



Evidence-based Guidelines on Health  
Promotion for Older People:

Social determinants, Inequality and  
Sustainability

## **Overview on health promotion for older people in Austria**

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## 1 Introduction

Austria is a federal state composed of nine provinces on the basis of a parliamentary democracy. The country joined the European Union in 1995. Currently approximately 8.21 million people live in Austria. The share of older people in the Austrian population is about 20-21% of the total population. Experts in demographics predict a rising number of older people (“Generation 50+”) in the coming up years, namely a rise from 2.8 million to 4.1 million until the year 2050 (Kytir, 2006).

Life expectancy has increased in the last years (Kramser, Tschachler-Roth, & Sebeck, 2005). In the year 2004 it amounted to 76.4 years for men and 82.1 years for women. Life expectancy is even expected to increase in the coming-up years.

In 2002, the average Austrian with an age of 60 years was likely to live another 20 years (men: 20.2 years; women: 24.1 years). Furthermore, the subjective health of the Austrians (over the age of 15) is good because in 2001 34.3% rated their own health status as “very good”, 40.4% with “good”, 18.3% with “fair” and 6.9% with “bad or very bad” (EUROSTAT, 2006a, 2006b).

## 2 Policy initiatives for older people/health promotion

The Austrian national health system – history and political framework

The Austrian social policy system is rooted in the health insurance law from the year 1888. After having gone through several reforms, transitions and historical decades the now existing General Social Insurance Act (abbreviated “ASVG”) was implemented in 1956. In 1992 health promotion was introduced into the ASVG reacting to European developments, especially the WHO-Ottawa Charta on Health Promotion from the year 1986. In 1998 the Health Promotion Act (GfG, 1998) came into force which constituted the first national law on health promotion in Austria. Older people are specifically mentioned in the above mentioned law as a target group of health promotion apart from chronically ill people, children/youth and employees. There has been a Ministry for Health since the year 1972.

The Austrian health system is based upon a division of labour and responsibilities between (i) the federal government, (ii) the federal states and local governments, (iii) social health insurance funds and (iv) self-administered public corporations in the health system (Hofmarcher & Rack, 2006, p. 34).

Health insurance in Austria is linked to employment. Employees and their families are obligatorily insured in the health insurance fund of their federal state or their company. If they wish, they may additionally choose a private insurance (Wasem, Gress, & Okma, 2004) call “supplementary private health insurance”. Currently there are 20 social health insurance funds in Austria and seven private ones. Institutions

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dealing with retirement insurance and accident insurance are held separately. In sum more than 99% of the Austrian population are insured in the federal health insurance system. Only about 32% of the population were additionally insured through a private health insurance fund in 1999 (Badelt & Österle, 2001, p. 44).

20 billion Euros were spent on health expenditures in Austria in the year 2004 (~7% of the GDP) – about 70% by public authorities. The most important actors and financiers were the social health insurance funds (Streissler, 2004, p. 60).

The responsibility for health, medical and social care of older people in Austria is covered by the respective health or social services either provided by the state, the federal states or the municipalities. Older people in need of health care can be treated in inpatient or outpatient facilities as well as day-care-centres.

Health and social inequalities can unfortunately also be observed in the Austrian health system especially targeting at migrants, children, people living in poverty, the unemployed and older people. Social stratification plays a major role regarding the unequal distribution of health, income, education and the like. Older people, who spent their lives in a lower social class – including lower education and lower income – often face greater health problems when getting old than older people from higher social classes (BMGF, 2002).

### **3 Health determinants**

Fifty-one references of the Austrian literature data base, which is more than 40% of all N=121 reviewed articles/books, cover different health determinants of the general population and older people's health. Since the Ottawa-Charter on health (promotion) was released we tend to speak about main factors of health which are physical, mental and social in nature (WHO, 1986). This is one first differentiation we can apply on the data. Determinants of health can also be distinguished into uni- and multi-dimensional factors. Few authors think about certain feed-back processes and other authors underline that health must be seen as a development process. Perhaps the list of different approaches, disciplines, paradigms and theories can be added endlessly but that explicitly shows that approaches in health sciences are very diverse.

Nevertheless, work-life balance factors for health are covered in the Austrian literature on occupational health promotion. Hence, the conclusion can be drawn that a long and motivated healthy work progress helps people to stay fit. Lifelong learning is also – and that is not only true for the older workforce – mentioned as a main determinant of health as well as the social support of colleagues and supervisors (Abbassi-Nik, 2004; APA, 2005a, 2005b). Especially for low wage jobs involvement, rewarding, job satisfaction, communication and a social support structure as factors of social capital are mentioned as health determinants for the older workforce (eg Hilschner, 2004; Wolf, 2004; Wolf, 2005). A stabile work structure, work organisation,

work process and work environment are mentioned here as well (eg Karazman, 1995; Meggeneder, 2002).

Not surprisingly physical activity such as sports and regular exercise, as part of the physical variable, are essential for health (Diketmüller, 1997; Lames & Kolb, 1997). This is nowadays also discussed in terms of cost reduction for health services and minimisation of societal expenditures (Halbwachs, Weiß, & Bauer, 2000). Activity factors for health are often strongly related to the life-style issue (nutrition, smoking, alcohol, drugs, etc.) and are sometimes only seen as a simple income-outcome determination of health (Elmadfa & Freisling, 2005; Kiefer, 2004a; Noack & Reisklingspiegl, 1999; Pils & Neumann, 2006; A. Rieder, 2003). Risk reduction is mainly discussed regarding the so-called civilisation diseases (eg Dorner & Rieder, 2004; A. Rieder, 2001). Some authors also emphasize the importance of preventive factors which are mainly discussed in terms of risks, safety, accidents and falls of older people (eg Perrig-Chiello & Bürgi, 1999).

From the (social-)psychological perspective, different factors are crucial for a good health status. First of all quality of life, well-being, life satisfaction, luck (Diketmüller, 1997), optimism (Abbassi-Nik, 2004), self-determination (Glabisch, 2005), the capacity to act and self-efficacy are described. Quality of life factors and wellbeing – operationalised with self-care, affect balance, autonomy and independence – are explicitly mentioned as main factors for health (Wegscheidler, 2004). Furthermore, Rosenmayr strongly emphasizes the human ability to cope with one's fears, to be creative and the possibility to experience luck (Rosenmayr, 2004).

Last but not least, social factors are also dominant health factors. Due to the demographic change in western societies social scientists also speak of a "singularisation" of society. Therefore, the factor "social support" through a partner, family, children and friends is an important determinant and protection or interaction factor for health (Abbassi-Nik, 2004). But the most frequent health determinant is the socio-economic status (SES) – mostly measured by education, occupation and income. These factors are mainly responsible for the existing health inequalities (GOe, 2003, 2005; Kiefer, 2004b; Pochobradsky, 1995).

To have the possibility to develop the self, many results on empowerment are available. First of all an activation can loosen hidden resources and activities with the aim to strengthen potentials and to raise the awareness of the individual. This can lead to better health outputs which is also strongly connected with the issue of lifelong learning (Amann et al., 2005; Dietscher & Nowak, 2001; Kiefer, Groman, & Rieder, 2001; Meggeneder, 2005; Polat-Firtinger, 2003).

Despite these mainstream factors other perspectives are also very interesting. Some authors suggest a more dynamic approach towards determinants of health and therefore argue for a biographic approach (e.g. death of/divorce from the partner, retirement, wages/wealth, illness as critical life events and as stressors of life) in which the socialisation process is dominant (Pochobradsky, 1995). In this discussion

the factor “living condition” is additionally mentioned (Przyklenk, 1996) which leads us to the factor “(geographical) region” which is not covered thoroughly enough by the literature study at hand (Kiefer, 2004b). Surprisingly this is also true for the gender perspective because only some references explicitly discuss possible gender gaps in detail.

## 4 Search strategy

The search of scientific and non-scientific literature on health promotion for older people was carried out from July 2006 to January 2007 in several stages. Firstly, keywords for the Austrian literature search were defined by the German terms for “health promotion” and “older people” (age 50 plus). Then the search took place with these keywords considering the search restrictions “Austria” and “1995 and later”. Secondly, several data sources for the literature search were selected. The national literature search was carried out with:

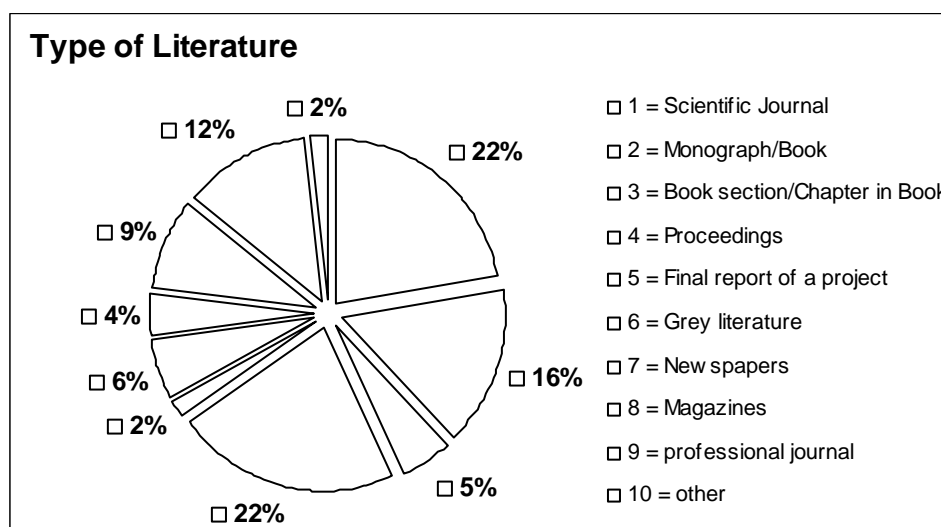
- National and international scientific literature/project data bases (e.g. SSCI, PubMed, Psylit, Gerolit; FORIS, SOLIS, etc.),
- Federal Ministries and governmental institutions in Austria (e.g. BMSG; FGOe etc.) and health related organizations (e.g. NPOs, NGOs, LBIs),
- National and municipal libraries (e.g. National Library, University Library; Stadtbücherei Wien; IHS, WiFo, etc.),
- Health and health promotion/prevention relevant newspapers and magazines (e.g. Gesundes Österreich, Sichere Arbeit, APA Zukunftswissen, etc.) and
- The Internet (google, google.books, google.scholar).

In the next step it was necessary to select the relevant literature regarding the large number of search hits. Therefore it was necessary to review the selected hits by strict application of the search and work package aims. The result was a total sample of N=121 literature pieces in the database on health promotion for older people in Austria.

The literature is – to characterise the literature data base roughly – dominated by scientific journals and conference proceedings (each 22%), monographs/books and book sections (20%). 12% come from professional journals and 9% of the data base result from magazines (see figure 1).

Furthermore, about 80% of the reviewed literature is written in German and 20% in English. Analysed by the year of publication a clear increase can be pinpointed: 18% was published from 1995 to 2000 and 82% in the time period from 2001 to 2006.

Figure 1: Type of Literature



## 5 Themes

### 5.1. Promoting mental health

Approximately every third to fourth case (29%) of all Austrian literature was on “health promotion for the elderly” contained issues targeting at mental health promotion. Rough sub-categories were depression, stress and burn-out, memory-training, self-respect or dignity and emotional support. All categories had three to nine pieces of literature in the Austrian health promotion literature except for self-respect and dignity (only one).

#### 5.1.1 Addressing depression

Psychological contributions to mental health promotion in Austria focus on raising awareness of mental disorders, like depression, and promoting tolerance towards people suffering from depression (Braunsteiner-Reidinger et al., 2006, p. 220). Sports also have a positive impact on stress and depression, sports even help to reduce depression (Halbwachs et al., 2000, p. 101). Women and men experience different forms of depression (Habl, 2004, p. 95) – men suffering from depression often act more aggressive and irritated than women. Habl also states that there are not enough men-specific therapies in Austria.

### **5.1.2 Addressing stress and burn-out**

Stress is one of the major negative health determinants for men in Austria (apart from lifestyle, accidents etc.) (Habl, 2004, p. 90). Older people in the workplace are often exposed to stressful situations and face depression due to work related strains. Health promotion can help to reduce these stresses (Spicker, 2004, p. 43) e.g. feelings of isolation can be reduced (Amann et al., 2005). Older employees can be exposed to increased stress when organizations re-organize. These processes are often slanted towards younger people who are flexible and healthy. Older employees, however, face augmented stress (Meggeneder, 2003, p. 34). One project specifically targets at reducing stress and establishing a work-life-balance (Wolf, 2005, p. 25). When getting older people's abilities to remember and learn usually decline. This can cause emotional stress for older people – "brain jogging" and laughing can be utilized as strategies to prevent emotional stress (Bruck, 2004).

### **5.1.3 Cognitive issues: memory training**

Memory training and life-long learning are key issues for promoting older people's health (Glabischnig, 2005, p. 113). In order to stay mentally active until one's death one article suggests doing "brain jogging" referring to regular cognitive training (30 minutes a day) and a well-balanced diet (Bruck, 2004) to stay fit. Another article stresses the argument that older people should keep up their cognitive abilities through exchanging know-how or engaging in volunteer work (Przyklenk, 1996). Rind suggests playing chess, halma or other card games to stay mentally healthy (Rind, 1995, p. 51).

### **5.1.4 Self-respect / dignity**

Only one article mentions the aspect of self-respect and dignity (EURAG Österreich, --b). In our society dignity is an important factor often expressed through one's occupational status. Experts state that older people who retire lose their dignity and self-respect as a consequence of retirement or unemployment. This so-called „retirement shock“ entails depression, decrease of self-respect and passivity. Volunteer work in the framework of health promotion is a possible solution for this problem (EURAG Österreich, --b).

### **5.1.5 Emotional support**

Emotional support is given through regulars' tables for older people who speak and discuss about their impairments on a regular basis (Glabischnig, 2005), psychosocial support (Weidenauer & Sonnleitner, 2000), self-care (Wegscheidler, 2004) while others develop emotional wellbeing on their own through the sense of coherence (abbreviated "SOC") (Müller, 2002). The SOC, first introduced by Aaron Antonovsky (Antonovsky, 1997), also aids to reduce consequences of traumatic events (Müller, 2002, p. 1).

One article states positive effects of age on mental health: When getting older mental abilities like creativity, problem solving competences, intuition and intelligence increase (Dietscher & Nowak, 2005, p. 5).

### **5.1.6 Other**

No other results.

## **5.2 Empowerment**

About half of all Austrian literature on health promotion for older people stresses the issue of empowerment, which indicates its importance for the health status of older people. Both individual empowerment and the empowerment of groups are mentioned in the Austrian literature.

All data stress the argument that the individual responsibility must be increased and also that older people must be supported in developing relevant structures for a healthy environment (J. M. Rieder, 1999). Older people themselves possess immense (physical, mental and social) potential, they need to be actively involved in health promoting programs and in activities as well as in the healing process after being sick (Dietscher, Herbek, Hübel, Mosser, & Nowak, 2001a). This even contributes to a higher quality of life (Dietscher et al., 2001a).

Empowerment is often also equated with "motivating someone to do something", adopting a healthier lifestyle, organizing one's leisure time, pursuing a healthy lifestyle etc. (Dietscher & Nowak, 2005; Kurz, 2003; A. Rieder, 2003; Rind, 1995). It is about keeping older people active as long as possible to avoid social isolation (Kurz, 2003). Activating older people contributes to their social health. Activities like volunteer work, singing in a choir, doing sports together, working for Non-Profit Organizations or taking care of pets are some of the social activities mentioned in the Austrian literature (Bruck, 2004; Diketmüller, 1997; Przyklenk, 1996; Rind, 1995).

Unfortunately being socially active when getting older is unequally distributed among the older population in Austria as well as in other countries (Rosenmayr, 2004, p. 8).

People from lower social classes have less possibilities and resources to be active when they get old than people from higher social classes.

Self-help groups are often mentioning in combination with empowerment (Dietscher, Herbek, Hübel, Mosser, & Nowak, 2001b, p. 106). Through information, training and active support of self-help groups empowerment can be implemented into the practical context of health promotion.

Empowerment inevitably seems to be linked to quality of life and social participation. Empirical research results support the theory that empowerment goes together with a higher quality of life (Nowotny, Dachenhausen, Stastny, Zidek, & Brainin, 2004) and that older people are co-producers of their health. So Dietscher and colleagues conclude that empowerment needs to be the main goal of all health promoting programs for older people (Dietscher et al., 2001b).

### **5.3 Social participation – inclusion**

About two fifths (or 42%) of all data include information on social participation or inclusion in form of life-long learning, education for older people, social support and networks, self-help groups and volunteering. Six literature cases included several forms of participation/inclusion simultaneously.

#### **5.3.1 Life long learning and education of older people (health)**

One quarter (26%) of the data touch the aspect of life-long learning. Intergenerational programs and education can be impulses for physical, mental and social well-being (Kurz, 2003). Education fosters empowerment and self-management, individual competence and autonomy (Kolb, 2003, p. 189). Learning makes happy and supports one's health (Rosenmayr, 2004, p. 7). Life-long learning should be an active part of older employees' working conditions. Older employees need to keep learning in order to contribute to the success of their organization (APA, 2006). One article suggests life-long learning and an intergenerational learning at the workplace so that organizations do not lose know-how when older employees retire (Dietscher & Nowak, 2005). Where there is no will to learn, foster, support or change circumstances, health promotion has reached its boundaries (Österreichischer Seniorenrat, 2003, p. 29).

#### **5.3.2 Social support / networks**

Conversely to lifelong learning, only 8% of the data deal with social support and networking. Family support and marital status have an impact on older people's health condition (Abbassi-Nik, 2004). Health promotion can also take place in a social

setting like a sports club (Lames & Kolb, 1997). One article points out possible forms of social support and networks for older people: traveling together, living together, volunteering, exchanging grandmothers/grandfathers and senior associations (Przyklenk, 1996). Older people leaving the workplace for retirement can be specifically supported on their way to retirement through workshops, coaching, health panels, seminars to prepare for retirement and discussions between employer and employees (Schierl, 1995, pp. 147-148).

### **5.3.3 Self-help groups**

Only two articles involve self-help groups as a form of social participation or inclusion “strategy” in health promotion of older people. But fact is that in Austria approximately 30% of all participants in self-help groups are men, instead 70% women (Habl, 2004, p. 95). And still there are too few self-help groups in Austria dealing with men’s health and generally more emphasis should be on self-help groups as intervention level for health promotion. Despite this result, self-help groups are more thoroughly covered in the empowerment section (see Section 5.2).

### **5.3.4 Volunteering**

Also only a limited number of articles (4) deal with the topic of volunteering. Those which do so underline the positive side of volunteering. Volunteering can help to get more social contacts, volunteering can strengthen one’s mental health status and development and increased mobility in general (Amann et al., 2005; Przyklenk, 1996). This is especially true for retired older people who are still active or want to stay active longer.

### **5.3.5 Other**

No other results.

## **5.4 Lifestyle**

A healthy lifestyle is composed of nutrition, physical activity, sexual activity, safety, the prevention of abuse and violence, diseases and substance abuse.

### **5.4.1 Nutrition**

Which role healthy nutrition plays in the discussion about health promotion for the entire population as well as for older people is relatively clear. There are several determinants of health and causes for ill health such as wrong nutrition (Habl, 2004; Pochobradsky, 1995). This is – often in combination with other life-style factors such

as exercise, smoking, etc. –responsible for a (long-time) increase of risk factors resulting in ill health (EURAG Österreich, --c, --d; Pelikan, Nowak, & Dietscher, 2002). Hence, diseases are the result like e.g. adiposity/obesity, high blood pressure, diabetes, cardiovascular diseases, etc. which people very often suffer from in highly industrialized countries like Austria or other EU-countries. Obesity is one characteristic of such societies (Kiefer, 2004a, 2004b) because “nowadays, weight problems are the norm.” (EURAG Österreich, --a, p. 2)

In the Austrian literature about health promotion/prevention for older people nutrition plays an important role because about 20% of all references deal with nutritional factors. Thirteen (10%) are mainly about nutrition and eleven literature sources (9%) cover nutrition partly despite other themes and issues.

The literature generally speaks a common language because it is widely accepted that (i) lifestyle factors such as nutrition are important for one’s health and wellbeing, that (ii) an unhealthy nutrition raises risk factors for major diseases and (iii) that health promotion can be (and sometimes: has to be) a strategy to combat them. The literature also agrees with general opinions that it is important for each individual to increase self-care and that the aim of health promotion should be the raising of individual resources. Still health promotion strategies – in connection with nutrition – mainly have the aim of activation and motivation of individuals, strengthening awareness and increasing knowledge.

As a result of the literature analysis there are a lot of awareness raising programs concerning life-style factors (Dietscher & Nowak, 2001; Kiefer, 2004b), reduction of risk factors for several diseases (Böhmer, 2001; Dorner & Rieder, 2004) and actions for increased self-care in connection with life-style and risk factors (e.g. nutritional counselling) (Dapp, Anders, von Renteln-Kruse, & Meier-Baumgartner, 2003a, 2003b).

The connection between optimized nutrition and a healthy life style as well as reduced risk factors has already been touched several times within the literature and can therefore be seen as evidence-based (Elmadfa & Freisling, 2005). Especially through a well calibrated approach towards the target group (eg Turkish migrants: Haider-Koumansky & Özsoy, 2005) and within the right setting – e.g. hospitals (Dietscher & Nowak, 2001), nursing homes or geriatric care (Böhmer, 2001; Dapp et al., 2003b), mobile care (Anders, Dapp, von Renteln-Kruse, & Meier-Baumgarten, 2003) – good results in terms of raised individual health awareness, reduced risk factors and an ameliorated life-style seem to be predictable.

### 5.4.2 Physical activity

There are many studies on the influence of physical activity on health and wellbeing of older people in Austria (Diketmüller, 1997; Pochobradsky, 1995; Schildhammer, 1996; Wegscheidler, 2004; Wiesmann, Eisfeld, Hannich, & Hirtz, 2003).

Sports can be an individual as well as a group's activity, which makes exercise a main point in empowering older people and in helping them escape isolation. Doing sports in sports clubs or groups of older people has side-effects apart from "keeping one's body fit". When the literature talks about sports it does not necessarily mean working out at a gym and exhausting oneself. Physical activity like gardening, going for long walks and dancing are also mentioned as important activities for older people (EURAG Österreich, --b). Sports can even be seen as a countermeasure to social isolation and alcohol addiction (Schildhammer, 1996, p. 34). Doing sports keeps one's body healthy, provides mental wellbeing and improves the social situation of older people (Schildhammer, 1996, p. 131).

It is reported that ageing has significant influence on one's medical condition. When getting older chronic diseases are said to rise and a decline in physical strength and stamina as well as a decreased ability to respond emerge (Dietscher & Nowak, 2005). More than 37% of all Austrians die due to cardiovascular diseases (EURAG Österreich, --f). Working out for 2-3 hours per week helps to prevent specific diseases like the above mentioned cardiovascular diseases (EURAG Österreich, --e, p. 7).

Through physical activity older people are able to build up (i) perseverance, (ii) strength, (iii) mobility, (iv) velocity and (v) coordination-abilities. (i) Regular, persevering exercise (e.g. jogging, walking, hiking or cross-country skiing) helps to train the circulatory system (Halbwachs et al., 2000, p. 91) and thus prevent cardiovascular diseases. (ii) Physical strength can be built up by doing all kinds of ball games (e.g. volleyball, basketball). Strong muscles and stable bones prevent osteoporosis as well as falls/accidents and contribute to the stabilization of the spinal column (Halbwachs et al., 2000, p. 95). (iii) Being mobile in terms of being able to (un-)dress oneself, to tie one's shoes and to (un-)zip one's clothes require a minimum of mobility. Keeping one's joints and muscles loose helps older people to maintain their normal course of life. (iv) The literature recommends training quick responding and reacting for older people. Acting, reacting and making decisions require an active and cognitively well-trained mind, which is also of great importance for coping with (road) traffic. (v) Working out usually involves moving several muscles at once. This presupposed ability to coordinate one's body is essential for keeping up the normal course of life (Halbwachs et al., 2000, p. 100).

Older people from lower social classes do less sports with preventive effect than people from higher social classes (Pochobradsky, 1995).

### **5.4.3 Sexual activity**

Only two of all literature sources treat the influence of sexual activity on health for older people. The sexual life of older people still seems to be a great “taboo” – it is rarely mentioned in the relevant literature. Because of physical changes taking place when getting old, also sexual activity alters (Przyklenk, 1996). Another article states that sexuality and mental health are inevitably linked (EURAG Österreich, --e). Suffering from mental health problems like depression or stress can hinder sexual activity.

### **5.4.4 Substance abuse (smoking, alcohol, drugs)**

Health promotion projects for the elderly often target at developing healthier lifestyles. Handling risky behavior like smoking or drug abuse should be an important part of individual health promotion (Pelikan et al., 2002). Apart from individual behavior health promotion also has to be about developing healthy environments (e.g. smoke-free areas) in order to avoid substance abuse and promote a healthy lifestyle (A. Rieder, 2003).

### **5.4.5 Safety (e.g. prevention of falls, accidents and injuries)**

Only about 5% of the Austrian literature treated safety in combination with health promotion for older people. The prevention of falls, accidents and injuries is linked to health promotion in the setting of older people’s homes (see Section 6.3) or hospitals (Schwendimann, 2003).

Cognitive impairments and decreasing mobility as well as medication can be seen as the main reasons for falls and accidents. A psychological article in this context cautions against older drivers (Bukasa & Panosch, 2006). Demographics predict the number of Austrian drivers over the age of 60 to reach over 30% by the year 2030. The traffic system will be significantly influenced by this demographic trend. Getting old, however, is not necessarily connected with a decrease in performance and a rising number of accidents. Older people with a self-critical behavior, the will to learn and an accident-free previous history can still drive without any difficulties (Bukasa & Panosch, 2006, p. 194).

### **5.4.6 Preventing abuse and violence against older people**

Not much is known about preventing abuse and violence against older people in the Austrian health promotion literature. The point is that this topic is largely hidden since it takes place in the familial and non-institutional context and there is therefore not much empirical data about it. One single reference was found on this issue (see Hörl, -).

#### **5.4.7 Prevention of diseases**

The Austrian literature differs between the primary, secondary and tertiary prevention of diseases (Habl, 2004, p. 88). Preventing diseases is linked with the development of a healthy lifestyle while being young. The overall goal of the literature treating the prevention of diseases is the development of healthier lifestyles for older people by means of active health promotion in combination with disease prevention.

The most common causes of death in Austria are cardiovascular diseases, cancer and cerebrovascular diseases (BMSG, 2001, p. 20). Reducing risk factors like high blood pressure (EURAG Österreich, --c; Habl, 2004), obesity and overweight (Kiefer, 2004b; A. Rieder, 2001) or smoking (EURAG Österreich, --f) is an important step towards generating a healthy lifestyle. The literature states that certain risk factors like smoking lead to cardiovascular diseases (Schildhammer, 1996, p. 37). Other diseases which have reached tremendous dimensions and therefore have to be addressed when doing health promotion for older people are osteoporosis (Halbwachs et al., 2000; Noack & Reis-Klingspiogl, 1999; A. Rieder, 2001), cancer (BMSG, 2001; Garbe, McLeod, & Buettner, 2000; Halbwachs et al., 2000; A. Rieder, 2001; Schildhammer, 1996), dementia (A. Rieder, 2001; Schildhammer, 1996), hypertension (Pils & Neumann, 2006; Schildhammer, 1996) and falls/accidents (Österreichischer Seniorenrat, 2003).

The majority of texts addressing the prevention of diseases differentiates between typically male and female diseases. Some diseases are more common for men than for women and vice versa.

#### **5.4.8 Other**

Three texts explicitly mention other issues regarding a healthy lifestyle in combination with health promotion for older people. Issues addressed in these articles were communication (Meggeneder, 2002; Wimmer-Puchinger & Baldaszti, 2001) and creativity (Rosenmayr, 2004). Communicating health risks and threats to older people determines their usage of the health care system and of health promoting activities (64). Language barriers are the number one hindrance for older migrants to take part in health promotion. This problem could be solved by falling back on community-interpreters or communication training in community settings. Creativity is also an important part of ageing although not equally distributed over the social classes. Rosenmayr argues that older people from the upper social classes have more means to engage in creative – which also means healthy – activities than people from lower social classes.

## **6 Transversal issues**

### **6.1 Research Methods**

Concerning the adopted research methods used here, the question is mainly which evidence-base do Austrian health promotion literature for older people have? The most striking result is that out of the N=121 articles reviewed about two thirds (42%) mention a clear qualitative (11%) or a quantitative (22%) or a mixture from both approaches (9%). One quarter (27%) clearly states non of these two options and is therefore theoretical or general about health and health promotion and prevention. In 31% of all cases it does not become clear which research method was adopted.

Regarding qualitative methods different approaches were used: The articles report qualitative interviews (narrative interviews; biographic interviews; expert interviews) and qualitative methods with groups of persons (focus group discussions; working groups; health panels). Furthermore, assessments and counselling are applied in other qualitative research methods and two other references define their work in terms of qualitative literature reviews.

Within the quantitative research methods (cross-sectional or cross-national) surveys and questionnaire designs are most often mentioned. About 20 references state these quantitative methods and three references cite meta-analysis as the basis of their analysis. Last but not least there are some single references with research methods such as explorative studies, longitudinal studies, trend/time series analysis, psychological tests and „casual samples“.

### **6.2 Strategies of health promotion**

Health promotion not only targets at improving personal health skills and capabilities of individuals but also emphasizes changing social, environmental and economic conditions. The Ottawa Charta names three strategies to promote individual and public health: advocating, enabling and mediating. All three strategies can be found in the Austrian literature. Advocacy embraces the creation of essential conditions for health, like the making available of social support (Abbassi-Nik, 2004, pp. 26-27; Dorner & Rieder, 2004). Enabling means helping people to achieve their full health potential or developing personal health skills. A number of articles stress enabling or empowering older people and helping them to learn practical abilities (Dorner & Rieder, 2004; Halbwachs et al., 2000; Przyklenk, 1996; Rind, 1995). There is a much stronger focus on enabling and advocacy in the literature, and less on mediating.

Other strategies often used in health promotion are health communication, organizational development (Badura, 2005), self-help, health education, creating supportive environments/settings (Glabischnig, 2005; Noack & Reis-Klingspiogl, 1999) or developing active social/health policies (BMAGS, 1999). Most of these strategies are used in combination. Health communication involves informing the

public or specific groups of people on health potentials and health threats (Dietscher et al., 2001b; Dietscher & Nowak, 2001; Dorner & Rieder, 2004; Wimmer-Puchinger & Baldaszti, 2001).

Recapitulating it can be said that *health communication* and *enabling* older people are the prevailing health promotion strategies found in the Austrian literature.

### 6.3 Settings

It is remarkable that a relatively high number of health promotion articles for older people noted settings. Settings were mentioned in n=68 cases (71%). The most dominant mentioned setting in Austrian literature – were health promotion for older people took place – is the workplace followed by community (e.g. cities, regions) and people's own homes as well as residential homes.

Health promotion measures for older people at the workplace mostly target at improving the health and working conditions of the target group. The literature stresses that organizations benefit from healthy employees in more than one way (increased efficiency and performance, motivated employees, improved working atmosphere etc.). Older employees have a rich potential of experience, knowledge and loyalty at hand (Meggeneder, 2005, p. 5). Still the number of days older employees report sick increases over the age of 50. Organizations can react with health promotion projects specifically aimed at older employees.

One Austrian study showed a significant relationship between one's quality of life and one's living situation (Wegscheidler, 2004, pp. 84-85). Older people who live in residential homes show a poorer quality of life than people still living at home. Self-care and independence are highly important aspects for older people living in residential homes.

One Austrian health promotion project aimed at empowering older people in the community setting (Amann et al., 2005). It contributed to a positive reception of elderly people in society, reduced the feeling of social isolation and increased the number of social contacts of older people in an urban setting. There are a number of health promoting projects with a community setting approach the Austrian literature mentions (Amann et al., 2005; Bukasa & Panosch, 2006; Diketmüller & Kolb, 2003; Dorner & Rieder, 2004; A. Rieder, 2003; J. M. Rieder, 1999; Sprenger, 2005). Their overall goal is on the one hand the enhancement of independence and individual responsibility for one's health and on the other hand the making available of social support and respective contexts (e.g. telephone hotlines, rooms, brochures, walking miles, cookery books, practical activities etc.) for promoting older people's health.

An increasing number of older people is said to live alone due to divorce, death of the partner or children who do not live in the same cities (Weidenauer & Sonnleitner, 2000). The emotional and social needs of older people cannot fully be met by extramural care or the like, but volunteer workers could additionally support many

older people still living at home. Homes of older people need to be in a secure condition (e.g. no cables across the floor, secure bathrooms, safe carpets etc.) in order to prevent falls or other injuries due to constructional failures (Österreichischer Seniorenrat, 2003).

Apart from the above mentioned settings there were findings on health promotion for the elderly in families, sports clubs and hospitals in the Austrian literature. Health promotion for older people in neighborhoods or schools is not common in Austria. There is no literature on those two settings in Austria from 1996 to 2006.

## 6.4 Inequality and Diversity

Especially in terms of social inclusion of all members of a society and the European Union it is important to look at inequality issues. The EU-wide political objective is to combat social discrimination, marginalisation and conflict, e.g. due to age, disability, poverty and ethnicity. This is particularly important due to the diversity of ethnic groups with the soon to be enlarged EU. *So, how is inequality addressed in literature on health promotion for older people in Austria?*

The result of the analysis is that every fifth (21%) article in the Austrian data base includes inequality statements. On the contrary, the *diversity* subject became apparent less often (14%). Firstly, *inequality* and *diversity* are highly correlated with each other and are mainly interrelated with social groups such as gender (Berchtold, 2004; Diketmüller & Kolb, 2003), isolated and vulnerable groups in society (e.g. older people) (Hörl, -; Kreamsberger, 2003), the migrant population (Brockmann, 2002; Haider-Koumansky & Özsoy, 2005; Reinprecht, 2003a, 2003b, 2003c; Wimmer-Puchinger & Baldaszti, 2001), and social inequality due to one's social economic status (e.g. education, occupation, income) (GOe, 2005; Meggeneder, 2003; Pochobradsky, 1995; Pochobradsky, Habl, & Schleicher, 2002). Secondly, many inequality/diversity issues were found regarding special risk groups for health, for instance people suffering from cardiovascular diseases (Dorner & Rieder, 2004) or people at risk for mental illness (EURAG Österreich, --b) or in need of care (Noack, Sprenger, & Kahr-Gottlieb, 2005).

## 6.5 Sustainability

Only 19% of all literature implicitly or explicitly target the topic of sustainability in promoting health for older people. But worthy to mention is that in 17% of the cases it was not sure whether or not there was "sustainability" there.

Sustainability of projects for older people can be guaranteed if older people themselves are extensively empowered and motivated to act upon their (ill) health (Dietscher et al., 2001a, 2001b; Kiefer, 2004b; J. M. Rieder, 1999), which means that consumers of activities, projects or programmes need to be actively involved

(Glabischnig, 2005). A positive effect regarding sustainability can be noted if structures/organizational contexts/frameworks etc. are held up after a project has ended (Noack & Reis-Klingspiegl, 1999), e.g. one article states that sports clubs focused on promoting health of older people. After the project was finished, activities could still go on and so a sustainable effect was achieved (Lames & Kolb, 1997). Another piece of literature stresses the cooperation between pharmacies, general practitioners and other institutions from the community setting. By working together sustainability is enforced (Sprenger, 2005).

## **6.6 Cost-effectiveness**

Little information about health promotion for older people in connection with cost-effectiveness can be drawn from the Austrian data due to the scarce number of articles found. Only 5% of the literature informs the reader about issues of efficient use of costs concerning their health promoting outcomes (of older people).

However, some articles interestingly cover cost-effectiveness in relation to physical activation and sports for the aged. For instance older people can be reached through health promotion in sport clubs. Lames and Kolb state that health promotion in sport clubs is practicable, efficient and economical (Lames & Kolb, 1997).

Additionally, cost-effectiveness from a more structural perspective was deeply analysed by Halbwachs and colleagues (2000). They discuss the development of a health-economic based cost-benefit-analysis, the costs of sport injuries and the societal benefit of sport. This study and other studies as well have shown that it is a myth that a bad health status is highly correlated with age, which is an pure “ageism”. Nevertheless, since falls are more dominant in the higher age groups the medical costs for falls are high (Schwendimann, 2003; Ziere, van der Cammen, Pols, & Stricker, 2003). In 2002, the Austrian Senior Club also vehemently discussed the cost factor of security for older people in an own enquête (Österreichischer Seniorenrat, 2003). This issue was also often discussed by the Austrian Network of Health Promoting Hospitals (see OENGGK, 2006).

Besides the cost factors, health promotion in hospitals and nursing homes is strongly linked with empowerment, well-being and quality of life, especially of the elderly (Dietscher et al., 2001a). Because older people who live independently and at home tend to have a higher quality of life and “they are less likely to experience functional decline than those living in residential care. Additionally, it is a much cheaper option and hence more cost-effective to enable elderly people to live at home.” (Sprenger, 2005, p. 33)

## **6.7 Consumer involvement**

There are a lot of studies in Austria which take the voice of older people into account. Consumer involvement can be split up into quantitative measures in the form of surveys or questionnaires (Diketmüller, 1997; Elmadfa & Freisling, 2005; Wimmer-Puchinger & Baldaszi, 2001; Wolf, 2004, 2005) and qualitative research measures like group discussions or interviews. Empowerment is often mentioned in combination with consumer involvement. Older people are involved in health promoting activities through focus group discussions (Hörl, -), interviews (Müller, 2002; Nowotny et al., 2004)), health panels (Hilschner, 2004; Wolf, 2004, 2005) or activity programmes like health fairs (APA, 2005a; Haider-Koumansky & Özsoy, 2005).

Guidebooks also require older people to take part in health promoting measures through practical guidelines like exercising on a regular basis, healthy nutrition or involvement in self-help groups etc. (Bruck, 2004; EURAG Österreich, --a; Rind, 1995).

Dietscher et al. (Dietscher et al., 2001b) stress the fact that older people need to be involved in actively configuring a healthy lifestyle. Without the consumer's involvement good results are unlikely (Dietscher & Nowak, 2001; Nowotny et al., 2004).

### **6.7.1 Other issues**

No other results.

## 7 Conclusions and summary

- a. *The need to address individual health AND changing social, environmental and economic conditions.*

Health promotion is a strategy for the improvement of individual health and increased control over one's personal health determinants, as well as an instrument for changing social, environmental and political conditions to raise the population's health status. So on the one hand the literature embraces the raising of personal skills and capabilities in order to improve one's (health) behaviour but on the other hand also takes setting-oriented aspects into account (e.g. national laws, political situation, access to the health care system, organizational contexts). Health promotion for older people needs to address both behavioral and setting-oriented factors in order to be sustainable and at the same time effective.

Behavioral aspects are widely covered by the Austrian literature in the form of empowerment, adopting healthy lifestyles and enabling older people to gain more control over their health. The Ottawa-Charter (WHO, 1986) underlines the need of "enabling" or motivating people to mobilize resources to actively promote their health. In fact "enabling" is one of the three key strategies of health promotion the Ottawa-Charter mentions. Austrian health promoting initiatives clearly cover this issue. Providing older people with information on healthy lifestyles is one of the main goals of many projects in Austria.

Empowering older people is mentioned in half of the texts from 1996 to 2006. Being engaged in self-help groups and volunteering are key solutions for reducing isolation and empowering the patient/older people to engage in social activities. Regarding the essential aspect of empowerment a distinction can be made between individual and community empowerment. Community empowerment stresses the need for initiatives, programmes or projects specifically targeted at older people at the workplace, the community, nursing homes etc. Individuals who collectively act to gain increased influence over the social, environmental and political determinants of health in their city, district or community are still scarcely addressed in the reviewed literature.

Behavioral aspects are widely covered in the reviewed literature but setting-oriented aspects are commonly left out. Some exceptions prove the need to address the influence of environments or organisations on individual health. Whether you work in an (un-) healthy organization, live in a (un-)healthy city, or in (un-)healthy family relations determines your health.

*b. Holistic approach: The need to address bio-psycho-social health and not only one of these factors.*

Health is and has always been the combination of physical, mental and social factors. The need to use strategies of health promotion addressing bio-psycho-social health determinants is described as important in the Austrian literature. Several texts only target at one of the above mentioned aspects and therefore lose their holistic status. Literature with a medical focus tend to highlight physical health, while psychological data are likely to emphasize aspects of mental health. Health promotion in Austria still needs to stronger emphasize a holistic approach in the up-coming years.

*c. The need to address specific target groups in specific settings (as opposed to the general public)*

The majority of texts in the Austrian literature emphasize the need to address older people in specific settings. Doing health promotion for the general population is less likely to affect specific target groups than doing health promotion in specific settings with particular tools and goals. Older people, older migrants, older women, older men, older employees etc. have special needs which need to be met during health promoting activities. Lumping all target groups together – reaching everyone and noone – is not the most effective way of doing health promotion. The settings “workplace”, “community” and “people’s own homes” are the most important in the Austrian literature. Without the setting approach health promotion in Austria would not be conceivable any more.

*d. Consumer involvement: The need to consider the voice of older people for the success of health promotion initiatives.*

Involving older people in health promotion programmes is essential for the success of the projects. Professional domination can be hindering for the empowerment of individuals or communities. Consumer involvement in the reviewed literature mainly took place in the form of surveys/questionnaires or interviews/group discussions. Terms used in the practice of health promotion like “active ageing”, “active involvement” or “participation” underline the need for consumer involvement in health promotion. Patients are always co-producers of their health. Professionals cannot take over all the responsibility for people’s (good or ill) health. Keeping up good health and reducing ill health needs active involvement of older people themselves.

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