SHOULD PHYSICAL ACTIVITY BE ON THE HEALTHY AGEING AGENDA?

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Abstract

Physical activity makes a notable contribution to one's independence, ability to perform everyday tasks and quality of life in the later years, but engagement in this health-related behaviour decreases with age. It is therefore not surprising that numerous intervention strategies have been applied in many settings to encourage a physically active lifestyle. Nonetheless, these have little long-lasting effect. Knowing how best to promote such behaviour to people over 65 years old in a way that makes them feel *I want to engage* is still in its infancy. This paper reflects on how ageing influences the decisions people in later life make in relation to adopting a physically active lifestyle, and how any advocacy needs to look beyond the physical experience. Knowing of the potential benefits to be gained from this self-regulating behaviour means it warrants a more prominent place on the promoting healthy ageing agenda.

INTRODUCTION

The positive relationships between physical activity and factors such as functional capacity, motor ability, psychological health, cognitive functioning and wellbeing have been clearly shown (DiPietro 2007, Sarkisian et al. 2005, Spirduso et al. 2005, Taylor and Johnson 2008). Nevertheless, the majority of the 65-plus age group lead a relatively sedentary lifestyle (Chodzko-Zajko et al. 2005, Sport and Recreation New Zealand 2003), something the World Health Organisation lists is a major health risk. It is, therefore, not surprising that many countries are endeavouring to find ways to effectively promote physical activity as one way to support healthy and independent living in people's later years.

However, such developments are in their infancy and the rhetoric of how best to do this is idealistic without being overly effective (Brawley et al. 2003). In this article I comment on how the older person is positioned by multiple discourses with regard to health and

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well-being, reflect on the value and changing nature of physical activity in later life, and suggest why more credence and resources should be given to promoting physical activity as part of the healthy ageing agenda.

As yet in New Zealand there is no national strategy for promoting this behaviour to the older population, although the message is inherent in many documents without being explicit. For example, when publishing a *Positive Ageing Strategy: Diversity, Participation and Change*, the Government, via the Ministry of Social Policy (2001), recognised the need for creating a society in which all people can age positively. The intent was to improve and protect the health and wellbeing of the older population and advocate for a full and continued involvement in all aspects of community life – including the physical. Subsequently, the Ministry of Health (2002) published the *Health of Older People Strategy*, one aim of which was to encourage older people to take responsibility for preserving their health through healthy living, which includes being physically active. The National Heart Foundation, a not-for-profit organisation, is a strong advocate of physical activity, but like so many of their initiatives they primarily target the whole population. Another example is found in the vision statement for another government agency, Sport and Recreation New Zealand (SPARC), which aims for New Zealand to be "the most active nation". However, with the exception of the Green Prescription, where a medical practitioner encourages physical activity in conjunction with or in the place of medication, SPARC gives limited attention to the older population.

When reflecting on the relationship between ageing and physical activity, it is important to realise that the older sector of the population have lived through a time when exercising for the *sake of it* or for *health reasons* was deemed unnatural. They have also been subjected to many definitions of *good health*. For much of the 20th century the emphasis in later life was on passivity and contemplation, with rest being considered the virtue of old age. It was legitimate for older people to take a well-earned rest and opt for a passive lifestyle. However, times have changed. Given older people carry the highest load of chronic disease, disability and healthcare utilisation (Ministry of Health 2002), which can be positively influenced by physical activity, finding ways to promote active ageing seems a worthwhile goal. But in so doing we should be cognisant of the differences that exist between the medical and scientific definitions of exercise, fitness and health, and their socially and culturally constructed meanings. This difference is exacerbated by the beliefs older people have about what their body should or should not do, could or could not do (Grant 2002).

Engaging in a physically active lifestyle during one's later years is about more than a physical experience. Hence, giving attention to physical activity alone is insufficient for the promotion of quality of life in old age (Chodzko-Zajko 2000). Trying to

sell physical activity to the older population solely on the basis of quality of life, quantity of life, or even salvation is likely to be a lost cause. As Locke (1996:427) contends, sedentary lives may be endangered lives, perhaps even impoverished lives, but "most people don't exercise because we hold out some distant and existential advantage – living longer or living better". Nevertheless, as this sector of the population increases in the future there will be even greater emphasis placed on the reduction of morbidity and non-communicable diseases through the promotion of self-managed health-related behaviours such as physical activity. But given the less-than-favourable social and cultural meanings attached to "being old" this will not happen by chance.

THE UNKNOWN COST OF AN AGEING SOCIETY

Within a few decades the proportion of people over 65 years old will dramatically increase. As Dunstan and Thomson (2006) have explained, in 2005 10% of the population was aged 68 years old and over and by 2026 over 10% will be over 74 years old. In addition, the fastest growing cohort will be the over 85 years old. Such a change to the structure of the population is expected to have a number of unprecedented social and economic consequences, including a greater demand for health and disability services in New Zealand (Cox and Hope 2006).

Demographic fears are often played upon when arguing how a larger, older population will affect the economy of a country, an idea perpetuated by a belief that growing older is inevitably linked with high levels of frailty and dependency. This attracts considerable attention from politicians, entrepreneurs, researchers, public commentators and community groups. As Julie Robotham (2006), the Medical Editor of the *Sydney Morning Herald* suggested, it is difficult to know whether longer lives will turn out to be a blessing or a curse. Nevertheless, from an economic perspective and self-preservation point of view, promoting health and wellbeing in later life is a worthwhile endeavour (Staehelin 2005).

In contrast to the tales of woe, groups such as insurance brokers, advertisers and entrepreneurs are inspired by a growth in the older population. After all, it is probable the provision of a diverse range of home-based services (eg gardening maintenance, collecting groceries, hire a 'hubby', exercise tutoring) in addition to multiple forms of health care could represent one of the fastest growing areas of investment and employment over the next couple of decades (Atchley and Barusch 2004). The ageing landscape is seen as a potentially lucrative one as each profession identifies its boundaries when espousing their specialty service (Wilson 2000). Meanwhile, the social and cultural implications of an ageing population remain largely unexplored (Gilleard and Higgs 2000). It is evident the focus tends to be more on the deficits

associated with ageing, at the expense of attending to opportunities, growth and development (Cruikshank 2003).

There is no certainty about the demands an older population will place on the healthcare system. Nevertheless, the consumption of health services and the pension link ageing closely to the economy (Victor 2005). For example, in the USA, Medicaid expenditure that targets help for the aged is escalating. It is beginning to outpace the Federal Medicare multi-billion-dollar health care scheme for seniors, and is now the second largest expenditure in some state budgets (Lynn 2004). Recently there has been considerable speculation about the way a larger, older population might affect the health and social services budget (Kalache et al. 2005). Speculation about the cost of ageing becomes evident when declines in health threaten independence, but it is possible that in time we may find this to be less severe than currently predicted (Mullan 2002, Wilson and Rodway 2006). After all, there is no unequivocal evidence to suggest an unaffordable burden is looming on the horizon (Haber 2003, Mullan 2002). However, it is imperative that an appropriate, accessible and affordable support system (ie within and beyond medical care) for older people remains on the healthy ageing agenda (Moon 2006, Walker 2005).

RE-POSITIONING AGE

The stereotypes and negative images frequently associated with old age have hindered personal development as well as infiltrating public opinion and the attitudes of young and old alike (Thornton 2002). No one wishes to embrace or choose the identity "old" in a consumer-oriented society. Nevertheless, people in later life have been situated in ways where they are the recipients of much prejudice and placed on the margins of society. Frailty has been espoused at the expense of a more active image. It is, therefore, not surprising that an age-resistant culture is emerging through terms such as successful ageing, active ageing and positive ageing (Gilleard and Higgs 2000). However, the images are no longer of disengagement from an active life but rather ones of self-fulfilment and self-realisation (Featherstone and Hepworth 2004).

In the past, much of the research on ageing was grounded in pathology and tended to target ways to reduce morbidity and mortality. Ageing was viewed as a problem (Wilson 2000) and great efforts made to keep us alive, but little attention given to strategies that encourage us to live (Kirkwood 2001). In more recent times, however, there has been greater emphasis on maintaining health and independence through lifestyle choices, quality of life, and learning more about how to counter negative perceptions and stereotypes of ageing and retirement. We have been encouraged to rethink much of what is known about the ageing process and the process of ageing, and this has contributed to the notion of positive ageing being "adopted as a policy principle by the New Zealand Government" (Boston and Davey 2006:2).

There's no dispute that our genetic disposition is critical to who and what we are, but as Kirkwood (2001) and others have noted, this only accounts for approximately a quarter of how long the majority of people live. Longevity and quality of life are primarily influenced by nutrition, lifestyle, socio-cultural and environmental factors, as well as an array of unforeseen circumstances. These factors are all subjected to various forms of intervention at the political, community, family and personal level throughout the life span, and as a consequence the ageing process and one's lifestyle are continually being altered. This can be in either an enabling or a disabling way.

There is no panacea for a disease-free life or for maintaining one's youthfulness. Neither will medical treatment by itself produce enormous gains in lifespan and quality of life. The evidence does suggest, however, that adopting a range of health-related behaviours (eg physical activity) that are known to deflect the impact of non-communicable diseases can make a significant contribution to a person's functional capacity, efficiency and independence in later years. But in spite of the overwhelming support for what supposedly represents a healthy lifestyle, the technological advances of the past 50 years have produced the most sedentary society in our history (Overdorf 2005). It is against such a backdrop that active living policies have to be situated.

Many countries are currently grappling with ways to better link public policy and supportive environments to enable older people to live independent, healthy, active lives. In New Zealand, for example, the Government initiated the Positive Ageing Strategy (Ministry of Social Policy 2001) in recognition of the fact that too many older New Zealanders have been inundated with a rhetoric more closely associated with decline and degeneration rather than growth and development, leisure and pleasure. The underlying tenet is that positive ageing is about positive living, and hence the need to reduce situations where older people are unwittingly undervalued, unproductive and dependent. Older people are entitled to participate in all aspects of the community in ways suited to their needs. Although, as Kirkwood reminds us, this sometimes requires an initiative at governmental level, achieving change will not be easy:

> We face a revolution in longevity that is shaking the foundations of societies around the world and profoundly altering our attitudes to life and death. Not only are we living longer but the evidence shows that old age itself is being transformed. … We need to look afresh at what is happening for there is a great deal that needs to be done to develop a more positive attitude to the challenge of ageing if the successes of the past are not to turn sour. (Kirkwood 2001:ix–x)

A Consciousness about *Good* Health

Many ailments are attributable to non-communicable diseases, so it is time to redress the imbalance between investment in medical care and the promotion of preventive activities (Bernard 2000, McGinnis et al. 2002, Haber 2003, Mullan 2002). This is important, because any action intended to improve the health of a population must extend beyond the provision of services (Kalache et al. 2005). This is reflected in more public–private partnerships in some services in a society that places greater emphasis on individuals taking more, rather than less, responsibility for their lives. Although individual responsibility may be an important value, human beings are gregarious and often need support, particularly in a deregulated society. After all, not all older people have the freedom, knowledge, prior experiences or resources to opt for an alternative and/or healthier lifestyle and free themselves from the feeling of being a burden to society (Cruikshank 2003, Gilleard and Higgs 2000, Polivka and Longino 2006).

When health is viewed primarily from a disease perspective, older people have had a voracious appetite for medical care. But there are signs of a paradigm shift to a more salutogenic agenda in which the self has a more critical role (Antonovsky 1996, Ferraro 2006, Staehelin 2005). Greater emphasis is beginning to be placed on non-medical influences with regard to maintaining good health and enhancing quality of life in the later years (Bowling 2005). Therefore, health promotion should seek to better understand how policy and social environments could inspire individuals to modify specific health-related behaviours – including physical activity. Although raising the level of consciousness about good health has merit, there is uncertainty about the effectiveness of promotional strategies that ignore the influence of physical and social environmental determinants (Bernard 2000, Brawley et al. 2003, Thurston and Green 2004). Many intentions are commendable, but whether or not a person adopts a particular health-related behaviour in their later years is the consequence of numerous structural, cultural and personal factors.

At the personal level, New Zealanders over 65 years recognise the benefits of physical activity (Grant et al. 2007) and tend to consider themselves *fit and healthy* in the subjective sense and healthier than their contemporaries (Ministry of Health 2002). This illustrates how the values and meanings attached to what being healthy supposedly means vary dramatically. After an extensive review of numerous studies on healthy ageing, Peel et al. (2004) concluded that being healthy is a complex multidimensional construct and one about which we have much to learn. In addition to considering physical, psychological and social wellbeing, there is a need to be cognisant of an individual's capacity to function well with regard to daily living, and to adapt to environmental change and challenges. Older people may be the experts on their lives and impute meanings about what is happening in their respective worlds, but their

voice is mostly absent from the health advocacy literature and not always strongly represented in the policy-making process.

RHETORIC OR ACTION?

The benefits of regular physical activity are well substantiated and outweigh the risks of adopting a sedentary existence – particularly in later life (Franco et. al. 2005, Reed et al. 2004, Rikli 2005, Spirduso et al. 2005, Taylor and Johnson 2008). Although adopting a sedentary lifestyle becomes more popular with age, some of the reasons for this are embedded in socially and culturally constructed norms about what it is to be old. Furthermore, the social context is very influential in moderating the motivation for healthy action (Dishman et al. 2004). The emphasis for older people may have once been on slowing down, but we now know that irrespective of one's state of wellbeing, old muscles are supposed to be activated (Chodzko-Zajko et al. 2005, Kirkwood 2001, Overdorf 2005). But deciding whether or not to be physically active in later life is more difficult than it sounds, particularly when many older people believe they are already healthy enough (Booth et al. 2002, Ministry of Health 2002).

Choosing not to engage in a physically active lifestyle should not be construed as losing the zest for living or participating in a variety of forms of active leisure (O'Brien Cousins 2000, Grant 2002). After all, many older people share a great enthusiasm for participating in activities and community programmes, but their long-term adherence to leisure of the physical kind is poor (Brawley et. al. 2003, Dishman et al. 2004, King 2001). Like their younger cohorts, older people think of leisure as something worth doing. However, being deliberately physically active, in whatever form, is not an overly popular choice or considered fun for many in their later years (Grant 2002).

Since the World Health Organisation classified a sedentary existence as a risk factor, a number of countries have developed a range of proactive strategies aimed at changing this behaviour. Convinced by the empirical evidence that a physically active lifestyle can extend years of active independent life, reduce disability and improve quality of life, a coalition of 46 organisations in the USA has produced the National Blueprint: Increasing Physical Activity Among Adults Age 50 and Older (the US National Blueprint) (Chodzko-Zajko et al. 2005). Similarly, the Canadian Active Living Coalition for Older Adults launched a campaign for an active older population. It stated:

> There is a realization that the growth of an aging population is not simply a trend but a reality. As such, government and non-government agencies and organisations across the country are searching for ways to address this challenge. Recognized among such needs is the necessity to maximize the health and well-being of older adults through a physically active lifestyle. (Canadian Active Living Coalition for Older Adults 1999:1)

In Australia, the Commonwealth Department of Health and Aged Care (1999) produced the National Physical Activity Guidelines (NPAG), which make reference to a more active over-65 population. It encourages this age group to be active every day, to think of movement as an opportunity – not an inconvenience – and to put together at least 30 minutes of moderate-intensity physical activity on most days of the week. However, in a study examining the attitudes of people aged between 65 and 84 years old to the Australian NPAG, it was discovered very few people knew about the guidelines (Henley and Jackson 2006). The findings from this study, coupled with the writings of others (eg Grodesky et al 2006, Rasinaho et al. 2007, Rejeski and Brawley 2006, Rikli 2005), suggest a need to rethink how best to promote physical activity as a health-related behaviour to the older sector of the population. As noted earlier, New Zealand has yet to give any serious attention to a national physical activity strategy targeting the older population – quite the opposite when compared to what is happening for the younger generation. Such a strategy could incorporate the recently released *International Guidelines for Preparing Physical Activity Instructors of Older Adults* (International Society for Aging and Physical Activity 2004).

PROMOTING A PHYSICALLY ACTIVE LIFESTYLE

Most people know something about the positive relationship between physical activity and health, but only about half of older adults are sufficiently active to ensure optimal health (Mummery et al. 2007). Furthermore, engagement in physical activity decreases considerably with age (Grant et al. 2000). This is of some concern, because inactivity has the potential to negatively influence independence and functional ability with regard to performing everyday tasks, and consequently one's quality of life (Bowling 2005, Ministry of Health 2007, Rikli 2005, Spirduso et al. 2005). There is much to do if the prevalence of withdrawing from this health-related behaviour is to change for the better. However, we should tread with caution, because it is difficult to make accurate claims about the health status of the population by relying almost exclusively on self-reporting national surveys. This being the case, one of the challenges for those intending to influence older adult behaviour via policy and community programmes is to accumulate a more empirical and trustworthy evidence base. According to Schoenberg and Rowles (2002), this is possible if we employ the full arsenal of approaches available to the scientific fraternity.

Internationally, the past 15 years have seen many intervention strategies in numerous settings, drawing on a range of social, cognitive and affective theories, endeavouring to activate an increasing proportion of the older population. But in spite of the good intentions, the efforts have mostly failed to result in any long-term success for a large proportion of the participants (Brawley et al. 2003, Grodesky et al. 2006, Thurston and Green 2004). One possible explanation for this is that the activity promotion models

tend to ignore the structural and environmental influences on physical activity (Adams and White 2005). Hence, there is a call to integrate theory and concepts from a broader group of disciplines (Grant and Kluge 2007), as well as make environment and lifestyle factors key areas when targeting older people (King et al. 2002, Thurston and Green 2004). There is also a need for much more research to be undertaken in conjunction with health promotion initiatives (Brawley et al. 2003) and combat ageist stereotypes and images that inhibit personal development (Angus and Reeve 2006). This is particularly important if the aim is to support policy and programmes that enhance an independent and healthy lifestyle of the older person (Bernard 2000).

Trying to activate a greater proportion of the older population requires more than spreading the word or modifying one or two determinants. A good example of this is the US National Blueprint (Ratzan 2001). The US National Blueprint is a comprehensive plan and has 18 strategies linked across five areas (see Chodzko-Zajko 2005 for a detailed outline):

- home and community partnerships
- marketing and communication practices with specific target groups
- medical systems that focus on educating patients
- clearly defined public policy agendas
- research projects that translate into community-based programmes.

This illustrates how there are multiple levels at which interventions can occur to improve public health. It also seems that such a strategy is imperative if the intention is to keep active ageing at the forefront of the nation's public health agenda.

When promoting physical activity to those in later life, we need to accept that this is a self-regulated behaviour influenced by a multitude of factors. Some of these include stereotypes and prejudices, economic conditions, social and cultural expectations, community resources, previous experiences and living arrangements. Furthermore, some of these take on greater significance with age because related inequalities experienced in earlier life tend to be accentuated in the later years – particularly for women (Gilleard and Higgs 2000, Stoller and Gibson 2000). In order to adopt a physically active lifestyle in the later years in a way that reflects desirable health outcomes, Conner and Norman (2005:18) suggest the individual should have:

> …a strong intention, the necessary skills to perform the behaviour, an absence of environmental constraints, perceives the advantages outweigh the disadvantages, perceives the social pressures to perform to be greater than not to perform the behaviour, the behaviour is consistent with the individual's image, anticipates positive rather than negative emotional reaction and high levels of self-efficacy.

Any health promotion strategy aimed at increasing the levels of physical activity among the older population must extend well beyond the individual and embrace opportunities in supportive environments. According to Kirkwood (2001), this means putting greater emphasis on extending the health span while leaving the life span as it is. It is also time to refute the socio-cultural belief that physical ill health, functional incompetence and disability are the norm for the majority of older people (Kalache et al. 2005). This may be the essence of health promotion in ageing, but it will be some time before masses of older people take to the walkways, gyms, pools, fitness centres, outdoors, community classes and the like of their own volition. After all, active ageing *for health* is a relatively new phenomenon for the current older generation.

Exercise may not be an elixir for healthy living but, if we accept there are multiple benefits for the individual and society, then we should adopt an expanded perspective on policy development in order to promote this behaviour. Physical activity needs a more prominent place on the healthy ageing agenda, and long-term change will require commitment from a range of sector groups.

CONCLUSION

So, what is worth considering when addressing the promotion of this health-related behaviour? The first thing to acknowledge is that ageing is as dynamic as it is complex, full of ambiguities and inconsistencies, and that older people are not easily manipulated and managed by policy and programmes. However, appropriate policy can provide a co-ordinated catalyst for change. Secondly, there is a need to promote physical activity as being something more than a way to prevent ill health and reduce an economic blow-out on the health budget. Thirdly, we need to recognise the heterogeneity of the older population and debunk the many stereotypes of ageing with regard to what the ageing body should and should not do. After all, physical activity is a personal experience related to one's needs and state of wellbeing. Fourthly, we need to engage with environmental assessors and planners in the local community to minimise barriers while creating opportunities. But we also need to recognise that accessibility and availability of facilities and resources by itself is insufficient. Fifthly, coalitions might better utilise resources and ensure cohesion between the various agencies and community groups in developing realistic targets. The older voice needs to be incorporated. Finally, we must acknowledge that older people do not necessarily respond to a prescription for physical activity in a way that reflects what is supposedly necessary for optimal health.

If the health status of the older population is of any concern, then a more concerted effort should be directed towards encouraging physical activity – a self-regulated multi-dimensional behaviour – so that it becomes a greater part of older people's lifestyle.

However, being physically active for a health-related reason is not always as easy as it sounds. There are many challenges at the personal, community and national level. Nevertheless, such an initiative has the potential to reduce disablement and mortality while enhancing quality of life in the later years, something that can occur irrespective of gender, ethnicity and/or social grouping. This being the case, it would be well worth the effort to find ways to give physical activity more prominence on the healthy ageing agenda.

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