Promoting the health of older people
The next step in health generation

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and
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GILLIAN GRANVILLE is the Head of Research and Policy at The Beth Johnson Foundation, a national charitable organization, based in North Staffordshire, which aims to develop and research innovative practice development that raises the status and value of older people. She trained as a nurse and health visitor, and worked in primary care settings as a generic health visitor and practice teacher. Gillian has gained her doctorate in researching the meaning of menopause to midlife women. Her other research interests include feminist methodology and the development of a feminist analysis in gerontology. She has published work on health promotion and gerontological nursing, and, more recently, on intergenerational activity as a means of influencing social policy.

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**Anne Squire** is the Director of Health Promotion at the University of Wales, Bangor and a UWB teaching fellow. She teaches the principles and practice of health promotion to a wide variety of students, including doctors, nurses, social workers, carers and professionals allied to medicine, lay and older people. Anne is particularly interested in empowerment of the disadvantaged and works as a consultant with BASE and HelpAge International, with whom she has worked in Romania.

**David Stears** has worked for 32 years in all sections of education: primary, secondary, further and higher education. He is Reader in Health Education and Head of the Centre for Health Education and Research at Canterbury Christ Church University College. His current duties include research, undergraduate and postgraduate teaching in health promotion and health education. He is director of a World Health Organization Collaboration Centre.

**Keith Tones** has worked in secondary school teaching and lectured in teacher training, specializing in the psychology of education and educational methodology. In 1972 he established, at Leeds Polytechnic, the first postgraduate course in the UK for health education specialists. He has acted in a consultative capacity for a number of national bodies, including the Health Education Council, Cancer Research Campaign, British Heart Foundation and Alcohol Education and Research Council, and internationally, including the World Health Organization, Pan American Organization, European Commission and various universities in Europe, Scandinavia and Australia. He has published
widely and is co-author of the popular text Effectiveness and Efficiency of Health Education, and has just published a chapter on health education and health promotion in the latest edition of the Oxford Textbook of Public Health. He is also the editor of the international journal Health Education Research.

JOANNA WALKER has had an interest in older people throughout her career, commencing as an information officer at Age Concern England on matters of health services and health policy, and continuing at the Health Education Authority in the Education and Training Division. She joined the PRA’s newly formed Educational Development Group in the mid-1980s, specializing in educational resources. As a member of the University of Surrey’s School of Educational Studies (joint appointment with PRA), she has developed an academic interest in the changing relationship between retirement, ageing and learning in later life. She published in 1992 with PRA/Age Concern a practical book for personnel managers, and in 1996 a more academic text, Changing Concepts of Retirement: Educational Implications. She is a founder member of the Association for Education and Ageing, and edits reviews for its international journal.

BOB WYCHERLEY has worked as a clinical psychologist in a health authority. During this time he developed an interest in empowering and enabling people. This led to his editing and writing a practical group manual on life skills development. Currently, because of his interest in architecture, he is a full-time design student.
Now that in the second year of the new century we are some 16 books into the ‘Rethinking Ageing’ series, it seems appropriate to review our original aims. The series was planned in the early 1990s, following the rapid growth in ageing populations in Britain and other countries that led to a dramatic increase in academic and professional interest in gerontology. In the 1970s and 80s there had been a steady increase in the publication of research studies which attempted to define and describe the characteristics and needs of older people. There were also a small number of theoretical attempts to reconceptualize the meaning of old age and to explore new ways in which we could think about ageing. By the 1990s, however, there was a palpable gap between what was known about ageing by gerontologists and the very limited amount of information which was readily available and accessible to the growing number of people with a professional or personal interest in old age. The ‘Rethinking Ageing’ series was conceived as a response to that ‘knowledge gap’.

The first book to be published in the new series was Age, Race and Ethnicity by Ken Blakemore and Margaret Boneham. In the series editor’s preface we stated that the main aim of the ‘Rethinking Ageing’ series was to bridge the knowledge gap with books which would focus on a topic of current concern or interest in ageing (ageism, elder abuse, health in later life, dementia, etc.). Accordingly, each book would address two fundamental questions: What is known about this topic? And what are the policy and practice implications of this knowledge? We wanted authors to provide a readable and stimulating review of current knowledge, but also to rethink their subject area by developing their own ideas in the light of their particular research and experience. We also believed it was essential that the books should be both scholarly and written in clear, non-technical, language that would appeal equally to a broad range of students, academics and professionals with a common interest in ageing and age care.
The books published so far in the series have ranged broadly in subject matter – from ageism to reminiscence to community care to pensions to residential care. We have been very pleased that the response from individual readers and reviewers has been extremely positive towards almost all of the titles. The success of the series appears therefore to justify its original aims. But how different is the national situation in gerontology more than ten years on? And do we now need to adopt a different approach?

The most striking change is that, today, age and ageing are prominent topics in media and government policy debates. This reflects a greater awareness in the media and among politicians of the demographic situation – by 2007 there will be more people over pensionable age than there will be children.\textsuperscript{1} Paradoxically, however, the number of social gerontology courses is actually decreasing.\textsuperscript{2} Why this is so is not entirely clear, but it is probably related to the difficulties which today’s worker-students face in securing the time and funding to attend courses. Alongside this is the pressure on course providers to respond only to the short-term training needs of care staff through short, problem-focused modules. Only a few gerontology courses are based around an in-depth and truly integrated curriculum, one that draws upon the very many different academic disciplines and professional perspectives which contribute to our knowledge and understanding of ageing.

There appears to be even more interest in ageing and old age than when we started the ‘Rethinking Ageing’ series, and this persuades us that there is likely to be a continuing need for the serious, but accessible, topic-based books in ageing that it has offered. The uncertainties about the future of gerontological education reinforce this view. However, having now addressed many of the established, mainstream topics, we feel it is time to extend its subject-matter to include ‘emerging topics in ageing’ and those whose importance have yet to be widely appreciated. Among the first books to reflect this policy were Maureen Crane’s Understanding Older Homeless People and John Vincent’s Politics, Power and Old Age. Most recently, Mike Hepworth’s Stories of Ageing was the first book by an author based in the UK to explore the potential of literary fiction as a gerontological resource. Promoting the Health of Older People is another welcome addition to the ‘Rethinking Ageing’ series. It reflects the increasingly significant contribution which health promotion is making to the knowledge and understanding of the health and well-being of older people.

In future, we hope to continue to rethink ageing by revisiting topics already dealt with (via second editions of existing titles) and by finding new titles which can extend the subject matter of the series.

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References
1 Guardian (1999), 29 May.
One in five people in Western society today are over 65 years old; in 2025, one in three of the population will attain that age. There are today, in Britain, 20 times as many centenarians as there were in 1951. There are currently four people of working age for every pensioner; by the year 2040, there will be only two.

There can be few people who are not at least beginning to acknowledge that we are living in societies which are growing inexorably older. Even the young who have, traditionally, been able to defer the unpalatable thought of growing old are now forced to recognize this reality when they are warned by government that they will not be able to rely on state support in their old age. They are regularly exhorted to subscribe to privately funded pensions, since the proportionately few people of working age will not be too happy to contribute to the tax burden needed to provide a reasonable standard of living for the clamouring horde of older people! Add to this gloomy prospect the already negative image of ageing prevalent in Western countries and we who are approaching our twilight years would seem to face a bleak prospect – not least of which are the fiscal and economic strategies that chancellors of the exchequer will be pursuing in order to limit the economic burden about to be imposed by the elderly on the working population. This present book is, thus, particularly timely – especially as it should mitigate some of the gloom and despondency that tends to be associated with the ‘problem’ posed by the anticipated demands of a large population of older people.

A problem-centred approach is itself problematic – especially the adoption of a traditional preventive medical model which relies overly heavily on cost-benefit analysis. It is well recognized that geriatric medicine is expensive: as people get older they typically make substantial demands on health and

Foreword

KEITH TONES

With the ancient is wisdom; and in length of days understanding.

Job 12:12
social services (hence the note of panic and urgency in promoting private pensions and forecasts of subsistence level state pensions). Moreover, even if the curve charting the decline in health of an elderly population can be ‘squared’, i.e. if the various aches, pains, illnesses and various kinds of distress – to which we will all inevitably be subject sooner or later – can be deferred until relatively late in life, the demand for care and health services will still be there. Accordingly, it is not entirely flippant to observe that the only really efficient cost-benefit strategy is to ensure that people stay fit and healthy until the point at which they die!

Clearly there are in fact many potential problems requiring a preventive approach – problems, for example, such as the 3,000 people aged 65 years and over who die from falls in the UK each year. It would be, therefore, foolish not to anticipate these and, following John Webster’s dictum, ‘seek wisely to prevent’ them. More important is the fact that although years are indeed being added to life, many of these years are not healthy years. According to the current British government’s health policy, Saving Lives: Our Healthier Nation, at present men’s average life expectancy is some 75 years, and, on average, this will include 15 years of longstanding illness or disability. Similarly, of women’s 80 years of expected life, 17 years will be spent with some degree of ill-health. In short, we must strive not only to ‘add years to life’ but also to ‘add life to years’ and ‘health to life’.

We should, of course, be wary of considering older people as a homogeneous group. First, by no means are all older people infirm and incapacitated and it is sensible to differentiate between the young, active old and those older people who are genuinely frail and need a good deal of care. To some extent the young old have ‘never had it so good’ – to borrow Harold Macmillan’s classic Panglossian dictum – unless, of course, they are poor. A much more important differentiation, therefore, is to distinguish those who have a reasonable income from those who are eking out a living on state benefits. Inequality and inequity afflict older people just as they afflict society at large. In the recent government inquiry into inequalities in health, it is noted that the mortality rate in people aged 60–74 who had been living in local authority rented accommodation showed a 16 per cent excess, whereas those living in owner occupied accommodation showed a 13–14 per cent deficit. Not surprisingly, life expectancy at age 65 years is 2.5 years greater in men (and two years in women) from social classes I and II than in those men from classes IV and V. Older people from lower socio-economic groups also experience greater morbidity – for example, higher rates of total tooth loss, lower respiratory function and higher blood pressure. To some extent, then, problems of health in old age are merely a reflection of problems at an earlier age: health promotion for older people must therefore begin at a much earlier stage in life.

However, although we must acknowledge the specific illnesses and diseases to which older people are prey, it is both more ethical and more efficient to develop a positive approach and seek to enhance well-being of older people. The most useful way of encapsulating such an approach is in terms of empowerment.

Individual or self empowerment is now generally recognized as a state
involving the possession of a relatively high degree of control over one’s life and health. Associated with it is a set of optimistic beliefs about life and capabilities and a relatively high level of self-esteem. The ‘sense of coherence’ popularized by Antonovsky is related to such a desirable state. A sense of coherence involves a belief that life is, in general, manageable, understandable and meaningful – both intellectually and emotionally. A sense of coherence is in most respects healthy and health promoting. There are several studies demonstrating the positive effects of acquiring a sense of control and a belief that life is manageable. For instance, classic studies by Langer and fellow researchers described the health status of a group of frail elderly in a nursing home (who almost by definition had a relatively low degree of actual control in their lives). These older people were encouraged to take advantage of their existing options, such as choosing their own menus. They were additionally invited to have the furniture arranged in their rooms just as they wanted it and were given plants to look after. Not only did they subsequently achieve a higher score on the scale of well-being than a control group, they also lived twice as long.

I mentioned above that a sense of coherence is in most respects health promoting. We need to add a caveat, however, about the concept of meaningfulness. Now it is undoubtedly true that individuals with a terminal illness, or people who are living in circumstances that cannot be changed, will be more contented and mentally more healthy if they can ascribe meaning to what is happening to them – for example, being comforted by a strong religious conviction. On the other hand, there is always a danger that a sense of meaningfulness, a feeling that (to quote Voltaire) all is for the best in the best of possible worlds, can be illusory and can stifle initiative. Indeed, in accordance with Marxist notions of ‘false consciousness’, the existence of such a level of unfounded optimism has been a device for maintaining flagrant injustice and inequity for centuries. In other words, perhaps the most important aspect of empowerment is the possession of that mix of critical awareness, indignation and a conviction that it is really possible to change things. Together with the skills needed to do so, this will lead to social action and social change. It is well recognized that as a result of the socialization occurring in most Western societies, older people are likely to have negative attitudes to ageing, together with low expectations and a feeling of helplessness. Accordingly, the single most useful strategy for promoting the health of older people is one that seeks to empower individuals and, above all, to mobilize the community of older people. The contemporary interest in ‘social capital’ is clearly relevant to this assertion. Equally if not more relevant is the Ottawa Charter for Health Promotion’s major goal of fostering the achievement of an ‘active participating community’. While the frail old may make a relatively small contribution to active campaigning, the vigorous young old could quite readily be mobilized. Although the prospect of an active chapter of ‘Hell’s Grannies’ might seem somewhat comical, an organization of ‘Grey Panthers’ in the USA has in fact undertaken such a role. There are many issues about which older activists and their allies might organize. In fact, the current English government’s drive for a ‘healthier nation’ has explicitly talked about ‘building a better Britain for older people’, and its proposed aims
look beyond the traditional preventive approach to older people. They include: healthy living (a principal aim for the new Health Action Zones is the health problems of older people); income (acknowledges the problem facing those on moderate incomes); employment (acknowledges the expertise and experience of older people and calls for a more flexible approach to retirement); travel (acknowledges the health-related implications of transport policy for older people); at home (stresses the importance of a warm and comfortable home); tackling crime (acknowledges the all-round damaging effect on mental and social health of crime and anti-social behaviour in the community); care and carers (recognizes that many of the six million carers are themselves pensioners – and need support); active lives (argues for the importance of helping older people to stay active and continue with life-long learning).

As with all health promotion, a broad horizontal programme (which deals with the underlying social, economic and environmental determinants of health) rather than vertical programmes (that concentrate narrowly on diseases or disease-related behaviours) is more likely to achieve efficient results not only for the promotion of well-being and positive health but also for the prevention of disease. However, radical action costs money – and the attainment of a really effective ‘healthy public policy’ that addresses the fundamental causes of ill-health in older people will only happen if there is sufficient public pressure to persuade government to invest money and if necessary actually increase taxation. There is, however, a potentially dramatic source of political pressure readily available. I noted above the dramatic increase in the number of older people; if older people were to use their votes and the power resulting from their numbers, they could form political pressure groups having considerable clout. Clearly, the young old who are showing an increasing and welcome tendency to be assertive would need to take the lead; they would also need the support of a coalition of health promoters and health workers. Examples already exist of community-wide coalitions that have launched initiatives which have achieved quite substantial progress. For instance, ‘The Boise Experience’ – a programme designed to ‘build a positive image of ageing’ in a small American city – created an effective coalition which ultimately appears to have produced a sea change in older people’s attitudes, capabilities and health. In short, they were empowered both as individuals and as a community. During the first 30 months of the programme, some 3500 older adults (approximately 20 per cent of the population of 60 and over) participated in the scheme – and this resulted in measurable effects on their health and well-being. Their average age was 70. Apart from the behavioural and health outcomes generated by the coalition, important changes in local policy directly ascribed to the programme were recorded. Moreover, the initiative had a general ‘knock-on’ effect on policy at the state level. Aspects of the programme were also replicated in 30 other states nationwide and, at a national level, the programme was recognized by a US Department of Health and Human Services Award of Excellence.

I have so far, in this foreword, argued the case for adopting a radical and horizontal approach to health promotion for older people. Needless to say, if we are serious about getting to the roots of health problems, we should also
adopt a lifespan approach and consider ageing from a health career perspective. After all, the factors that create inequality and inequities in the health of the whole population – whether they be children or working age adults – also lay the foundations for inequity in the older generation. To try to address such issues for people once they have achieved the age of 65 is to take action far too late. Similarly, the negative attitudes to ageing in general and to specific life events such as retirement are laid down quite early in people’s health career. Health education and health promotion for ageing starts in youth.

Readers might note that this book was written in the United Nations International Year of Older Persons. The UN has identified four central issues, all having implications for horizontal programmes. They are:

- the situation of older people;
- life-long individual development;
- multigenerational relationships;
- the relationship between population ageing and development.

The programme emphasizes such empowerment goals as independence, participation, care, self-fulfilment and dignity. As so, by way of emphasizing the importance of this book, I complete my reflections with the words of the UN Secretary General Kofi Annan.

A society for all ages is one that does not caricature older persons as patients and pensioners. Instead, it sees them as both agents and beneficiaries of development. It honours traditional elders in their leadership and consultative roles in communities throughout the world. And it seeks a balance between supporting dependency and investing in lifelong development . . . A society for all ages is multigenerational . . . it is age inclusive . . . and committed to creating an enabling environment for health life-styles as people age.
Acknowledgements

This book has been ‘a long time in coming’ in the sense that its origins have been in the development of our understanding and view of appropriate ways to value our elders. In this book the term older person is used, as currently it still appears less pejorative by association.

Our specific thanks go to the chapter authors, who have brought their experiences, ideas, and practice to their contributions. We would also like to thank those people who have read scripts or drafts and passed comment on the developing materials: Charles and Anthea Cleary, Patricia Hayman, Terry Larter, Caroline Nash, Joanne Parker and Karen Walker.

We are grateful to the Department of Health for permission to use the Health Survey for England data and to the ESRC Data Archive and Manchester Computing Centre for access to data. The analysis is the responsibility of Ginn, Arber and Cooper alone. The research was funded by the Health Education Authority.
This book attempts to highlight the potential of holistic health promotion in the process of enhancing the positive health status of older people, and also includes some chapters which provide an innovative and fresh approach to negative health prevention among older people.

The task of editing this book has been a challenging and rewarding experience, not least from the standpoint of recognizing the possibilities for promoting positive health. Health promotion is often recognized as a worthwhile activity and investment when directed at young people, ‘because they have the whole of their lives before them’. Logically, this argument is associated with an ill-health or disease prevention objective. Health promotion is simply equated with activities aimed at containing or eradicating negative health: for example, the prevention of illness, disease and unwanted states which could have negative effects on a person later in life; to say nothing of the future costs to the health services.

When focusing on older people, however, it is easier to identify the link between health promotion and the objectives of enhancing well-being or positive states of personal experience and fulfilment. Primary health prevention takes a rear seat, while perceptions of health associated with such outcomes as ‘quality of life’, ‘peace of mind’, ‘emotional security’ and eradication of ‘dis-ease’ are thrust to the forefront. We are therefore directed towards a consideration of positive health objectives when applying health promotion to this age group.

The quest continues for clarification of what positive health, as opposed to the mere absence of disease, really is. Only when a clear understanding is established can a proper relationship be developed between health promoters and the wider public. As epitomized in this book, health is more appropriately viewed as a holistic concept encompassing spiritual, mental, intellectual, social, emotional, physical and sexual well-being. With this concept in mind
health promotion is best conducted as a process of informing, equipping and empowering rather than directing and coercing.

Health promotion has been described as being composed of three overlapping spheres of activity: health education; prevention; and health protection (Tannahill 1985). Within this model both health education and prevention are seen as legitimate health promotion activities. Within the context of this book it is useful to distinguish between activities which work towards preventing ill-health, disease, disability and unwanted states, and those that promote positive health and contribute to well-being. However, clearly there are contributions to both aspects of prevention and positive health promotion within the chapters which follow.

Mima Cattan’s chapter on practical health promotion is a fitting first chapter, as it poses the question ‘what have we learnt so far?’ Mima Cattan highlights the lack of strategic planning and investment in health promotion for older people. Although the author makes reference to specific targeted health promotion campaigns that have been focused on older people, it is a revelation that there has been no comprehensive survey mounted of health promotion and older people in the UK. The chapter specifically focuses on the type of health promotion provided by health professionals in the UK. Health promotion specialists are shown to be mainly concerned with accident prevention and other government targeted areas of ill-health prevention (though these areas of health promotion can be innovative and holistic in their approach to health promotion, as epitomized in Alison Allen’s chapter). Mima Cattan also refers to the potential of primary health care to promote health. Practice nurses working within primary care and with pharmacists are already used to providing opportunistic health promotion advice and would be ideal facilitators of the kind of health information and knowledge that Stephen Clift and Matthew Morrissey refer to in their chapter on travel health and older people (Chapter 11).

The chapters by, respectively, Ginn, Arber and Cooper, and Gillian Granville (Chapters 2 and 3), both provide important perspectives on health promotion for older people within a broader public health context. These inputs relate in particular to practical issues which underpin health development for this age group. They therefore pinpoint key challenges that lie ahead during the new millennium.

In Chapter 2, Jay Ginn, Sara Arber and Helen Cooper reflect upon their research into health-related behaviour among older people. In doing so they clearly indicate inequalities based on age and gender. This chapter is important, in the sense that it outlines an evidence-based health promotion agenda, which is a central component of the UK government’s strategic health plan (DoH, 1999). Public health interventions in the future are likely to be based solely on research and development which offers clear evidence of outcomes.

The chapter indicates barriers to healthy lifestyles which are often beyond the older person’s control. These barriers are acknowledged as being socially created. Therefore, certain health-related behaviours are examined by the authors in the context of specific socially created circumstances. The health-related behaviours of diet quality and physical activity of older people compared to younger age groups are focused upon. Analysis of data demonstrates
that material deprivation and ageing are negatively related to health behaviour, while gender shows a more complex and variable relationship.

Although the authors acknowledge the part health promotion can play in enhancing the health-related behaviour of older people, they are acutely aware of the influence of social disadvantage. The authors therefore highlight the need for strategic measures to face the poverty and improve socio-economic conditions experienced by this section of society. Such positive changes can only be developed through a genuine partnership on the part of health promoters, local and national authorities.

Older people can be placed in what some science fiction writers have referred to as ‘a time warp’. Individuals become stranded in the time warp of old age, with an entry gate of senior citizen status and a departure gate of death. In Chapter 3, Gillian Granville makes us rethink the consequences of this form of social stratification. Her chapter provides an interplay between a definition of citizenship and the potential societal-health damaging effect of a time warp or generation gap. This is a relevant and challenging notion for health promotion because it focuses on the principles of participation and empowerment of people and communities.

The chapter draws on evidence to support a claim that active citizenship has been promoted in the United Kingdom through socio-political, health and educational initiatives, all of which are directed at social inclusion, individual and community participation, and empowerment of people to take an active part/role within their communities. In juxtaposition, the author’s description of the generation gap that was created during the latter part of the twentieth century, particularly in the USA and UK, is revealing.

The chapter provides a convincing argument based on a case study for developing intergenerational health education and health promotion by bringing together older people from one generation with young people from another. Indeed, this radical or ‘upstream’ model of health education (Tones and Tilford 1994) not only has the ability to enhance genuine citizenship through broad-based community involvement, but can provide the kind of intergenerational support found in extended families and close-knit communities of a bygone era.

Robert Wycherley develops the theme of personal growth in his contribution on lifeskills (Chapter 4). His review of key models of adult development leads naturally to a description of skills for successful ageing and continued personal growth. This chapter provides a useful bridge between the humanistic perspective of person-centred support during bereavement and loss and a wider discussion of spiritual health. The bridge comes in the form of ‘transcendence in older age’, what the author describes as the highest level of skills acquisition during the ageing process. This ultimate goal is epitomized by a management of change which includes acceptance of existential challenges and living beyond the physical body. The author separates this stage of development from a spiritual position by suggesting that transcendence is more closely associated with a state of release from the preoccupations of ageing. Although lack of research prevents a clearer definition and understanding of this advanced lifeskill, it is expected that increased longevity will equate with more experience of this level of skill acquisition. Robert
Wycherley, throughout his chapter, emphasizes the potential of older people to experience positive health and adds the transcendental dimension of health to an already established holistic concept.

The dimension of spiritual health requires a detailed exploration for its impact on health and its relevance to health promotion. As our society becomes more diverse the contribution of secular spirituality and non-secular spirituality (religion) to individuals’ understanding of themselves, their potency, health and community increase in relevance (Howse 1999). A question is whether there are spiritual components which have the capacity to enhance health, or are they separate meta-physical entities which lead to different constructs of well-being? A health promoter would be advised to assess the way individuals value and utilize spirituality, meaning and purpose in their own lives and the way this impacts on their health. It has also been suggested that health promoters could undertake specific training in this area (Hills and Stears 1995).

This notion of the spiritual self is further developed in a very reflective way by Caroline Nash in Chapter 5. Caroline reviews the concepts of an ageless self within the context of a holistic approach. She explores holism by considering the way people come to identify themselves as being composed of separate parts, which are fragmented and can be competing with each other. When these parts compete negatively imbalance is created, which may lead to ill-health and disease. By reference to various different cultural traditions and approaches to the whole self, Nash builds an image of a human in which ageing can be limitless; where growth and maturation are continuous. This does not deny the realities of physical ageing, but suggests ways in which even these processes can be influenced (Biggs 1999).

The chapter will be challenging for our current ways of thinking. It asks difficult questions to assist the reader in broadening their understanding of the ageless self. Specifically, it challenges commonly held views concerning the greater integration and harmony that Westerners often believe exists in some Eastern cultures. Clearly, dynamic changes are taking place in most cultures and Caroline Nash is seeking to encourage a process which will contribute to the overall well-being of the individual. She extends the concept of wholeness to the individual within a larger group, the concept of the whole being greater than the sum of its parts and the idea that a division of ‘labour’ is essential to produce an effective operating community.

Health economics is clearly an important discipline underpinning the purpose and direction of health promotion as applied to older people. This fact is drawn upon in Joanna Walker’s chapter on health and productive ageing (Chapter 6). She explores the relationship between human productivity and health status, suggesting that health is central to older people’s ability and obligation to be recognized as productive. The chapter contrasts and compares the notion of retirement as a non-productive period of people’s lives with the post-industrial and postmodernist concept of ‘third-age lifestyle’. The shift that Joanna Walker highlights for older people in retirement is from a traditional work ethic to a third-age busy-ness ethic, and, more recently, to a third-age healthy ethic. The significance of productive ageing for health promotion is to highlight the extrapolation of self-fulfilment among older people.
towards an appreciation of health literacy and acceptance of the healthy ethic.

The place of fulfilment and health is considered by Mary Davies in Chapter 7. She includes concepts of illness, health prevention and promotion and considers the underlying causes of many of the difficulties older people can experience in achieving a fulfilling sexual role and life. This includes the need for openness and non-judgementalism concerning the rights of older people as sexual beings on the part of a range of professionals.

These rights may also need to be recognized by older people themselves, because of prevalent ageist views and the stereotyping of older people as ‘non-sensual and non-sexual beings’. Mary Davies highlights the particular kinds of problems, their origins and potential means for resolution, going into some depth on practical solutions. Overall, this chapter provides valuable insight into the sexual difficulties and traumas some older people may face if various impairments and disabilities occur. The approach is encouraging because of the clear suggestion that most, if not all, sexual difficulties can be overcome by careful thought, attention and caring for oneself or another.

There are fundamental difficulties in personal and societal attitudes which can collude to reduce the potency of an individual. This may particularly apply if the older person is in residential accommodation, where the attitudes and environment can severely limit opportunities for sexual expression and fulfilment. These issues will need careful attention from those involved in caring and supporting older people.

In Chapter 10, Anne Squire develops the theme of applying current health promotion theory to practice. Following an analysis of theories and models of health promotion in the context of working with older people, the author introduces the notion of a health-promoting residential setting. The settings approach to health promotion has been well documented (Baric 1992, 1993) and theoretically modelled with specific institutions in mind (Beattie 1996; Parsons et al. 1996). However, this chapter provides an interesting and potentially stimulating alternative to descriptions of the health-promoting school and health-promoting hospital. The health-promoting residential setting for older people offers a truly holistic approach to health development. It enables health professionals to move away from the medical and behaviour change approaches to consider the full implications of creating an environment for older people which might stimulate mental, psychological, societal, spiritual, physical and sexual health.

In Chapter 8, Alison Allen reports a broad based multi-agency fall prevention intervention within a general practice setting. The chapter highlights the value of sound baseline data, in this case on falls among the older population, to establish a prevention programme. This innovative programme recognizes the importance of recording holistic health gain among the study group. Psychological and physiological changes are monitored against those of a control group of patients. The chapter demonstrates the degree to which prevention programmes can reflect successfully on qualitative and quantitative data, empower older people, and incorporate a holistic health concept.

Patricia Hayman and Nerys James (Chapter 9) continue the holistic approach in their focus on bereavement and its management. Central to their
approach is the importance of knowledge and understanding of the bereavement process, the meaning of attachment, the significance of loss and the ‘natural process’ of grief. Their placement of bereavement within cultural contexts, and as a component of the transition of change, provides meaning to the process of mourning for the health promoter. Similarly, clarification of grief as a psycho-social process informs the task of providing positive health promotion by highlighting the potentially health damaging effect to older people who become entrapped within the process.

The argument for a ‘holistic approach’ to working with grief and loss takes an interesting twist halfway through the chapter, where the notion of multiple grief is discussed. It is made apparent to the reader that we are reflecting on the loss of a significant other at a time when the bereaved older person is already in the process of experiencing grief through the loss of elements of his or her holistic health. It is at this point that the authors move towards the positive health-promoting role of supporting agents. The Rogerian influence, used to support the argument for working holistically with the bereaved older person, introduces a distinctive humanistic perspective to the enhancement of positive health of older people, one which has been emphasized by contemporary philosophers of health who recognize the significance of human potential and the potential for personal growth (Seedhouse 1986). The chapter reinforces the argument for the development of health promotion processes that inform, equip and empower older people.

Perhaps it is necessary to place Hayman and James's chapter in the context of ‘scientific enlightenment’. The experience of death remains a difficult challenge for human comprehension. One of the twentieth century’s most prominent philosophers, Hans-Georg Gadamer, relating how knowledge structured by Christianity had been challenged by scientific investigation, made the following observation:

But if it is true that even if this scientific enlightenment, like that of the ancient world, finds its limit in the ungraspability of death, then it remains true that the horizon of questioning within which thought can approach the enigma of death at all is still circumscribed by doctrines of salvation. For us, this is the doctrine of Christianity in all its diversity of churches and sects. To reflective thinking it must seem as ungraspable as it is illuminating that true overcoming of death cannot lie in anything but the resurrection of the dead. For those who believe, this is the greatest certainty, while for those who do not it remains something ungraspable, but no more ungraspable than death itself.

(Gadamer 1996: 69)

The final chapter, by Stephen Clift and Matthew Morrissey, extends the negative health and disease prevention approach. Travel-related health issues are reviewed by the authors, with the intention of highlighting potential and realistic health risks for older people. The descriptive epidemiology used in this chapter is supplemented with references to the holistic health of older people when travelling. Travel-related health issues exemplify a range of relatively new areas of public health risk. Without sufficient knowledge of the
potential risks to their health, and self and community empowerment to take preventive action, older people will surely remain a vulnerable group within society.

The central tenet of Mima Cattan's first chapter is the development of a strategic framework for an integrated approach to health promotion for older people. This would need to include the recognition that older people are a diverse group and have a wide range of health-related needs. However, such a strategy will need to include markers for effective health promotion and health education. These markers are illuminated within the pages of this book and include theory and practice which support:

- a holistic appreciation of positive health;
- social inclusion through an integrated approach;
- evidence-based interventions;
- development of health-promoting settings.

In summary, this text attempts to go beyond merely describing health promotion as applied to older people. It provides a mosaic of perspectives on health and health promotion which can be used to inform future debate on, and practice in, health promotion for older people.

References


