‘Healthy ageing’ and its future

An exploratory study from Austria

Master’s Thesis

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Abstract

'Health in old age' or ways of 'healthy ageing' are central priorities and aims, especially within continuously ageing societies. Yet, what real meanings such concepts have at different societal levels often remains obscure. This study explores the interests, notions and views of people in various individual, social and professional positions in Austria towards the concept of 'healthy ageing'. It was thereby not the purpose to achieve conformity of naturally differing interests and necessities, but rather, to engage in an intergenerational and interdisciplinary dialogue and to question one-sided perspectives or taken for granted circumstances and health care approaches. This posed an essential task of and challenge for research as we face a growing number of older people, who all want to age in good 'health'. We have to ask ourselves, how we will be able to take good care of 'health in old age' in the future and whether policies in Austria are actually in accordance with the needs and interests of those ageing.

In applying a 'multi-level perspective' this exploratory study brought together the viewpoints and expertise of participants at five differently defined levels and, additionally, comments and reflections from national and international experts in the field of 'ageing and health'. Twenty-seven qualitative interviews as well as open conversations and discussions were undertaken and complemented by a broad review of specialized literature.

Such a comprehensive research approach necessitated, in a first step of the study, a reformulation of the concept of 'healthy ageing', making it more related to a context of individual positions and to the lived experience of ageing people. A variety of components, constituting and generating 'health in old age' was found and 'healthy ageing' turned out to be an intrinsically dynamic, heterogeneous and subjective process, rather than a static and objective state of being.

In a second step, future tasks of prevention and health care priorities for older people in Austria have been explored and findings clearly reflected the previously identified characteristics of 'healthy ageing'. In interpreting and providing an overview of different ideas and concrete interests of participants, a clear tendency towards more flexible, collaborative and individually adapted health care facilities in Austria presented itself. It appeared that only by this way, an individual 'culture of health' could be viewed appropriately and 'ageing' could become a more 'healthy' concept for the future.
Acknowledgements

At this point it is of utmost priority for me to acknowledge and express my thanks to all my participants of the different ‘levels’ of this study: Older people, families, health professionals, policy makers as well as contributing experts in the field of ‘ageing and health’. They all generously offered their time and personal expertise to me. Without their patience and help, I would not have been able to discover this variety of clarifying and valuable findings and to write the thesis.

I am very grateful to Prof. Andreas Helier and the ‘Department of Palliative Care and Organisational Ethics’ in Vienna (Faculty for Interdisciplinary Studies/ University of Klagenfurt), for their friendly support during my fieldwork in Austria, and for offering me the possibility and means to attend the ‘8th International Conference on Ageing’ in Copenhagen.

My special thanks go to Prof. Sjaak van der Geest, my faithful supervisor, who accompanied me in all phases of developing and conducting this study and assisted me with his advice and his always valuable ideas. I also wish to thank Pride Linda for reading my thesis and for very helpful comments.

Finally, I would like to express my gratitude to my family, in particular to my parents, and to all other people around me, who supported me in various forms, whilst writing this thesis. I am especially grateful to Ursula for helping me with her continuous and inspiring energy at my side and for her understanding patience with me during the whole period of preparing, undertaking and completing this study.
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Chapter I

Introduction

Ageing populations have expressed increasing concern about the social and the economic consequences of this development for today and the future. ‘Health in old age’ or the concepts of ‘healthy ageing’ and ‘successful ageing’ (Rowe & Kahn, 1987; Kahn 2002) appear thereby as major components of such concern at different public and societal levels.

To age in good health and to maintain independence and health as long as possible, even in very old age, are not only high goals for individual persons, who tend to deny their own ageing, and fear frailty and dependence in later life (Bytheway 1995: X; Schirrmacher 2004). They are also of political-economic interest, affecting the future sustainability of welfare states and health care systems and of great importance for biomedical science and research, where combating physical diseases is a professional priority and where concepts of ‘healthy ageing’ have become internalized standards (Carnes et al. 2005: 22).

But it will be a great future challenge to fulfil these high expectations and values at all different levels as the transformations in the age structure of our populations seem to be “unprecedented” (Commission of the European communities 2005: 2) and taking place in a remarkably short time (Walker & Maltby 1997: 11). Eurostat projections predict, for example, “that the share of elderly people (65+) will grow from about 15% in 2000 to about 30% in 2050 (Grammenos 2005:1). Austria, a member state of the European Union where this research has been conducted, is affected by these transformations too and can therefore serve as one example for a wider development. In order to react accordingly to such significant demographic changes in the future and to do justice to central concerns within our societies, we will have to prepare and adapt our health care systems, the orientation of future research and our own attitudes towards the ‘problem’ of ‘health in old age’. This is especially so as we are all partaking in the continuous process of ageing.

But what is ‘health in old age’? And what meaning does a concept of ‘healthy ageing’ have for different people, generations and public stakeholders? A variety of different underlying
Interests and viewpoints, which depend on one's individual situation and often quite temporal position within a society (Ewing 1998; Westerhof et al. 2003), may be inherent in such taken for granted terminology. This can create substantial confusion and misunderstandings and, if not recognized, mislead important decision making on the orientation of policy and research strategies and about future necessities in health care systems, which may, ultimately, not be in accordance with the real needs and health priorities of older people themselves.

Additionally, we are facing the dilemma that life expectancies are currently growing faster than the ability of modern biomedicine to combat or even eliminate certain age related diseases (Carnes et al. 2005; Howse 2005). This means that in the future an increasing share of people will age while experiencing forms of chronic illness, disability or dementia. Thus, although, it became possible to ‘compress’ morbidity into very old age (Fries 1980), it appears that in the future we will face the ‘uncomfortable’ situation where new forms of medical intervention, better treatment of diseases or advanced technological inventions alone can obviously not guarantee a form of ‘health in old age’ as it has been widely understood and defined so far.

Against this background two specific research questions have been addressed in this exploratory study in Austria.

1) What priorities and interests do people at different levels in Austria have when they speak about ‘health in old age’ and what do they regard as most important components or as ideal definition of ‘healthy ageing’?

2) What contributions do they think will be necessary and what changes in the Austrian health care system are expected to support such a reformulated concept of ‘healthy ageing’ in the future?

The sequence of these questions intends to first clarify basic terminology and to reformulate a concept in accordance to interests and expertise at different levels, before asking for feasible support and contributions to this concept in a second step.
A medical anthropological approach and previous research

The questions posed above are obviously broad and ambitious. But it is not the purpose of this small and exploratory research to come up with quantitative and statistically representative data nor to predict or even solve future scenarios in Austria. It is far more the objective of this study to provide an overview of wider tendencies and to render what is “at stake” (Kleinman & Kleinman 1998) for people in various positions. Medical Anthropology can thereby provide qualitative research methods, which allow to adapt a new perspective on and to raise questions about taken for granted circumstances.

Adapting and exploring different perspectives will also play an important role in the course of this whole study. First, a theoretical ‘background’ discussion about perspectives on ‘ageing, health and future’ is based on the statement that perspectives or ‘ways of seeing’ affect ‘ways of knowing’ and in turn ‘ways of doing’ (Sidell 1995). We will complement this statement and add a preliminary step as we find ‘ways of seeing’ affected and intrinsically shaped by underlying interests at different societal and public levels. Then, the study will move on to ‘a foreground’, that is, the reality in the field. A multi-level perspective will thereby be used to explore experiences and viewpoints of older people, families, health professionals and policy makers at the same time. By ‘translating’, describing and interpreting their various interests and views it is intended to understand basic needs, to identify desired changes in the health care for ageing people in Austria and to outline crucial themes for future research and intervention.

Many studies, which have been undertaken on the topic of ‘ageing and health’, have mostly concentrated on a single level or have, for example, compared the differing understandings of ‘health’ or ‘life quality’ between two levels, e.g. between medical professionals and older people (Covinsky et al. 1999; Faber et al. 2001; Koch 2000). They have either focused on urban settings or on rural areas (see Phillipson & Scharf 2005; Wenger 2001), and many of them have been conducted in hospitals or care facilities, which has probably contributed to the more negative image of ‘health’ in the older years. Therefore, and for the complexity and dynamics of the underlying research problems, it appears as a necessary and challenging task to perform a study, which intends to look at and from different levels and backgrounds at the same time.
Although, a lot of previous research work has already clarified that there are misunderstandings between generations and people of different societal levels and that the present situations and services are not satisfactory or promising for the future, few ideas for improved approaches and creative concepts towards the future of aging and health have yet been presented. This study aims to take a first step in filling this gap.

The setting: Austria

The country of Austria has a dimension of 83,853 square meters, currently around 8.2 million inhabitants and the demographic developments reflect wider European trends and predictions (source: Statistik Austria 2005). In the year 2004, people aged 60 years and over constituted 21.9% of the Austrian population, a share which is predicted to grow to 33.5% by the year 2050 (Statistik Austria 2005). The average life expectancy at birth is currently 76.4 years for men and 82.1 years for women (Statistik Austria 2006) and the official age for retirement is 65 for male and 60 for female employees. The majority, around 75%, of people in Austria are Roman Catholics, followed by around 5% Protestants and other smaller religious groups (Statistik Austria 2005).

The capital of Austria, where a large part of the planned research has taken place, is Vienna with 1.6 million inhabitants (Statistik Austria 2005). The geographic and topographic situation of Austria as situated within the Alps lends itself to a variety of different possible sites for this study. Beside the city of Vienna, Graz, a smaller town in the south of the country, has been another location for the research and interviews have also been conducted in a rural area in the province of Styria (Steiermark).
Chapter II

Methodology: Studying views and interests at different levels

The study was designed as a qualitative exploratory study. In planning the research it was my intention to contribute to the answering of the question:

- How will we be able to take good care of the ‘health’ of a growing number of older people – and ourselves – in the near future?

It was through my profession as a medical doctor, my work experience with older people in hospitals and consultancies in Austria and my study of ‘Medical Anthropology’ during the last year, that I was motivated to investigate more in depth this topic. Many times, while preparing this study, I felt overwhelmed by the enormous dimension of my project and I feared my incapacity to come up with sufficient and meaningful data on such a wide question.

Already the three dubious terms, ‘ageing’, ‘health’ and ‘future’, which escape a clear definition, often appeared as inaccessible to me. But, finally, it was exactly this difficulty that stimulated me to clarify basic terminology at and between different levels, and to ask people for their personal interests, conceptions and future propositions with respect to ‘healthy ageing’. Moreover, while proceeding in fieldwork, my basic interest and motivation for the research developed into a continuously growing enthusiasm as the topic and the final research questions seemed relevant for almost everyone ‘in the field’. And thus, with great curiosity, I listened to stories, experiences and ideas of my various interviewees.

The research method of a ‘multi-level perspective’

As ‘ageing, health and future’ affects societies as a whole and not only a particular group of people, the research approach of a ‘multi-level perspective’ appeared as most appropriate method for this study. I chose this method with the intention to make use of a more dynamic and participatory approach towards a complex issue. It was thereby my primary and central purpose to explore and compare the viewpoints of people at the following five levels:
I. Older people (75+) in good physical condition
II. Older people (75+) in reduced physical condition
III. Families (related or unrelated to ‘older people’)
IV. Health professionals (in hospitals, caring institutions or general practitioners).
V. Policy makers (incl. officials from national health insurance companies)

At this point it is important to clarify the term ‘level’ as I use it in the study. On the one hand, ‘levels’ can be seen here as a rough grouping of a wider society into different organisational structures and groups of people with ascribed tasks and roles or as exposing characteristic patterns like ‘physical health condition’ or ‘age’. Such grouping neither aims to create a specific kind of categorization, nor should it be abused to represent ‘levels’ in a hierarchical order. However, specific interests at and power-relationships between these ‘levels’ are often evident and can generate particular perspectives, as we shall see in chapter III.

On the other hand, the term ‘level’ refers in this study to a certain position of individual people. Depending on the context, the personal situation or the professional circumstances people perceive and define their self and identity differently (Ewing 1998) and take positions, which are built up on underlying and pursued interests. But as the context, situations or circumstances are always changing they continuously have to reorganize and readjust their perception of identity and in turn their positions and viewpoints. In respect to the dynamics of our ageing process, Westerhof et al. (2003) describe this phenomenon of changing interests and meanings and the continuous re-positioning of people, who, at the same time, experience remarkable consistency and stability of self and life as the ‘ageing paradox’. We will again meet this ‘paradox’ in the course of the next chapters.

Thus, when I use the term ‘level’ I am not only referring to a specifically characterized social group but very much to the individual position of people with their personal viewpoints and interests.
Five differently defined levels more closely

In applying purposeful sampling criteria I aimed to provide an insightful variation at and a range of contrasting cases between the five above listed levels of this study. I tried to recruit a balanced mixture of men and women from urban as well as from rural areas in Austria and from different socio-economic backgrounds in order to ensure good variability of the sample.

The first and second level (I + II) includes a total of nine older people between the age of 75 and 85 as participants. I distinguished older people in apparently ‘good’ (four participants) and apparently ‘reduced’ physical condition (five participants) as I expected that statements and opinions about ‘health in old age’ would much depend on the current physical condition of a person. I was aware that the coping mechanisms and subjective perceptions of what is a ‘good’ and what is a ‘reduced’ condition might vary significantly within each of the groups. For this reason I planned to select quite contrasting cases, and thus I recruited all ‘older people in reduced physical condition’ from within a hospital. But it was surprising and significant for this study, at the same time, how difficult it remained – even for me with my medical background – to correctly assess a person’s pure ‘physical condition’ as a separate entity or criterion.

At the third level (III), ‘families’ were chosen as representing the older people of the future and as those, who are presently making their intergenerational experiences with ‘health in old age’ and are thereby developing certain opinions and ideas about ‘healthy ageing’. Selection criteria at this level were widely defined. ‘Families’ included all younger generations under the age of 75 as far as I expected that they could generate ‘rich information’ for the objectives of the study (Curtis et al. 2000: 1003). This does not mean that people aged 75 years and above do not have or belong to a family, but rather that they should, for practical and structural reasons of this research, be represented at another level. I ended up interviewing six family members between the age of 36 and 62.

The fourth level (IV) represents ‘health professionals’. It has been established as people at this level are usually exposed to high expectations from other societal levels and are confined to professional and scientifically defined standards and ideologies of ‘health’ (Carnes et al. 2005: 22). The voices and experiences of two general practitioners, two hospital doctors, the
management director of the hospital and the medical director of a nursing home in Vienna (in total six participants) are represented at this level.

The fifth level (V) has been reserved for Austrian policy makers in the sector of health and health-care. I expected that ideas and priorities at this level would be influenced by growing financial and economic constraints on a welfare state and by therefore current policy strategies. I have conducted three interviews at this level. One with a high medical officer in the Austrian Federal Ministry of Health and Women, one with a health politician in the municipal authority of the city of Vienna and one with an official from a large public health insurance company. I wanted to include the latter viewpoint, as insurance companies appear to be exposed to a tension field of differing interests of health-care providers, patients and larger policy strategies.

Data collection methods

A review of selected literature, ...
which are continuously and extensively published on the topic of ‘ageing and health’, can be seen as my first and basic method of data collection for this study. It is a never ending process, which has given me a lot of insight and has provided an important basis for my whole research, as well as for the more theoretical background discussion in the next chapter. Literature, written by an author or published by an institution, also represents a certain viewpoint or interest from a specific position and should therefore be taken into account when applying a multi-level perspective.

Interviews and discussions in the field
A total of 22 semi-structured qualitative interviews were undertaken at the five research levels. In four of the interviews two informants participated at the same time, which created the atmosphere of a more open conversation. Interviews lasted between 30 minutes and one and a half hour and were all tape recorded and complemented with field notes. I interviewed an older couple in Vienna twice as they provided a lot of interesting viewpoints and information and became sort of core participants, who I planned to present as examples of cases in my study.
A set of three specific questions in combination with several sub-questions were used as a rough guideline and orientation for building up my interviews:

1.) What do you regard as central components or as an ideal definition of ‘health in old age’?

2.) How do you think your ‘level’, institution or generation might contribute to such a concept of ‘health’ or ‘healthy ageing’ in the future?

3.) What do you think or expect other levels should/will contribute and how will they have to change in order to manage a continuously increasing population of older people, who want to age ‘healthily’?

The wording of specific questions depended on the concrete interview situation and level and changed slightly during the course of the research process in line with the inductive character of this study. It turned out to be a helpful and inspiring aspect to confront interviewees at one research level with viewpoints and opinions of participants from another level.

After explaining the nature and purpose of the study, and ensuring confidentiality, informed consent was obtained from all participants. I usually started a conversation by asking my interviewees about their personal situation and their experiences with ‘healthy ageing’ – either referring to themselves or to people in their surrounding. In using such personal examples and descriptions I tried to create a basis and context for the following interview and people usually became more involved and empathetic with the wider topic. While moving through the three core questions I also provided some background information about current demographic developments and tried to reveal the concerns, interests and ideas of my interviewees as representing a specific position or level.

Direct observation...

was a continuous process, while conducting interviews and discussions. I expected that statements about ‘health in old age’ or ‘healthy ageing’ would be intrinsically influenced and shaped by the context in which they are made (van der Geest et al. n.d.). Therefore, I took notes about the circumstances of an interview or the personal situation of an informant. I found this information very valuable and helpful, especially later on when analyzing and interpreting data or quoting particular parts of conversations.
Reflections from ‘experts in the field’

In addition to semi-structured interviews at five different levels and a continuous literature review, I also met with several researchers and experts in the field of ‘ageing and health’. In this way, I obtained comments and overall reflections on my research questions or on particular themes of the study.

For four days during my period of fieldwork I attended the ‘8th Global Conference on Ageing’ in Copenhagen (30th of May – 2nd of June 2006). There I had the opportunity to visit many different lectures and presentations on a broad variety of topics and to interview two international researchers (from Denmark and from the US) more in depth.

In Vienna I had a conversation with the 81 year old and still professionally active sociologist Leopold Rosenmayr, who is an international, well-known expert in the field of ageing.

Finally, Prof. Heller, chair of the ‘Department of Palliative Care and Organisational Ethics’ of the ‘Faculty for Interdisciplinary Studies’ (University of Klagenfurt) offered me the opportunity to present my research project at the University and to receive feedback in a subsequent focus group discussion with six scientific collaborators of the department.

All information and comments I gathered by this way have been used during the period of fieldwork or have been included when analyzing and interpreting my data.

Quantitative data,...

for demographic background information on Austria and the European Union, has mainly been used in the preparatory phase of this study. In general, the whole research is based on qualitative and descriptive methods and only basic biographic data on participants have been obtained while conducting interviews.

Table 1 gives an overview of interviews and conversations conducted during fieldwork and of their particular locations in Austria.
<table>
<thead>
<tr>
<th>Levels and key informants</th>
<th>Interviews or conversations (with more than one participant)</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>'Older people in good physical condition'</td>
<td>4 1 in Vienna (city) 1 in Vienna (city) - 2 participants 2 in Styria (countryside)</td>
<td></td>
</tr>
<tr>
<td>'Older people in reduced physical condition'</td>
<td>5 5 in Vienna / hospital (city)</td>
<td></td>
</tr>
<tr>
<td>'Families'</td>
<td>5 3 in Vienna (city) 1 in Graz (city) 1 in Styria (countryside) - 2 participants</td>
<td></td>
</tr>
<tr>
<td>'Health professionals'</td>
<td>5 1 in Vienna / GP (city) 1 in Styria / GP (countryside) 1 in Vienna / hospital doctor (city) - 2 participants 1 in Vienna / hospital manager (city) 1 in Vienna / nursing home director (city)</td>
<td></td>
</tr>
<tr>
<td>'Policy makers'</td>
<td>3 2 in Vienna / health politicians 1 in Vienna / official from health-insurance</td>
<td></td>
</tr>
</tbody>
</table>
| Researchers  
In the field of 'ageing'  
(key informants) | 5 2 in Vienna 2 in Copenhagen / conference 1 in Vienna - focus group discussion (6 participants) |          |
| **Total** | **27** |          |

Table 1

**Finding participants in Austria**

Austria offers a representative example for the underlying research problems and a good variety of different research sites within a relatively small country. Organisational and personal reasons have also been relevant for choosing Austria as location for this study. For me, the researcher, Austria is my country of origin and German, the national language in Austria, is my mother tongue. Thus, the knowledge of common rules and customs and of the local language has obviously facilitated the research process. I have chosen three different study sites, the cities of Vienna and Graz and ‘Ramsau am Dachstein’, a region in the countryside in the province of Styria, where I am familiar with the local communities and know a lot of people. This gave me the possibility to use a variety of personal networks in combination with the snowball sampling technique for selecting and approaching most of my participants. In general, they had all been contacted in advance and asked for their willingness to participate in interviews or conversations.

A hospital in Vienna where I had worked as a medical doctor for about three years, served as an important location for my research. For the first moment it was a special experience for me to come back here, where, on the one hand, a lot of staff and things had changed but, on the other hand, the surroundings were quite familiar. In the end, it turned out that this situation...
generated a good balance of distance and closeness to my research site as well as the ease of getting access to people and their ideas and practices. I interviewed two doctors (Dr. Fried and Dr. Gabriel), as well as the management director of the hospital (Dr. Stein). In the internal wards of the same hospital it was possible for me to find and recruit – with the friendly support and advice from medical and nursing staff – five ‘older people in reduced physical condition’ (Mrs. Gruber, Mr. Kraus, Mrs. Anders, Mrs. Bergman, Mrs. Heid), who agreed to help and participate in my study. My profession as a medical doctor also facilitated me to get into contact with two general practitioners (Dr. Bauer in Vienna and Dr. Horn in ‘Ramsau am Dachstein’) and to conduct interviews with them.

By using private networks and snowball sampling technique I found informants for the level of ‘older people in good physical condition’ (Mrs. and Mr. Burger, Mrs. Rieder, Mrs. Kolb, Mr. Wild) and the level of ‘families’ (Mr. Unger, Mr. Pold, Mrs. and Mr. Maler, Mrs. Lang, Mrs. Grundner). People were very friendly and open in helping me to identify further interesting or interested participants for my research. Mrs. and Mr. Burger, who turned out to be central informants, were found by complete chance as they were living in the same house with me whilst I was in Vienna. In general, and probably due to the fact that we are all ageing and that the research problems highlighted in this study thus affect everyone within a society, it was not very difficult for me to recruit enough participants.

Informants in the political or official positions (Dr. Hrabcik, Dr. Schmidl, Mrs. Baumer) had already been contacted and asked for their willingness to participate by telephone or e-mail during the preparatory phase of the study.

As conducting interviews during my fieldwork was dependent on the time schedule and availability of a variety of people in the different positions, my work-plan had to be flexible in design and diverse as well. I found myself moving quickly from a hospital to the Ministry of Health and then to the home of an older person or a family within one or two days. This generated an exciting feeling of being a broker of – lively and fruitful – communication between different levels, professions and generations.

Finally, with the help of private and professional networks and, additionally, by attending the ‘8th Global Conference on Ageing’ in Copenhagen, I had the chance to meet with national and international experts and researchers. They participated, either in individual conversations
(Dr. Vogt; Dr. Lewinter, PhD; Dr. Smith, PhD; Prof. Rosenmayr), or in form of a group discussion (‘Department of Palliative Care and Organisational Ethics’ / Prof. Heller) in my study.

All mentioned participants of this study and my encounters with them are briefly presented in an Appendix.

**Data analysis**

As soon as possible after interviews or discussions, I checked my field notes for completeness and, if necessary, completed them with comments or important cues that I had remembered. Taped conversations were not transcribed word for word, but rather summarized. Only key statements were transcribed literally and complemented with information from written notes about any relevant context.

After that, I used manual deductive coding in combination with inductive coding techniques in order to identify and categorize important and the more frequently discussed research themes. Already during the course of data collection, I intended to use interesting viewpoints and new emerging themes in subsequent interviews or discussions. I also designed graphical documentation in the form of tables or diagrams with the intention of getting a better overview and to compare the most crucial findings at the five different levels. Finally, while writing my report, I incorporated helpful comments and reflections from researchers and experts in the field, which contributed to the interpretation of data and the final conclusions of the study.

All interviews were conducted in German. When summarizing taped conversations I directly translated the content into English. In general, but especially when transcribing literal quotations, the translation was very carefully, paying attention not to change the meaning of what had been said by my participants.

In conclusion then, for me as the researcher, the whole process of transcribing and analysing interviews and of drawing tables or diagrams, has contributed a lot to a careful and conscious reflection on revealed data. It enabled me to recognize the variety of interests and viewpoints
of people at different levels in a contextualized way. But, I also identified that it would not be a useful or valid strategy to directly compare and contrast five different societal or research levels, as I had planned initially. On the one hand, my sample size at each level were simply too small and, on the other hand, even with a lot more participants, it would have been impossible and against the basic idea of this research to generalize or categorize the situations of individual people. I found the participants often taking positions ‘in between’ my wider research levels or as having valuable expertise at more than one of these levels at the same time. For this reason, I maintained the levels as a rough grouping of society but my focus was more on comparing and interpreting individual viewpoints and interests in the context and influence of different societal levels.

Limitations of the study

Although, the design and methods of this study appear as more appropriate for the dynamics and complexity of the current research problems, the limitations of an ambitious project also have to be recognized and presented. Obviously, a small scale and first exploratory study can only reveal a very small amount of information. Participants were selected from various backgrounds and levels and the quality or length of interviews could not be standardized, as each interview situation was different from the next. Also, as mentioned above, due to time constraints the number of people interviewed was limited. But, on the other side, it was the aim of this study to provide a first impression of the diversity and complexity of a situation and to find out about the needs and get ideas for new approaches, rather than presenting or claiming complete or statistically representative data.

It was often not an easy decision to exclude or restrict certain themes in my research. This was necessary in order to respect, on the one hand, the exploratory character and limited framework of a small study and, on the other hand, to preserve a certain focus on particular themes that emerged from my interviews. For example, I was neither able to include a separate discourse on the gender aspect of ‘ageing and health’, nor to elaborate in sufficient depth on the wide topics of euthanasia or palliative care. Also ‘dementia’ as a theme of growing future importance or the complex financial aspects of ‘healthy ageing’ would deserve a more focused attention, which would have exploded the framework of this exploratory
study. These limitations have thus been highlighted here to avoid the impression that important themes have been underestimated or neglected at all.

**Ethical issues**

It was an essential consideration in conducting this exploratory study that it was ethical and that the privacy and interests of all participants could be guaranteed. I always explained the nature and purpose of the study before collecting information and gave the participants the opportunity to ask questions about the research. Voluntary informed consent and the permission to tape record conversations were obtained from all interview partners. They were informed that all collected data about them would be kept confidential and only used in conjunction with the writing of the study. With the exception of policy makers and researchers, I decided to use pseudonyms for all participants and told them about this decision before the interview. They were also informed that they could receive feedback or have insight in the final results of the research if they so wished. Finally, it should be mentioned that people with severe cognitive problems, who would have had difficulties in understanding the questions asked, have not been included in the selection criteria for this study.
A background

Chapter III

Varying perspectives on ageing, health and future

Ageing has become an issue central to public and scientific interest in our societies. Demographic trends in the structure of populations have stimulated a wide range of research efforts, hardly excluding any scientific discipline from entering the field of discussion. In this way, a variety of perspectives on the consequences of increasing life-expectancy, on the biological aspects of ageing and, in particular, on the older people themselves – often labelled as the homogenous group of ‘the elderly’ – has been generated and shaped.

Yet, it is a trait of perspectives which are usually taken from the ‘outside position’ and which are themselves rather static and focused on specific parts of a larger and dynamic reality, that particular and different interests are prevalent for people. But, at the same time, they can be powerful and influential for the wider social attitude and action. And thus it is, according to Sidell (1995), that different perspectives or “ways of seeing” affect “ways of knowing” and in turn “ways of doing”.

Departing from this idea and based on reviewed literature, the first part of this chapter aims to explore how, at different public and societal levels stereotypical and often one-sided perspectives on older people and their assumed health priorities are being developed. It shall be outlined what concerns they carry and what impacts such ‘ways of seeing’ can have on attitudes at the other levels and on the lives of older people themselves. Understanding that ‘health in old age’ is one of the major concerns within such perspectives and in our modern societies as a whole, the second part of the chapter will then briefly examine what might be necessary in order to adapt rigid perspectives more appropriately to arising challenges of the future.
I. Powerful perspectives on old age and health

At first glance, one may probably identify two common and dominating perspectives on the generation of older people in our societies. The first perspective gives rise to very negative, deterrent and frightening connotations and labels older people mainly as 'the burden on society' and as the growing and homogeneous mass of dependent and chronically sick 'elderly'. The second perspective, which seems to carry more positive images, represents old age mainly as a pleasant and active stage of life, where people are finally able to enjoy their pensions, where they have time for their 'well-being' and where they become consumers, travellers and pleasure seekers. It is thus a picture of the 'fit and the frail' that is represented in such highly stereotypical perspectives on old age. Perspectives or "ways of seeing" that are "all based on very powerful myths", as Sidell puts it (1995: XVI). In her research she uses the term 'myth' in order to describe the views, opinions and assumptions that are prevalent and in common usage "but whose claim to validity is debateable not because they are untruths or fictions but in so far as they claim to represent 'the' truth" (Sidell 1995: XVI).

But why are such strong and popular perspectives generated at different levels of a society? What concerns and interests do they carry? How are they shaped? And what are their possible impacts on the perspectives and attitudes of other levels, and thus, on common and general 'ways of seeing'? In the following three sections, I will address these questions by looking at three different public levels or 'outside positions', namely the political-economic arena, the societal or individual level and the level of biomedical science. All these levels seem to have different interests as they are differently related to or affected by the 'problem' of old age. Therefore, they develop focused and often stereotypical viewpoints, which, finally, confirm and influence each other in their concerns.

The political-economic arena

The picture of the 'fit and the frail' appears to be quite contrasting and mutually exclusive. It appears to represent a positive versus a negative perspective and gives the impression that there exists a more and a less 'successful' way of ageing. I will argue that, on a closer and second look, these two perspectives are not so different and contrasting. They appear rather, as transporting one and the same ideology and orientation towards a 'matter of public
concern'. Nowadays, the growing number of old and always older people, in combination with reduced birth rates and increasing costs in the health care sector has become an enormous matter of such concern for policy and economy. What once was the ‘golden dream’ of old age and longevity seems nowadays to have mutated into a threat and danger to the stability of our welfare states. Warnings of ongoing demographic developments and future scenarios come from the highest political levels and are often expressed in dramatic language and terms.

Without doubt, we are facing a new era of ageing within our societies and a distribution of age groups, which, in this form, has never existed before. And the identification of these future challenges has generated a certain tone and language in a political-economic arena. On the one hand, a sometimes strong and even dramatic ‘way of seeing’ and presenting is probably necessary, at this level, in order to adjust to a common way of political discussion and to receive the appropriate attention for an arising ‘problem’. To better define, demarcate and approach such a ‘problem,’ it might even be understandable that an effort is made to look at it and represent it as one homogenous entity, that is a single object. But, on the other hand, by mainly “concentrating on numbers and using terms like ‘the rising tide’ and ‘burden of dependency’ the individual and her/ his experience is lost and the problem becomes ‘the elderly’ who are blocking hospital-beds and devouring resources which could be put to better use” (Sidell 1995: XVI). Thus, this is the first step by which a political concern and perspective can influence other levels in society and generate a broader public opinion or at least a common ‘assumption of knowing’ and stereotyping toward ‘the elderly’.

The second popular perspective, which depicts older members of our societies primarily in relation to well-being, fitness and pleasure, seems to be of more recent origin. This has to do with a slightly increasing and somehow positive recognition that “the terminology used to describe this group and the associated metaphors – elderly, old, retired – seem to be out of tune with their subjects” (Walker & Maltby 1997:17). Nowadays, a distinction is made “between the third age (50-74) – seen as the period of life when, freed from paid work and parenting, people can involve themselves in active, independent life – and the fourth age (75 and over) – the age of eventual dependence” (Laslett 1987, 1994; Midwinter 1991). The Austrian sociologist Leopold Rosenmayr (2005: 8) describes how the period of old age is currently praised and styled with the help of advertisement for wellness and travelling and with cosmetics and “happiness pills”. Older people, in particular those in their ‘third age’,
represent a new target group for economy and marketing. In order to reach this growing group of new consumers, advertising campaigns are needed, and from television, brochures and packing materials of healthy food or pills we are all familiar with the image of happily smiling and ‘successful’ elders. But to what extent, can such conceptualizing perspectives and simplified ‘ways of seeing’ represent ‘the’ or at least ‘a’ truth?

Obviously, it would be a mistake to equate retirement nowadays with “the straightforward entry point to old age” (Walker & Maltby 1997:13) or dependency. There is even a positive trend that not only life expectancy but also the expectancy of life years without “age-specific disability” is increasing (Howse 2005: 4) and that life-threatening diseases can be more and more compressed into very old age (Fries 1980). But what about those people who suffer from chronic diseases or disabling health conditions already before their ‘fourth age’? Those who are sixty years old and who feel well and successful in their lives but are dependent on the help and assistance of others? And what about those who are in their ‘fourth age’ and still enjoy good ‘health’ and independence? ‘The’ truth seems to be far more complex. Praising and advertising one certain group and category of old people, which, additionally, turns out to be only of the upper class who can afford the offered wellness and pleasure (Rosenmayr 2005:8), does neither acknowledge the heterogeneity of real life nor of this generation in particular. It contributes, rather, to a generation of stereotypical positive views on one group or category and reinforces thereby a negative and generalizing ‘assumption of knowing’ about another group of people. As Sidell (1995: 163) describes it, it “serves to reinforce the worship of fitness and adds to the disadvantage of those who do experience chronic illness and disability”.

I argue, therefore, that a perspective which distinguishes between the ‘third’ and the ‘fourth age’ and between the ‘fit and the frail’ is only able to capture certain aspects of a whole truth and reality, a ‘way of seeing’ that is mainly useful and consistent from one specific level. It seems that in propagating older people as ‘the consumers of tomorrow’ policy and economy have recognized at least a small chance of compensation for the financial and social burden, which this group of people has already imposed on the state. And to motivate them to stay fit, active and ‘healthy’ helps to reduce their demands on cost-intensive health care services and empowers them as consumers at the same time.
In this sense, the two common perspectives on ‘the elderly’, which I introduced in the beginning of this section, do not appear so different and contrasting any more. They both deal with one and the same concern, interest and ideology and seem to have their main roots in a political-economic arena. But they are powerful myths and ‘ways of seeing’ and by this way they have an important impact and influence on other levels, hence, also on a wider society and the attitudes of individual persons as I will outline in the following section.

The societal or individual level

For a wider society and thus, for each of us, strong and influential perspectives as described above and as created on ‘higher’ national and international levels provide a certain framework and basis for taking a particular point of view on older generations. This is, somehow, a framed and static view, such as looking out through the window of a house, to witness a certain ‘problematic’ group of people from a safe distance.

According to Schirrmacher (2004:13), no human being likes to get old. A statement that is somewhat debateable. However, it appears that we tend to look with ambiguity and scepticism at this phase of life. Our attitude even involves a certain form of “denial of our own ageing, a fear of personal old age which leads us to treat older people as, somehow ‘a race apart’, different from ourselves or what we can bear to think we might become” (Bytheway 1995: X). Alienating ourselves from older people and looking at them, from an ‘outside position’ with feelings of fear, ambiguity and insecurity about our own future makes us obviously more susceptible and vulnerable to stereotypical perspectives which are given by ‘higher’ levels of politics and economy and which then easily become internalized views on ‘the elderly’ within a whole society. Walker and Maltby (1997: 9) even go so far as to note that “the adverse effects of social policies on older people often result in the dominant values towards them remaining age discriminatory or ageist”. This is not to say that such a negative perspective and the extreme attitude of ageism – which Butler and Lewis (1973) define as “the systematic stereotyping of and discrimination against people because they are old” – is the predominant or most common perspectives of the wider society on an older generation. But it is obviously a way that permits younger generations to regard older people as distinct from themselves and to cease identifying with them (Butler & Lewis 1973). The question remains, what generates such a strong desire for distance and separation?
Part of the explanation may be a basically 'human', but also a culturally constructed feeling that makes us fear death and thus, the proximity to death in old age as well. The famous Austrian writer T. Bernhard, for example, knew how to describe, very well, how we as a society and as humans prefer to avoid the misery of the sick and the dying. Fear and insecurity may also be a reason why it is that we find "the proximity of chronic illness discomfiting" (Sidell 1995: 65). But additionally, it is my intention here to demonstrate that an important part of the explanation for a certain attitude and perspective towards older people in our society – particularly, frail older people – is also a consequence of internalized 'ways of seeing', which can find their roots at other levels, e.g. a political-economic arena. It is not surprising, therefore, that a society tends to distance itself from a whole generation, which at official levels is often represented negatively as burden and threat or as a homogenous group of economically and physically dependent people, which give rise to social and fiscal crises. Nor is it surprising that dependency and frailty in old age is highly feared, if it is propagated that one has to age 'successfully' and 'healthy' and should always be able to participate in the wellness, fitness and happiness of our consumer-world. It appears that disability and chronic illness are "shameful, to be hidden away and not admitted to...because they render people incompetent by the standards of fitness aspired to by the rest of society" (Sidell 1995: 163).

Personalizing and simplifying the complex problem of demographic changes in the form of 'the elderly' and in emphasizing the fit and the 'healthy' old people in a political-economic arena has, therefore, important implications and problematic ethical consequences for 'ways of seeing', for 'assumptions of knowing' and finally, for ways of caring for and caring about older people and their 'health' within the wider society. On the reverse, strong opinions, common assumptions or personal insecurities of individuals at this level will also influence or even determine a certain political landscape.

Exposed to the mutually reinforcing perspectives and expectations of the political-economic arena and the wider society is the field of biomedical science and research, a level that I will explore in the next section.
The level of biomedical science

To take a focused perspective or a concentrated view on certain circumstances in order to identify and investigate underlying problems or detailed aspects of these problems is a very useful and effective tool in the field of science and research. Shedding light on a small part of a larger structure can help a scientist to separate a problem from other disturbing factors and influences. Almost metaphorically here, appears the example of a surgeon who focuses his spot light only on the operation field of the patient he is going to operate on. Such a form of concentration is an important factor that makes effective scientific work possible. And in the one or the other form, we are all often users and beneficiaries of its results and possibilities.

With the help of such concentrated research, modern biomedicine has also been able to combat and reduce a lot of diseases, which typically appear in older age, and to invent new pharmaceuticals and methods of intervention. This science has contributed to a “compression of disease” (Fries 1980) into very old age, and, in combination with the ability to delay the natural moment of death, the contributions and working ideologies of modern medicine are very much in accordance with the expectations and perspectives of societies, where (life-) threatening diseases and death are most feared and preferentially denied.

But problems remain unresolved. It seems, for example, that even with the best medical treatment of diseases or their complications, our natural process of biological ageing cannot be influenced (Carnes et al. 2005: 22). As such, certain forms of disease intervention may even contribute to “augment the burden of age-determined morbidity by converting lethal diseases to chronic diseases. Further, by delaying death these interventions provide more time for age related pathologies to emerge (Olhansky et al. 1998; Wilson 2004)” (Carnes et al. 2005: 22). But how will biomedical science and research be able to manage and finance the treatment of all these “age related pathologies” if more and more people are getting older and older and if the financial resources of the welfare state are getting smaller and smaller? How can they fulfil the strong expectations of politics, economy and society, which hold and praise the perspective of ‘successful’ and ‘healthy’ ageing people? Additionally, medical professionals have internalized such a perspective as well and “the concepts of successful ageing (Rowe & Kahn, 1987; Kahn 2002) or healthy ageing have become standard components of medical training, thinking and practice” (Carnes et al. 2005:22). Thus, how
will they themselves be able to act accordingly to their own high standing working ideologies and principles in the future?

Due to demographic changes and financial constraints, the distribution of resources for biomedical interventions and the orientation of scientific research on health issues in old age have and will become more selective and focused. This tendency will probably become more significant over the next few decades as changes in the age structure of populations continue and it is not expected that the financial sources of our welfare states will recover or grow, possibly quite the reverse. Howse (2005: 4) states that “even the most optimistic of the health scenarios... points to a substantial increase in overall prevalence of disability” and this will happen, especially, over the next 20 or 30 years and with the largest increase of disability rates in people of 80+, who “will triple across the EU by 2050”.

Against this background, instruments of measurement, e.g. the concept of quality-adjusted life years (QALYs) (Baldwin, Godfrey & Propper 1990; Mc. Dowell & Newell 1996), are established with the aim to estimate the impact and burden of a certain disease on one’s life and to identify the most cost-effective interventions in order to re-establish ‘quality of life’ or ‘health’. Debates about different and other forms of rationing, like the reduction of routine screening programs for cancer after a certain age or “decisions not to resuscitate certain older people” (Sidell 1995: 151) are logical consequences of such tendencies. Even the ‘hot topic’ of euthanasia in old age enters the field of discussion and “raises some important anxieties about the implications such a move may have for older people, particularly older people with chronic illness and disability” (Sidell 1995: 151). It seems that “the most health for the money” is required (Hyder et al. 1998:196). And thereby highly sensitive and ethical questions arise on what is ‘quality of life’, ‘success’ or ‘health’ in old age? And which criteria are used and by whom to define these terms? Especially, in biomedical fields, a positive quality of life is still very much defined by the absence of physical deviations, irrespective of a wider context or the potential of an individual’s coping mechanisms. As a consequence, these definitions do not allow “persons with physical conditions deviating negatively from the social norm” to claim a positive life quality (Koch 2000: 422). We will be confronted with these ethical problems and dilemmas more apparently when moving to “the field” in the next chapter.
A lot of research work in social sciences and in medical anthropology over the last years has revealed that ‘quality of life’, ‘successful ageing’ or the term ‘health’, as perceived and measured by professionals or people from an ‘outside position’, has often little in common with the perceptions and priorities of patients or older people themselves (Covinsky et al. 1999; Faber et al. 2001; Sidell 1995; Koch 2000). Often, “quality of life determinations by normal, healthy persons tend to reflect the prejudice, fear or concerns of the observer, not those of the person whose lived existence is being judged” (Koch 2000: 422). A phenomenon described as the “ageing paradox” (Westerhof et al. 2003), which I briefly mentioned in the previous chapter, can partly explain such divergence in viewpoints. The theory assumes a continuous shift in perception and interpretation of life and self as inherent in the ageing process. When the perspective of an health professional, shaped by a focused scientific background and influenced by official and societal opinions about ‘the elderly’, is then confronted with such a phenomenon, it easily happens that “lives which observers consider of poor quality are lived quite satisfactorily by the one living that life” (Jonson, Siegler & Winslade 1982: 111).

Hence, also in the field of biomedical science, ‘ways of seeing’ from one single level and angle can only reveal one certain aspect of a larger reality and of ‘the’ truth. Therefore, medical perspectives on the health situation of their elder patients are often mere ‘assumptions of knowing’. But such assumptions can have serious implications on ‘ways of doing’, on treatment regimes and on general attitudes towards patients in an everyday practice of medicine and can, at the same time, reinforce opinions and assumptions at other levels.

**Closing remarks**

The first part of this chapter has demonstrated how powerful and often stereotypical perspectives on ageing, older people and on the issue of ‘health in old age’ are being generated at different societal and public levels for different reasons. A strong concern about the future of ‘healthy ageing’ appears prevalent and inherent in all these perspectives, which tend to influence and mutually reinforce each other. Thereby they can enter into a cycle and, finally, form an amalgam of static, categorizing or taken for granted views on ‘ageing and health’, which turns into something distant and problematic. But it does not require any high degree of Introspection or self reflection to realize that we ourselves are all partaking in a
continuous process of ageing within ageing societies (Schirrmacher 2004: 11), where nobody can claim an ‘outside position’.

‘Ageing’ or ‘health in old age’ is neither a distant ‘object’, which we have to operate on, nor is it a dangerous state of being or a category of dependency, which just passes by in front of a window. It appears rather as a dynamic process that seems to have much more to do with continuity and adaptation (Faber et al. 2001; Sadler 2004; Börsch-Supan et al. 2005) than with mere categories or particular diseases. In order to cope with such a dynamic and complex process and to act and react accordingly, we will have to set in motion what are otherwise too static and one-sided perspectives. It seems necessary that approaches and attitudes towards the ‘health’ of older people develop a more dynamic character and that different levels and generations communicate their needs and mutually complement – instead of adopt and reinforce – their perspectives.

II. Complementing and ‘setting in motion’ rigid perspectives

I will start this section by briefly looking at another level, namely the field where current research on the issue of ‘ageing and health’ takes place. I shall then outline some ideas and more dynamic concepts, which might be necessary in order to match and approach the challenges of ‘healthy ageing’ and its future.

Specialised research on ‘ageing and health’

The level of focused research on ‘ageing and health’ has and will have important influence on the wider societal and professional attitudes and possible new approaches towards the issue of health and quality of life of older people. With the exception of specialized research institutions, which dedicate their work and investigations explicitly to the ‘pure’ (micro-) biological and physiological aspects of human ageing or explicitly to its ‘pure’ social aspects, most of larger research organizations in this field emphasize a multi-disciplinary approach and seem to acknowledge ‘health in old age’ more within a wider context and as influenced by psychological, social or environmental variables. This can obviously be seen as a positive approach.
Nevertheless, it appears that, despite such an emphasis on multi-disciplinarity, the central focus of interests and the orientation of research work is still very much dominated by the ideologies of biomedicine and by a sort of ‘pathogenic paradigm’ of ‘health in old age’. It is probably not surprising, but even quite natural that, especially at this level, the orientation of research and the distribution of funding for such research is exposed to and influenced by public interests and concerns. On the reverse, tendencies and scientific theories as generated in these research fields may have strong implications for a wider public as well. They can somehow become a ‘model of’ and ‘model for’ (Geertz 1973) other levels. Townsend (1986: 19) even argues that “a body of thought” can be created in these specialties, which legitimates a form of ageism in society and politics as it “attributes the causes of most of the problems of old people to the natural consequences of physical decrescence and mental inflexibility”.

Obviously, the importance and value of physical or mental health in old age should neither be underestimated nor the possible contributions of biomedical research and intervention diminished. It is rather, as Eisenberg and Kleinman (1981) emphasized, “not to diminish the role of the biomedical sciences...but to supplement them with an equal application of the social sciences”.

Supplementing or complementing different perspectives, opinions and experiences can be a valuable tool when we want to achieve more appropriate and effective forms of prevention and intervention in the future. The contributions and insights which the social or also other sciences can offer should therefore not be marginalized as sub-perspectives or abused as mere ‘decoration’ in order to appear modern or multi-disciplinary. Different scientific approaches or views are neither mutually exclusive nor to be feared as dangerous competitors, as a useful specialization of each science shall not be questioned and always remains important at the same time. But it is necessary to rethink sometimes rigid categorizations and conceptualising working attitudes and to continuously ask, if the aims and outcomes of research work or of medical interventions are in accordance with the priorities and what is really ‘at stake’ for older people themselves. It is probably not always so clear for those who develop a new intervention, what effects and dimensions it may have on another level and what forms of mortality and/or morbidity might replace a ‘successfully’ eliminated disease (Carnes et al. 2005: 24). They simply can’t see such effects from the position of their own, single level.
In general, it might be necessary in the field of research to maintain a certain distance from the ‘subject under study’. But in order to do justice to the multi-layered reality of human ageing and health we will continuously have to change our positions and our viewpoints like moving from one window to another in a house. We will have to go out of the house, move closer to the subject of our study and come back again to maintain a good overview. We will have to move around and in and out and set ‘ways of seeing’ in motion. The most challenging, in this, might probably be to find a practical and effective balance between a concentrated specialization and a comprehensive understanding or between a ‘thin’ and a ‘thick’ description in the metaphor of Geertz (1973). This already starts when we are dealing with basic terms like ‘health’ or ‘old age’.

‘Health’ and ‘old age’ – a continuum?

Antonovsky (1984) came up with a new ‘way of seeing’ when he argued that we can not be classified as “either healthy or diseased”, but that we all, also in old age, are continuously moving along a continuum which he calls “health-ease-dis-ease”. He describes:

We are all somewhere between the imaginary poles of total wellness and total illness. Even the fully robust, energetic, symptom-free, richly functioning person has the mark of mortality: he or she wears glasses, has moments of depression, comes down with flu, and many well have as yet non detectable malignant cells. Even the terminal patient’s brain and emotions may be fully functional.

(Antonovsky 1984: 116)

Sidell (1995:15) argues that such a point of view could offer new insights into the issue of ‘health in old age’ and would make it possible to look behind mere numbers and taken for granted categories of diseases. But at the same time, this might also impose problems of vague definition and unclear language as we shall see at the beginning of the next chapter.

If it is proposed that we see ‘health’ as a continuum and not as a certain category, then it would probably be even more arbitrary to regard ‘old age’ as a state of being and not also as a kind of continuum. The situation that the entry point to retirement does not ‘help’ us any more to classify someone as ‘old’ and the fact that nowadays “there is a potentially active pool of older people” (Walker & Naegele 1999: 11) can underpin such an assumption.
Some research concepts point in this direction as well. For example, under certain circumstances, it might be a helpful approach to see ‘ageing’ and ‘getting old’ as a form of psychological transformation or as a slow shift into another stage of life as it is proposed in the concepts of gerotranscendence (Tornstam 1999) or to regard humans as passing a series of metamorphosis throughout their lives (Rosenmayr 2005: 8). There could also be an advantage in accepting death, which in our culture is defined as one specific moment at the end of life, more as a process of dying. Barker (1990), for example, describes such an understanding of death as a process “between humans and ghosts” as very helpful and consistent concept for younger and older people in another culture. And sometimes, one might argue that it is a valid research approach to regard older people as a kind of particular cultural (peer-) group within a society.

But no such concepts and perspectives should ultimately be abused to demarcate or alienate ‘the elderly’ and to see ourselves apart and excluded from the communal and continuous process of ageing. Not at least for this reasons, Rosenmayr (2002) calls for a “new culture of ageing”, which will probably also have to include ‘a new culture of health for the ageing’. In order to work successfully on such a cultural project, new forms of responsibility, solidarity and creativity might be of need.

New ‘ways of responsibility’

Sidell (1995: 111) states that “most of the time people take care of their own health”. This is, on the one hand, an important fact, which sometimes seems to be overlooked, when dramatic future scenarios of a growing dependency in old age are painted. On the other hand, discussions about the future role of families in the care taking of older people are more than reasonable. Opinions and research results about the increasing or decreasing desire of families to take care of their older family members and their health in the future seem to be quite divergent (Laslett 1971; Qureshi & Walker 1989; Berger-Schmitt 2003). However, based on a large European survey, Walker and Maltby (1997: 103) write that “as far as European senior citizens are concerned, the family is less willing to care for older relatives”. But then, who will be more willing to take responsibilities in the future?
At the professional level, biomedicine seems to face quite a paradoxical situation as well. On the one hand, a ‘holistic’ medicine is expected, which can offer treatment for a whole person and not just a passive body by taking into account peoples life circumstances. On the other hand, “biomedicine is criticized for its tendency to incorporate more and more dimensions of everyday life” which results in a “medicalization of life” (Hadold 2001: 142). Thus, where shall ‘medicalization’ start and where shall it end? What will the future responsibilities of a hospital ward be, when the number of older patients with chronic, but not disabling, diseases increase continuously? Will these responsibilities be those of specialized and, therefore necessarily focused, medical interventions, or can they cover a broader care-taking in combination with ‘soft’ medical support? In the latter case the problem and reasonable fear arises that “‘expensive’ older patients will not prove attractive to hospitals” any longer (Walker & Maltby 1997: 98). Additionally, Sidell (1995: 112) describes the problematic situation that on the one hand, older people are inappropriately taking up acute - and expensive - hospital beds and that on the other hand, the services that are provided there often do “not meet their needs”. These are circumstances, which I can definitely confirm from my own professional experience with older hospitalized patients. However, long-stay beds in specialized clinics will obviously have to be reduced in the future (Walker & Maltby 1997: 98) and a better adaptation of facilities and responsibilities, which can meet the needs of ongoing demographic changes more appropriately, will be necessary.

In the end, the question remains of the possible future role and responsibility of general practitioners. Will and shall they provide a mainly medical service or is it realistic to expect from them to take a more ‘holistic’ view on the health and ‘well being’ of older people, including all wider social and psychological affairs of a person. Fainzang (2000: 36) writes that “it is striking to see how many people go to see a specialist when they have functional or organic disorders, but go to the general practitioner when their problems are more social or psychological”. But the current problem seems to be that most national health insurance systems do not reward a general practitioner for such time consuming procedures. There is a continuous lack of time and then, the only possible solutions for these doctors are often to rapidly prescribe pills and pharmaceuticals against social and psychological problems. The result are elders who end up with much more prescribed drugs than they are willing to take or able to manage (Sidell 1995: 125). This can neither be a satisfactory nor an affordable future scenario or ‘way of doing’.
Solidarity in research and caring

Older people, those for whom a lot of new health care concepts and medical approaches shall be developed in the future, are probably the first level that should be asked and integrated more intensively in the planning process of such developments. Although, as I outlined above, there are a lot of potentially active older people (Walker & Naegele 1999: 11), their voice is seldom heard or incorporated in research literature about old age and health or in concepts for new forms of intervention on their behalf. This might mean to dismiss an important source of valuable information for effective and successful new approaches.

The majority of those who perform research (Bytheway 1995: 97) or are responsible for the medical treatment of elderly patients come from another generation than their ‘subjects of interest’. And the question is, how can those who are often half a century younger - although ageing as well - claim to know what is really important in old age? And as we have seen above, younger people might be guided mainly by their own fears, concerns and insecurities about health and life quality in old age.

An intensified and closer (research) co-operation with older people can not only provide a chance to identify what are perceived differences in ‘ways of seeing’ and ‘assumptions of knowing’, but could, at the same time, also contribute to reveal that in many respects this generation is not so different from values, expectations and needs of younger people. It seems, for example, that for a lot of older people the idea of becoming ‘a burden’ is one of the things most feared, probably even more than death itself (Sidell 1995: 143). And remaining independent is an important value and feature of a good quality of life for older generations as well as for younger people. Hence, it might be an important task to develop – together and in solidarity with ageing and older people – more understanding and dynamic concepts of caring, which can provide help and assistance where necessary, but, at the same time, also respect and maintain a certain form of personal autonomy and dignity.

In this sense, including the voices of older people and respecting an ‘ageing paradox’ more in the planning of research concepts and in the development of new forms of intervention would not only allow for more solidarity between generations, but could also be an important tool for more efficiency and success.
'Moving' towards creativity and approaching a foreground

According to Rosenmayr (2002), 'creativity' will be an important requirement for those who want to cope successfully with the new challenges of ageing and old age in the future. I would state that such 'creativity' or the continuous generation of new and innovative ideas will also play an essential role when we want to work with progress on 'a new culture of health for the ageing'.

Additionally, and as it has already been mentioned in the Introduction of this study, we are facing the 'uncomfortable' situation, where medical intervention and improved treatment of diseases alone can not solve the problem of 'the elderly' and guarantee 'health in old age'. And we realize that we will also have to question our own attitudes and change taken for granted perspectives as we are all participants of the same process. Thus, we will have to prepare for the future of health in the older years, if we do not want to deceive ourselves. A vast number of questions remain open for discussion and research and deserve new ideas, creativity and the courage to test alternative 'ways of doing'.

Finally, it appears from this 'background' that for comprehensive and promising future research on 'ageing and health', we will always have to look on and from more than one level at the same time and take different interests and priorities into account. On the one hand, we may, in this way, help to intensify the dialog between different generations, sciences and policy approaches and can contribute to a communication and exchange of different needs and experiences. On the other hand, we can empower often static perspectives to move around and in and out a 'problem' in order to develop a better understanding and more flexible attitudes. To set perspectives in motion might, finally, enhance our potential to rethink taken for granted concepts and to generate new ideas and more creativity when facing future challenges of 'health in old age'.

For this reasons, I regarded the research method of a 'multi-level perspective' as most appropriate and promising tool for performing an exploratory study on 'healthy ageing' and its future and for moving to 'a foreground' and the field in Austria.
Chapter IV

Reformulating a concept of 'healthy ageing'

"In my case one can not speak of 'health in old age' any more." This was the first reaction of Mrs. Burger (83) after I had explained the purpose of my study and had asked her and her husband to participate in an interview while I was standing in the doorway of their apartment. Mrs. and Mr. Burger were living in the same house where I was staying during my fieldwork in Vienna. I had often seen them before but we had never really met. Two days later I was standing in the living room of this friendly older couple and Mr. Burger (84) offered me a seat while Mrs. Burger was bringing some drinks from the kitchen. It was remarkable for me how well organized they seemed to live and to manage their life. After a bit of small-talk, I then asked them to describe their current health situation.

Mrs. Burger started to explain that she was suffering from 'macula degeneration' for three years now. This disease was affecting both of her eyes and had reduced her sight in a way that she could not read a book or a newspaper anymore. Additionally, the perception of particular light effects had changed and she had become very anxious to go out of the apartment on her own. She also mentioned that she was suffering from chronic pain in various joints as a consequence of chronic rheumatoid arthritis and that she had had a hip replacement operation ten years ago.

Mrs. B: It was really a significant change for me when this problem with my eyes started. - it's very limiting and I hardly go on the street any more. I feel insecure - it's sometimes hard for me to see the cars or the traffic lights...

Mr. B added: Before, we liked to travel a lot. We went to a museum or just downtown. Sometimes my wife even helped me in my work - now that's all impossible, that's really limiting... - Sometimes I print texts from the internet for her and enlarge the letters to an extent that only two words fit in one line - so she can read a bit.

Mr. Burger asked his wife to bring and show me her special glasses. They offered them to me to put them on and I tried the glasses for a moment. Both explained that reading had always been something very important for Mrs. Burger and that she experienced her disability as a great loss.

Mrs. Burger had always been working at home, had been raising two children and was now still doing the main part of the housework. Although, from my point of view Mrs. Burger appeared as quite vivid and mobile when moving within her own flat, her health situation had changed during the last years in a way that she couldn't experience 'health' or real life-quality anymore.

The situation of Mr. Burger was quite different and contrasting. He was also more dominant during the whole conversation. He had been working as a teacher for geography and physical education till the age of 60. When I asked him about his 'health' he first told me that, after his retirement, he had started to collaborate with a friend, who was an archaeologist at the
University of Vienna. In this way, he became engaged in projects and had started to specialize in a field of archaeology, where he could use his knowledge as a geographer. The fascination for this new field of work, where he could also spend a lot of time doing fieldwork outdoor, had become a central interest and new content of Mr. Burger’s life. He was now, at the age of 84, still giving lectures and writing publications. Mr. Burger talked about 15 minutes about his work and seemed so enthusiastic that, only in the end and very briefly, he mentioned that he had been diagnosed with a prostate carcinoma, that he had also had a hip replacement operation a few years ago and that he was experiencing progressive problems with his hearing and his memory.

Mr. B: But that’s not really a problem for me, I had radiation therapy because of the carcinoma and sometimes there are problems with my hearing, especially when I have to follow a larger conversation, but that's all not really a problem. – I feel healthy, I feel old but I really feel healthy! (– ich fühle mich gesund, ich fühle mich alt, aber ich fühle mich wirklich gesund!)

And referring to his new profession: I think everybody should have something like this...

I then asked Mrs. and Mr. Burger, how they would define ‘health in old age” or what they would regard as most important components for experiencing ‘healthy ageing’.

Mrs B: I have quite a negative point of view. All these propagated things like pleasure, travelling and wellness in old age – I don’t see this so much. – In the media one can hear and see a lot about this issue and you see the 95 year old, who is still going skiing and doing whatever things – sometimes you almost get complexes when you see this...

Mr. B: I think it depends on the interests one has and the ability to follow and maintain these interests. This is something I can do and which she can’t do anymore. – I think being healthy is very much a psychological process – and it’s motivation as well... - On the other hand, if I am constipated I can really feel sick...so, what is ‘healthiness’ and what is ‘illness’? – One has to define these terms. – If you define ‘health’ in a strictly medical sense, nobody can really be seen as ‘healthy’ in old age.

So, does ‘health in old age’ or a concept of ‘healthy ageing’ exist? And how is ‘health’ related to ‘old age”? In posing these questions we are, as Mr. Burger indicated, facing a problem of definition and, at the same time, a semantic dilemma. Already the word ‘health’ represents fluent terminology in our everyday language. One can alternatively refer it to a narrowly defined concept of physical health or – and almost at the same time – use it in a wide and metaphoric way. In the latter option the well known phenomenon is created where ‘health’, which is such a central issue in our societies, easily spreads as a moralizing and strictly medicalized concept and everything in our lives turns into something more or less ‘healthy’.

The use of the first option and to retain ‘health’ to a basic meaning and definition of physical health and functioning seems to simplify the semantic dilemma and, without doubt, it has advantages to preserve a precisely defined language. But at the same time two new problems are generated.
First, the question appears of what then is ‘physical health’ or ‘functioning’ and who is justified to define this and based on what values and means of measurement (an ethical problem I have already indicated in ‘a background’). Second, we have the problem that to narrow ‘health’ to a state of complete physiological functioning or, the other way around, to ‘the absence of disease’ neglects a natural course of life. Physical decline, personal value systems and a process of dying do not fit into normative concepts and are not accepted as normal or ‘healthy’ parts of human existence. As a consequence, ‘health in old age’ can not exist and ‘ageing’ becomes an ‘unhealthy’ concept in our societies.

In this chapter, and with the help of participants at different levels, I shall question this statement. I will explore what priorities people have towards ‘health in old age’ and try to develop – with their voices and expertise – a more realistic and feasible concept of ‘healthy ageing’.

Combining the term ‘health’ with the dynamic process of ageing obviously adds to the confusion of the discourse and a precise definition of what ‘health’ really is becomes even more difficult to condense. But I doubt that an intention to do so is worth the effort. Does it make sense to separate ‘health’ as a naked and general concept, unrelated to a process of human existence and a context that is moulding and generating it? ‘Health’ in itself would become something artificial and unnatural, like a fish taken out of the water. And ironically, the more we narrow our conceptualization of ‘health’ the more we recognize how much it is intertwined with and dependent on almost all other aspects of one’s life (van der Geest 1985). It turns into something idiosyncratic and subjective rather than something objective.

Understanding the evasive ambiguity of the terminology and building up on my findings in the field, I propose that it is legitimate and even more realistic to establish a relativized and contextualized concept of ‘health (in old age)’, located in between the mere fact of physiological functioning and the pitfall of an all embracing and medicalizing metaphor. In this way, we will see ‘physical health and functioning’ as one important value and factor, embedded in the whole equilibrium of individual ‘health’. We may even be able to rediscover ‘health in old age’ and to rethink ‘healthy’ forms of ageing.

The case of Mrs. and Mr. Burger represents two characteristic findings of my research, which are related to the two above mentioned problems and also indicate the two proposed concepts.
First, ‘health in old age’ cannot be defined from an ‘outside position’ but has to be related to a person and interpreted by individual perception. Thus, it is something *relative and subjective*. And second, ‘health in old age’ does not depend on a single variable such as a certain physical condition, but on the dynamic interplay of a variety of components. Thus, it is created within a *heterogeneous context*. Below, I shall elaborate more on these two findings. Based on the results of my fieldwork and a variety of viewpoints, I will question the overruling and defining power of a biomedical paradigm and reformulate ‘healthy ageing’ according to the interests of the participants of this study.

I) A more relative and subjective concept of ‘healthy ageing’

‘Health’ is not only of personal importance, but has become one of the highest values in our culture, which one might describe as “a shared system of norms and values” (Nanda & Warms 2004). In ‘a background’ I have outlined that the concepts of ‘health’ or ‘healthy ageing’ are not only “standard components of medical training, thinking and practice” (Carnes et al. 2005: 22) but that they are internalized at all different levels of society. A culture of the body and physical health has become a kind of religion and the metaphoric use of the related terminology is a good indicator for this development. Biomedicine, as so called evidence based science, is thereby in a powerful position to determine and control the standards of such a ‘religion’. Norms, as defined in this science, determine whether something or someone is ‘healthy’ or not. The dominance of this biomedical paradigm was evident in the whole course of my research, also on the ‘8th International Conference on Ageing’ in Copenhagen. At the end of one conference day I spoke to M. Lewinter, who was concerned about this situation.

L: I have the feeling that research on ageing and also conferences like this here are still too medically oriented. – I am concerned about this idea that certain professional people begin to gain control and are telling elderly people what is good for them and what not and they are defining what is ‘successful’ what is ‘good ageing’, what is ‘healthy ageing’, what is ‘health’...

(researcher)

She gave me the example of a specific level of blood pressure, defined as ‘normal’.

L: …If the definition would be changed a bit, suddenly millions of people wouldn’t be ‘healthy’ any more, they would have to go to the doctor and so forth. The question is – who really profits from this?

(researcher)
With this concluding question M. Lewinter points to the situation that differing interests and priorities are being pursued under cover of a concept of ‘healthy ageing’. And we may ask if a clearly defined and ‘healthy’ norm of blood pressure is more in the interest or to the profit of a patient, a policy maker a doctor or a society? And first of all, what is the profit?

As a valid answer one might clearly emphasize ‘preventive measures’ or a necessary ‘orientation’ in the form of strictly defined standards. But then we face the problem that we are all individual beings, exposed to a continuous process of changes and in reference to medical standards our lives represent a continuous history of losses rather than something positive. One has then to decide, if wearing glasses, living with prostate cancer, having grey hair, a certain bone density or a certain amount of neuronal cells is something normal for a person’s age or not. These are important decisions with wide reaching consequences for those being judged and it is worth questioning them. I remember very well, sitting with Mr. Kraus in his hospital room, and asking him for the reasons for his admittance and his physical complaints.

K: In reality they are not so serious or problematic... The doctors have decided that there was something wrong with me...
(older p. in red. phy. c. / 83y)

I asked him, if he would regard himself as a ‘healthy’ person.

K: Well... yes – but with the catheter and being here in the hospital....
(older p. in red. phy. c. / 83y)

One may ask now: How ‘healthy’ does an older person have to be and how ‘unhealthy’ is one allowed to be in a certain phase of life? Mr. Burger, who was ageing with various physical deficits, had clearly told me: “…I feel old but I really feel healthy!”

With Mrs. Rieder, who had a progressed form of osteoporosis and chronic renal dysfunction, I was sitting in her room in her daughter’s house.

R: I would describe myself as a healthy person – although I am disabled (ich würde mich als einen gesunden Menschen beschreiben – obwohl ich behindert bin). But I feel well and healthy – I can move around, I can think... I am very thankful for this. And I have my daily job – praying and reading – and sometimes playing cards... (she laughed).
(older p. in g. phy. c. / 84y)
And Mr. Kraus said:

K: You know it's not so important to be free of disability, in order to be healthy...

(older p. in red. phy. c. / 83y)

At the conference in Copenhagen I gave M. Lewinter the example of Mr Burger’s health situation and she replied:

L: The problem is that the experience of this gentleman you just talked about, is not evidence based – although, he seems to feel very happy and healthy...

(researcher)

She was right. The viewpoint of Dr. Hrabcik (I did not tell him the example of Mr. Burger) was quite contrasting.

H: To say it in quite a radical way, one who has a carcinoma and has well adapted and learned to live with it is still not a healthy person...

(policy maker)

Dr. Horn, a general practitioner in the countryside had also a different understanding of ‘healthiness’ than Mr. Burger or Mrs. Rieder.

Dr. H: Well, nobody over a certain age will be completely healthy, – you just have to check all the laboratory parameters and you will always find something (Nun, ab einem bestimmten Alter wird niemand völlig gesund sein, – Sie brauchen da nur alle Laborwerte kontrollieren und Sie werden immer etwas finden).

(health professional)

Obviously, we are here only confronted with a different use of language. And it might be useful at this point to briefly clarify that it is neither my intention here to disrespect biomedical achievements nor to question physical health as a value of central importance for human existence and ageing. A fact I will come back to at the beginning of the next section. But the question is what practical consequences for the orientation of treatment and the lives of older people it has to prefer a ‘radical’ and technical conceptualization of the term ‘health (in old age)’ over an experienced and lived one.

Mrs. Baumer, who was working as an official in a large Austrian health insurance company, had been working as a nurse for many years before her present job. We spoke about that time, while we tried to define ‘health in old age’.
B: For me 'health' is a very subjective state. It is a question of attitude. And I cannot agree with the WHO definition, because that is not achievable. – Probably, my attitude is influenced by my long work experience with chronically ill patients – where many of them are simply not ill in that sense. They have their diabetes, like other people have fair or black hair, and they can live perfectly with it. One is, therefore, not necessarily ill. – But in our biomedical and pathogenic model this is illness. That is why I am much more in favour of a salutogenic model, where it depends on the resources one has and can use. I think this is very important, because we often make people sick. We make them free of health rather than free of illness. ... So, I think it depends on how one is feeling, it's subjective... - who can decide about someone else?

(policy maker – health insurance official)

In respect to the theme of a 'pathogenic' approach and of 'making people sick', Dr. Vogt told me a story about one of the largest nursing homes in Vienna – an institution, which was still structured in the way of a large geriatric hospital for about 2000 long-term patients. He was shocked and angry that after the political decision had been made to reduce the capacity of this institution, a commission of medical professionals themselves had decided that only 20% of the patients could live in old people’s homes or in assisted living arrangements and 80% had to be hospitalized – for the rest of their lives.

Another viewpoint on these themes came from the position of Dr Fried as a young hospital doctor and specialist for internal medicine.

F: Often I am surprised when we admit a patient to our internal ward and they tell me that they feel very well. If I then read the accompanying medical report I find ten diagnoses of different diseases for this patient – so there must be well being and 'health' despite these diseases (- also es muss da eine Form von Wohlbefinden und 'Gesundheit' trotz dieser Krankheiten geben).

(health professional)

The consequences of a differing use of language and health concepts and of a pathogenic approach seem not only evident in the problem of over-hospitalization of older people in Austria. Also the growing medicalization, technicalization and a paternalistic control over a certain phase of life are the result. Here we come back again to the question of M. Lewinter, who asked: “… – Who really profits from this?” She herself continued:

L: There is suddenly this big market in the field of ageing – the market in controlling older people and old age...

(researcher)
Prof. Heller articulated this fact differently and raised the obviously provocatively meant question of why it is that we are suddenly so concerned about and interested in old age and that older people became such a topic? – And here we may ask again: How is ‘health’ related to ‘old age’?

Dr Vogt: I think it is not correct to define the term ‘health’ in dependence on age or phases of life – Someone, who is old can be and feel ‘healthy’ in the same way as a young person. And there are a lot of young and a lot of old people, who never feel ‘healthy’. But, in the same way, there are old people, who feel ‘healthy’ till the very end.

(health professional - researcher)

Dr. Fulda: I don’t see a very specific age, which represents a turning point for one’s health. There are examples of very old people – we just had an old lady of the age of 109 – who are quite well, even in very old age. Old age should not be mixed up with sickness, even if there are deficits and declines...

(health professional)

But based on the prevalent value system in our culture, all energy, hope and trust seem to be focused on combating such deficits and declines by all means and money. This appears to be in line with interests at the level of health-policies in Austria.

Dr. Hrabci: ...Biotechnology is making continuous progress and I am quite optimistic that there will appear solutions within the next ten to fifteen years...

(policy maker)

Although, a compression of morbidity (Fries 1980) into very old age became possible, predictions still indicate that the prevalence of chronic and disabling diseases will increase over the next decades (Howse 2005: 4). And even if we are in favour of a pure medical and semantic definition of ‘health’, and even if we understand the value of a good physical condition, the crucial question arises: How long should and can we invest in such an unobjectionable form of clinical ‘health in old age’, guaranteed by biomedical achievements?

This question generates crucial ethical problems and I could recognize the interest and need for a more dynamic and differently defined concept of ‘health in old age’ among many participants of this study, especially health professionals.

Dr. Fried: I think we will more have to define ‘health in old age’ as well adjusted physical condition, which might as well include a chronic health problem or disability...

(health professional)
Dr. Gabriel, an anaesthesiologist in the same hospital, emphasized a better balance between personal expectations of patients and helpful medical possibilities.

**Dr. G:** A patient will have to adapt or reduce his personal expectations of what is possible in his particular case and biomedicine can offer certain therapy to improve a condition – then they have to meet in between...I think this will be a common future scenario.

*(health professional)*

Even Dr. Horn, who was obviously a medical professional with quite a conservative attitude in my study, seemed often confronted with an ethical dilemma when treating older people in the countryside.

**Dr. H:** I notice that I have to become more generous in certain situations – often one decides to wait a bit before something acute is done – although, I don’t want to accuse any colleagues...

*(health professional)*

Prof. Rosenmayr regarded it as one possible and important contribution to old age research to redefine ‘health’ in a more comprehensive way and to integrate more components in the term. He added:

**R:** ...Of course, this will need a lot of effort – but it’s a paradox that there is no real continuity after the great ideas of Freud and Ringel.

*(researcher)*

**Closing remarks**

It appears as a contradiction in our language to call someone ‘healthy’, who has deficits in physical health and functioning. Yet, many participants of my study regarded themselves as ‘healthy’, obviously in the sense of ‘healthy’ as a process in between a state of complete physical functioning and a metaphoric use of the term. One may call this a linguistic and rather philosophical discussion. But language is a powerful instrument in a culture, dominated by the norms and ideologies of a biomedical paradigm. The approval or disapproval of being ‘healthy’ or not can have wide reaching consequences in the form of hospitalization, medicalization or other forms of intervention as “the most ‘health’ for the money” is required (Hyder et al. 1998: 196) – especially in old age.
But how ‘healthy’ is so much ‘health’ delivered by a medicine that mainly aims to fight a single value with disproportionate means, irrespective of a natural course of life – including its limitations – and obviously often unrelated to the lived experiences of ageing people? Over-hospitalization and medicalization of a certain phase of life does not add to the ‘health’ (even in its most narrow sense) of those who are supposed to benefit. On the contrary, the ‘hazards of hospitalization’ for older people are a well described phenomenon. (Creditor 1993; Strausbaugh 2001). And how often are patients asked for their own expectations of a therapy, their own ideas about ‘health in old age’ or even for their own wishes or decisions of dying. All of them are individual people with their own unique life history, their own private “explanatory models” (Becker & Kleinman 2000: 470) and their own variety of – probably not shared – values within an individual ‘culture of health’.

In spite of a certain tension field between a more general and a more narrowly defined understanding of ‘health’, my research and interviews indicated a fundamental interest in and necessitated a more appropriate and realistic concept of ‘healthy ageing’ for the future. In the initial part of this chapter it was therefore a first step to question a taken for granted and normative defined concept of ‘health in old age’, with the help of participants in different positions. In combining their viewpoints, comments and expertise I found that ‘health’, irrespective of age, is a process, which has to be defined by and related to an individual in order to respect human dignity and a complex ‘culture of health’ of an ageing person as we all are.

II) A more contextualized and multi-factorial concept of ‘healthy ageing’

In a second step, I shall now analyze what the participants of this study regarded or experienced as most important components and values for individual ‘health in old age’.

The introductory case of Mrs. and Mr. Burger, as well as many other examples in my research, clearly demonstrated that an experience of ‘healthy ageing’ depends on a variety of components. In this respect ‘healthy ageing’ is closely related to a concept of ‘successful ageing’ or well-being. Previous research by Faber et al. (2001) revealed that ‘success in old age’ from the viewpoint of older people is not constituted by the mere presence or absence of
physical functioning but as well by a process of adaptation or by social contacts and satisfaction. This is also true for a concept of ‘healthy ageing’.

Additionally, and by using a multi-level perspective I could find that not only older people but also many participants at other levels shared and prioritized a multi-factorial understanding of ‘health in old age’. Another finding was that ‘healthy ageing’ was not experienced or regarded as the simple co-existence of different components side by side but rather by their intricate interaction and interdependence. Located in different aspects of one’s life, these components appear to be a precondition and the result of each other at the same time. Together they form, what I have called, an individual ‘culture of health’ or an equilibrium of interacting personal resources. And referring to a comment by L. Rosenmayr, these resources are “continuously in danger in old age”. A statement and phenomenon I will come back to at the beginning of the next chapter.

Following and by speaking in and for the voices of my participants, I will give an overview of those constituting components of ‘health in old age’, which were most frequently mentioned during my fieldwork. I found them located in biological, psychological, social and spiritual aspects of people’s lives.

The biological aspect of ‘health’

- Physical condition

Without a doubt, the physical condition – which one might call the central aim of biomedical effort – is an essential part of personal ‘health’. This was also clear in my study. The example of Mrs. Burger shows, how a loss in physical condition can destabilize a whole and sensitive equilibrium, especially, if other components or resources are affected (e.g.: reading, mobility, etc.) or scarce (e.g.: social contacts, further interests, and so forth) at the same time. Referring to the case of Mrs. Burger, Dr. Vogt commented:

V: You see if ‘health’ is missing in a form that one can not participate in activities or follow self-determined interest, then the whole condition of this person can decline rapidly – thus, it is a very important part...

(health professional - researcher)

With ‘the whole condition’ Dr. Vogt referred to a more general concept of health as well as to the mere physical condition again. We just have to look at the situation of Mr. Burger for a
moment. Who knows how his physical condition and functioning would have developed and how he would experience his ‘whole condition’ without his former profession, his friend at the University, his fieldwork outdoor or his feeling of responsibility for his wife. Thus, physical condition is a substantial part and a treasure in the ageing process of Mr. Burger, but could neither exist nor be seen without a surrounding context.

This was also evident in the case of Mrs. Bergmann, who I visited in the hospital. She could only lie on one side of her body in the bed as she was suffering from a severe decubitus, which had appeared as a consequence of bedsore after a hip-replacement operation several months ago. We talked for about half an hour and she seemed very tired and didn’t speak very loudly.

**B:** When I am lying here like this, then I have the feeling that there is nothing better than physical healthiness – that’s quite natural I think...(Wenn ich hier so liege, dann hab ich das Gefühl, dass es nichts Besseres als die körperliche Gesundheit gibt – ich denke, das ist ganz natürlich...)

(older p. in red. phy. c. / 76y)

In the same conversation I found out that Mrs. Bergmann had lost her husband some weeks before her hip-replacement operation and that she was concerned about her financial situation and security. Additionally, she seemed to be very lonely:

**B:** ...yes, that would be important, that one does not feel so lonely. – You see, I am here in this room and I always hope that someone comes to visit...

(older p. in red. phy. c. / 76y)

Again we see the intricate linkage of circumstances and their mutual interplay. How would the health situation and recovery of Mrs. Bergmann have developed after the operation, if her husband would still have been alive? Or if she would have regular visits and less financial concerns?

However, the possible contributions from the side of ‘good’ medical treatment (I will come back to this ‘good’ in the next chapter) should be appreciated and valued with respect. Mrs. Grundner (62) told me about all the difficulties and the pain she had to go through, before she had had her ‘successful’ hip-replacement operation about six month ago.
G: That time I really felt thankful that this kind of operation exists and that we have this kind of medicine nowadays...

(family)

Beside the difference in age, most other circumstances in the life of Mrs. Grundner were also very contrasting, compared to those of Mrs. Bergmann. She was a very active lady, living under good socio-economic circumstances in a large house with garden in Vienna, she was married and had children and always a lot of people around her.

Thus, the improvement of a ‘physical condition’ as a component of an equilibrium can add a lot to the ‘health’ of a person in younger as well as in older age. But this is only the case if other factors or resources are present or, if they are taken into account and supported at the same time. Such other factors are not only linked with and influencing a physical condition, they are more, as mentioned by my informants, representing components of ‘health in old age’ in themselves. I found some more of them within the biological aspect of one’s life.

- **Physical activity and mobility**... were mentioned frequently in my interviews and represented important components for a feeling of ‘healthy ageing’ for most participants in this study. The dimension of such activity or mobility was thereby variably important.

Mr. Kraus: You know it’s often just the small things...to be able to enter a bus, for example, as long as I can do that I can also feel healthy...

(older p. in red, phy. c. / 83y)

Mrs. Anders: What is important is not to rest too long, because that makes you feel even more tired afterwards...

(older p. in red, phy. c. / 75y)

Mrs Kolb shared this experience:

K: Movement is very important for me – to work in my garden – now I am often not able to do everything like in former times. – But I would miss the activity and if I don’t do it I become even weaker...I don’t mind, if I need much more time nowadays - I have the time and it makes me feel well...

(older p. in g. phy. c. / 80y)

Mr. Wild, who was still an active farmer, had other plans:
W: A lot of movement is important I think. – A bit of sport... I still go for skiing and I like to do this, I enjoy being in the mountains – then I feel well and healthy!

(older p. in g. phy. c. / 77y)

And he continued to tell me a long story about his last excursion in the mountains.

- *Mental health and self-care...* were two further and very interrelated components. I decided to list them within the ‘biological aspect’ of life. Dr. Fulda, medical director of a large nursing home in Vienna explained her point of view:

F: For me ‘health in old age’ means that a patient is able to take care of himself in the daily necessities and tasks. This is the most important. ...A person should maintain certain orientation – because this is the most frequent reason for admittance here – patients, who can’t stay at home alone anymore. Especially those, who loose orientation and leave their house or the old people’s home by night and can’t find home any more... – I guess dementia will become a huge topic in the future.....

(health professional)

For Mrs. Kolb and Mrs Heid mental activity was important in order to experience ‘healthy ageing’.

K: That your head is healthy – this is the most important – that one can still think clearly and that he can recognize his surrounding. ....well, pain is something you have to bear, you have to find your way to manage, but the head is very important I think....

(older p. in g. phy. c. / 80y)

H: You know it is the mental things, which make me healthy... *(Wissen Sie, es sind die geistigen Dinge, die mich gesund machen...)*

(older p. in g. phy. c. / 85y)

Only my youngest informant, Mr. Unger (36), was not at all concerned about his mental health in later life.

U: What I do not fear at all about old age is my mental healthiness. If I will suffer from dementia in old age then I will probably not recognize that anyway – as long as I stay more or less healthy for the rest... I don’t think it will bother me a lot.

(family)
And Dr. Horn, a general practitioner, seemed also more concentrated on the pure physical condition of his patients.

H: I think sport, nutrition, regular medical check-ups and the control of certain laboratory parameters are important for health... and – how shall I say – somehow, mental issues also belong a bit to health...

[health professional]

The psychological aspect of ‘health’

That psychological factors can influence our ‘physical condition’ seems to be generally acknowledged and has, for example, contributed to the development of psychosomatic medicine. Yet, emphasis is here mainly given to negative psychological influences, e.g. those of stress. In my study I found various psychological components, which were not only representing positive contributions, but also forming part of the whole personal ‘health’ of participants.

- Continuity of interests and tasks ... was not only contributing to the ‘health’ of Mr. Burger. Mr. Kraus had already started to explain his understanding of ‘health’ in the last section.

K: You know it’s not so important to be free of disability, in order to be healthy. It’s more important that one can continue a form of life he was used to.

(older p. in red. phy. c. / 83y)

In respect to continuity the moment of retirement was regarded as a sensitive event. Mrs. Rieder told me how much she had liked her former profession as a paediatrician and that she had continued this work till the age of 71. She saw this factor as part of her ‘healthy ageing’.

R: And now my healthiness (she had a progressed form of osteoporosis and renal dysfunction) is obviously connected with the fact that I regard reading and praying as my daily labour. – I think one should not stop...

(older p. in g. phy. c. / 84y)

Mr. Wild shared the experience about the importance of ‘daily labour’.

W: If I would not continue my present work, I would have to look for something else to do – for example, bees, I would start growing bees to have a task... otherwise I would get sick...

(older p. in g. phy. c. / 77y)
Dr. Bauer had observed that retirement could have significant influence on the whole health situation of her patients.

B: Although, it is a long expected and desired moment for many people, it often means an outbreak of an illness people had probably suppressed for a long time before. Especially men, they seem bored, become lonely - and start to complain about their health. It seems that they miss their job where they had been fully integrated. – and this influences their mental health and their wellbeing – and it also goes ahead with complaints about somatic health...

(health professional)

Having a task or interest in old age can also generate a positive feeling of...

- **Satisfaction** Mr. Pold (60) had been retired for six years now. But he had a further task, which created an essential feeling of satisfaction.

P: For me it was a positive moment when I could retire, it was the start of a new phase of life for me. I was looking forward to it – because I have a second job, which I like very much. That’s important for me...

Researcher (Res): Do you think your work has positive effects on a form of 'healthy ageing' for you?

P: Yes for sure, this helps a lot... I feel satisfied and it is good for my self-esteem as well, I feel better – probably even healthier.

(family)

- **Independence in decision making and will** ... was another valuable part of the ‘psychological aspect’. Such form of independence appeared to be of higher value for all of my older participants than complete physical independence or independence from external help at all. To preserve respect for personal priorities and human values was obviously a central issue and component of ‘healthy ageing’ as Dr. Bauer confirmed.

Dr. B: I think one of the most important aspects of ‘healthy ageing’ is the ability to maintain at least a certain autonomy and possibility to make own decisions – for example about home-help yes or no... – and not to be overruled by familiares, you know... I see this quite often and then people are not ‘healthy’ any more.

(health professional)

- **Adaptation** In a context of ‘successful ageing’ I found the process of adaptation as basic component and resource of ‘healthy ageing’ as well. A continuous “reorganization of one’s interpretations and goals concerning self and life (Dittmann-Kohli 1995) is a precondition for
this process. Adaptation itself can then create a remarkable experience of stability within the ageing process and is closely related with the already mentioned “ageing paradox” (Westerhof et al. 2003). And when I presented in the previous section the surprise of Dr. Fried about older patients, who stated a feeling of well-being, in spite of several medical diagnoses, this could obviously be explained by the confrontation with such an ‘ageing’ or ‘disability paradox’.

Mrs. Kolb and Mr. Kraus described this phenomenon from the position of older people. The process of adaptation had helped them to perceive their lives and health situation with more satisfaction and modesty.

Mrs. Kolb: You grow into old age (Man wächst ins Alter hinein) – before I couldn’t understand old age very well, but you slowly grow into it, you get used to it and then you better understand older people – that’s how ageing works…(she laughs) (older p. in red. phy. c./ 80y)

Mr. Kraus: I have recognized that one can become able to just sit for an hour and do nothing ... I didn’t know that in former years – because we had a garden – that’s not uncomfortable and I feel satisfied...

(older p. in red. phy. c./ 83y)

The process of adaptation appeared as inseparable from a feeling of acceptance, which represents a rather spiritual component of ‘health in old age’.

The spiritual aspect of ‘health’

- Acceptance The following quotations illustrate the importance of acceptance in order to maintain a ‘healthy’ equilibrium.

Mrs. Gruber: It was difficult when I realized that I was not able to walk so well and far any more. — A lot of things became more difficult... But now I am able to accept things better, that helps me also to feel better... (Aber jetzt bin ich fähig, die Dinge besser zu akzeptieren, das hilft mir dann auch, mich besser zu fühlen...) You know it’s nice, if you can get some help or treatment but anyway, you can’t cure the problems, you can’t eliminate them...

(older p. in red. phy. c./ 85y)

Mr. Kraus: I have reached a certain age and so there are more and more problems arising within a shorter period of time ... The treatment is very good here, but I am not creating any illusions, the moment will come, when it is over.

(older p. in red. phy. c./ 83y)
Mrs. Kolb: I have to be very thankful. I don’t have any pain during the night, for example... And often, if I do not feel so well I have to think: Be quiet, it could be worse — and I have to think of others — and this helps... and I feel better.

(older p. in g. phy. c. / 80y)

When Mrs. Grundner explained her point of view she came up with a nice little metaphor:

G: I think ‘healthy ageing’ starts quite early in life. It starts with the acceptance that things become more reduced but that one can, at the same time, still enjoy them... I had an old aunt, who I liked very much, and I still remember her saying: ‘Child, one has to remember that the macro-cosmos slowly turns into a micro-cosmos but still remains very interesting.’ — So, not to regard this reduction only as negative but also as a positive intensification and focus. I notice this with myself. I hardly find the time to peacefully read a book nowadays, I am always too busy — I could imagine that I might enjoy this very much in later life. So, I think ‘health in old age’ is also acceptance and a certain will to regard changes as something positive.

(family)

- **Belief and the process of dying** are obviously also components of ‘healthy ageing’ and linked with the spiritual aspect of one’s life. Mrs. Rieder was Roman Catholic and her strong belief seemed to help her a lot in finding a ‘healthy’ way of ageing. She repeatedly emphasized this in the course of our conversation.

R: I think it is only possible to age healthy, if people have a belief... Older people should not only sit in front of the television, they have to keep on doing and they need to have a belief for that...

(older p. in g. phy. c. / 84y)

Mrs. Lang was of the opinion that a process of dying should be accepted as normal part of our life and even of our ‘health’.

L: It is very important that the issue of dying becomes less a topic of taboo as it is nowadays. That’s important for ‘healthy ageing’ as well I think...

(family)

**The social aspect of ‘health’**

This was a frequent theme of discussion, where it became apparent, how ‘health’ is generated in the wider context of a person’s life.
- Social relationships and social engagement

To avoid loneliness and to engage in social relationships was a priority for many participants.

**Mr. Gruber:** It is important not to hide yourself. I think when people become lonely that’s quite dangerous – I see that with a friend of mine. People become more suspicious and anxious and then they don’t go out and then they get sick as well...

(older p. in red. phy. c./85y)

Mrs. Kolb mentioned how much she enjoyed living close to a farm, where a lot of tourists were coming all over the year.

**K:** I always hear and notice what is going on around me, there is movement around me – if they do not have any guests for some time, I really miss that. But as soon as there is movement and I hear the children around, I feel well and comfortable.

(older p. in g. phy. c./80y)

Dr. Bauer, who was a general practitioner in Vienna and thereby doing a lot of home-visits had a lot of experience with the theme of loneliness.

**B:** Loneliness is absolutely the important topic. Not coming out of your four walls. It is what I see on my home-visits when I go to older people, who can’t go out anymore... There the medical issues are far less important. It’s more that someone comes and talks to them or helps with organisational things around – that’s more important.

(health professional)

Often it is the death of a partner, which creates this loneliness. This was also apparent in the case of Mrs. Bergmann.

**B:** Since my husband has died everything has changed...also my health...
**Res:** In what way was this influencing your health?
**B:** Difficult to say ...but it was a very hard time for me after his death. – If I would still have my husband, everything would have been easier... he had always organized everything...

(older p. in red. phy. c./76y)

Dr. Fried and Dr. Gabriel, working in a hospital were familiar with such situations.

**Dr. F:** We often see the death or illness of a person after the death of a partner.

(health professional)

Finally, I want to mention a last issue forming part of the social aspect of ‘health in old age’.
- Socio-economic security

The importance of the socio-economic situation as influencing the ‘health’ situation of a person is well known. Many of my participants emphasized financial security and independence as essential preconditions for and parts of ‘healthy ageing’. I remember when Mrs. Bergmann in her reduced condition said to me:

B: To be healthy...I think it needs personal financial security – that’s very important...although, there is security from side of the state...but still – that you are independent somehow...

(Closing remarks)

The second part of this chapter has outlined the complex variety of components, which participants described as constituting or influencing ‘health in old age’. These components or resources can be attributed to biological, psychological, spiritual and social aspects of life. Taken together they represent a dynamic and heterogeneous context where individual ‘health’ is moulded and generated.

The finding of a contextualised and multi-factorial concept of ‘health in old age’ reflected the lived experience of younger and older, more or less healthy ageing persons as well as the professional experience of researchers and health professionals. Only few participants held exceptional viewpoints or prioritized a mainly physiological and one-dimensional understanding of ‘health (in old age)’. Again and as in the previous section a certain tension field between internalized biomedical ideology and a more comprehensive ‘health’ concept was apparent. At the level of policy makers statements made were often vague and ambiguous. Evidence based and medically defined norms of ‘health in old age’ seemed prioritized here while other aspects were mainly mentioned in favour of political correctness or to conform to ‘expected’ answers.

For me as researcher it was a clarifying experience and also part of my findings that my assessment of the ‘physical condition’ of older persons as either ‘good’ or ‘reduced’ was often not reflected in the way people described their ‘health’ themselves (e.g. Mrs. Rieder, Mr. Kraus, Mrs. Burger). This confirmed the finding that ‘health (in old age)’ is something basically individual and that assessments from an outside position are likely to be misled by dominating medical standards and norms.
At the end of this chapter, we have found – in spite of linguistic ambiguities and a powerful medical paradigm – that 'health in old age' and ways of 'healthy ageing' do exist. In bringing the findings of two sections and the viewpoints of participants at different levels together, we are now able to reformulate a concept, which seems more appropriate to the continuous and complex process of human ageing. This does not mean that we have to abandon valuable medical experiences or interventions but that we should rather question and supplement these aspects. In accordance with the interests of participants of this study and reflecting wider tendencies of my research, we can reformulate 'healthy ageing' in the following statements:

'Healthy ageing' or 'health in old age' is...

- ...generated and experienced in the complex interplay of various components, which are located in different aspects of one's life and which constitute a heterogeneous and sensitive equilibrium, including the physical condition of a person.
- It is therefore a dynamic process, which allows for change over time and which is not confined to a certain age or age group.
- Finally, it can only be interpreted by and related to a single person, possessing a unique 'culture of health' and a right for dignity and respect of personal values and priorities.

By first carefully analyzing the meaning of 'health in old age' and by developing a tangible concept of 'healthy ageing' in accordance to interests and priorities of participants of this study we have now paved the way to explore support and future ways of caring for such a reformulated concept in a second step – as I will argue in the next chapter.
Identifying contributions to ‘healthy ageing’ of the future

...When I had discussed with Mrs. and Mr. Burger how to define a more realistic concept of ‘healthy ageing’ I continued asking them, what necessary contributions and what kind of improvements in the Austrian health care services could they imagine in order to support such a prioritized concept in the future.

Mr. Burger took out a small sheet of paper with a lot of hand written notes. He moved forward in his armchair and looked at me.

B: Well, I expected you would ask for these things – so, I have already made some notes. You know, when growing older here together with my wife I often think about these things... – it is an important issue and I guess people should think about it early enough... I see a lot of things, which should be improved...

The following chapter will present what contributions people propose and expect and what changes in the Austrian health care sector are of interest to support a prioritized concept of ‘healthy ageing’ as developed in the previous chapter. My findings, based on fieldwork and subsequent interpretation, do not intend to predict future developments or solutions but rather provide an outline of major tendencies and interests. I will divide them into three sections.

In the first section I start by exploring preventive measures, which aim to establish or maintain ‘health in old age’. I shall then and in the second section move on to discuss prioritized forms of caring and expected or necessary changes in the structure and attitude of Austrian health care services for older people. Finally, in the last section, I will look at interests and ethical problems concerning a natural course and finitude of life as part of ‘healthy ageing’.

As we shall see, all three sections show a strong tendency towards more flexible and comprehensive approaches and reflect, in this way, the dynamic character of a reformulated concept of ‘healthy ageing’.
I) ‘Health’ generates prevention – prevention generates ‘health’

Prevention is a first step to good health care. Especially within ageing societies, the promotion of preventive measures has become a central issue of health policies (Howse 2005). This is understandable as ‘healthier’ older people will – by definition – create less demand on health care systems and financial resources of a welfare state. This strategy was confirmed in my research in Austria and, the importance of prevention was shared by all participants, especially those in important positions.

**Dr. Hrabcik:** Prevention and healthy lifestyle are the cornerstones for ‘health in old age’. This is underestimated nowadays... and preventive offers from public side are not sufficiently accepted. – It is a key question for us, how we will be able to attract and motivate people in their younger years to personally engage and invest in their health. This is the most important question to be addressed in the future...

**(policy maker)**

**Dr. Stein:** I am absolutely convinced that by advising patients and relatives and by providing information and education about healthy life-style and prevention, hospitals could contribute a lot..... Prevention should be supported in the future.

**(health professional – hospital management director)**

**Mrs. Baumer:** It is especially our aim to prevent before a disease occurs at all – so called primary prevention or intrinsic health promotion. So we organize a lot of education and prevention programs... I think it would already help a lot to promote better nutrition, exercise or the awareness for one’s blood pressure...

**(policy maker – health insurance official)**

Physical health and functioning is here obviously the goal of prevention. This is a positive and valuable effort. Yet, it is questionable how to promote a certain defined physical condition, which does not exist as a separate entity. Additionally, as Dr. Hrabcik already indicated in his ‘key question’, it appears difficult to motivate people to invest in a form of ‘health’, which does not cause any problem at that same moment – a dilemma, obviously inherent in every form of pre-vention.

If something is labeled as ‘healthy’ in our culture it usually has a moral connotation and refers to a preventive measure and to something that should be done in order to achieve good ‘health’ in later life. Prevention is then a linear process and has to do with obligations and
constraints rather than with something pleasant. It doesn’t surprise me, therefore, that it is difficult to ‘attract’ and ‘motivate’ people in this direction.

In my conversation with Prof. Rosenmayr he emphasized that “health should not be a goal in itself but a means to an end”. After I had analyzed and interpreted the data of my fieldwork I was able to better understand his comment. I found that this ‘end’ is nothing more than ‘health in old age’ in its reformulated meaning. And if physical health is a means to an end and ‘healthy ageing’ constituted by a variety of components – including physical health – then prevention becomes a circular rather than a linear process. Physical health is then not a goal in itself and a mere component but turns into a resource, as all components of ‘healthy ageing’ become resources for each other.

This very positive phenomenon and finding was already visible in the second part of the last chapter. What people experienced as a component of ‘health’ was usually at the same time a resource or preventive measure for (other components of) ‘health’. For example, ‘physical activity’ – in the mountains, in the garden or just by entering a bus – generated a feeling of healthiness for participants of this study. At the same time, hiking or garden work can, for example, contribute to a person’s ‘physical condition’ in the same way as entering a bus can help to maintain ‘social relationships’ or add to ‘independence in decision making’ as examples of other mentioned components of ‘health in old age’.

Mrs. Grundner told me about her mother, who was 84 years old and living quite far away in the countryside.

**G:** She has always been used doing things on her own and to take care for everything – I think this has contributed a lot... She is still proud, if she can organize things herself and she is interested in playing and even in teaching bridge or in communicating with friends via internet... Somehow this has always been part of her healthiness...

(family)

Thus, ‘social engagement’ could act as a resource for the ‘continuity of interests and tasks’ and for a feeling of responsibility. Mr. Wild, whom we know already as a still active farmer, explained to me:

**W:** Generations should help each other, there is always something to do here, for everyone... And I have this feeling that one must not stop – one has to do something, one must not do heavy things any more, but small things... to look after the cattle or something... I think this is really like that – I have the feeling that, if I would stop now I would become ill – or
mentally sick or something, you know ... (Ich hab das Gefühl, wenn ich jetzt aufhören würde, ich würde krank werden, oder geistig krank oder so was, weißt Du ...) (older p. in g. phy. c. / 77y)

Dr. Bauer shared this experience in her daily work and when doing home visits in Vienna.

B: I see a lot how people become depressed in old age. They let themselves go, they have no will any more to get up, to do things,... They also start thinking about their relationship with their children, if they have done something wrong that they do not come to visit them any more - and then they lie in their beds, get bedsore, get weaker and weaker, get sick...it's a cycle...

(health professional)

Being ‘active’ was also a resource for Mrs. Kolb’s feeling of ‘mental health’.

K: If I can go out in my garden I feel well. And my thoughts are completely absorbed and only concentrated on the garden work (she laughs). If you just sit around you start thinking too much and you don't feel well any more.

(older p. in g. phy. c. / 80y)

Mr. Pold, who had chronic hepatitis, had experienced that his family relationships and his grandchildren were not only something that made him ‘live with energy’ as he said, but also represented a sensitive preventive measure for his ‘physical condition’.

P: The relationships in the family, that’s very important. Especially in my case with my chronic liver infection – I notice it immediately, if something is wrong in the family – I see it then in the results of my regular blood samples - if something is not balanced I can see it directly ... – These are the important things, otherwise life is not worth living... (Das sind die wichtigen Sachen, sonst ist das Leben nicht lebenswert ...) (family)

What we have found here is that ‘health in old age’ can be a very positive cycle of mutually reinforcing resources, where ‘health’ generates prevention and prevention generates ‘health’. In this way, a lot of constraints and obligations fall off and preventive measures become something more pleasant. But we have also seen that prevention for ‘healthy ageing’ is a very sensitive equilibrium. At this point I come back to the comment of Prof. Rosenmayr, who stressed the fact that “all resources are continuously in danger in old age”. Some of them might even get lost and other resources have to compensate these losses. This seems to be a quite a natural process and it appears then as the main task of prevention to invest in a personal equilibrium and to continuously maintain, improve and develop one’s resources. Especially when growing older – but this starts quite early in life. And the promotion of
better personal awareness of blood-pressure or campaigns in nursing homes for healthier nutrition – as mentioned priorities of a national health insurance – only support a single component of ‘healthy ageing’ quite late in life.

Mrs. Lang, who was working as a school doctor in her profession, emphasized more health education among school children.

**L:** From my work I get the impression that it would be important to have more time in order to generate and promote a certain sense for the own body and health among school children, but it is difficult because there is not enough money for such campaigns...

(family)

For Dr. Vogt prevention and ‘healthy ageing’ was rather a question of general education.

**V:** In my opinion much will depend on how much is invested in education – one, who has acquired education and can arrange his life with the help of this education, will always find new interests and there will always be continuity and activity... – It is always the same, those, who still have some interest and who read a book and do not deteriorate in front of the blaring TV – those have still maintained a certain degree of health...

(researcher – health professional)

These findings point to the fact that a cycle of mutually reinforcing components and resources does not only exist in old age but that ‘healthy ageing’ is also true for young age. ‘Health in old age’ then slowly mutates into ‘health in all age’. Investment in personal resources and the awareness of a positive cycle of individual ‘health’ – rather then for blood-pressure alone – should therefore already start in the younger years of life. Such wide changes in education, thought and values obviously represent great future challenges. Additionally, sensitive ethical questions concerning the fairness in distribution of health care resources and end of life scenarios are imposed and a biomedical paradigm has to be questioned. I will come back to some of these ethical questions in the last section of this chapter.

As a positive consequence, we have discovered that older people can and should still contribute a lot themselves to a process of ‘healthy ageing’. To support and allow for this cheapest form of prevention, certain changes in public attitude and political regulations concerning a better involvement of older people were most emphasized by participants. One important theme was again the issue of retirement.
Mrs. Anders: It would be important not to emphasize retirement but to stay within a certain profession as long as possible – this helps to stay in contact with younger generations and to maintain or stimulate interests...

(older p. in red. phy. c. / 74y)

Mrs. Gruber: Often there are older people, who would like to work longer but are not allowed to do so.

(older p. in red. phy. c. / 85y)

Mrs. Lang: I think the process of working itself can contribute a lot to one's health. But there should be models where one can reduce step by step, especially in heavy jobs. – It's important, even if one is already retired, to maintain a certain structure and certain tasks in life...

(family)

More dynamic and individually adapted solutions seemed necessary. Some other participants mentioned a higher age of retirement mainly for economic reasons.

The theme of 'volunteer work' among older people was an important topic at the '8th International Conference on Ageing' in Copenhagen. Models for organized volunteer work have been successfully developed and implemented in various countries. Within Europe achievements of these programs seem to be outstanding in the UK and in some of the Scandinavian countries. The idea is that older people help older people, do home visits, bring meals on wheels or engage in other social activities. It appears that such activities do not only have positive effect on the health situations of clients but also on those of volunteers. In Austria organizations in this direction are still less developed. Only Dr. Fulda told me that she had already had positive experiences with some volunteers working in her nursing home.

I confronted Mr. Burger with the idea of volunteer work for older people...

B: I would be very much in favour of such an idea. I think it could be of use for both sides... - especially those, who just retired, they are often happy to receive a new task. Probably, it is enough to visit someone once a week... Or to do another volunteer job – at the university, for example, people often ask me, if they can contribute something...

(older p. in g. phy. c. / 84y)
Closing remarks

Findings in this section indicate that the important issue of prevention can be a very natural and positive cycle where ‘health’ is a means to an end and a means in itself. It appears therefore as the main task of prevention of the future to continuously develop maintain and improve a personal network of resources. This should be an accompanying process of lifelong ageing and not be impeded but rather supported in older age, when resources are more in danger. By investing in a personal equilibrium of ‘health in all age’ people can contribute a lot to their own form of prevention. Advantage should be taken of this cheapest and most motivating form of prevention by providing more flexible regulations and an infrastructure in Austria that facilitates the development and the continuity of personal interests, engagement and activity. Additionally, this valuable equilibrium of ‘health’ also deserves future contributions and adaptations from the side of public health care as we shall see in the next section.

II) Caring for ‘health’ – What is expected for the future?

Again it was Mr. Burger, who looked at his notes and provided the appropriate words to open a new section of my report.

B: I see two core problems for health care in old age: Staying at home as an older person and staying in a nursing home or another institution. – I imagine if I would die and my wife would be alone here in the flat – what can she do? She could go into an old people’s home or stay at home. Obviously she would like to stay at home – most older people would prefer to stay at home, me as well...

(older p. in g. phy. c. / 84y)

The two ‘core problems’, which Mr. Burger mentioned will provide the framework of this section. In my research I found a diversity of themes in between the two poles of home care and institutionalized health care, which clearly reflected the inherent dynamic and the necessary respect for heterogeneity and subjectivity within ‘health in old age’. Following, I will move along between these two poles and provide an outline of the most important themes that have been discussed. By lining up core-quotations participants will thereby mainly speak for themselves and create a kind of dialog between different levels.
Caring – where, who and how?

- At home versus institutionalized care

The suggestion that “most older people would prefer to stay at home” was generally confirmed in my fieldwork – at least as long as possible...

Mrs. Anders: Older people should try to manage at home as long as possible and avoid a nursing home. I always say: ‘One does not transplant an old tree any more’ (‘Einen alten Baum setzt man nicht mehr um’).

Mr. Wild: I would prefer to stay at home of course, I am not a person for an old people’s home, I don’t like it... I think it’s very sad nowadays when families bring their older people directly in such an institution.

Mr. Unger, 36 years old, told me that he had sometimes visited relatives in nursing homes and he still seemed frightened of this experience:

U: When I remember the atmosphere in these houses... I would prefer to be struck by a lightening on a mountain rather than ending up in such circumstances. It’s so sterile there and people are treated like stupid persons...

Mrs. Rieder said that one should reserve a place in an old people’s home in time. But she herself was in the situation that she could already live with the family of her daughter – even if she would need more care. And she added:

R: ...to be honest, I don’t want to go into an old people’s home – I need my own and peaceful place, where I can read. Home help would be the better form of help for me than a nursing home...

The atmosphere in large caring institutions and to lose their own home and independence for ever seemed most frightening for participants in my interviews. But who was expected to take care of them at home? Mrs. Rieder had already indicated the next important topic:
**-Professional care versus family care-

Especially in urban surroundings I found a clear preference for formal care services. This is not only due to the fact that families usually live separated in Austria and children often far away but also because people do not want to become a burden on their relatives. Mr. Burger was not in favor with the idea that his children should take care of him one day.

B: I am against that... I know some cases and it's terrible. I fear the time, when I should need help from my children, even if they would like to do it... I do not want to become a burden... *(Ich will keine Belastung werden...)*

(older p. in g. phy. c. / 84y)

Mr. Unger had the same feelings already in younger age.

U: I have difficulties to imagine that my children should take care for me - I am not someone, who likes to ask others for any form of help - in the extreme case I would prefer to go into a nursing home or, if possible, I would like to have professional help at home.

(family)

Physical care should be provided by professional home help while families where expected rather to give emotional support.

Mrs. Grundner: My children will probably work till the age of 75 or they are living far away. How should they, despite certain emotional support - probably via telephone, take care for me? I think this is utopia. - We will have to rely on other networks in the future. - Additionally, I would feel uncomfortable about the idea that my children could take care for my physical health If older people are not doing so well any more they become more demanding sometimes even shameless - because they can't any more - this frightens me somehow - so I wouldn't like to demand from my children to take care for me...

(family)

Even Mr. Pold, who was willing to take care of his parents in law at home, if this should become necessary one day, emphasized the importance of additional external help.

P: I think professional care is very important, because I have to take over more the psychological caring - to give a relative the feeling he is in our middle...

(family)

In general, I found the situation of caring in the countryside rather different as care for older people within the family compound was still more self-evident. Mr. Maler, living together with parents and children on his farm explained.
Mr. M: The role of families here in the countryside will have to change in so far as existing structures and family networks have to be maintained for the future – in contrast to social trends... A system where the young look after the elder generations – Of course, it is often difficult to live together under one roof with three generations, but the solution to bring older people into a nursing home would not be possible for us, we couldn’t even afford it...

The very last comment of Mr. Maler might be disputable in so far as in the case that intense physical caring for an older familiar would really become necessary. An obviously complex structured, but quite generous social system in Austria would provide financial support for caring for the family of Mr. Maler in the same way as for other families in Austria. However, it was my impression that Mr. Maler was anyway more emphasizing the moral and emotional ‘impossibility’ and reluctance to just bring his parents, who had been living with him and his family all life long, to a caring institution. And Mrs. Maler added:

Mrs. M: Caring is something, which happens more self evident here, you just do things for your elders, you do not think so much about it, it’s like children – if you work at home it is much easier it happens just like this, and more natural...

In spite of such situations, professional home help was the widely prioritized concept among participants in my study as a whole. But it was also then a frequently mentioned concern of where and how to recruit enough and affordable formal care-givers.

Mrs. Lang: I guess it shouldn’t be the future task of families to take care for their elder family members – in the sense of health care. But this means that care professions will have to become more attractive for younger people and care service will have to be available for lower prices in the future. Anyway there are enough unemployed people in Austria. And why is caring possible with nurses coming from Slovakia? ... I think that should also be possible within our own country...

It is a well known phenomenon in Austria that affordable home care over a longer period is only provided by people from eastern European countries.

Mrs. Grundner: Now we ask people from Slovakia, next from Ukraine, in a few years we will probably ask people from Kyrgyzstan or from Africa to take care for us...

This very well established black market of foreign care-givers in Austria creates some concern at the political level.
Dr. Schmidl: We have to think about solutions between the black-market and the high professional care services, which are not affordable – neither from public side nor for private persons. – This will be a future challenge for policy...

(policy maker)

While Dr. Schmidl preferred a ‘solution in between’ with less qualified personnel, Mrs. Baumer emphasized better education and acknowledgment for the care profession as a whole.

Mrs. Baumer: I know very well about the lack of care-professionals in Vienna and this simply has to do with the fact that the care profession is not acknowledged appropriately. We should redefine the profession of caring. My idea is nursing schools in the form of institutions for higher education, which can provide a basic and good quality education and allow someone to still develop her or his personal career afterwards...

(policy maker)

Thus, better availability of affordable and professional home care was the widely shared interest. But to care for ‘health in old age’ at home is not a one dimensional task. Another topic of discussion was therefore:

-Multi-professional teams versus fractionated home care

A well organized and more flexible infrastructure appears as necessary in order to allow for creative solutions and individual home care as long as possible.

Mrs. Lang: I think home help organizations should work in teams and provide a combination of medical help and care service and enable an older person to stay at home or even within a family compound – without becoming such a heavy burden. – Often it’s just small things you need, for example an infusion to substitute fluid, when one can’t drink enough for one or two days...

(family)

Mr. Burger was still thinking about solutions, how his wife could manage alone at home.

B: I think like ‘meals on wheels’, there should also be something like ‘doctors on wheels’. Look, if I wouldn’t be here, it would already be very difficult for my wife to reach a general practitioner – with her eyes, the stairs, the street, then you have to wait so long there ... It would be enough, if such a service could call regularly – twice a week – and ask for health problems or for other important things. Then they can pass by together with a medical doctor and this doctor could make a short check and prescribe a certain treatment – or even carry a small pharmacy. I think doctors and social services are inseparable – doctors are a social service as well – so there should be a connection. I could imagine that there should be one doctor responsible for one district, so the patients know the doctor and the reverse...

(older p. in g. phy. c. / 84y)
Dr. Hrabcik was aware of the problem that older people were often hospitalized due to the fact that they couldn’t reach or consult their general practitioner any more.

H: Obviously, there is often not really the necessity for hospitalization, but older people are at the same time unable to see their general practitioner. So, we will have to think more about mobile services, where not the patient goes to the doctor but the doctor comes to the patient - which does not mean hospitalization...

(policy maker)

And what was the opinion of general practitioners or hospital doctors themselves?

Dr. Bauer: I think it would be very important to have more teams. Teams, which are better able to care for a person at home – this is not just a medical task, it requires much interdisciplinarity. I only fear that medicine at home will often be limited by the fear of people, who are restricted by regulations and laws.

(health professional)

Dr. Fried: I think this would be the ideal solution – bringing medicine more to the home of the patients. (Ich denke, das wäre die ideale Lösung – die Medizin mehr nach Hause zu den Patienten zu bringen...)

(health professional)

All these statements, which show an interest in more mobile and medically supplied team care point to a shift in the future role of general practitioners.

Future tasks and responsibilities of general practitioners

This group of medical doctors is, in Austria, often the most important and first consultants for ‘health’ problems of older people and holds a key position in linking institutionalized and external health care services. The tendencies in my interviews showed that a more fluent and heterogeneous concept of ‘healthy ageing’ for the future will also impose greater challenges on this intermediate position. Tasks and responsibilities of general practitioners will have to become more multi-dimensional, mobile and interdisciplinary.

One important concern and theme from the point of view of older participants in my study was the ‘attitude’ of general practitioners, which – often due to time constraints – didn’t allow them to take the whole ‘health’ situation of an older patient into account. In speaking about her general practitioner Mrs. Anders complained:
A: With general practitioners it is quite difficult, because usually they do not have enough time for their patients – I call mine the two-minutes doctor...  

(older p. in red. phy. c. / 74y)

For Mrs. Gruber a general practitioner should have more time for conversation.

G: Often a good conversation is better than a pill, you know – that can help more I think. Often people go to get their pills there, but they want to talk. And sometimes they don’t take their medication in the end...

(older p. in red. phy. c. / 85y)

Mrs. Kolb told me that she had recently changed her general practitioner because...

K: ...the old doctor I used to go to, he was not interested in you as a person – this is what I expect from a doctor, that he shows interest in you as a person and that he knows about you as a whole.... My former doctor just said: ‘So, - what do you want?’ (So, - was wollen Sie?) He did not even ask me, how I was feeling...

(older p. in g. phy. c. / 80y)

For Mr. Burger such ‘attitude’ had more to do with necessary psychological training and competence of doctors and was not only a question of time.

B: I think doctors should be better educated psychologically. Often they do not really concentrate on the patient. And then patients do not really know what the doctor wants or what he says. – The patient should not have the feeling of being treated like on the assembly line – like a thing. I don’t think that this always needs more time. It’s just to do or say it differently...

(older p. in g. phy. c. / 84y)

Another frequently mentioned theme concerning general practitioners was – and Mr. Burger had mentioned it already before – a strong interest in better ‘accessibility’ and even ‘mobility of general practitioners’ of the future.

Dr. Bauer, working as a general practitioner in Vienna, saw a great future challenge for her profession in this theme.

Dr. B: I think a general change in attitude is necessary as people are growing older and are often not able to come to our practice. So we have to go there. – And it’s not only necessary to know the most modern and state of the art therapy of a certain severe disease, that’s far less frequent... It’s more common that you need to know how to help in all the psycho-social issues around... - A home visit takes me at least three quarters of an hour – if I hurry. And then I have not really practiced a lot of medicine, but probably done a lot of other things... (Und dann habe ich nicht wirklich viel Medizin gemacht, aber womöglich eine Menge anderer Dinge getan...)

(health professional)
Again, participants of my study, who were living in rural regions of Austria seemed, in
general, more content with the available services of home-visits than in urban areas. Dr. Horn
had worked as a general practitioner in the countryside for 30 years and was doing a lot of
home visits.

Dr. H: I often and regularly do home visits and they are very important. I know colleagues, who
don't do that... Somehow I can understand them – it doesn't bring any money... That should be
better rewarded and acknowledged and it should be more attractive for us to do home visits.

(health professional)

Taken together these findings indicate that the future role of general practitioners in Austria
should go more in the direction of mobile services or be integrated in such services.
Additionally, more time and responsibility for the bio-psycho-social reality of an (older)
patient was expected but should also be rewarded appropriately in the future. In summarizing
these issues, Dr. Hrabcik led to the next theme of this section.

H: If general practitioners have to take new roles and responsibilities, we will need more
general practitioners than we currently have. And we will need a better network, where social
and care services, as well as doctors take care for older people at home... But these groups are
still too separated and need to work together in a better way.

(policy maker)

Frameworks for multi-professional cooperation

Dr. Schmidl: I think that is also a cultural issue in Austria. There is a long tradition to separate
the hospital and the external health sector. But I think there should be changed a lot for the
future and it will need to establish new forms of distribution of services within the health care
sector.

(policy maker)

This tradition and established infrastructure appeared to be a core problem, which impeded a
lot of dynamic and multi-professional solutions in Austria – although, these solutions were
widely desired.

I found that the realization of various structural reforms is obviously a crucial precondition for
the implementation of a health care system in Austria, which would be able to better meet the
needs of an ageing population. The central point of all these reforms is the establishment of an
intensified cooperation between the so-called intra- and extramural field of health care. Basic
regulations concerning fragmented financing and separated health insurance policies currently inhibit such a better cooperation in Austria. In this respect my conversation with Mrs. Baumer from a large health insurance company in Vienna was very enlightening.

B: At the moment our health insurance company is only directly involved in financing prevention and treatment outside the hospital. But we are only indirectly involved in the treatment of a patient within a hospital or in financing care for this person – that is responsibility of another level. We try to improve this cooperation now because it is not only a question of where doctors go it is more a question of what a system allows and enables.

Res: If I understand correctly, this means that in the current system it is in your interest that a patient is referred to a hospital rather than treated at home or by a general practitioner, because then you are not directly involved any more...?

B: This is exactly the case, yes.

To change this situation at the political level will be a great necessity for the future. This was also confirmed by other policy makers but especially visible in the practical field of health care in Austria. Good cooperation and even conversation with hospitals was often experienced as very difficult from the side of general practitioners.

Dr. H: Of course! By seeing a patient at home a lot of money and resources could be saved – but someone gets the impression that there is no real public interest and that the tendency still goes towards the hospital – I don’t know why...

Dr. B: The best and modern high-tech medicine is useless for me if the prescribed medication of the hospital is not available for the patient, or if it takes at least a week to organize it. – Or, if a patient in daily life and for practical reasons is not able to follow the instructions or an advised plan of therapy of the hospital. There should be a much better cooperation. False advises can often make more stress for a patient than they can contribute to their health situation...

Rigid regulations were also a clear concern and reason for complaint from the side of hospital doctors like Dr. Gabriel:

Dr. G: Hospitals will change to specialized places for acute treatment – because the hospital beds simply become too expensive – and this means that we will need a much better and upgraded network of general practitioners and medical treatment outside the hospital. But nowadays, even if you find a general practitioner to treat a person at home, they do not have enough possibilities to do this or to prescribe certain drugs or to do certain interventions. There are too many regulations, which impede this. And so patients stay in the hospital, although there is no real need for this, nor do they want to stay...
Dr. Vogt was angry at such circumstances and the lack of communication between health care institutions for older people. In commenting this theme he brought up the term of ‘good medicine’, which I already referred to in the previous chapter.

V: Why is it not possible that one old people’s home collaborates with one particular hospital? And why is it not possible that a doctor from this hospital comes to the nursing home with an infusion for example? – But there is always this rigid separation between the sectors – and it is not only that they do not go there, they do not even communicate with each other... We don't need fragmented treatment! - If you always give a case away after a certain intervention you do not see the outcome and the problems and you do not learn or improve... If you do medicine, you have to take it seriously and do complete and ‘good medicine’ – then it is cheap medicine! If you do ‘bad medicine’ and always interrupt it and refer patients to someone else then it becomes expensive! If you do ‘good medicine’, then you can bring older people home again and give them back their independence. This would save a lot of money and would generate a lot of health!

(researcher - health professional)

Dr. Stein, as hospital managing director was interested in finding much more solutions ‘in between’. He mentioned improved management of hospital delivery for older people, institutions for short-term treatment ‘in between’ a specialized hospital and a pure nursing home or a concept of hospitals as ‘health centers’, where more prevention and rehabilitation could have a place.

Dr. Hrabcik, on the political level, emphasized the importance of ‘evidence’...

H: We need studies and experience, which provide evidence for the economic and practical usefulness of this intensified cooperation between hospitals and extra-mural services. If there is a clear advantage, no political party in Austria will accept the present system...

(policy maker)

This comment supports the efforts of my own study but also shows that concrete political action is mainly built up on quantitative evidence.

Finally, it appeared from my fieldwork that any framework for enhanced multi-professional cooperation could be easier realized and implemented in...
Smaller and more flexible structures

Only in this way, health services as well as living- and caring arrangements could better meet the needs of individually ageing people and do justice to the heterogeneity of ‘healthy ageing’.

Dr. Vogt, by continuously engaging in the improvement of the caring situation for older people in Vienna, had the impression that mobile and multi-professional solutions could only be affordable and possible within small structured organizations.

V: I have seen the system in Munich and the mobile care works much better there, because it is distributed between the districts and all services are interconnected for that district and work together in a useful way...

(researcher - health professional)

Smaller structures were also prioritized by the clients of health- and caring services themselves. For example, by Mrs. Gruber in the city or Mrs. Kolb in the countryside.

G: I feel much better treated in this small hospital than in a larger one – the large hospitals are like factories...

(older p. in g. phy. c. / 85y)

K: I think it was a big mistake to give up the local old people’s home here in the region. Now people have to move down to the valley, to another village and use the large old people’s home... There you don’t feel at home any more, you have to look up, and we are used to be here in the mountains... If it would still be here in our village a lot of people would like it. – I could even imagine going there as well.

(older p. in g. phy. c. / 80y)

More flexible models for the use of old people’s homes seemed very much in the interest of my participants. Such models could help to reduce the threat of a lost identity and independence, a situation, which was often associated with institutionalized care.

Mrs. Grunder had heard of positive experience with such solutions.

G: I think it would be ideal, if these institutions would provide part time care. Then you could receive care in the institution for half a year and spend the other half of the year, for example during summer, at home. – I know this exists and I know an older person, who is very happy with this concept...

(family)
When I asked Mr. Wild for his opinion about such a model he seemed almost enthusiastic.

**W:** Yes, this would be good! - Not to go there from one day to the other and with the idea of not going home any more... To go there for two or three month and recover and then come home again, this would be ideal. - You know this is what one fears, that you have to stay there and you don't like it. If I would have to be somewhere, where I wouldn't like it, I would become mentally sick anyway and I would die there sooner or later.

(older p. in g. phy. c./77y)

That older people should live together, just because of the fact that they are old, was strongly rejected by older participants.

**Mrs. Rieder:** I don't think it is a good idea that older people live all together and separated in large cities for older people, for example. Older and younger generations are inseparable for me. Older people can hardly speak with each other if there are not also younger people present.

(older p. in g. phy. c./84y)

**Mr. Kraus:** older people should not be separated - I always have to think of the saying: 'When are you moving to the old people's home? - Oh, I don't go there, it's only old people there!' ('Wann ziehen Sie ins Altersheim? - Oh, dort geh ich nicht hin, da sind ja nur alte Leute!') We need the younger generations...

(older p. in red. phy. c./83y)

To organize her elder years together with friends within very small and individually adapted living arrangements was a vision of Mrs. Lang.

**L:** What would be an ideal concept for me - and we discussed and developed this together with friends - would be a kind of living arrangement, where more older friends or couples could live together in a larger house. We could share and organize professional help from outside together or even help each other... I don't know if such an idea could be realized, but it would be my vision.

(family)

Mrs. Grundner had a similar plan and added:

**G:** ...From the side of architecture could come a lot of new contributions for more flexible solutions as well. - I like the idea, for example, where younger and older people can stay close together and even help each other.

(family)

Dr. Vogt was of the opinion that a tendency towards home care and smaller living arrangements was a rather natural and logical development over time, which should be respected in the planning of future structures. His following statement also summarizes quite well the general tendency of this whole section in form of a provocative...
Closing remark

V: ... In the 70s older people were queuing in front of old people's homes in order to get a place – because the living standard was better within the old people's home than at home. Nowadays this has changed. And if you see these shabby houses – I call them 'barracks for the elderly' – most of them are over 100 years old... But they build them again, with more than 300 places each! These are again 'barracks for the elderly' – and who wants to go there? – Nobody! – But they build them again, this is the terrible thing about it! If we want to support places were 'health in old age' is preserved as long as possible, I have to think of all the possibilities in mobile care and combine them with very small structures of living arrangements, around ten places each...! – Where something can be developed and where medicine and care should be kept out as long as possible. Because as soon as they enter the field, things start... these services should only be allowed when they are called. Because I am convinced that 7 or 8 people in their 80s or 90s can still arrange and organize a lot on their own, if you give them the chance and show them how. – But they immediately fall in a lethargy as soon as you take them and refer them to a nursing home – there they usually live a year or two then they are dead anyway...

(researcher - health professional)

This concluding comment leads directly to the last section of this chapter.

III) How much 'health care' will be 'healthy' for the future?

After having discussed the issues of prevention and caring for 'health in old age' I will, finally, look at the natural limitations of human life as well as of biomedical possibilities. Both themes in combination impose sensitive ethical questions and human dilemmas on health care systems and on all ageing persons alike. But as my interviews in the field confirm, 'good medicine' and caring for older people of the future should be able to respect these limitations and integrate a natural course of human existence as part and parcel of 'healthy ageing'.

Creating dilemmas

A well established health care system, which can provide qualitative high standing medicine for a whole population, is something a welfare state like Austria is and can be proud of. Especially a system with a social and generous attitude, which currently does not restrict
medical benefits for patients over a certain age, was repeatedly emphasized by various of my interviewees at the official levels in Austria.

**Mrs. Baumer:** There is no age limit for insured medical treatment in Austria. We do not have this form of rationing... and I think this is very important. – Who has the right to decide for another person? 

*(policy maker – health insurance official)*

Dr. Schmidl stressed ‘health’ as a valuable future ‘product’ of this system.

**S:** I think this system should be seen as very positive, because health is also a valuable product and outcome – people would react much more euphoric, if the product would be cars, but health should be respected as valuable product for the future. 

*(policy maker)*

And Dr. Hrabcik...

**H:** Health professionals have to accept that older people have the same right for life quality as younger generations and that interventions should not be withheld just because someone is too old. 

*(policy maker)*

In moving on to the level of health professionals and to those, who are dealing with the daily reality of ‘illness and health in old age’, a certain professional pride on medical achievements and possibilities was still recognizable. But at the same time, this pride was clearly confronted with ethical and professional dilemmas when treating and caring for old and very old people. Dr. Horn, for example, often recognized an economic dilemma in his daily work.

**Dr. H:** It can’t be that necessary drugs or operations are not paid or done, because someone is too old. But who will pay for all this? Can we limit the demand for such medical interventions, should we limit it? – On the other hand, we shouldn’t stop the progress in medical developments and inventions, because they help us a lot...

*(health-professional)*

From the position of Dr. Fulda as medical director of a nursing home it was rather a human and ethical problem. She was often confronted with the results of high-tech medicine, where ‘a lot’ is possible nowadays...

**Dr. F:** ...If you look at intensive care medicine – doctors working there only see that they have saved someone’s life – we see what comes afterwards. – But we can’t cure here anymore, we just maintain... for sure, we do not make people healthy anymore here (...*wir machen Leute hier sicher nicht wieder gesund*).

*(health-professional)*
Dr. Gabriel worked a lot in intensive care units as an anesthesiologist and seemed very familiar with this situation.

**Dr. G:** You know, often a lot is done for a patient without thinking. – Often, just because of an underlying anxiety that everything has been done for a patient, regardless of the wider circumstances. That’s very problematic. – On the other side, I am also afraid of certain ways of measurement of ‘health’ or ‘life quality’, which might be dominated by economical interests...

Dr. Gabriel regarded this “underlying anxiety” also as responsible for the situation that in Austria old people are hardly ‘allowed’ to die in an old people’s home. They are rather referred to a hospital before – although, most of them would prefer not to die in a hospital.

Dr. Bauer, in working as a general practitioner, told me that she was regularly confronted with old patients, who did not want to live any more.

**Dr. B:** Sometimes they ask me, why they have to wake up everyday again, and even that I should give them something to end their life. - Then it is often difficult to react appropriately, because sometimes I can understand them very well...

It should be a matter of course that patients have the possibility and right to express their will and priorities concerning medical interventions. Yet, it was the fear of many participants in this study that, especially at the end of life and in a culture dominated by biomedical ideology, appropriate respect for such a will could get lost. The theme of a patient’s declaration, which had just recently been introduced in an official form in Austria when I was conducting this research, was therefore an important topic of discussion.

**Mr. Kraus:** I don’t want to become a case in complete need of care – I have even sought information concerning a patient’s declaration for me. But it seems complicated and you have to pay an advocate for it... I think that should become easier and less formal.

(older p. in red. phy. c. / 83y)

**Mrs. Grundner:** I think the issue of patient declarations will become very important in the future. I and my husband and most of our friends will make such a declaration very soon... Although, I see an important ethical problem arising with these declarations for end of life scenarios or even for euthanasia...

(family)
Additionally, such declarations can generate a dilemma for ageing people. To what extent could a phenomenon like the ‘ageing paradox’ finally change their decision and viewpoint at the end of life? Many participants seemed well aware of this ambiguous situation.

Mr. Burger: Personally I think a human being has the right to say: 'Now I don't want to live any more.' I am even in favour of euthanasia... well, this is a personal issue, I am agnostic. – But I can also imagine that my point of view could change in a certain situation finally...

(older p. in g. phy. c. / 84y)

In discussing this topic with Mr. Wild he came to tell me a small story about his uncle.

W: I think about such declarations, because I don't want all these things. You know, to keep me alive by all means – and there I fear a bit the additional health insurance I have, because there is this tendency then that they like to profit from it... but I told my family about it... - Oh, now I remember – among my relatives we had this uncle. He told us that in case he would be very sick and would know that there is nothing left that could help him, he would prefer to shoot himself. But then, when it really came like that and he got very sick, it was not as he had said any more. He was even too sick then to get up and shoot himself...

Res: Do you think it could also be that he had changed his decision then?

W: Yes, I fear this might happen as well – that the will to survive becomes so strong finally (– dass der Überlebenswille letztendlich so stark wird). – I don't know, if this is like that... – It's the problem that it is so difficult to estimate in advance...

(older p. in g. phy. c. / 77y)

Mr. Pold was also insecure about making a definite decision in advance.

P: If I imagine, I would lie there and I couldn't do anything any more... – But I don't know how I would react, if I would really be confronted with such a situation, if I would still think the same way... – I think of examples now – life could still be worth living...

(family)

Finally, we have found an ethical dilemma more at the level of biomedicine as well as one at the level of an ageing society as a whole.

Approaching solutions

The possibility for improved ethical decision making, the acceptance of limitations and the change of a larger value system were articulated priorities and interests for the future from the side of health professionals, but also mentioned by some other participants.
Dr. Fried: There are a lot of technical possibilities in our hospital nowadays. I think in the future we will have to think more and more what forms of treatment we should offer to very old patients. Just recently we had a long discussion about a very old and decrepit patient and if we should start artificial nutrition with the help of a gastric tube. – Or we have this whole issue of dialysis in old age… It is often very difficult and I would wish we could have a kind of ethical board within the hospital or more cooperation and exchange... Where we could decide together, including the general practitioner and the family, who know the patient best....

(health-professional)

Dr. Hrabcik – from political side – saw this as a great future challenge as well.

H: For doctors it will not become so easy as they will be more often confronted with the situation where they can’t use what they originally have learned to do and want to do…this will create changes and deserve re-orientation...

(policy maker)

To re-orientate certain attitudes and values could be integrated in preventive programs according to the idea of Dr. Stein.

S: I think it would be very important for the future to rethink concepts of human values and to find new forms of acceptance and understanding for illness and for people suffering from chronic diseases – not to hide them only in hospitals. – I think this should also be part of future education and prevention programs.

(health professional – hospital management director)

And Mrs. Heid, who was suffering from dementia herself,…

H: That people stop and look at you because you are not normal – that should be eliminated – that would be an important step...

(older p. in red. phy. c./85y)

To find better solutions for end of life scenarios, more in accordance to the will and personal wishes of an older person and patient, was another important topic in my interviews and conversations. Two contrasting themes appeared, the option of palliative care treatment versus euthanasia. Among my participants I found that certain preference was given to the option of palliative care rather than to a concept of ‘pure’ euthanasia. This might also have to do with the remembrance of events in Austria during the Second World War.

Mrs. Gruber: I am very skeptical with the solution of euthanasia. You know, in our generation one easily feels reminded on the times of the Second World War. – It might be dangerous, if families want to get rid of an older family member… (– Das könnte gefährlich sein, wenn Familien einen älteren Angehörigen los werden wollen…)

(older p. in red. phy. c./85y)
Dr. Fulda was completely against the introduction of euthanasia in Austria.

**Dr. F:** I am glad that the new form of patient's declaration exists in Austria but does exclude any form of active euthanasia. I hope that euthanasia will never become a topic in Austria. – Simply, because there are not only nice children or relatives... – But it doesn't even have to come so far. – Just imagine the enormous pressure on an older person, who needs long term care and sees how all property and money gets slowly lost and nothing remains for the children... - Then this person might think: 'Well, then they should better kill me...' I think this is a terrible scenario!

(health-professional)

It was more for religious reasons that Mrs. Lang was in favor of palliative care but not of euthanasia.

**L:** For me, euthanasia was never a theme. I think modern medicine has reached possibilities where terrible forms of suffering and heavy pain are almost not necessary any more...

(family)

She continued saying that palliative care and medication, which could probably cause or accelerate the natural process of dying, was something different for her than active euthanasia. From her point of view “a good form of assistance in dying” was important.

Such form of caring for ‘health in old age’ was also what Dr. Bauer had found as her personal attitude and solution, when terminal old patients asked her to give them ‘something’...

**Dr. B:** ...I then try to act more in direction of intensified palliative treatment with more pain medication... - Often it's also that I receive informal written statements from patients. I take note of such requests then and try to ask people every half a year again, if the statement is still in accordance with their present opinion...

(health-professional)

More flexible solutions ‘in between’, which allow to better respect and adapt to what ‘health in old age’ really means for a single ageing person, appear here again as the main need and interest.

**Closing remarks**

A human and natural form of ending one’s life is part of ‘healthy ageing’. In this last section we have seen that this should be the concern of ‘good medicine’ and ‘good’ health care as well and not get lost due to certain ideologies within the biomedical paradigm and culture. As I found in Austria, policy makers, health professionals and an ageing society as a whole are
continuously confronted with ethical dilemmas. Only by investing in more team work and communication and by finding dynamic solutions in small dimensions, do improvements seem possible and an individual 'culture of health' can be preserved and respected with dignity. Without doubt, comprehensive ethical decision making and the reformulation of social values and human attitudes will impose great future challenges. Obviously, they have to be based on the acceptance of natural human and biomedical limits and on the equal distribution of health care resources.
Chapter VI

Conclusion

The main objectives of this exploratory study were twofold. First, it was the purpose to reformulate a concept of ‘healthy ageing’ in accordance with the lived reality and experience of ageing people and the expertise of participants at different levels. Second, this study aimed to explore how such a prioritized concept could be supported and respected in the future ‘health care’ for older people. The setting of this study was Austria. In recruiting participants from different levels and from various locations within Austria it was intended to provide an overview and an interpretation of wider tendencies and interests concerning the future of ‘health in old age’ in this country. The research followed a sequence of two steps:

1) Reconstructing meaning and setting the stage

There are various possibilities to interpret and use the term ‘health’. If we stick to a strictly biomedical understanding and definition, a concept of ‘health in old age’ or ‘healthy ageing’ does not exist, ‘is an illusion’ as Prof. Rosenmayr commented. It would even become irresponsible terminology as it adds to the discriminative and stereotypical distinction between a ‘third’ and a ‘fourth age’ or between the ‘fit’ and the ‘frail elderly’. Yet, I found that many older participants of my study experienced ‘health in old age’ or regarded themselves as ‘healthy ageing’, irrespective of a differing biomedical conceptualization or assessment of their condition. It was therefore a first step of my research to explore this apparent contradiction, which represents a field of tension between biomedical ideology and human experience.

In developing ‘a background’ of the study we have seen that ‘health in old age’ is a central concern within ageing societies. Medical value systems and evidence-based forms of ‘health’ have become internalized standards and interests. They dominate ‘ways of seeing’, saying and doing, and obtaining ‘good’ physical health is almost a kind of religion in our culture. As this form of ‘health’ is in danger in older age or deviating from established social norms, the consequences are an increase in medicalization, hospitalization and technicalization of a
certain phase of life or age group. ‘Healthy ageing’ mutates into a new business under the paternalistic control of a biomedical paradigm, where an individual and their not evidence based experience easily gets lost.

In moving to the first part of ‘a foreground’, and to Austria as the location of my research this field of tension was obviously very present in many of my interviews. But in bringing the voices of all participants together and by including valuable comments of researchers, it was possible to identify and reformulate an existing concept of ‘healthy ageing’. Such a concept is located in between a narrow and medical definition and a wide and metaphoric (ab-)use of the term. This does not imply that often useful definitions or necessary linguistic specifications are being dissolved, but that they are rather related to the lived reality of an ageing person. When this happens, the importance of the term and component ‘physical condition’, for example, does not disappear, on the contrary, it becomes possible to recognize it in relation to a natural course of life and as exposed to changes over time. Based on the experiences of my interviewees, ‘healthy ageing’ can be described as a process, not confined to a certain age, and necessarily related to and interpreted by a unique ageing person.

Additionally, participants explained ‘health in old age’ as constituted in a heterogeneous equilibrium of interacting components. These components were located in biological, psychological, spiritual or social aspects of their lives and represented in themselves parts of ‘health’, as well as resources for each other. ‘Continuity of interests’, ‘social relationships’, ‘physical condition’, ‘acceptance’ or ‘self care’ were some examples for such prioritized components or resources. Understanding the existence of this complex equilibrium can explain why a person is able to experience ‘health’, although a certain part of it might be affected. Or, why a certain component and thereby even the whole equilibrium of ‘health’ can deteriorate, in spite of all efforts made to improve this one component.

Only by first asking different people for their personal experiences and priorities and by understanding the intrinsic individuality, dynamics and heterogeneity behind ‘healthy ageing’ in chapter IV we were able to explore, in a second step, appropriate and desired future support for this concept. It was a remarkable part of my findings that all major characteristics of ‘healthy ageing’ were clearly reflected in mentioned priorities for improved future ‘health care’ for older people in Austria. And reversely, these priorities confirmed again the reformulated concept. It is therefore my basic conviction that such sequence of action should
be self evident when planning new forms of intervention. Otherwise, certain ideologies and standards are defended and maintained by all means, but are, finally, neither in accordance with real needs nor possible to be financed for the future.

2) Identifying implications for the future

Figure 1 provides an overview of central findings of this study. We can see that the tendency in health care priorities for older people in Austria is very well in accordance with the concept of 'healthy ageing', which is more related to the experience of an ageing person and to a wider context. A logical change in the tasks and meaning of 'prevention' is also apparent under such circumstances.

<table>
<thead>
<tr>
<th>Dynamic and life-long process</th>
<th>Static and confined to age group</th>
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<tbody>
<tr>
<td>Heterogeneous equilibrium</td>
<td>Homogenous entity</td>
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<td>Subjective and self-interpretation</td>
<td>Objective and external interpretation</td>
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A life-long process and positive cycle | A means to an end and an obligation

Home care
Professional carers
Team care
General practitioner with new responsibilities and mobility
Multi-professional approach
Small and flexible structures
Ethical decision making and palliative care

Institutionalized care
Family care
Fractionated care
Current general practitioner
Separated specialization
Large and rigid 'geriatric ghettos'
Combating death and decline by all means

Figure 1: 'Ageing and health' in the context and tension-field of a wider reality

We should look at this diagram cautiously and be aware that we are facing a deceptive simplification of a complex reality. I present this diagram here with the purpose to illustrate certain tendencies and interests within this complex reality rather than to suggest an
unambiguous shift from one reality or pole to another. Moreover, contrasting biomedical and socio-cultural views and values has another problem. Biomedical viewpoints, interests and internalized standards are very much part of our social and cultural reality. What is ‘subjective’ or ‘objective’, for example, is often difficult to distinguish and not necessarily exclusive, in the same way, as ‘professional care’ does not inhibit or diminish the importance of family support. To neglect this situation or to exclude and oppose one part, rather than taking it into account would be naïve and was not the intention of this study. Its aim was rather to question one powerful and overruling part and paradigm of reality and to explore, if widely taken for granted norms and circumstances are still in the interest of people at different societal levels, who are living and ageing in a comprehensive present and future reality.

Below, I will briefly comment and summarize the most important themes and priorities as revealed and discussed in chapter V – the second part of ‘a foreground’.

**Prevention** The continuous development, maintenance and improvement of a personal network of resources appeared as the main task of future prevention for ‘health in old age’. Prevention is thereby closely linked to the concept of ‘healthy ageing’ itself. It is a life-long and individual process where ‘health in old age’ is the result of a person’s entire life rather than a mere product of biomedicine. This means that ageing people are able to contribute a lot themselves. But better adapted frameworks and regulations in Austria, which can support a self-determined continuity of interests, activity and engagement, seemed necessary and were in the interest of all participants. More investment in general education is probably most difficult to achieve for the future but could obviously enhance the awareness for personal values and mutually stimulating resources. In this way, motivation and interest in care taking for one’s own ‘health’ would become something self-evident and prevention a positive cycle rather than an unpleasant obligation.

**Home-care, informal-care and team-care** were prioritized by the majority of my participants. A preference for staying ‘at home’ – as far as such a place is definable and existent – as long as possible in old age rather than moving to an institution seems not only a consequence of a socio-economic development over the last decades in Austria as Dr. Vogt commented. One’s own home and house was seen as resource for individual ‘health’, where a certain independence and well-being could be preserved. In order to support this possibility
and independence, general preference was given to professional assistance at home. It did not appear from my interviews that family care should therefore be crowded out completely but the future role of families in Austria was more described as providing emotional support for their elders. The availability and affordability of sufficient formal carers was a hot topic and concern for people in my conversations. To redefine the respect, education and general acknowledgement for the care profession in Austria appeared as a common interest. But as ‘health’ is something heterogeneous and multi-factorial most participants described social care as inseparable from medical care. This was confirmed in my conversations with older people, health professionals and policy makers alike and mobile forms of medically supplied team care were emphasized. It was widely recognized that the avoidance of unnecessary hospitalization could add to the whole ‘health’ of an older person and reduce the economic burden on the Austrian health care system.

**New responsibilities for general practitioners in Austria** A huge demand for more flexible and interdisciplinary responsibilities of general practitioners in Austria can be seen as the logical consequence of the above mentioned tendencies. To engage in mobile services, to intensify cooperation with the ‘intramural’ health care sector and to provide a comprehensive and bio-psycho-social form of medicine will gain in importance but it is time consuming and will have to be rewarded appropriately in the future.

**Multi-professional cooperation in small and flexible structures** The outcomes of my interviews indicated that an improved framework from the side of Austrian health policy is urgently necessary in order to implement a multi-professional form of health care, which is economical and adapted to the needs of ‘healthy ageing’. Only if intensified cooperation becomes possible in Austria and if complete care and medicine can be provided within small and flexible structures, then cheaper and ‘good’ medicine – in the sense of Dr. Vogt – and a ‘healthier’ form of health care for older people can be achieved. The priority for home care, small hospital facilities and individually designed living arrangements for smaller groups of old people, reflected the aversion of participants to large and impersonal institutions and the fear that ‘the individual’ could get lost within rigid and controlling ‘geriatric ghettos’ (Metz and Labrooy 2005).
Comprehensive ethical decisions and palliative care  Possible biomedical interventions and support were obviously appreciated by participants of this study as valuable contributions to 'healthy ageing' in Austria. But it was also the clear interest in my interviews that limitations of medicine and human life should receive more attention and acceptance as part of 'healthy ageing' of the future. Only in this way would it be possible to preserve humanity, dignity and a rational fairness in the distribution of health care resources at the end of life. To improve the preconditions for comprehensive ethical decision making in health care institutions or to provide palliative care, which can respect the will and dignity of a dying person, rather than radical medical interventions, were tendencies that represented this interest.

In reviewing and concluding this list of themes, we find that a variety of future health care implications and concrete priorities for the care of 'health in old age' in Austria have been revealed. Yet, at the same time, it should be mentioned again and obviously not be disregarded that this study followed an extremely exploratory approach and basically represented a first attempt in the search for the most relevant issues within the larger debate on 'healthy ageing'.

Finally...

Culture is not only “a shared system of norms and values” but is also “continuously changing” (Nanda & Warms 2004) in the same way as societies are continuously ageing. Austria is no exception. As ‘simple’ medical cure and repair of this very human process is not an available solution, future attitudes and approaches towards the care for ageing and older people in Austria will have to shift as well. This needs the courage to question what has been taken for granted so far and implies to adapt and relate mere terminology to a changing and lived human reality.

By following this approach in the small dimension of this exploratory study we have, firstly, been confronted with the rather confusing heterogeneity, dynamics and individuality of ‘ageing and health’. But secondly, and based on these findings, a variety of very realistic and valid health care implications could be developed. They appear in accordance with the wider
interests and viewpoints of people at different levels, and logically fit into a reformulated context, where ‘health in old age’ is obviously generated and experienced.

A lot of future research in all different disciplines will be of need to better explain the complexity of this context. The scientific branch of psycho-neuro-immunology might, for example, be able to show how the development of our physical condition is intrinsically shaped by other aspects of life. Thereby, evidence for the existence of circles which generate ‘health’ and not only for those which generate illness could be provided and add to a more salutogenic health care approach. But one hopes that political action and reforms in the health care for ageing people in Austria are not only based on quantitative evidence, but also “driven anecdotally” – as T. Smith emphasized – and based on the qualitative stories and experiences, which people can offer. By listening to these stories, by taking different viewpoints into account and by putting a face on raw data we may then be able to find out and accept that the most ‘evidence’ and the most of the one ‘health care’ does not necessarily imply the most ‘health’ for an ageing person nor the ‘healthiest’ solution for the future.

Intensified collaboration and communication and the courage to respect different interests, to adapt strategies and to implement innovative solutions in the Austrian health care for ageing people is obviously needed for the future. But in order to develop promising and feasible future approaches it will also need that different disciplines and professions bring their energies together, exchange their experiences and practice inter-disciplinarity. In the same way as adapting and relating mere terminology, this does not mean to give up valuable expertise or to merge what is useful specialization. It is rather to combine this knowledge and to relate future approaches to continuous cultural changes and to a lived human reality.
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Appendix

The participants of this study at the different levels

As outlined in the methodological chapter, it was one intention behind the use of different ‘levels’ to achieve a rough grouping of participants in this study. Yet, it was often difficult to clearly relate the individual position and situation of my informants to one specific level. This was especially true for the distinction between older people in ‘good’ (I) or in ‘reduced’ (II) physical condition – a difficulty which should, finally, support the findings of the study.

All participants at the first four levels were given surname pseudonyms. Only policy makers and researchers are referred to by their real names.

I. ‘Older people in good physical condition’

- Mrs. and Mr. Burger: This older couple acted somehow as core participants of my study and represented two characteristic and clearly contrasting cases of example. Mrs. Burger (83) and Mr. Burger (84) had two sons and four grandchildren and were living on their own in a flat on the second floor of an apartment building in Vienna. I myself was staying in this same building during my fieldwork and it was by chance that I had asked them to participate in my research. I had two long conversations with them in their own home and they were very open and welcoming towards me. Both appeared very interested in the research topic and it was possible to discuss a variety of central themes with them. On first encounter I had estimated the physical condition of Mrs. and Mr. Burger as rather ‘good’. Yet, their personal experience and perception was different from my assessment.

- Mrs. Rieder: an 84 year old widow lived, most of the time, alone in her own house just outside of the city of Vienna. Two days of the week she stayed with the family of one of her daughters in Vienna. Mrs. Rieder had four children and eleven grandchildren. At the age of 71, she had retired as a paediatrician. Her husband had already died many years ago. At first glance Mrs. Rieder seemed to experience ‘good’ health and not to suffer from any severe physical problems. But just before the interview I was informed by one of her grandchildren – a good friend of mine – that she had been diagnosed with a progressed form of osteoporosis, elevated blood pressure and chronic renal dysfunction. I also knew that she was a quite strictly believing Roman Catholic. I met Mrs. Rieder in her daughter’s house, where she had a small but bright room for her own. She was sitting at a table and playing cards on her own when I entered.

- Mrs. Kolb: was 80 years old and living in the countryside (‘Ramsau am Dachstein’) in a separate house within the compound of buildings of a farm. She was the sister of the old farmer and the aunt of the currently active farmer and was born on the farm herself. She had never been married and had no children. But for a long time she had been living together and taken care of her father, who had lived till the age of 95. He had died 17 years ago now and since that Mrs. Kolb was living alone in the house. In former years she had been renting out rooms to tourists but she had eventually given up doing so over the last years as she didn’t like to have foreign people in the house anymore. She told me that she had good contact with her relatives on the farm but
that she enjoyed having her own home, where she could follow her own life rhythm. We were sitting in her kitchen and talking for quite a long time about a lot of things, which were not directly related with the research topic but which created a good context and basis for my questions. Mrs. Kolb told me that she had some problems with osteoporosis, which was sometimes painful and caused difficulties for her in walking upright, and she also mentioned some problems with her sight in her left eye.

- Mr. Wild a farmer in the province of Styria ('Ramsau am Dachstein') was 77 years old. He was a 'Bio- Bauer' in the region, which meant that he was growing and producing biological products on his farm. Since I know this region I have always recognized him as a very active and friendly person. One could constantly see him working in the fields and even in cold weather he was usually wearing short trousers. He gave me the impression of ageing 'in good health' and so I decided to ask him to participate in my study. This was not a problem and he was very willing to help me with my investigations. He only asked me to wait a few days with the interview, as the weather was so nice and sunny at the moment that he had a lot of work with the harvesting of the field. I came to see him one evening and I found him – as usual – outside around the farm. During the interview we were sitting in the old kitchen of the farm house. He had two children and five grandchildren, but had not yet officially left the farm to his son. Apart from some accidents, he didn't mention or recognize any problems with his physical health condition.

II. 'Older people in reduced physical condition'

I recruited all participants on this level on the internal wards of a small hospital in Vienna. Conversations took place in the rooms of the patients or in a separate room on the ward, where interviews were not disturbed. All participating patients were normally living in or around the city of Vienna.

- Mrs. Gruber was 85 years old. She had chronic cardiovascular problems, chronic gastritis and thrombosis with bilateral pulmonary embolism had been diagnosed when she had been admitted to the hospital ten days ago. She was a friendly older lady and always smiling, although she appeared to be quite tired. During her life she had first been working in a café and later on as a secretary in an office. Her husband had died from pulmonary embolism about 15 years ago already and so Mrs. Gruber had become quite anxious when she had heard of her present diagnosis. She had two children and three grandchildren and was still able to manage and live on her own.

- Mr. Kraus had been diagnosed with a prostate carcinoma, anaemia and slight urine retention. He was 83 years old and mobile, in spite of a permanent urine catheter. Mr. Kraus had one daughter, 3 grandchildren and to 2 great-grandchildren and had worked as a civil engineer till the age of 60. After his retirement he had been engaged in planning and constructing a house for his daughter. He spoke with great enthusiasm and pride about this period. He himself was living together with his wife in their own house with a garden.

- Mrs. Anders a 74 year old blind lady. She had been hospitalized for an intensified treatment of her progressed osteoporosis, as well as for her hypertension and for some cardiac problems. Mrs. Anders gave me the impression of being a very positive and lively person. She was able to move around on her own and could still manage to live in her own flat. She had been married, but had
lost her husband around 12 years ago. She had one daughter and two grandchildren. Her blindness was as a result of an accident in her childhood. But, in spite of this disability it had been possible for her to live an independent life and to work as a telephone operator until the age of 60.

- **Mrs. Bergmann** a 76 year old patient, had been referred to the hospital from a nursing home because of a problematic decubitus in her right hip due to bedsores. She had also been diagnosed with diarrhoea, emesis, rheumatoid arthritis and general weakness. About half a year ago Mrs. Bergmann had lost her husband and some weeks after that she had had a hip-joint operation. She had then moved to a nursing home as she couldn’t imagine managing alone at home for the first few weeks after her surgery. Her daughters had also persuaded her to do so. But her health situation had not improved in the nursing home. First, she had contracted a long lasting viral-infection and due to the long period of bed rest she had then developed bedsore and her general physical strength had continued to decline from that time. Mrs. Bergmann had two daughters, both living in Vienna, but no grandchildren. She had been working as a house-wife all her life and her husband had been a shop-assistant.

- **Mrs. Heid** was a hemi-paretic patient due to the occurrence of infectious meningitis many years ago. Usually, she was staying in a nursing home just outside of Vienna. Mrs. Heid was 85 years old and was sitting in a wheelchair. One year ago she had suffered from a cerebral stroke. Now she had been admitted to the hospital because of urinary tract infection, diarrhoea and depression. She was also suffering from dementia and so it was not possible for me to discuss all my questions with her in an appropriate or useful way. But I decided to include her in my study and to use her most interesting comments.

III. ‘Families’

- **Mr. Unger** was a musician in Vienna and at 36 years, he was my youngest informant. He was a father in a so called ‘patchwork family’. He had two children in the age of six and nine years with his first wife and two children in the age of one and three years with a second wife, with whom he was currently living. As this is not an untypical situation of family constellations nowadays, I was interested to select him as interviewee. He had just finished restoring an old house just outside of Vienna and was now living there with his new family. His parents were living separately and independent, but Mr. Unger seemed a bit concerned about the start of problems of his father’s mobility. We met in a café in the inner city of Vienna and talked for more than an hour.

- **Mr. Pold** was a 60 year old man living close to my parents’ house in the city of Graz. He was retired already for 6 years, as he had been employed with the Austrian national railway company, where – at that time – the regular age of retirement had been that low. Mr. Pold told me that he was suffering from chronic Hepatitis B but that he wasn’t really limited in his daily life by this infection. He had two children and 4 grandchildren, living in or near Graz. The interview took place in the garden of Mr. Pold’s house and, after a while, his wife joined the conversation, but she only made a few comments. Since his retirement Mr. Pold was working as a salesman and advisor for a bank institute and was thereby responsible for many private customers. Mr. Pold’s parents had died already but we talked a bit about his parents in law. His mother in law was 83 years old and his father in law 91 and both were still able to live independently.
- **Mrs. and Mr. Maler** were farmers in ‘Ramsau am Dachstein’ and both in their forties. I had originally planned to interview them together with two other farmers in the form of a group discussion. However, all farmers in the region were very busy with harvesting during this time, and I was lucky at all that the Malers could take the time for an interview. They followed an invitation to the house where I was staying during fieldwork and after having coffee together we had a conversation about ‘ageing, health and future’ in the countryside, which lasted about one hour. Mr. Maler’s parents were living on the farm as well. They were both around 80 years old and had recently been experiencing ‘health’ problems.

- **Mrs. Lang** was the daughter of Mrs. Rieder. She was 55 years old and a mother of four children between the ages of 20 and 27. She worked part time as a school doctor and, was also a housewife. With her husband and two of the children, she lived in a family house in the outskirts of Vienna. For two days a week, Mrs. Rieder, her mother, was now living with the family. Our conversation took place in the kitchen and the atmosphere was very relaxed. Mrs. Lang knew already a bit about my research as I had interviewed her mother two days before. Although, Mrs. Lang - in her profession as a medical doctor - was somehow taking a position ‘in between’ my levels, I wanted to include her in the group of my informants as I regarded her as someone, who could provide rich information for my study.

- **Mrs. Grundner** was a 62 year old lady, living in a house with garden in the city of Vienna. She was a distant acquaintance of mine and I had arranged an interview with her several days in advance. I had been invited to come to Mrs Grundner’s house one morning and as the weather was nice we could sit in the garden. These circumstances contributed to a relaxed atmosphere of our conversation. Mrs. Grundner had had a hip replacement operation about six months ago, but didn’t mention any other physical problems. She had two adult daughters, one living in Vienna and the other, who already had two small children herself, was currently living in Paris. In the course of the interview we talked quite a bit about Mrs. Grundner’s mother, who was 84 years old and living alone in a rural area quite far away from Vienna. The future care for her mother was apparently a matter of concern for Mrs. Grundner.

IV. ‘Health professionals’

- **Dr. Bauer** was a general practitioner in the city of Vienna and about 40 years old. I found her by private recommendations of friends. From the very first moment she was willing to participate in the study and via telephone we arranged a date for a conversation in her private consultancy. We met there one afternoon, two hours before she had scheduled to see her first patients for that day. So we had enough time and the atmosphere of the interview was very relaxed.

- **Dr. Horn**, a general practitioner in ‘Ramsau am Dachstein’, was not originally from this region, but had lived and worked in this rural and mountainous area for more than 30 years. He was 61 years old and with his practice he was responsible for the population of a large region. From interviews, which I had undertaken before with people from the same area and from my own local experience, I knew that Dr. Horn had the reputation of being a rather traditionally oriented family doctor, with all its pros and cons. I had arranged a meeting with him for one afternoon after his work in his practice and we talked for about one hour.
Dr. Fulda was a middle aged woman and a medical director of one of the largest nursing homes in Vienna. This nursing home was more or less conducted in form of a geriatric hospital and existed in close cooperation with other departments of a neighbouring hospital. Medically oriented care was provided here for patients, who did not have the opportunity to live at home, in assisted living arrangements or in old age homes any longer. I met Dr. Fulda for about one hour in her office and could get a first impression of the concerns, ideas and viewpoints from her particular position.

Dr. Stein was a managing director of a small hospital in Vienna. He was 40 years old and appeared to me as quite a stressed person. His position carried a lot of responsibility of the hospital, which was in continuous competition with other and larger public hospitals in the city. The hospital had two wards for internal medicine, two wards for surgery and one large department for gynaecology and obstetrics. The interview took place in the office of the management director and in the course of our conversation, Dr. Stein became more relaxed and very interested in the topic of my research and he developed a variety of concrete ideas and propositions.

Dr. Fried was a medical doctor who specialized in internal medicine. He had his private consultancy, but was also working in the nearby hospital, where I had already conducted interviews with some patients and the management director. Dr. Fried was 40 years old and I knew him from my former work as a medical doctor in the same hospital. I visited him there on a Sunday when he was on duty for the weekend. He was not too busy and so we could talk without any disturbance in the hospital garden.

Dr. Gabriel, the anaesthesiologist on duty with Dr. Fried, passed by after a few minutes and we invited her to join the interview as I didn’t mind to have a conversation with two hospital doctors at the same time. She was also around 40 years old and was working in the hospital for half a year now. Before that, she had been employed with a smaller hospital in the countryside. Recently she had started to specialize in palliative treatment of terminal patients and it was part of her tasks as an anaesthesiologist in the hospital to take care of patients in the intensive care unit.

V. ‘Policy makers’

Dr. Hrabcik was chief medical officer and chairman of the agency for safety in health care in the Austrian federal ministry of health and women. He had a medical background himself and, besides the minister of health herself, he was one of the highest ranking officials in Austrian health policies. I had arranged a meeting with him several weeks before my fieldwork. It took place in the office of Dr. Hrabcik within the ministry and we had one hour to talk about my topic. Although, I tried to create a good basis and a kind of personal atmosphere in the beginning, our conversation remained quite formally and I was impressed how well politicians were trained to evade any personal questions. In his way of talking Dr. Hrabcik often seemed to provide normative and official formulas, rather than direct answers to my questions. This was significant for me to recognize how, in exactly such a situation, the power of language and the hidden interests behind mere terminology became very evident.

Dr. Schmidl was a leading official in the municipal authority of the city of Vienna and in charge of planning and developing structures for the health sector of the city. He had time to talk with me for a bit more than one hour and the atmosphere was very relaxed in his large and bright office. Dr. Schmidl was smoking during the interview and did not create a very formal situation. Yet, I
had similar difficulties as in the interview with Dr. Hrabcik to obtain concrete answers on my questions. The content of what Dr. Schmidt was saying was often vague and very general and it was not easy to catch his point or to find out about real interest behind the political language.

- **Mrs. Baumer** was working in the Viennese regional office of one of the largest public health insurance companies in Austria. Here she was responsible for structural and preventive programs and planning. She told me a lot about her career. First, she had been studying medicine for a while but had then changed her mind and had been attending a nursing school. After that she had been working for several years in a hospital in Vienna and had thereby been engaged in founding education programs for chronically sick patients—especially for patients with diabetes. Following that she had been studying in a program for ‘quality management in the health care sector’. During the last four years Mrs. Baumer had been working in the Austrian federal ministry of health and women and had been involved in the planning of health reform projects. Currently, she was studying in a Master’s program for ‘public health’ at the University of Vienna. Our conversation took place in the building of the health insurance company in Vienna, in a large office room and Mrs. Baumer had enough time to talk for almost one and a half hour.

**The experts in the field:**

- **Dr. Vogt** was an advocate for problems and complaints around the issue of caring in Vienna. This official position had been established in the year 2003 after a caring scandal in one of the nursing homes in Vienna. Dr. Vogt was 88 years old and a retired surgeon, who—already before his present function—had always been well known for his political engagement with improvements in the Austrian health care system. The problem of caring for older people in a city like Vienna had then developed into being the core issue of his activities. In his ‘new profession’, Dr. Vogt had started very offensive campaigns and had brought to the attention of the public the circumstances and problems present in the caring sector. In this way, he had obviously not made any friends and, at the time of our interview, it was under political discussion, in Vienna, to abandon the independent role of an advocate for caring issues and to integrate it in the more general and already existent position of a lawyer for the rights of patients. Facing such circumstances and the possible, forced end to Dr. Vogt’s position stimulated a vivid and very revealing conversation with him, which took place in a café in Vienna.

- **Prof. Rosenmayr** was an international well known Austrian sociologist and philosopher at the University of Vienna and had founded and developed ‘social gerontology’ in Austria. Currently, he was 81 years old, but still active and giving lectures at the University. I met him in a small office, which he could still use at the institute for Sociology at the University of Vienna. We started our conversation there but we were often disturbed by telephone calls. We then continued talking on the way to and in a restaurant, as Prof. Rosenmayr wanted to eat something before he attended his next meeting. All this movement and disturbances represented the vivid and active lifestyle of Prof. Rosenmayr, in spite of his advanced age, and somehow confirmed his philosophy and ideology about ‘healthy ageing’.

- **Prof. Heller** was head of the ‘Department of Palliative Care and Organisational Ethics’ in Vienna. This department belongs to the ‘Faculty for Interdisciplinary Studies’ of the University of Klagenfurt. I had been in communication with Prof. Heller over the last year and he invited me to present my research project in his department in the last week of my fieldwork. He and five scientific collaborators were present during the presentation. In a subsequent discussion of more
than an hour I received valuable reflections and comments on my research questions and first findings in the field, which contributed to my final interpretation of data.

- Dr. Lewinter, PhD was a Danish sociologist, specialised in the field of ageing, at the University of Copenhagen. I met her at the international conference on ageing in Copenhagen and we were talking for half an hour at the end of a conference day. She was in favour with ‘critical ageing research’ and specialized in caring models for older people in Denmark. During our conversation she repeatedly expressed her concern about current developments in the field of ‘ageing and health’.

- Dr. Smith, PhD was from the US and was president and chief executive officer of ‘Ageing in America’. He was also a professor at the Fordum University in New York. I got to know him when he was giving a presentation at the international conference on ageing in Copenhagen, where he emphasised the growing need for ‘assisted living properties’ and ‘independent housing programs’ in the US. After that I had the opportunity to meet with him and we talked for around 30 minutes about his point of view on important future tasks in the field of ageing research.