Active ageing: Dream or reality

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Abstract

Noting the New Zealand Minister of Health's encouragement that occupational therapists assert their role in population health, Wilcock argues that individual therapists and the profession at large should support active ageing, both in their day-to-day practice and through political activism. Citing personal, historical and research evidence, and UN and WHO policy, she puts the case that only those older people who act against western cultural stereotypes of a sedentary old age can achieve healthy ageing. Occupational therapists, with their knowledge of health through occupation, are urged to support this vision as a matter of human rights.

Key words

Public health, well-being, older people, human rights

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At the opening ceremony of the NZAOT Conference in 2006 the Minister for Health addressed the need for occupational therapists to recognize and assert their role in population health particularly for those who are ageing. By so doing he offered New Zealand occupational therapists an important opportunity that should not be missed. To that end, I recommend that as many as possible embrace graduate study in the field of public health. Speaking as a member of the global community to which we all belong, and as a doctor of public health, I believe this is where the future of occupational therapy lies, and it is with this orientation that I address you.

As a preliminary to this paper about 'Active Ageing' and with particular reference to the western world, I draw to your attention the fact that many older people have a great deal of expertise to point the way to the maintenance or improvement of their own health, particularly as it relates to their physical, mental and social well-being. This differs from many in government and the health professions who deem the ageing population as health problems by relating health solely to the absence of disease or dysfunction. For example, the politician opening the World Federation of Occupational Therapists (WFOT) Congress in July 2006 discussed the ageing population as a challenge that needs to be overcome in the present time and more so in the years ahead. Such framing reflects the patronising and derogatory views of ageing held by many who are not yet aged. I am one of the challenges, and I draw on other experts on ageing – namely those who are experiencing it. I suggest that occupational therapists, if they are to enter the population health field, particularly those who address the issue of active ageing, also need to accept and support the expertise of those successfully finding their own way in largely unexplored territory.

Ageing happens! It has happened to me and it will to you. Chronic disease does not necessarily happen with ageing and it can be substantially contained by ongoing activities that promote physical, mental and social well-being. The latter idea is at the heart of active ageing, and to my mind, it is the rationale for taking an occupational perspective of health for all people.

Active ageing does not necessarily happen. That it should will provide the essence of this paper. It is not alive and well in communities such as ours. That is except amongst some of those striving to be active agers who often, daily, have to fight against conventions, bureaucracy, families, and health professionals for that right. It is a difficult fight for many. It may call for the fight of their lives, at a socio-political level as well as a personal one, and it places huge demands at a time when many are financially strapped, physically hobbled, emotionally fatigued, and socially ignored.

Let me share a few quotes of commonly held ideas about ageing that are counter to active ageing. They are from an appropriately 'aged' 1979 text entitled *A Good Age* by Alex Comfort, an enlightened physician. The following citations are from a section called Folklore and Nonsense. In answer to the myth that "After sixty-five your mind deteriorates" Comfort argued:

> The only thing that declines a little is speed of response; there is no change, normally, in intelligence and little in memory. Any blunting we do see in the absence of

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> actual disease commonly results not from age but from neglect, boredom and exasperation. (p. 92)

To "Everyone knows old folks are past having sex" he reported "every study shows that a high proportion of old folks are either still having it or would welcome an opportunity to have it because they are fully able to enjoy it" (p. 91). To "After sixty-five everyone goes steadily downhill" he advised that "about half, or possibly more than that, of any decline that is observed is due to boredom, inactivity and the awareness that infirmity is expected" (p. 90). To statements such as "disengagement is a natural acceptance of old age limitations" he suggested "most of the handicaps of oldness in our society are social, conventional and imaginary... it exists only in societies which create it by the way they classify people" (p. 93). Comfort also proposed, tongue in cheek, that "people really like being kicked out of the living community, put to grass or treated like lepers – because if they made a fuss about it, that would be inconvenient for our planning" (p. 93). In fact, it is scrap heap time for many who have passed the accepted age for paid employment in an era dominated by youth culture.

Ageism versus active ageing

We might ask what the genesis of such ideas is? One answer is that it occurs in places where people view others according to their chronological age and set unwritten rules for the behaviour expected of them. Those close to my own age will know and understand that age is not chronological. I prefer to view people according to their felt age, to their action or doing age, and I recommend that you do the same. In Sydney, last month I sat on a bus next to a woman who told me she was 81. I told her I was 26 and asked her how old she felt. Without any other prompts she replied: "When I am playing soccer with my grandson, kicking and heading the ball I am 8. When I am with my daughter and she is stiff, I am 40."

Think about the old people you or your colleagues work with. How old are they in 'felt years'? Have you ever asked such a question? Have you ever asked about the occupations that help them feel young or excited about living? Have you helped them towards expression of those occupations that promote their feeling of well-being? Are they members of the general population or is the work you do largely restricted to those referred from medically-based health and social service? How many older people in the population at large miss out on your wisdom about active ageing on their occupational health?

We can even ask whether all occupational therapists have wisdom about active ageing to offer. Most modern occupational therapy texts, even those written for the general population and those that centre on occupation, tend to address only the needs of people with medically defined disability or ill-health. Despite, I think, good intent, the authors appear to be unaware that they are doing it and that by doing so, they segregate people with disability from the rest of the world's population and deny the occupation for health needs of everyone else. Limiting the offerings to accepted visions of what older people can and should do is commonplace and needs to be challenged because it is counter to the spirit of active ageing.

This paper draws heavily upon a chapter I wrote in a recent textbook titled *Occupational Therapy and Older People* edited by Anne McIntyre and Anita Atwal that will provide more useful information about this topic (Wilcock, 2005). Within it I discussed a way to start thinking about active ageing by considering two vastly different 'occupational' visions of older people that together:

> … provide a snapshot of western views of aging. The first is of a seated row of sleepy, unresponsive men and women wrapped in crocheted blankets, isolated and alone in front of a blaring unwatched television. The second is of energized vibrancy as elderly performers strut their 'stuff' in front of bemused audiences at theatres, festivals, and the like, ready to take to the road again towards another performance. (p. 14)

It may appear that those able to focus on the second vision require no help but that can be far from the case. For example on 7th July 2003 in his TV programme *Enough Rope* Andrew Denton introduced guests from The Older Women's Network Theatre Group thus:

> You may not be able to see or even hear my next guests because they're all women over the age of 60 and, according to them, that makes them invisible, which is a pity because they've got things they really want you to hear. (Denton, 2003)

He went on to ask them whether people thought that because of their age they were demented. The women replied that was the case half of the time, as well as being seen to have passed their use-by date: their opinions usually didn't count for much; and they were considered useless and unable to do "things". The women queried why people appeared not to worry about how they feel, and they talked of feeling "sort of pre-dead", "transparent" and that "the older you get, the more you get to the top of the dead list" (Denton). When Denton asked them about the wisdom they'd gleaned from life they answered:

> We have to get rid of ageism. I mean, after all, being young is wonderful, but it's not a lifetime career, is it? Age isn't anything to be afraid of….it's what other people put on us, I think. We have a saying one of the things we do, is that ageism is a bias directed towards older people by the temporarily young.

Empty or dynamic vision

The occupationally empty vision of the slumped, blanketed figure mentioned earlier is a common reality and one that many people fear may be their ultimate fate. Because of economic factors and current medical priorities, that scenario is no longer adequately addressed by occupational therapists. To improve the situation requires improved political and rhetorical strength from all occupational therapists. The dynamic vision of older people getting their message across and performing before incredulous audiences suggests that the world can still be the potential oyster for those who are able or enabled. Even this may require increased rhetorical support and publicity of the links between occupation and health. The disparate realities of the two visions "lead to questions about whether or not either

is a matter of choice, a matter of cultural expectations, a matter of economic necessity, a matter of health or illness, a matter of access or, even, a matter of justice" (Wilcock, 2005, p. 14). The range of possibilities between either extreme invokes questions about the nature of enabling or empowering ingredients that assist older people to continue to do, to be and to belong in ways meaningful to each of them: for them to become "Active Agers".

For me, active aging is a process that sits well with my view of doing, being, becoming and belonging that I discussed in the recently published second edition of An Occupational Perspective of Health (Wilcock, 2006). My research shows all four are essential to survival, health and well-being. My ultimate formula, like Einstein's theory of relativity, is remarkably simple. It is that doing, being, becoming and belonging are essential to survival and health, or $d+b^3=sh$.

Active ageing as a right

World authorities hold views that support the formula and its distinctive parts, and in the Universal Declaration of Human Rights (United Nations, 1948) there is support for the idea of occupation (though not by that name) being considered a human right. This has recently been acted upon by the World Federation of Occupational Therapists (WFOT), in adopting a Position Paper on Human Rights (WFOT, 2006). A report of the United Nations (UN) resolutions following the first World Assembly on Ageing held in Vienna in 1982 reaffirmed that the Rights:

> …apply fully and undiminished to the ageing and recognized that the quality of life was no less important than the longevity, and that the ageing should therefore, as far as possible, be enabled to enjoy in their own families and communities, a life of fulfillment, health, security and contentment, appreciated as an integral part of society. (p. 1186)

As well, it was recognised that "the aged are an asset not a liability to society because of the invaluable contribution they can make by virtue of their accumulated wealth of knowledge and experience" (p. 1186). Those statements "support the enabling of older people to continue to fulfil their occupational needs and wants towards enhancement of personal potential, growth, and belonging" (Wilcock, 2005, p.16). To "ensure that the humanitarian needs and developmental potential of the aged" (Flynn-Connors, 1989, pp. 688-689) are adequately addressed, the UN argued that by 1989 national strategies should attend to biological, social, and economic requirements as well as demographics and epidemiology. Policies and programmes, it said, should also be aimed at encouraging and supporting older people with "self-help initiatives" and income security.

In 1999, 80 nations were involved in the International Year of Older Persons, which had as its theme A Society for All Ages. During that year important issues were raised about recognising older people's potential roles in society, consulting with them about their needs, and recognising and eliminating any violations of human rights caused by discrimination and stereotyping (Gordon, 1999). Two years later the UN Year Book urged governments and societies at large to promote the development of programs for healthy, active ageing. These, (Gordon, 2001) argued, should ensure quality of life and full enjoyment of human rights through activities that meet needs for independence, equality, participation, and security (Wilcock, 2005, p17). Population justice and health initiatives such as these are available to occupational therapists for politicisation and utilisation in their programs.

At the second UN World Assembly on Ageing held in Madrid in 2002 the World Health Organization (WHO) provided its contribution to the theme of active ageing. In a policy framework to promote healthy ageing it was recognized that there could be "dramatic differences in health status, participation and levels of independence amongst older people of the same age" (Wilcock, 2005, p.17). To enable those who are able to contribute to society in important ways, and to prevent discriminatory action that can be counter productive to well-being, it was recognised that policies and programmes need to take such variations into account. Important issues relevant to human rights and justice from an occupational therapy point of view were raised. These included questions related to assisting people as they age to remain active and independent; to the strengthening of health promotion and illness prevention strategies for older people; to the improvement of their quality of life; and to supporting them in continuing to play important roles in caring for others (WHO, 2002, pp. 2-5). These appear sensible and worthy issues from which a question arises: "Why there appears to be so little emphasis in health and social welfare literature on encouraging older people in the general population to engage in the active ageing process?" (Wilcock, p.17). Instead, emphasis is placed on economic concerns regarding the possibility of increasing numbers of people as they age becoming a burden to health and social welfare systems and families. Population health strategies and questions about these issues could form a basis for argument to support new occupational therapy programmes in the area of active ageing for the population at large.

Occupational therapists as agents of active ageing

Despite some occupational therapists already having answers and expertise about some of these issues, and the WFOT having begun to take a more proactive stance with regard to Human Rights (WFOT, 2006) and showing increasing interest in WHO strategies, I am compelled to ask:

- Do the leaders of public health in your locality really know of occupational therapists' potential role in active ageing?
- Does the WHO actively seek occupational therapists out as experts on active ageing?
- Do your political masters recognize your expertise?
- Are all occupational therapists active enough in making clear how all of people's occupations relate to health and well-being?
- Do all occupational therapists actually believe the latter and act on it?

The latter can be queried because the focus of both occupational therapists' literature and funded programmes

for older people is on routine self-care tasks, risk management to prevent accidents, and "sedentary occupations that may or may not hold interest for recipients" (Wilcock, 2005, p.17) who are largely referred from amongst the ranks of those who are medically-challenged. This may well be a flow-on from caregivers as well as families often discouraging more active pursuits, apparently because they are fearful of increasing dependence. It may also be because of "economic concerns about the cost of institutional care" or the "increasingly litigious nature of western societies" (Wilcock, p.17). However constituted, any such limitations are discriminatory and possibly a cause of occupational injustice (Wilcock). Failure by occupational therapists to challenge the restrictive outcomes of such factors is a failure in terms of the foundational beliefs of the profession. I suggest that much more advocacy along such lines is called for. Such advocacy should also push the need for understanding that as part of an active ageing process, occupations must provide opportunities for people of all ages to meet unique occupational wants and needs and sense of belonging, despite some risk.

Commonly and arrogantly, the occupational goals of people beyond paid employment years are deemed non-essential in name of risk management. Indeed, "there is general acceptance that risk management is a necessary and admirable objective within advanced western societies despite the fact that, in many ways, it encourages restrictive, externally imposed strategies that can dis-empower recipients" (Wilcock, 2005, p.15). Risk management strategies make the provider feel better and are viewed as worthy by insurers, families and governments, and get the media 'tick of approval'. However, such strategies "fail in many respects to recognize individual experience or potential, or the morbidity and mortality links between what people do or do not do. In that way it is not appreciated that lack of balanced, health maintaining, and satisfying occupation can be a risk in itself, and that restriction of occupational aspirations can be viewed as a matter of discriminatory and unhealthy practice" (Wilcock, p.15). Not knowing that, or not being able to explain it, restricts what occupational therapists can offer the market place (Wilcock, 2006).

An active ageing society would be one that provides opportunity for older people as well as younger ones to continue to develop their distinct talents, not straitjacketed by societal or familial expectations. The opposite is possible because the organisation and privileging of occupations is socially constructed and taken for granted. In post-industrial societies older people commonly have to contend with attitudes and approaches at legislative, societal and personal levels that are antithetical to occupational well-being and causative of illness in the longer term. This implies that occupational therapists could aim their work at legislative, societal and personal change: become, in fact, legislative, societal and personal change agents (Wilcock, 2005).

At legislative level occupational therapists working either with older people leading ordinary lives in the community, or with residents in aged care facilities, could become more proactive in examining and assessing policies for potentially damaging legislation. They could join in debates as policies are discussed and enacted, and articulate and publish views about the occupational needs of older people. Because provision of professional expertise about occupation as a fundamental requirement for health and well-being is lacking at a legislative level, compulsory retirement policies, pension provision, limited resource allocation and occupational facilities are often problematic. This can restrict access to the multiple of occupations that enable older people to shape their daily life in ways that have meaning to them and maintain or improve their health.

At a societal level, occupational therapists need to put forward ideas about how society can be organised so that the occupational experiences of all older people are valued, and considered as a matter of health, right and justice. There is a need to become more articulate about active ageing – about what older people can and should be able to do to achieve meaning, quality of life, health, happiness and well-being. There is a further need to become more articulate about older people's empowerment within the society in which they live. Emphasis could be placed on the common and patronizing expectations of older people's lack of physical or mental acuity. This impacts the behaviour of many, diminishing the belief that they can continue to develop their own occupational potential, shape their community or participate in the social world in ways that are valuable and valued (Wilcock, 2005).

At a personal level, occupational therapists espouse that occupations are most health giving when embedded with purpose and meaning: when they enable individuals to express and experience individual pleasure, a sense of vocation, and meet spiritual needs. Yet even caring families can lovingly restrain older people from continuing with occupations that have been central to their sense of self. Even when restraint is suggested or enforced with the 'good of the person' in mind, there may be unhealthy consequences of lack of physical, mental or social occupations. Active or passive denial of opportunities and resources for older people, limited resources, and situations of isolation are forms of restraint and major sources of occupational dysfunction and injustice in the western world (Wilcock, 2005).

However to create occupationally healthy and just societies for older people is not without difficulty, even in advanced capitalist economies. Consider this story told by Rose, a woman in her late eighties, to a group of occupational therapy students in Sydney. Amongst other things, she told how she had learned to cope with the loss of two husbands, a stroke, a mastectomy and then almost total blindness. When asked if she considered herself "well", her instant response was "Yes. I feel very lucky to be sitting and talking to you young people. I am still part of the community and making a small contribution". She went on to describe how excited she was to be able to read letters again on the reading machine she had loaned through the Royal Blind Society. "I am thinking of buying one, but my family say it is far too expensive at my age and I won't get my money's worth. But that is not my dilemma. You see the postman has brought my post to the front door for years, stopped and read out the

bills, postcards, in fact everything, to me. I would be gaining some privacy but losing regular contact with a real friend." (J. Crowe, personal communication, 25 July, 2006).

At the start of the 21st century, the Commission on Human Rights (2001) reaffirmed "the right of everyone to the enjoyment of the highest standard of physical and mental health" (p. 574). This inclusive policy suggests that occupational therapists need to consider closely what constitutes physical and mental health for older people, and what occupation-based interventions can enable their enjoyment of its highest standard. To implement ideas and strategies arising from such consideration is made complex by post-industrial economies being largely driven by monetary considerations rather than the enabling or enhancement of human capacities, despite rhetoric to the contrary.

Occupational therapists need only be true to their own rhetoric. This embraces words and concepts such as participation, empowerment, sharing, choice, fulfilment, growth, satisfaction and opportunity through meaningful, purposeful and diverse occupations; the right to satisfying occupations specific to individual needs; the nourishment of body, mind and spirit of communities as well as individuals; and attention to the participatory and cultural nature of occupations. It is cautionary that the rhetoric seldom directly addresses reducing the disadvantage of life for older people in countries that care for their aged by restricting their need for fulfilment and empowerment through decreased engagement in diverse occupations.

The evidence

There is an amazing amount of evidence, both antiquarian and modern, that does more than suggest that the occupation for health message is a lynch pin. Such evidence makes it possible to claim that engagement in occupation can benefit health and prolong life. The evidence includes two American randomised controlled trials that justify occupation as a potential health source for older people and a deterrent to early death, one from Harvard (Glass, de Leon, Marottoli, & Berkman, 1999) and one from the University of Southern California (Clark et al., 1997). Evidence from earlier work is also valuable, such as Ornstein and Sobel's (1988) explanation that the brain minds the body and maintains health through making 'countless adjustments' that preserve stability between "social worlds, our mental and emotional lives, and our internal physiology" (pp. 11-12). Those things that people do – their occupations – are the usual mechanism for integrated functioning of mind and body to enable people to survive healthily and successfully. The thoughts and experience of scholars from much earlier times can also provide evidence, such as a 19th century findings of physician, Thomas Southwood-Smith (1836), who argued that "to add enjoyment, is to lengthen life" (p. 101). His physiological premise maintained that "it is, in fact, the pleasurable consciousness which constitutes the feeling of health" (pp. 81-82).

Occupational therapists need greater skill in recognising evidence; in coming to understand what to tell and how to tell it; in dealing with issues of diversity and difference rather than conformity; in lobbying politically and selling the messages of occupation for health to populations as well as for those with medically defined dysfunction. In the case of older people, an additional message about overcoming indoctrination of the economically-driven youth culture that dominates the western world is essential. To be effective, occupational therapists need to:

- Recognise cultural and environmental contexts as well as individual problems in occupation-based personal, communal or socio-political initiatives
- Advance understanding of the relationship between health and occupation in public and political forums
- Extend the enabling role to the population at large
- Explore socio-cultural-political factors that undermine occupational determinants of health and occupationally justice.

Case study

In conclusion, let me share with you a single case study that spans a four-year period. The study highlights the inactive and active ageing experiences of an Australian man, now in his mid eighties chronologically. First I will set the scene. Always an active being with multiple practical skills, Graeme grew up in a farming and community service conscious family and followed those traditions. In World War II he became an aero engineer and was consequently deafened. Returning home, he became a hardworking and successful grower and exporter of apples. When he eventually retired he followed a long held dream and built a 60-ton steel charter boat, got his skipper's licence and, for a decade, captained tourists and keen fisher-folk around the robust waters of the Southern Ocean. Following his second retirement, he became involved in community service and learnt to fly gliders. By the time he reached 80 he was a widower and, conforming to the norm of his society, decided he needed to retire for a third time. He built a small home on his daughter's property in which "to wait for God", looking forward to spending his days sitting, looking at the view from his house and reading.

At the start of this study we find Graeme enjoying the break from active ageing, but becoming less fit, less healthy, and putting on weight. His vision was becoming poor because of cataracts. Discouraged by his family from active participation in many of the pursuits in which he had formerly excelled, because they might be risky for someone of his age, he slept a lot. Boredom was a problem and his deafness led to him not seeking out social stimulation.

Because of his age and the social norms, Graeme's situation is replicated around countries such as ours. A slowing down and a reduction of interest in doing are accepted as normal and part of the ageing process. No intervention would be considered necessary despite the UN and WHO population health directives towards the encouragement of active ageing. Indeed few of us would have picked that intervention at individual or population level was required. So what happened next? Graeme remarried. He moved with his wife, an occupational therapist, to a new home and started to re-engage in life, once more

working hard, building and gardening, enjoying entertaining and taking holidays overseas, despite family disapproval of what they perceived to be risk-taking behaviour. In the last three years he built a walled garden, an enclosed orchard and produce garden, a double carport, a two-roomed hen coup, an outdoor entertaining area with kitchen, garden room and dining area, and supervised and contributed to innumerable other projects like removing and replacing a kitchen and building a couple of glass enclosures that required him to knock down parts of brick walls.

His legs are not always reliable or pain-free but that does not stop him climbing ladders or working on roofs. Consulting his local doctor about this last problem Graeme explained that he was finding it difficult to stand on one leg to wash his feet in the shower. His doctor said he should not be able to do that anyway. As Comfort (1979) advised, if "you find one (that is - a doctor) who thinks that you have to be infirm, crazy, impotent or the like, by virtue of chronological age, change doctors" (p. 69). Graeme did just that. His vision has improved with cataract removal. His deafness has increased but he is involved in life to the full and is still taking on board new ideas, by now knowing a great deal about occupational therapy and active ageing as he critiques his wife's work every day.

Conclusion

What can an occupational therapist do when situations such as the one I described are difficult to recognise and unlikely to be referred for professional intervention at a one-to-one level? This is a time and place for population health initiatives. Most importantly, there is a need to increase awareness of the occupational needs of all people and the initiatives of the WHO that call for active ageing and that are a matter of occupational justice. I offer the thought that to change practice towards active ageing requires only that occupational therapists are true to the concept of occupation for health. I have found that the ideas make sense to everyone. And remember, there is the philosophical rationale and might of the UN and WHO as back-up.

Key points

- Doing, being, becoming and belonging are essential to the health and survival of all people.
- United Nations and World Health Organization policies support the concept of active aging.
- Societal perceptions of ageing as diminishing ability lead to diminished well-being of older people.
- Supporting active aging requires occupational therapists to be true to the rhetoric of their profession, that occupation supports health.

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