Promoting health in old age
RETTHINKING AGEING SERIES

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‘Open University Press’ Rethinking Ageing series has yet to put a foot wrong
and its latest additions are well up to standard . . . The series is fast becoming
an essential part of the canon. If I ever win the lottery, I shall treat myself to
the full set in hardback . . .’

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Promoting health in old age
Critical issues in self health care

MIRIAM BERNARD
Contents

Series editor's preface vi
Preface and acknowledgements viii
1 The challenge of an ageing population 1
2 Promoting health in old age 17
3 Perspectives on self health care 33
4 Developments in self health care 51
5 Self health care in practice: the Self Health Care in Old Age Project 69
6 Research in action: evaluating the Self Health Care in Old Age Project 87
7 Self health care in action: participation, accessibility and informed choice among older people 103
8 Self health care in action: skills development and empowerment among older people 119
9 Self health care in action: its impact on volunteers and staff 135
10 Learning the lessons: the role of self health care in future policy and practice 156
References 173
Index 190
As the new century begins we are some 15 books into the Rethinking Ageing series with several more planned, it seems appropriate to review our original aims in the light of reader responses and the concerns which gave rise to the series. The Rethinking Ageing 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 British research studies which attempted to define and describe the characteristics and needs of older people. There were also a smaller number of theoretical attempts to reconceptualize what old age means and to explore new ways in which we think about older people. But by the 1990s there was a perception of a widening gap between what was known about ageing from such gerontological research studies, and the limited amount of knowledge and 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 situation.

The first book to be published in the series was Ken Blakemore and Margaret Boneham’s Age, Race and Ethnicity. In the series editor’s preface we stated that the main aim of the Rethinking Ageing series was to fill this knowledge gap with books which would focus on a topic of current concern or interest in ageing (elder abuse, health and illness in later life, dementia etc.). 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 to a broad range of students, academics and professionals with a common interest in ageing and age care.

The books published so far have ranged broadly in subject matter – from ageism to reminiscence to community care to pensions to residential care. The response from individual readers and reviewers has been very positive towards almost all of the titles. The overall success of the series appears to justify the original aims and approach. But how different is the national situation in gerontology ten years on? Compared to even the early 1990s age and ageing are increasingly prominent topics in media and government policy debates. This reflects a greater awareness of the demographic situation – by 2007 there will be more people over pensionable age than there will be children (The Guardian, 29 May 1999). However, as a recent article in Generations Review noted, despite these developments the number of social gerontology courses are actually (and paradoxically) decreasing (Bernard et al., Vol. 9, No. 3, September 1999). The reasons for this are not straightforward or entirely clear, but they probably reflect the difficulties today’s worker-students face in getting sufficient time and funds to attend courses. Alongside this is the pressure on course providers to respond only to the short-term training needs of care staff. Short, problem-focused modules and courses predominate, rather than longer gerontology courses based around an in-depth and truly integrated curriculum that combines the very many different academic disciplines and professional perspectives which contribute to our knowledge and understanding of ageing.

The fact that there appears to be even more interest in ageing and old age than when we started the series persuades us that there is likely to be a continuing need for the serious but accessible topic-based books in gerontology that this series has offered. The uncertainties about the future of gerontology education reinforce this view. However, having already addressed many of the established topic areas in the Rethinking Ageing series, we recently felt it was time to extend its subject-matter to include emerging topics or those whose importance has not been 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. Miriam Bernard’s Promoting Health in Old Age combines elements of both the mainstream and the emergent. Whilst focusing on health, a topic of traditional concern to older people, practitioners and policy makers, Bernard’s book arises out of an innovative action research project – the Beth Johnson Foundation’s Self Health Care in Old Age Programme – which aimed to find new ways of meeting health needs. During the next decade 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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The writing of this book has, as my editor at Open University Press knows only too well, taken a very long time. Its genesis lies in the work I undertook while research officer for the Beth Johnson Foundation, a small voluntary organization which initiates and supports a variety of projects with older people. During the mid-1980s, we became heavily involved in educational work around health issues, establishing the innovative ‘Self Health Care in Old Age Project’ in 1986. The establishment of this project, together with its associated monitoring and evaluation, forms the core of this book. The project is set in a broader context, through an exploration of the theory, extent and practice of self health care in later life. Bringing together literature from the areas of health education and health promotion, self-help and self-care, and social gerontology, it examines the self health care practices and capacities of older people. It also provides an overview of the main research approaches and developments in this field, drawing on projects from Britain, North America and Israel. In these ways, the book aims to illustrate some of the major issues which confront policy makers and professionals as they strive to understand more fully the part that self health care can play in maintaining the health and well-being of the older population.

This book is, therefore, a synthesis of both practical experience and academic endeavour. It is also the product of a very personal set of circumstances and I have dedicated the book to the memory of my late father and to the continuing energies and insights of my mother. My parents retired and moved to be nearer to us, and my then newly arrived first son, in the autumn after the Self Health Care in Old Age Project was launched. From that time on, they both became involved with aspects of the Foundation’s developments: my mother enrolled on one of the early Look After Yourself (LAY) courses and was joined soon afterwards by my father. My father took many of the photographs we used for publicity purposes (some of which are included
here) – thus maintaining and using his skills from his career as a professional freelance photographer. Over the years, this involvement was important to them both: initially as a means of making new social contacts and maintaining their own health and well being (my father in particular had suffered with angina for quite some time); and then as an important thread of continuity when my father became very ill some years later. Friends made through the courses stayed in touch during the two years or so that my mother was a full-time carer for my father. Then, when he eventually died just before Christmas 1997, the support was such that my mother found it one of the most natural things to want to return to the group. There, she was welcomed by friends who hugged her and told her very simply that they understood exactly what she had been through, that they shared her sadness and that while life would never again be the same, things would move on.

For me, the intensely personal experience of watching how my parents dealt with the course of my father’s developing illness, within the wider context of family and community links, brought home to me exactly the kinds of attitudes and practices we had been trying to achieve through the project. My mother’s own account conveys, more vividly than I could ever hope to emulate, the resilience and determination with which they approached this phase in their lives, alongside the difficulties and struggles. With her permission and blessing, I reproduce here what she wrote about this experience:

It began in 1982. Increasingly frequent and severe bouts of indigestion proved to be angina and the start of 15 years of medications, moderations in life style and self help. It seemed under control and we went away, but severe attacks occurred almost daily, aggravated by anxiety and a degree of panic. A doctor at the hotel heard that Cyril was ill, came to us and offered practical advice and reassurance. Back home, we insisted on further investigations and, after this, he was given increased medication and warned that surgery might be indicated. I vividly remember two letters arriving by the same post – one from our doctor striking Cyril off his list, the other for an appointment with a leading cardiac specialist. But, after anxious hours at the hospital we were told there was no question of surgery.

For several years we lived with this – regular medication, low cholesterol diet and extra walking for exercise. Walking uphill became progressively more of a trial, and cold weather aggravated problems so we didn’t go out on winter evenings.

In 1986 we retired and moved to be near part of our family. We were fortunate to register with a GP who proved to be exceptional. It was on holiday in 1990 that I realised Cyril, who was by now receiving medication for high cholesterol, had symptoms which could be diabetic. This proved to be correct – he was diagnosed N.I.D. [non-insulin-dependent] and began a regime of more medication and further changes to diet, but arranged to continue treatment through our GP, monitored by home urine tests and regular blood tests at the surgery.

All went well for a while, and we adapted to the common
difficulties of diabetics. I carried the emergency rations and reminded him it was time to eat, but we both suffered when things went awry and he had a hypo and began to sweat and feel faint. Nevertheless, we lived as fully as we could, travelling, going to classes, seeing family and friends.

The diabetes got worse and, in the autumn of 1995, after a full blood picture, there was real bad news - chronic lymphatic leukaemia. Treatment involved weekly visits to the clinic, each with a long wait while blood samples were analysed, and more medication. We asked to be told the truth, so knew that the leukaemia could be controlled but not cured. He still felt ill, and full of aches. Further tests brought more bad news - he had developed haemolytic anaemia and his immune system had turned against him. There was more medication - one drug used for short periods made him feel terrible.

In the spring of 1996 we were allowed a holiday but, soon after we got back and feeling rough after a chest infection, he called in to see our doctor, who at once sent him to hospital. Following assessment he was given a blood transfusion and, after a few days, was allowed home. Within a couple of days his condition deteriorated and he was racked with chest pains. So, it was back into hospital for a 7-unit transfusion and talk of a splenectomy.

This is not the place to tell the story of the Saturday night panic when the blood ran out and the remaining units were ‘lost’, but it was a time of the utmost emotional and physical stress. He came out of hospital in a very poor state - purple with bruising all over his body and so weak that it was only with the greatest determination that he got upstairs with my help. Although we moved a bed into the lounge for daytime rest, he insisted on getting upstairs to bed, and to shave and dress every day. But then he got so weak that this was impossible.

He was determined not to go back into hospital for anything, and not to have a splenectomy which carried high risks for him. With our doctor's cooperation, we all agreed he would be looked after at home. Again, we asked for the truth, and learned that he might have six months left. At this point, and in view of his state - depressed in every sense - he was prescribed morphine and agreed to visits from a nurse specialist in palliative care from the local hospice.

Unexpectedly, he began to improve and to fight back. By the end of the six months he was able to travel again, and we managed to go away for a weekend. There were many problems, many adjustments, some conflicts. It was difficult at times to support him in what he wanted to do, but this was essential for his confidence and integrity. We tried to make the best of every day, and to do whatever we could, whenever he felt well enough. The support of our family, friends, doctor and nurse were essential in sustaining the remission which gave us an extra, worthwhile year (but which had its own crisis when he developed pneumonia - also successfully treated at home).

Unbelievably, in the autumn of 1997, we managed to go to Spain for a week. His courage and determination carried him through but
when we got back, he was an exhausted, frail, sick man and we knew it wouldn’t be long. Eventually it all became too much for him to manage. A week before Christmas, he decided to go into the hospice for assessment, but died in his sleep five days later.

It is my hope that readers of this book will learn something of what it is actually like to engage in the kinds of self health care practices vividly expressed in my mother’s account, but also through the experiences recalled by many of the older participants and volunteers who will be encountered in the following pages.

In writing this book, I have been fortunate to come into contact with a wide range of people to whom I owe a considerable debt of gratitude. First, I must acknowledge the many many older people with whom I have worked since I first stumbled quite by accident into gerontology in 1982. Their enthusiasm and optimism for what we were doing gave me the courage to continue down this road when sceptics questioned my sanity about ‘what a young woman like you is doing in a field like this!’ Second, my special thanks go to Dr Frank Glendenning who, as chair of the Beth Johnson Foundation, took the ultimate leap of faith in appointing a callow Geography and English graduate to the vacant post of research officer. As mentor, colleague and friend Frank has been a constant and much valued presence in my life. To my colleagues during the time I was at the Foundation: particularly Arthur Creber (Director) and Vera Ivers (Principal Officer – Development), I am forever indebted. Their belief and trust in me was undoubtedly key to my own development as a gerontologist, and I hope they feel that I have done justice to the creative years we were all together.

Over the years, I have also met and talked to colleagues around the world who are engaged in similar research and developments to those I discuss in this book. A number of them have commented on parts of this text, sent me information and words of encouragement. In this context, I must first acknowledge my good friend and colleague Kathy Meade, but also Meredith Minkler from the University of California, Sandra Cusack from Simon Fraser University in Vancouver, Beryl Petty from Century House, Ilana Mizrahi and her research colleagues from the Brookdale Institute in Jerusalem, and Yosefa Ben-Moshe from Eshel: the Association for Planning and Development for the Elderly in Israel. Since taking up my post at Keele University in 1988, past and present colleagues have provided support and a stimulating intellectual environment in which to develop these, and other, ideas to the full. Long may we continue to do so! My appreciation also goes, as ever, to the many students on our gerontology courses. For a decade now, it has been my privilege to present some of the ideas and views debated here to these most discerning and reflective of ‘consumers’, at both undergraduate and postgraduate levels.

Thanks go too to other colleagues, but particularly to Gilly Crosby at the Centre for Policy on Ageing, who has always willingly tracked down elusive references for me; to Professor John Benington, who, as the external evaluator on the project, urged us to have the courage of our convictions and to pursue the action research route to the full; and to Sue Allingham, for her
help with the final stages of this manuscript and especially for her continuing, and daily, support.

Last but by no means least, it is customary on these occasions to record the disruptions to family life and the fortitude of close family. For me, this period of my life has truly been a family affair – my eldest son Jacob was born in the summer the project came into being, and I have pictures of him at just over a month old at the official opening of the Senior Health Shop. My youngest son Ben was born four years later just as the initial European funding for the project was coming to an end. My parents – Cyril and Margaret – were early participants in the project, and my partner Steve has, in very recent months, taken on the task of monitoring and evaluating the Foundation’s newest developments in intergenerational work. For us all, self health care has been a constant reality as well as a research-based endeavour!

Finally, my appreciation goes to the people at Open University Press who have held faith with me in the belief that this book would eventually see the light of day. Brian Gearing offered constructive criticism in the latter stages and, to Jacinta Evans, Editorial Director, and Joan Malherbe, Senior Editorial Assistant, your persistent cajoling and encouragement has at long last, I hope, been vindicated.
Introduction

At the start of the new millennium, the ageing of the UK population is one of the most important challenges to be faced. While the prolongation of a healthy life and the prevention of disabling diseases are undisputedly desirable goals, the recognition that there is scope for older people themselves to improve their health has been a long time in coming. However, during the 1980s and 1990s, there was growing interest and mounting activity in Britain around health issues, with older people being a key group in these developments (Bernard and Phillipson 1991).

The growth of health promotion generally, and the development of the Beth Johnson Foundation’s Self Health Care in Old Age Project in particular, form the focus of this book. My argument is that although self health care is crucial to the maintenance of health and well-being, and has long been the most extensive and basic form of health care, its potential has been seriously neglected when considering later life. The task of this opening chapter, therefore, is to set the scene by examining the historical context which led to increasing interest in the health of older people in the latter part of the twentieth century. It first highlights the complexity of this issue and looks at how we, as a society, view older people. It then goes on to examine socio-demographic trends and the implications of these for the health status of older people. This is followed by a consideration of the resources and structures within which health is delivered, looking at the development of the National Health Service (NHS) and of primary health care in particular. The chapter concludes by emphasizing a number of key issues which underpin this whole area of concern.

More detailed discussions of the emergence and role of health promotion with older people will be found in Chapter 2 before moving on to look at the
research and practice of self health care in Chapters 3 and 4. Together, these first four chapters provide the broad historical, conceptual and policy context against which to set our examination of the Self Health Care in Old Age Project. Described by Sidell (1995: 128) as ‘one of the best examples’ aimed at improving the health and well-being of older people, the second half of the book illustrates how the research, ideas and developments discussed in preceding chapters can be made to work in practice, and what impact such a development has on the health and lifestyles of participants, volunteers and staff. The final chapter draws together the empirical findings with the earlier analyses, in order to highlight the relevance of such developments to current policy and practice.

**Thinking about health and old age**

The maintenance of health and well-being in later as in earlier life is a very complex, not to say contentious issue. The reasons for this are many and varied and have to do with what Sidell (1995) has eloquently described as the myths and mysteries surrounding the relationship of health to old age. The myths she identifies include:

- the notion of ‘the elderly’ as a homogeneous group – who share common characteristics and who can therefore be regarded as if they were all the same;
- the ‘medical myth’ – which perpetuates the idea that growing older is synonymous with disease and ill health;
- the mortality–morbidity debate – which claims that death is increasingly concentrated in the later years, and that people will remain fitter and healthier for longer before they die;
- the emergence of the ‘super oldie’ – a seemingly positive image but one which, in reality, may be just as oppressive as the medical myth.

To these she adds a number of mysteries:

- why it is that women live longer, but tend to suffer with more chronic and disabling diseases than men;
- where the responsibility for health lies: with the individual, the medical profession or the welfare state;
- why older people are an anomalous group in that they subjectively rate their health as good in the face of seemingly contradictory objective evidence;
- what it is we mean by health.

These link closely with two further issues which Henwood (1990) has argued work against older people maintaining good health. These are:

- the assumptions which we have about the quality of health which can be expected in old age;
- discrimination against older people in the provision of health care.

Together, these issues are fundamental to the discussions about health in general and self health care in particular. It is hoped that readers of this book
do not have to be convinced that old age is not itself a disease, nor are many of the associated conditions either inevitable or universal. Yet, this presents us with crucial dilemmas when we look at the relationship between health and older people, and the societal context of that relationship. How in fact do we tread those fine lines between promoting and encouraging individual responsibility for health but without letting it tip over into victim blaming; between state provision and individual or informal health care; between the health needs of older people and those of other groups; between an emphasis on treating sickness or on promoting health; and between getting the conditions and problems which older people suffer from taken seriously, but without it contributing adversely to further negative stereotyping? These are undoubtedly difficult issues but one way forward is to begin by looking at what we know about population ageing, and about older people and their health.

**Population ageing**

Britain, together with many other western industrialized nations, is in the vanguard of the ageing process. During the twentieth century, both the numbers and the proportions of people we now term ‘elderly’ increased dramatically. It is these increases that have given rise to the term ‘an ageing population’. Historically, Britain has never before had such an elderly population (Laslett 1996), and this situation will become even more marked in the new millennium.

Population ageing has occurred with great rapidity throughout the twentieth century. The major factor accounting for this has been declining fertility: the UK population is not ageing primarily because we are living longer (although we are) but because, crudely, we are producing fewer babies per woman. Coupled with this, we have also experienced declining mortality rates (notably infant and child mortality), alongside an increase in the expectation of life. Life expectation has risen steadily for both males and females, although the increases have been greatest for women. In 1901, life expectation at birth was 48 years for men and 52 years for women, figures which had not in fact shown any improvement since medieval times. In 1995, women had gained 27 years and could expect to live until about the age of 79, while men had gained 25 years and could expect to live until about the age of 73 (Office for National Statistics (ONS) 1996). Life expectation is still rising, but the differential gap between men and women is predicted to close slightly in the future.

While the ageing of the population is clearly evident at a societal level, we also have to be aware of the fact that the older segment of our population is itself ageing. This has been most marked during the 1970s, 1980s and 1990s. However, although the total pensionable population is projected to grow fairly slowly in the short term, longer term forecasts about the projected increases in the numbers of people aged 75 and over, and 85 and over, suggest that the former will double in size by the middle of the twenty-first century, and the latter will triple (Office of Population Censuses and Surveys (OPCS) 1997). Indeed, the older the age group one considers, the greater the forecast
percentage increases are. The growth of centenarians is perhaps the clearest indication of this trend, with their ranks being expected to swell from a total of 8000 people in 1999 (7000 women and 1000 men), to 34,000 (28,000 women and 6000 men) by 2031 (OPCS 1997).

This ageing of the population obviously has implications for health, and indeed for other social and welfare practices and policies. Yet, although Britain’s population will continue to age in the twenty-first century, it is important to view this continuing demographic challenge in tandem with other changes in the social, economic and political circumstances society is undergoing and which impact on older, as on younger, people (Wells and Freer 1988; Bernard and Phillips 1998). What then, at the start of the twenty-first century, does Britain’s ageing population look like, and what changes might we realistically expect?

**Older people in Britain**

At the start of the twentieth century, Britain had some 2 million people of pensionable age, who accounted for about 5 per cent of the total population. By 1951, the proportion of the population who were ‘elderly’ had risen to 14 per cent and by 1995 it was over 18 per cent – in other words, almost one in five people are over pensionable age (ONS 1996). The 10.5 million elderly people alive in Britain means that the twentieth century witnessed a fivefold increase in terms of absolute numbers. A related point to consider is that later life is, and will remain in simple numerical terms, primarily an experience of women. Two-thirds of those of pensionable age are women and one-third are men, with ageing becoming a progressively gendered experience such that at age 75 and over, women outnumber men by two to one; at age 85 and over by four to one; and, at the age of 100, by seven to one (OPCS 1997). This ‘feminization of later life’, as it has been termed (Arber and Ginn 1991), is further reflected in other related socio-demographic characteristics such as marital status and living arrangements.

There are increasing numbers of widows and widowers in old age, while the rise of solo living has become ever more prominent (Evandrou 1998). Currently, nearly half of older women are either single or married, with the other 50 per cent being widowed. This contrasts with only 17 per cent of men who are widowers (ONS 1996). The experience of widowhood also increases with increasing age and, by the time women reach 85 years of age, over three-quarters of them will be in this situation. Moreover, half of women over the age of 65 live alone compared with only 20 per cent of men. As a consequence of other changes, notably predicted increases in separation and divorce, this tendency to live alone in old age is predicted to go on increasing for both men and women (Falkingham 1997). We also know that lone elderly people are considerably under-represented among owner occupiers and over-represented in the rented sector, and that they tend to reside in the worst housing conditions with significant minorities still lacking amenities such as a bath, an inside toilet or central heating (Peace and Johnson 1998).

A further important dimension of socio-demographic change is the growth
in numbers of black and minority ethnic elders. Currently, the percentages are relatively small: typically only 2 or 3 per cent. However, census comparisons and demographic trends suggest that although minority ethnic groups have what is termed a ‘young age profile’, the coming decades will witness a marked growth, particularly in the numbers of older people of Asian and African Caribbean origin, as those now in middle age get older. Given associated influences such as the geographical distribution of these groups, changing family structures and the myths and assumptions surrounding family care giving, it is evident that meeting the particular health and social care needs of minority ethnic elders and planning appropriate and accessible services, will become a matter of increasing importance. Indeed, the numbers can now no longer be dismissed as being too small to cause concern in respect of policy and practice (Atkin 1998).

In sum, older people now find themselves in a very diverse set of circumstances, in contrast to the myth of homogeneity highlighted earlier. Alterations to the structure of our population have been accompanied by profound changes in the size and composition of the family, as the effects of lowered fertility and increasing divorce begin to make their impact felt on the older generations (Bernard and Phillips 1998). Moreover, the dramatic changes which have been wrought to the age structure of Britain’s population over the twentieth century are not temporary – they are not some statistical aberration – they are permanent gains for humankind, and we should regard it as a matter for celebration that more and more people are surviving into later life (Jefferys 1988). The key features of these changes include the rapidity with which our population has aged; the ageing of the elderly population itself; the feminization of later life; the changes in marital status and living arrangements; and the growing numbers of black and minority ethnic elders. These features raise innumerable challenges for us in relation to health, and it is to this that we now turn.

**Older people and health**

The medical myth referred to earlier has perpetuated the idea that growing older is inevitably linked with disease and disability and has resulted in the bleak but popular and all powerful image of health in old age, described by Scrutton (1992) as:

> One associated with an increase in pain, discomfort, illness, disease and dependence; loss of energy and personal drive; significantly greater need for rest; long and increasing periods of sickness; permanent experience of pain and discomfort; increasing immobility; the gradual loss of personal control and responsibility; the onset of incontinence, with resulting loss of dignity and self-respect; increasing confusion; and, ultimately, the most feared condition of all, senility.

(Scrutton 1992: 10)

Such is the dominance of this view that it has, in turn, contributed to much research on the health of older people being not about health at all, but about the prevalence of ill health and about specific medical conditions (Victor
1991). It is not, however, the purpose of this discussion to detail the conditions from which older people suffer; readers with particular interests in this perspective can find explanations in numerous other texts (see for example Bennett and Ebrahim 1995). Rather, this discussion begins from the premise that articulating what it is that older people mean when they talk about being healthy is important both for the kinds of health promotion activities which form the core of this book, and for formulating policy objectives which can be translated into successful practice.

Thus, we begin by looking first at how health is conceptualized and understood for, as Sidell (1995: xix) argues: “‘Ways of seeing’ affect ‘ways of knowing’ and health is a much contested concept.’ We then go on to explore some of the paradoxes and dilemmas which exist around health and older people. In particular, we look at acute and chronic health problems and at functional disability in an attempt to illuminate why it is, in Nathanson’s (1977) words, ‘women get sick, but men die’. In addition, this will also help shed light on how and why older people’s subjective ratings of their health status seem to be at odds with more objective evidence. This part of the discussion will conclude with a look at the future in terms of the mortality-morbidity debate.

**Being healthy**

For older as for younger people, health is crucial to the maintenance of well-being. However, in much the same way as our views of ageing and old age are socially and economically structured, so too are our ideas about what it is to be healthy (Sidell 1993). It is a difficult concept to pin down and many commentators have pointed to the variations and differing implications which arise, according to whether we look at lay perspectives (that is bottom-up, from ordinary people) as opposed to professional perspectives (that is top-down and official) (Victor 1991; Jones 1994; Sidell 1995; Hardey 1998). Ever since the World Health Organization (WHO 1948) defined health as ‘not merely the absence of disease and infirmity but complete physical, mental and social well-being’, the literature has become replete with debates about whether health should be defined negatively as the absence of disease, or more positively and holistically. In reality, as Hardey (1998) notes, both dimensions find empirical support from studies which have looked at lay ideas about health. However, the disease oriented perspective is strongly sanctioned in Britain by the tendency to rely on mortality and morbidity statistics as indicators of health, and to build national strategies and policies around targets designed to reduce ill health and disease under the guise of improving the health of the nation. Concentrating on death and disease in this way, while it may be used as a proxy for health, is very negative in that it tells us nothing about how people subjectively experience being healthy, how they cope with illness or disease, or how these terms may contrast or coexist with one another.

Studies in the UK and elsewhere have shown that beliefs and attitudes about health are ‘complex, inconsistent, dynamic and fragmentary’ (Hardey 1998: 29). They are based on people’s values and expectations, and linked
with social and cultural situations. Since Herzlich (1973) first explored how people define health and illness in the early 1970s, there has been a gradual accumulation of research on these topics using a variety of both quantitative and qualitative methodologies (R.G.A. Williams 1981, 1983; Pill and Stott 1982, 1985; Blaxter 1983, 1990; Cornwell 1984; Calnan 1987; Wenger 1988; Stainton-Rogers 1991; Backett and Davison 1992). Generally speaking, a synthesis of this literature seems to suggest that the lay population identify three broad dimensions to health: the absence of disease/not being ill; being functionally fit/coping with daily activities; and as a state of positive fitness (Victor 1991: 95). Variations and interactions are observable too with regard to dimensions such as class, gender, race, socio-economic status, living environments, cultural and religious beliefs, and age. A further complication, as Jones (1997b: 24) observes, is not only that different groups of people define health in different or similar ways, but also that ‘the same person may use several distinctive explanations or stories to make up a complete account’. This was certainly the case in Sidell’s (1991: 28) qualitative interviews with older women when, typically, ‘they would express sometimes conflicting beliefs and attitudes at different points in the conversation’.

Notwithstanding the above complexities, we do find that there is a greater tendency for older people to view health in functional terms, emphasizing the importance of resilience and of being able to cope, rather than fitness (Blaxter and Paterson 1982; R.G.A. Williams 1983, 1990; Blaxter 1990; Jones 1997b). In addition, the Health and Lifestyle Survey (Blaxter 1990) reveals that when asked what it felt like when they were healthy, well over half of the older men and women responded by saying that health was about ‘feeling good’. This emotional/psychological aspect was articulated with phrases such as ‘being happy’, ‘being unstressed’ and ‘being able to cope’ (Victor 1991: 97). These findings echo Rory Williams’s (1983, 1990) work with older Aberdonians, Cornwell’s (1984) work in the East End of London, and Sidell’s (1991) study on gender differences in health at older ages. However, the research also begs other questions, such as to what extent these conceptions are framed by Henwood’s (1990) argument about the assumptions that we have about the quality of health which can be expected in old age, and whether this will change in the future as younger cohorts have greater opportunities to be involved in health education and promotion. Succeeding chapters will attempt to address these issues further, but we turn now to look at the state of health of people who are old today, examining how healthy they think they are from both subjective and objective viewpoints.

**How healthy are older people?**

We have already noted the anomaly inherent in using mortality statistics to examine the health of older people. Yet, trends in late life mortality are an important part of the overall picture. In Britain, mortality rates for middle aged and older women have fallen continuously since the start of the twentieth century (Grimley Evans et al.1992). For men, this decline was marred from the 1930s to the 1970s due to increases from coronary heart disease.
and smoking-related diseases (Grimley Evans et al. 1992; Grimley Evans 1998). More recently though, improvements in male mortality have been greater than for women, with trends in smoking being the most strongly implicated reason (Sidell 1995). Despite this, the major causes of death are the same for both older men and women, with cardiovascular and respiratory diseases being the leading causes, alongside cancers and cerebrovascular disorders. The discernible gender differences are related more to the sites of cancers, and to the pace of death (Verbrugge 1989). Other authors have further shown how class, race and ethnicity impact on mortality rates, with the inequalities and differentials that are discernible earlier in life persisting well into old age (Estes et al. 1984; Marmot et al. 1984; Fox et al. 1985; Townsend and Davidson 1986; Whitehead 1987; Townsend et al. 1988; Raleigh et al. 1996; Balarajan and Raleigh 1997). It is also the case that the risk factors for many of the leading causes of death are now so well known that the argument for taking a positive, preventive approach is clear, and would provide a much needed corrective to the notion that where older people's health is concerned, they are simply a continuing financial drain and burden on the rest of society (Iliffe et al. 1998; Johnson 1998; Warnes 1998).

While age specific mortality rates have declined and life expectation has increased, the most important area still to consider concerns the extent of morbidity, illness and disability among the older population. There are various sources we can draw on here but much of our information comes from the General Household Survey which, since 1980, has included special sections on people aged 65 and over (Iliffe et al. 1998). Included among the questions, the General Household Survey asks respondents if they have any longstanding illness, disability or infirmity. Those who say yes are then asked if it limits their activities in any way (subsequently called a longstanding limiting illness). What we find is that three-fifths or more of both older men and women have such an illness, and that the prevalence increases with advancing age (OPCS 1995). More women than men are affected, although not everyone with a longstanding illness goes on to say that it restricts their activity. Following our earlier discussions about what health is, this suggests that it may be possible to define oneself as healthy even in the presence of illness or disability.

In terms of functional disability and chronic health problems, the General Household Survey also provides information about whether or not people can perform various activities of daily living such as those associated with mobility (for example walking outside or getting up and down stairs), self-care tasks (such as bathing and washing) and domestic tasks (for instance shopping and cooking). This reveals that older women have higher levels of physical incapacity than men. For example, Arber and Ginn (1991) report that among people aged 75 and over, twice as many women as men are housebound (22 per cent compared with 11 per cent). More recent data confirm this and show that nearly half of women over the age of 85 are unable to perform one or more activities such as going out and walking down the road on their own, getting up and down stairs, or getting around the house (OPCS 1996).
Older women are also less able than older men to carry out personal self-care tasks (Ginn and Arber 1998), although it must be remembered that we are talking here about minorities of older people. Indeed, 1991 data show that fully four-fifths of men and women over the age of 85 are still able to feed themselves, get in and out of bed, bathe themselves and get to the toilet without help, and that these figures are in fact a substantive improvement over the previous decade (Grundy 1996). In relation to domestic activities, Arber and Ginn (1991) also make the important observation that cultural assumptions about gender role behaviour are likely to influence findings because men are much more likely than women to receive help with these tasks in old age. A further issue is that these prevalence rates may well be underestimates because the General Household Survey data do not take into account older people living in institutional settings who, almost by definition, will have higher rates of disability (Grundy 1998).

Findings about the prevalence of longstanding illness, chronic health problems and disability also lead us to consider just what kinds of disorders result in these observable gender and age differences. Iliffe and his colleagues (1998: 4) list the major causes of disability as cardiovascular diseases (including cerebrovascular disorders), loss of vision and hearing, osteoarthritis, osteoporosis, urinary incontinence, depression and dementia; this list is confirmed by other national data sets and studies such as the Health and Lifestyles Survey (Cox et al. 1987), the Carnegie Inquiry into the Third Age (Grimley Evans et al. 1992) and the Health Survey for England (OPCS 1995). Some marked gender differences occur, particularly in relation to the already observed high prevalence of heart and circulatory disorders among men, and the difficulties which women experience with musculoskeletal problems including arthritis and painful joints (Grundy 1998).

Such gender and age differences are also observable in self-reports of the prevalence of acute health problems (Victor 1991). The Health and Lifestyle Survey (Cox et al. 1987), for example, shows not only that women report considerably more symptoms, but also that the widest gender differences occur in relation to pains in the joints, headaches, and trouble with eyes and feet. The latter also show marked increases with advancing age. As well as these physical symptoms, the Health and Lifestyle Survey adapted the General Health Questionnaire (Goldberg 1972) to develop what they called a malaise index. Again, we find marked gender differences with older women reporting more symptoms than men for all categories – difficulty in sleeping, and worrying being particularly notable. On the whole then, we can conclude that older women, much more so than older men, tend to accumulate highly symptomatic, but non-lethal, diseases and conditions (Sidell 1995).

Race and ethnicity further confound this picture. Although there is some evidence for higher rates of mortality for certain conditions and diseases (Balarajan 1995; Raleigh et al. 1996; Balarajan and Raleigh 1997) and the reporting of poorer health in comparison with the white population (Rudat 1994; Silveira and Ebrahim 1995), there are a number of observations and caveats to be made here. First, the gender balance among minority ethnic groups is not necessarily the same as among white elders. For example, the
ratio for African Caribbeans is similar, but there are more older men than women in South Asian populations (Atkin 1998). Second, we lack a comprehensive national picture of the extent, nature or experience of chronic illness or disability among minority ethnic groups, with the result that the information we do have has to be pieced together from small-scale and local surveys (Blakemore and Boneham 1993; Douglas 1997; Atkin 1998). Third, while there is a growth of interest in specific conditions and in studies examining the incidence of disability (Royal Association for Disability and Rehabilitation (RADAR) 1984; Greater London Association for Disabled People (GLAD) 1987; NHS Centre for Reviews and Dissemination 1996), work on issues such as mental infirmity is notable by its absence (Silveira and Ebrahim 1995). Given the present dearth of information, it is vitally important not to regard black and minority ethnic elders as a homogeneous group: there are differences among different ethnic groups in, for example, rates of limiting longstanding illness (Charlton et al. 1994; Evandrou 1996; Nazroo 1997), as well as similarities with white elders. These cautions apply too as we go on to consider additional aspects, such as older people's subjective perceptions of their health status, the use that older people make of existing services, and the responses they receive from health and social care professionals.

**Perceptions of health**

From the surveys discussed above, we also know something about how older people assess health status: both their own, and in comparison with other people. We saw earlier that three-fifths of older men and women suffer from some form of chronic longstanding illness or disability, and that substantive proportions of older women have high levels of functional incapacity, mental malaise and acute health problems. Yet, when assessing their health status, two-fifths of older people rate their health as ‘good’, although women are somewhat less optimistic about this than men (Midwinter 1991; Victor 1991; Sidell 1995). Moreover, with increasing age, both sexes tend to switch their health rating from good to fairly good.

Although a great deal of self-assessed health status tallies with objective measures, there is an anomaly here in that considerable minorities of older people persist in defining themselves as in good health in the face of contradictory evidence. We find this in both survey data, and in qualitative studies (Wenger 1988; Midwinter 1991; Sidell 1991). Explanations seem to relate to the tendency for older people to see themselves as in better health than their peers and as well enough to carry out their necessary activities (Cockerham et al. 1983); to want not to define themselves as ill and to keep going (R.G.A. Williams 1981, 1983); and to minimize health problems and not admit publicly to being unwell (Cornwell 1984; Wenger 1988). Whatever explanation we might favour, or data we choose to draw on, this reaffirms just how complex a subject the health of older people is, and how important it is not to fall into the trap of classifying them as ill, diseased or healthy without a proper grasp of how people conceptualize, understand and experience these terms.
A healthy later life?

Alongside the need to think further about the ways in which we view health, illness and disease, the literature of recent years has also emphasized the importance of devising ways which measure what has been variously termed active life expectancy (ALE), healthy active life expectancy (HALE) or expectation of life without disability (ELWD) (Grimley Evans et al. 1992; Grimley Evans 1993, 1998; Bone et al. 1995). The search for such measures has been prompted by the debate which has been going on since the 1960s concerning whether or not increasing life expectancy will be accompanied by better, or worse, health. This mortality–morbidity debate basically comprises two opposing views: one predicts a continued concentration of death in the later years (the rectangularization of mortality) with a concomitant decrease in the incidence of disabilities among the older population and their occurrence only during the last few years of life (the compression of morbidity); the other predicts substantial increases of very old people, many of whom will be suffering from chronic conditions and will simply be kept alive for longer (Bury 1988; Rogers et al. 1990).

Fries and Crapo take the optimistic view and argue from the basis that the human lifespan is fixed at around 85 years of age (Fries 1980; Fries and Crapo 1981). Their initial proposals were based on the contention that as a species, we are reaching the upper limit of our survival potential and that mortality improvements have led to increasingly rectangular survival curves. In other words, premature death has been reduced and more and more people are surviving into their eighties with the body finally wearing out at the end of the natural lifespan rather than succumbing to disease. Fries went on to argue that while western society may have been successful in controlling premature death, the challenge we now face concerns how to deal with longer periods dominated by chronic disease.

Using the case of two brothers – one of whom is a heavy smoker, while the other is a light smoker – he also suggested that it was possible, through preventive health practices and associated interventions, to postpone the onset of many chronic diseases. At the beginning of the twentieth century, the heavy smoker would have been quite likely, at around the age of 30, to have contracted pneumonia and died prematurely after an illness lasting perhaps for only three days. Nowadays Fries argues that, with penicillin, this man would survive pneumonia but at about the age of 40 he might develop a cough, wheezing and shortness of breath. If he continues to smoke he will be increasingly short of breath for the rest of his life. In his fifties he may have a heart attack. Again, prior to modern high-tech medicine it is likely that he would have died at this point. This is now controllable, although he might then go on to have a stroke a few years later involving considerable rehabilitation. Throughout, he remains short of breath and, finally, he develops lung cancer and dies in his seventies.

In contrast, the lighter smoking brother does not develop emphysema until much later in life – perhaps not until he is about 70. The heart attack is postponed as is the stroke, but he dies at the limit of his lifespan and does not succumb to the lung cancer at all.
What Fries is arguing is that if the onset of such chronic diseases can be postponed by preventive health care measures, by better use of health services, and by increasing personal responsibility for one's own health, then what is known as the ‘compression of morbidity’ will occur alongside the ‘rectangularisation of mortality’ (Bury 1988). Instead of lingering with chronic illness for many years like the first brother, individuals will be more vigorous for longer. From this basis, Fries is very optimistic about the future state of health of the older population. Indeed, since he first articulated his propositions in 1980 he has, with research colleagues at the Stanford Arthritis Center in California, undertaken numerous studies to examine and test this hypothesis. Since the mid-1980s in particular, they have been concerned with exploring the health benefits of long distance running (Lane et al. 1986, 1987, 1990; Fries et al. 1994). Alongside this, they have written about the relationship of age and gender to morbidity (Leigh and Fries 1994), while Fries himself has continued to argue that the compression of morbidity paradigm is an important policy strategy in the pursuit of cutting health care costs and extending disability-free life expectancy (Fries 1990, 1993, 1996).

Not surprisingly, Fries's early formulation was challenged, with a number of authors contesting that there was no empirical evidence to support his assumption that the human lifespan is fixed (Bytheway 1982; Manton 1982; Schneider and Brody 1983). Moreover, with regard to the compression of morbidity issue, Fries's opponents were, and still are, sceptical of his claims about whether or not the onset of chronic illness can be postponed (Bury 1988). Alternative interpretations even go so far as to anticipate that older populations will become less healthy, with alarming projections of the numbers who will be chronically ill and require long-term care, alongside increasing numbers who will be widowed, disabled and socially isolated - what has been graphically termed 'the increasing misery' scenario (Verbrugge 1984; Manton 1986; Olshansky et al. 1991). Some commentators further argue that the compression of morbidity paradigm, while it may fit with the experiences of older men, is inappropriate with regard to the situations of older women (Verbrugge 1984, 1989; Lewis 1985; Sidell 1991). Criticisms have also been levelled at the conception of dependency and disability as irreversible, with a focus on delaying onset diverting attention from the possibility that recovery may also extend disability-free life expectancy (Rogers et al. 1990).

The debate continues to flourish, partly because current evidence is unable to conclusively prove or disprove that morbidity compression is possible and partly because there is some basis for both views (Bone et al. 1995). In fact, it is also suggested that it is quite possible that both phenomena will be taking place simultaneously: that there may be an increasing proportion of individuals in quite good health up to the point of death and an increasing proportion with prolonged severe functional limitations. The proportion suffering from only a moderate degree of infirmity is therefore likely to decline. Part of the problem lies with the nature of the data we have because many of the studies of longevity and health are cross-sectional and often lead to the conclusion that increases in length of life are not matched by
increases in healthy life (Bebbington 1988; Crimmins et al. 1989). Optimistically though, some longitudinal US data are beginning to show that average lifespan is increasing and that disability in later life is falling (Manton and Stallard 1994; Manton et al. 1997). Although this may not be happening as fast as Fries and his colleagues predicted, it has led to the observation that ‘modest optimism seems to have better justification than panic’ (Tallis 1998: vii).

However uncertain or debatable the future, the evidence we have to date surely points, as Bond and Coleman (1993: 338) argue, towards a need to turn our attention seriously ‘to identifying ways of preventing ill health and maintaining health in elderly people’. Before doing this in Chapter 2, one further piece of the jigsaw needs to be added to our current exploration of the health status of older people. This concerns whether the diversity and complexity we have been discussing are also reflected in the use made of health services by older men and women, and how professionals working in the system respond to their health needs. It is to these issues that we now turn.

**Health care services**

Quite clearly, issues about the extent of disability and dependency among older people are at the heart of policy debates about how best to meet their health needs. Yet here again we are having to tread one of those very fine lines because it is important to remind ourselves that although only minorities of older people (albeit substantial minorities) suffer with chronic and disabling conditions and acute illnesses, they record the highest per capita expenditure in simple age-related terms, and are the major recipients of health and social welfare services (Robinson and Judge 1987; Victor 1991; Office of Health Economics (OHE) 1995; Dalley 1998). This is despite the fact that when we look at health expenditure by type of care provided, specialist services for older people currently come well down the list in terms of resourcing, along with services for mentally ill, mentally handicapped and physically disabled people (Victor 1991).

Moreover, continuing policy shifts, including the introduction of internal markets and the series of reorganizations leading up to the most recent changes in the wake of the National Health Service and Community Care Act 1990, mean that older people’s experiences of the NHS have been variable to say the least (Dalley 1998). It has also led some critics to argue that the NHS has treated older people particularly badly (Webster 1991) with attempts to reduce expenditure and cut long-stay beds, impacting most strongly on older age groups (Victor 1991). Set against this, however, it is important to recognize that the creation of the NHS in 1948 also enabled older people to deal with chronic illness in ways which had been impossible before the Second World War, and thus to live healthier lives than they had previously (Hardey 1998). Undoubtedly too, older people have also benefited from the achievements of medical science and its technological advances, from developments in the treatment of particular diseases and conditions, and from the strides made in palliative care (Dalley 1998). Yet even at the end of the twentieth
century, there is still considerable concern about the way older people are disadvantaged, discriminated against and responded to, in terms of health care practice and policy (Scrutton 1992; Titley 1997).

Of particular concern in the context of this book is the role of primary health care and older people's relationships with their doctors. Andrews (1990) has observed that primary health care is important for older people in that it constitutes a critical point of entry to the health system. How accessible that care is, what quality of service is provided and how people are treated in their encounters with their general practitioner (GP) will have a major impact on outcomes. This is especially important given that we know that in terms of consultation rates, older people (especially those aged 75 and over) are, with the under-fives, the highest consultants of doctors and that a substantial majority come into contact with their GP or a member of the primary health care team at least once a year (Victor 1991; Kennie 1993). Higher proportions of women than men consult at all ages, although over a quarter of women aged 65 and over do not consult their doctor at all in any given year (Royal College of General Practitioners (RCGP) 1986). Marital status, class, housing tenure and ethnicity all compound this picture and show that widowed women, those from social classes IV and V, council house tenants and elderly Asian and African Caribbean people are among the highest consultants of doctors (Sidell 1995).

However, high consultation rates do not necessarily automatically translate into satisfaction with either services or professional responses. Feminist writers in Britain have been at the forefront of articulating the nature of the doctor–patient relationship (Foster 1995), although it has to be observed that the concerns of older women are still notable by their absence from much of the feminist literature (Bernard and Meade 1993). In the mid-1980s, Roberts (1985), drawing on evidence from medical textbooks and medical training, doctors' letters, and interviews with women and their doctors, revealed how the male-dominated medical profession regarded women differently from men in the medical literature and in practice. Other commentators have shown how ‘many doctors still appear to regard women as innately more neurotic and prone to emotional instability than men’ (Foster 1996: 107). As a consequence, because they expect female patients to behave in these ways, they will tend to treat them differently, prescribe them more mood altering drugs, and offer insufficient and inadequate explanations for such complaints (Cooperstock 1979; Miles 1988; Ussher 1989). In combination with this sexist/patriarchal ideology, we must also be alert to both ageist and racist attitudes and practices, which have likewise been shown to influence people's satisfaction with the health care system in general, and doctors in particular (Ferraro 1987; Douglas 1992; Sidell 1992). For example, patient–doctor interactions are potentially difficult where cultural, racial and ethnic concerns such as language problems are concerned (Ahmad et al. 1989; Blakemore and Boneham 1993).

However, these kinds of issues do not, on the whole, get picked up by the large scale surveys to which we have already made reference and, again, we have to piece the evidence together from smaller scale qualitative studies (Sidell 1995; Beattie 1997a, 1997b; Bodie 1997). With regard to age, such
Qualitative data suggest that older people do not take the decision to visit their doctors lightly but that once they do, they may well be treated in an ageist manner or offered what seem to be inappropriate treatments (Bernard 1989; Sidell 1993). The manner in which information is both given and received is another area of dissatisfaction reported in some studies (Action for Health 1988; Wenger 1988; Sidell 1991). Older people feel that they are not listened to or given sufficient explanations about what the matter is with them, why they are given particular forms of treatment or what to expect. In the case of chronic illnesses this is especially important since effective management and treatment require a high level of patient involvement (Blakemore 1998).

Recent research concerning exercise advice and older people has also highlighted the dangers of doctors' stereotyping according to chronological age, of being too quick to assume 'it's just your age' and often believing that it was too late for older people to derive benefit from such activity (Eadie et al. 1996; Stead et al. 1997). One graphic illustration of poor doctor–patient communication comes from the Self Health Care in Old Age Project itself. It concerns an elderly woman who came into the Health Shop saying that she had been put on a low sodium diet by her GP. However, he had failed to tell her what this meant in practice – cutting down on salt – and she had been too anxious and too embarrassed to ask. Clearly, we still have much to learn about the interface between professional health providers and older people, points to which we shall return in subsequent chapters.

**Conclusion**

The discussions in this chapter strongly suggest that we need to reorient how we approach the subject of the health of older people. The information we have to date tends to focus on disease, illness and death, perpetuating the myths identified in the opening pages and reinforcing the negative assumptions about the quality of health which can be expected in later life. The treatment meted out to older people, and the discriminatory and ageist attitudes they often encounter in their dealings with health and welfare services and personnel, exacerbate this situation. Consequently, instead of focusing on death and disease as much of the above discussion has done, we may in fact benefit from looking more closely at how older people keep themselves healthy and how this can be promoted and facilitated. This would move us away from the pathogenic biomedical model which emphasizes sickness and treatment, and more towards the salutogenic or health seeking framework proposed by Antonovsky (1984, 1987, 1996). Such a reorientation means that rather than trying to define people simplistically as healthy or diseased, we regard these terms at either end of a continuum. All of us, older and younger people alike, individually and collectively, can then be located somewhere along this continuum.

The benefits of such a framework include its discouragement of the ‘percentage approach to assessing the health of older people’ in favour of an emphasis on looking at how and why people cope; the turning on its head of the notion that older people are a high risk group thereby reinforcing the
negative stereotype of them as disabled and diseased (Sidell 1997: 12–13); and a reaffirmation of the dynamic relationship which exists between people and their environment, including their relationships and social supports (Jones 1997b: 32). Indeed, such an approach underpins the Self Health Care in Old Age Project and lies at the heart of the health promotion and self health care activities detailed in succeeding chapters.