imagine keeping to guidelines for living a healthy lifestyle. They are so far removed from how he lives now and he doesn’t want to change his way of life.

Group 3: Unable but willing to be healthy

Jack’s story is an example of the impact practical barriers can have, in spite of a positive outlook on life and positive attitudes to healthy living. Jack is held back by his disabilities and has a lack of autonomy because he lives in a care home.

Jack is 85 and has lived in a care home in a small town for the past 5 years. He is widowed; his wife passed away 10 years ago, but he does see his children fairly regularly. He moved in to the care home after an accident, which left him infirm. Following the accident he can only walk using a Zimmer frame and this is only over short distances. He cannot stand up without assistance. He would like to live a healthier lifestyle but he feels that living in a care home and with a disability means that he doesn’t have autonomy over whether or not he lives a healthy lifestyle. He is dependent on the care home in terms of what he eats and how much exercise he gets. He cannot get out on his own and he cannot do any moderate exercise on his own. Despite his physical disability, Jack feels young mentally and enjoys socialising with other people in the care home.
Group 4: Unable and unwilling to be healthy

Tom’s story illustrates the group who perhaps present the biggest challenge. His case study is an example of the circular relationship between practical and subjective factors. His mental well being is now the biggest single barrier Tom has to leading a more healthy lifestyle, and is a consequence of bereavement.

Tom, a retired accountant is 76 and lives on the outskirts of a large city. He lives alone and has done so since his wife died 4 years ago. He has no children and no other close family. He was very depressed after his wife died and he still finds it quite difficult to cope. In practical terms, Tom’s wife used to do all the cooking and cleaning and he has found it hard to take on this role. He doesn’t like to cook for himself and often can’t be bothered; he tends to eat sandwiches and pre-prepared meals. Tom does not get out very much and doesn’t have many friends or family to visit. He tends to spend his day watching television and reading the newspaper.
4. Implications and recommendations for policy and practice

The research findings describe older people’s knowledge of and attitudes towards healthy lifestyles and the steps that many take to improve and maintain their physical and mental health. However, there are important barriers which some older people need to overcome to achieve healthier lifestyles and a requirement for targeted support to enable them to do this. To date, older people have not been made a focus of attention for policies to improve either physical or mental health. In its strategy for an ageing population, the Government has recognised that maintaining health is key to retaining a good quality of life for individuals and to tapping into the valuable contribution which older people make to society. To achieve these goals, older people need to become ‘fully engaged’ in their health and supported to choose healthier lifestyles. Key implications for the development of policy and practice to enable this to happen are discussed below.

4.1 Health Literacy

In order for older people to take more responsibility for their own health, they need to access, understand and be able to act on health information. Yet those who stand to benefit the most are the least able to do this. Conversely, people who are most able to take responsibility for themselves and make informed choices about health generally are the most able to access and understand the information and the most likely to respond to health advice. Inevitably, this has an impact on health inequalities.

This is not new – work on health literacy has shown that there is a socio-economic divide, not only in health outcomes but in people’s understanding of how to ‘be healthy’. This research has found an even more complex picture. Within socio-economic groups, there are differences in people’s attitudes towards and experience of diet and exercise which are culturally specific and culturally entrenched. Some people are likely to present attitudinal and cultural barriers and be far more resistant to health messages and advice. Again, these are likely to be the people who would benefit most from improved health literacy. This has significant implications for the way that health promotion messages and health literacy initiatives are designed and targeted for older people.

Recommendations

The Department of Health:

- Should ensure that the importance of health literacy and its impact on health outcomes is recognised throughout the healthcare system, and that quality measures and standards for health literacy are created to help make this an integral part of healthcare;

- Oversee the development of a health literacy skills index to identify the key components and levels of functional health literacy; and
Measure levels of health literacy among the general population to identify groups with low health literacy to inform the development of a targeted strategy for maximising the impact of health literacy interventions.

Healthcare professionals should:

- Recognise the importance of widespread variations between different population groups in health literacy levels and needs, and develop tailored health literacy interventions, as appropriate.

Those involved in promoting the physical and mental health and well-being of older people should:

- Recognise the importance of health literacy interventions in improving the health and quality of life of older people; and
- Receive appropriate training in assessing and improving the functional health literacy of older people to enable them to make healthy choices.

4.2 Communicating health messages

Communications to older people need to be clear, straightforward and consistent. There is an ‘information gap’ in terms of the detail and consistency of the health messages older people currently receive. Many older people would like more information about healthy lifestyles. However they have had many years of receiving health messages and in some cases, over time, prevailing knowledge and the resulting advice have changed. Information about food is disseminated via various means, including commercial advertising by the food industry, which, as the research shows, can become confused with unbiased ‘health’ messages. There is therefore a need for validation and quality assurance of information sources.

In 2004 the Department for Work and Pensions (DWP) in collaboration with other government departments and the Local Government Association, developed Link-Age to provide better integration of health, housing, benefits and social care for older people. In 2005 the DWP announced that a Link-Age Plus service would be piloted and this would be focused on promoting well-being and independence. There are important messages from the research for this service.

Older people have stated clearly that health information given through health professionals and within the health service is the most credible to them. It is also clear that older people are prompted to think more about healthy lifestyles through popular media. They are receptive to taking in health messages by suggestion in this way, rather than being ‘told’ what they ought to be doing.

Advice on diet and nutrition needs to reflect the reality of different lives and circumstances. Some older people are receptive to changing their diet but adopting some diet advice seems too big a leap from their current habits. Suggesting alternatives which are more in line with older people’s current lifestyles and which are more within their reach may help to overcome this.
Older people who are less healthy would benefit from guidelines on maximising health improvement from small changes to lifestyles as this would provide them with more of an entry point to healthy living. It is not currently clear to older people whether they need to follow some or all of aspects of a healthy lifestyle in order to have an impact on their health. Less healthy older people feel that they would be required to make too many and too radical changes to their lifestyle. For this group, making these changes is simply too difficult, yet making some smaller changes in the first instance would be acceptable.

Crucially, there is scope to give older people more information about the benefits of following advice on healthy lifestyles. Whilst people think that following guidelines would be a good thing to do, they are not clear about the immediate or longer-term impact it would have on them. Those who are less healthy feel that they should adopt a healthier lifestyle more because it is a virtuous thing to do, rather than because they could directly benefit.

Older people’s expectations of health benefits from healthy lifestyles also need to be managed. There is clear evidence that some older people might try to adopt a healthier lifestyle but too quickly return to their old routine if it appears not to make any difference to them within a short time.

Adopting social marketing techniques to the communication of health messages to older people could pay dividends. Changing or maintaining behaviour can be very difficult, but general marketing affects behaviour all the time – as demonstrated by participants’ recollection of adverts and health promotion messages on food labels. Social marketing offers the opportunity to design programmes that are truly focused on the individual and offer a real opportunity to affect positive behaviour change.

This research shows that raising awareness of health issues with older people is not enough in itself. Support that is targeted at particular individuals, groups or communities may also be required to ensure that positive health behaviour is not only an attractive option but an easy choice for everyone to make. It is also important to help older people maintain their healthy behaviour through endorsement and encouragement.

Recommendations

- The Department of Health’s proposals to market ‘health’ should be informed by older people’s views on health messages and the information they would like to receive.

- The Department of Health’s Food and Health Action Plan should be updated to incorporate issues on information about and access to healthy food in later life.

- Age Concern’s Ageing Well Programme should review the way in which it communicates health messages in the light of the views that older people expressed in this research.

- Organisations which provide information and advice to older people should consider the implications of the outcome of this research on both the content and style of information older people would like to receive about health. They should review their current information and develop new materials accordingly.

- The Link Age Plus pilots should test out how they can incorporate information on health and healthy lifestyles for older people backed up by support to take action.
4.3 Target groups for interventions

This research has identified a number of ‘target groups’ who will need additional support and intervention in order to lead a healthier lifestyle, including vulnerable groups such as older men living alone, and those who face practical or attitudinal barriers to adopting healthy behaviours. Although living alone is more common for women than for men, almost 30% of men aged 75 and over live alone. Those who lead the least healthy lifestyles need more support. Additional consideration is needed for some, such as people living in care homes who may have little or no say over what they eat, and those who have a physical disability or an existing health problem that makes it difficult to take exercise such as walking. Around one in twenty of the population aged 65 and over lives in a care home.

Some groups are more receptive to health advice and interventions than others. Those in their early 60s are often more receptive as they are at the stage of thinking about older age and how they might like to feel in 10 years time. In the main, they are more likely to be physically able to adopt new exercise regimes and are also more likely to be able to adopt new ways of cooking and eating. From the evidence, it seems that taking up exercise is easier, both psychologically and physically for this group. In later life, where exercise is ‘new’, older people can struggle with it.

Another obvious target group is those who are motivated but unable to maintain positive health behaviour. This group will require more active intervention and support to overcome practical barriers. This would be principally around raising awareness of and providing better access to facilities and activities. This group would benefit from being linked into semi-informal networks which might be facilitated through other older people, to provide company, support and to accompany them to and from services and facilities. This group are also more likely to have difficulty in shopping, cooking and maintaining a healthy diet. Where there is a lack of ‘social capital’ they would benefit from support with this too.

There is clear evidence that some older people, especially men, can fall into depression and negative health behaviours after losing their partners. There is a small window of opportunity to help this group adopt and maintain positive mental well being and health behaviours by providing support and, crucially, company. This group will need to be sought out more actively as they are often more socially isolated.

Some of this type of provision already exists in one form or another, although facilities vary in different areas. There is scope to publicise local services more widely and to provide older people in targeted groups with easy routes into support. This may be facilitated by involving more active and engaged older people in providing advice and support to those who are less able or motivated.

Clearly the most difficult group to help will be those currently unwilling to make changes. Opportunities to intervene at earlier stages before poor mental well being develops and attitudes to health become more fixed could be further explored. However some in this group are more interested in enjoying life, rather than sustaining it. Health professionals will need to play a role in identifying those at risk of poor mental or physical health, and in providing appropriate advice and information. Health information, facilities and organised activities for these older people should be provided with an emphasis on fun and enjoyment rather than on health benefits alone.
The White Paper on public health announced the introduction of Health Trainers to give personal support to people who want it, initially in the areas of highest need and, from 2007, progressively across the country. In August 2005 the first 12 areas were selected for the introduction of health trainers. The Health Trainers initiative has not identified older people specifically as a priority group to target. However, on the basis of the evidence presented in this report, older people should feature as a priority.

Since publication of the White Paper, the Department of Health has also announced the introduction of a wider range of providers into primary and community health services, including use of the voluntary sector. Some models which have close parallels with the Health Trainer role already exist in the voluntary sector which is likely to fit more closely with the aim of identifying health trainers from the local community. For example, Age Concern runs the Ageing Well UK programme - a health promotion initiative that enables older people to take control of their own health and promote healthy lifestyles to their peers. The programme recruits and trains volunteers who are 50 years or over to become Senior Health Mentors. The volunteers then make contact with isolated older people and community groups, providing links to health services and opportunities in local communities.

**Recommendations**

- The Commission for Social Care Inspection should consider how its review of the framework for regulation and inspection can be used to support care homes in promoting the health of residents.

- Care home managers should review their opportunities for promoting health and the ways in which they can offer and increase choices available to older people about healthy lifestyles.

- The Social Exclusion Unit should work with the Department of Health to address the practical barriers faced by some older people in following a healthy lifestyle. Primary Care Trusts in the most deprived areas should initiate pilot health promotion programmes targeted at the most vulnerable groups, working with established groups of older people to tap into local knowledge and resources.

- The Department of Health should ensure that the roll-out of the programme for Health Trainers specifically includes and addresses the needs of older people highlighted in this report.

- Primary Care Trusts should consider commissioning voluntary and community sector groups to deliver parts of their Health Trainer programmes.

- The Ageing Well UK network should work with the Men’s Health Forum to pilot further ways of working with older men to raise awareness of health issues and to promote appealing approaches to increasing healthy lifestyles.

- Health promotion campaigns, facilities and organised activities for older people should place an emphasis on social stimulation and company rather than on health benefits alone.
4.4 Timing of interventions

Habits are formed before old age and become increasingly difficult to change. Eating habits are entrenched often from childhood, followed by the routine of many years in work. In pilot studies undertaken by the Health Development Agency on health advice in the pre-retirement phase, this was shown to be a key time for effective interventions, provided that the advice and support was tailored to meet individual needs.

Retirement can be a time at which older people become more active or become far less active as they feel a lack of purpose without being in work. There is an opportunity at this time to help older people with ways that they could make the best use of their time and enjoy themselves.

Other critical events offer the opportunity for intervention to help older people adopt new health behaviour. In particular, bereavement and experience of ill health can result in changes in health behaviour for the better or worse. Whether health professionals are aware of or seize these opportunities can be a matter of chance.

Recommendations

- Employers and trade unions should work together to commission or provide pre-retirement planning for all employees, taking account of the holistic views of health expressed by older people and their preferences for receiving health messages.

- Health professionals and others involved in promoting the physical and mental well-being of older people should be supported in giving advice on healthy lifestyles through training and development programmes. The creation of ‘care pathways’ for the care and treatment of specific diseases or illnesses should include the opportunities for health promotion information and advice.

4.5 Mental well-being and quality of life

Older people make an intuitive link between physical and mental well-being and have a holistic view of health. There is an opportunity to engage older people more in information about this relationship and, in particular, how they can influence the lines of causality with their health behaviour. Older people would like to see, and are likely to respond to, advice and support which incorporate mental well-being and quality of life into messages about healthy lifestyles. These messages are far more tangible for older people and demonstrate benefits that really interest them.

Older people also note the link between taking an active role in the world around them, keeping busy and being in the company of others. Explaining why this is good for health is not difficult as older people instinctively recognise it as being bound up with good mental well-being and good physical health.
The action on mental health proposed by the public health White Paper does not include older people and there is a separation of action on healthy active lifestyles from consideration of well-being. The promotion of good mental health in later life has received scant attention to date in research, policy or practice. The research findings clearly show the importance older people attach to this aspect of a healthy lifestyle and the immediate connections they make with others aspects of healthy living.

This research has also found that older people are keen to lead an active and fulfilling life, but that, for some, this is made extremely difficult because of a lack of social networks and family support, the presence of depression or through a simple lack of knowledge about what support is available and how to access it. In order for this group of older people to take responsibility, they first need their knowledge of services and support to be strengthened.

Recommendations

- The Department of Health’s delivery of its priority of promoting healthy and active life amongst older people should include the goal of improving and sustaining mental health and well-being.

- The implementation of the National Mental Health Promotion Strategy should recognise the holistic view which older people hold of health.

- Primary Care Trusts, Local Authorities and voluntary organisations in contact with older people should prioritise action and resources to promote good mental health in later life and to prevent and/or treat depression.

4.6 Joined-up solutions

Better health for older people involves a range of services, including health services, leisure, transport, income, community initiatives and housing. Interventions to encourage older people to lead healthier lifestyles will therefore require joined-up thinking and joined-up solutions. A variety of national and local authority level services, from lifelong learning to social services, and voluntary and community sector organisations have roles to play in the solutions.

The Government’s strategy for an ageing population aims to co-ordinate activity across Departments to achieve its objectives, including the promotion of healthy living. A Cabinet sub-committee has been established to oversee and drive forward action in support of the strategy. There are key messages from this research which should inform the approach of the sub-committee in its work on healthy ageing.

Since 2001 Local Strategic Partnerships (LSPs) have provided an opportunity for the development of co-ordinated strategies to improve the health of local populations by integrating both the planning and delivery of services. More recently Local Area Agreements (LAAs) have started to provide the opportunity to merge a number of separate funding streams which can offer greater flexibility to Local Authorities and their partners. The involvement of older people in the development of LSPs and creation of LAAs has been variable to date.
Since its introduction in 2002, the Comprehensive Performance Assessment (CPA) has proved an important driver for improving local authorities’ performance in delivering services for local people.

Amongst the five priority groups and areas now included in the CPA are older people and communities. The development of a strategic approach to the issues older people say are important to them, the involvement of older people themselves in the development of the approach and design of services, and the co-ordination of services (both within Local Authorities and with other partners) form the key aspects of performance which will be assessed.

This research both underlines and sets fresh challenges for local government in meeting the needs of older people, most particularly in terms of access to services, transport and how older people are supported within their local communities. Older people taking part in this research have shown that improving older people’s health is directly related not only to health services themselves but to many local government services and initiatives (transport, income, leisure, housing etc).

Recommendations

- The Cabinet Sub-Committee on Ageing Policy should consider the areas in which older people will need informed choice and support in order to make changes to their lifestyles to improve health.

- Local Authorities and their partners should build on the key findings of this report in developing their strategic approach to the promotion of health amongst older people. Local Area Agreements should be used to develop services and support which will enable older people, including those who are most vulnerable, to take steps towards improving their health.

- The Audit Commission should consider the messages from older people about their views of health in developing its measures of performance against CPA targets.
References


‘As fit as butchers’ dogs?’

A report on healthy lifestyle choice and older people