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‘Active ageing’: from empty rhetoric to effective policy tool

KIM BOUDINY*

ABSTRACT

‘Active ageing’ is a topic of increasing attention in scientific and policy discussions on ageing, yet there is no consensus on its actual meaning. The current paper proposes a detailed classification of various definitions that have been used since its introduction. These definitions are subjected to critical investigation, and subtle differences with regard to such terms as ‘healthy ageing’ and ‘productive ageing’ are clarified. Bearing the hazards of previous definitions in mind, a comprehensive strategy is initiated. Given that earlier definitions have tended to exclude frail older adults, this strategy pays particular attention to the translation of the active-ageing concept to situations of dependency by centring on three key principles: fostering adaptability, supporting the maintenance of emotionally close relationships and removing structural barriers related to age or dependency.

KEY WORDS – active ageing, dependency, new ageism, lifecourse.

Introduction

Although ‘active ageing’ marks contemporary gerontological discussions, its roots can be traced back to the 1940s and 1950s, when socio-gerontologists stressed the importance of an active lifestyle in old age for personal life satisfaction, a viewpoint later termed ‘activity theory’ (Lynott and Lynott 1996). Because this theory emphasised the maintenance of activity patterns typical of middle age, it was criticised as overly idealistic (Walker 2002). In 1961, Cumming and Henry (1961) looked at the ageing process in a fundamentally different way by focusing attention on disengagement, or the mutual withdrawal between ageing persons and society. They assumed disengagement to be universal and inevitable, claims which soon came under attack by researchers reporting substantial numbers of engaged (very) old people. Disengagement theory was further criticised for largely ignoring

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older adults' own perceptions: behaviour considered a sign of disengagement could be interpreted very differently if the meanings ageing persons attach to what they do were taken into account (Hochschild 1975). Despite these and other criticisms levelled against both theories, the underlying themes reoccur throughout gerontological history: the portrayal of older adults in society and the role hereby assigned to activity.

For a long time, older people's limitations were emphasised in the socio-gerontological literature and the societal debate through the dominance of the deficit-model, which legitimised the trend towards early exit from the labour force, apparent amongst older men in most developed countries during the post-war period (Verté and De Witte 2006; Walker 2006). In the 1970s and 1980s, public policies of many European countries encouraged early withdrawal from the labour market as a solution to increasing (youth) unemployment (van den Heuvel *et al.* 2006). Similarly, Defined Benefit occupational pension plans, which were dominant in the United States of America (USA) until the early 1980s, were originally designed to encourage older workers to withdraw from the labour force by offering substantial early-retirement incentives (Hong 2006). Within this context, learning, working and resting were portrayed as three strictly successive phases throughout the lifecourse, with the latter stage characterised by dependency, decline and loss (Jacobs 2004; Townsend, Godfrey and Denby 2006).

Despite differences between industrialised countries in the extent and speed of diffusion of certain conceptions about older adults, the negative view of old age generally shifted towards more positive models in the late 1980s and especially throughout the 1990s (Bowling 2005; Jacobs 2004; Walker 2006). Fuelled by anxieties about the economic implications of global greying, such concepts as 'productive ageing', 'healthy ageing' and active ageing came to the forefront (Bowling 2005). Instead of equating the oldest phase of life with rest, the active-ageing discourse stimulates the ongoing participation of older adults in society. It involves some sort of 'competence-thinking': the historical focus on what older adults can no longer do (*i.e.* their deficits), is replaced by an emphasis on their competence and knowledge (Jacobs 2004).

Although the active-ageing concept has come into common usage during the last decade in policy, research as well as practice, it is still surrounded by a lack of clarity regarding its interpretation (Clarke and Warren 2007; Ranzijn 2010). In our view, two problems underpin this obscurity. First, there is lack of agreement on what constitutes active ageing, as authors do not correspond in their attempts to define the concept. Second, active ageing is often used interchangeably with such subtly divergent notions as healthy ageing and productive ageing (Ranzijn 2010), which are in turn defined differently by various authors.

This paper attempts to remedy or reduce these problems by providing a detailed classification of approaches towards active ageing. In addition to describing diverse views on active ageing, hazards related to various approaches are clarified. Where enlightening, nuanced differences with related terms are elucidated. This overview lays the foundation for the final section, which presents guidelines for future policy-making.

Conceptualisation of active ageing

The World Health Organisation (WHO) adopted the term active ageing in the late 1990s and played a major role in its rapid diffusion (Walker 2002). The WHO (2002: 12) envisioned a broad process of 'optimizing opportunities for health, participation and security in order to enhance quality of life as people age'. Since then, a great many definitions have been launched by different authors. We start with an overview of the traditional approaches and subject them to critical discussion.

Type 1: Unidimensional approaches

As the concept of active ageing is rooted in population ageing and its consequences for public finances, it is not surprising that several studies focus either on employment or on physical activity. After all, ageing workforces raise concerns regarding increasing costs for both pension and health care, resulting in efforts to respectively prolong working lives and stimulate physical activity – and thus health – at older ages.

The interpretation of active ageing in an exclusively economic framework is especially prevalent. In addition to an exclusive focus of many researchers on labour-market participation (*e.g.* Guillemard and Argoud 2004; van den Heuvel *et al.* 2006), national governments of many industrialised countries tend to place economic aspects at the centre of their active-ageing policies (Clarke and Warren 2007; Perek-Białas, Ruzik and Vidovičová 2006; Walker 2010).

Within this economic orientation, a further differentiation can be established (Walker 2006). Some approaches focus solely on promoting longer working lives through such supply-side measures as the adaptation of pension schemes (*e.g.* raising retirement ages and terminating early-exit options). Others draw additional attention to the demand side by emphasising the importance of combating age discrimination in employment and increasing the attractiveness of older workers (ActivAge Consortium 2005; Walker 2002). One instrument for this latter purpose involves re-training and up-skilling, as the labour market has undergone severe changes in recent decades, generating a demand for increasingly

complex tasks (Davey 2002). While the reference to education might indicate a broader conception of active ageing (*i.e.* beyond the purely economic sphere), this is not necessarily the case. For example, a recent research report states that relevant policy documents in the United Kingdom (UK) focus on the role of education in promoting employment in later life, rather than taking opportunities for personal development into account (Phillipson and Ogg 2010).

While the second stream of single-focused approaches is less pervasive, Sykes (2007) considers regular participation of older adults in physical activities that increase endurance, strength, flexibility and balance (*e.g.* walking, biking, fitness trails). Similarly, Partnership for Prevention (2001), a US policy-shaping organisation, only lists measures to foster regular participation in moderate-intensity physical activities (*e.g.* brisk walking, biking) in its catalogue of strategies to promote active ageing.

An improper reduction? Applying active ageing to a mere economic or physical framework is problematic for several reasons. First, such reduction contravenes the intention of the WHO (2002), which explicitly states that the word ‘active’ does not solely refer to the ability to be physically active or to participate in the labour force, but to continued participation in social, economic, cultural, spiritual and civic affairs.

Second, and more importantly, it does not correspond to older adults’ own perceptions, as many of them resist an exclusive emphasis on ‘youthful’ physical activities (Townsend, Godfrey and Denby 2006). This reluctance is not surprising since such approaches reduce the multidimensional nature of ageing to a single component (ActivAge Consortium 2005).

Third, narrow-focused conceptions tend to exclude certain groups from ageing actively, particularly those not engaged in paid employment or those suffering from severe physical limitations (Walker 2002). This mechanism of ‘exclusion’ may manifest itself in several ways, depending upon the active-ageing approach at hand. Closer examination of the two alternative streams within the economic framework illustrates this point. An exclusive focus on the supply side without considering features of the labour market results in further exclusion of vulnerable groups of older workers, *e.g.* displaced older workers. Hirsch, Macpherson and Hardy (2000) found restricted employment opportunities for older workers. Lahey’s experimental study (2008) amongst women applying for entry-level positions points to age discrimination, with younger applicants being more than 40 per cent more likely to be offered an interview than older candidates. Workers in strenuous jobs are another vulnerable group due to their higher risk of poor health, which is one of the most frequently cited factors in retirement literature (Kubicek *et al.* 2010). If these inhibiting factors are not addressed and pension ages

are raised 'in a vacuum', such vulnerable groups are likely to fare worse, and 'the active ageing option will not be open to all on an equal basis' (Walker 2002: 131), even if those involved want to continue working.

This line of reasoning supports the broader approach on active ageing, which focuses on a variety of inclusion-enhancing measures, including combating age discrimination and preventing poor health in the workplace. This vision emphasises that the active-ageing concept is not limited to responsibilities of the ageing individual, but that it also includes rights (*e.g.* the right to work), thereby obliging the State to create opportunities for remaining active (Mayhew 2005; Walker 2006). Even within this wider approach, however, a mechanism of exclusion can still be observed, albeit operating in a slightly different manner. Instead of increasing inequality within the group of work-willing people (*i.e.* those who are both willing and able to work, in contrast to those who want to work, but are unable to do so), it contributes to the devaluation of those who do not (or no longer) wish to work. Because this approach is exclusively directed towards work, other valuable contributions that older people can make to society are at risk of being ignored. For example, older adults may choose to stop working in order to care for their grandchildren. By doing so, they ease the pressure on their children and enhance the work-ability of this intermediate generation.

The approach also neglects the old-old,¹ for whom continuing employment is less common and not required. Although population ageing demands a greater proportion of the population to be active in the workforce, the old-old are not the target group. The view on education illustrates well the exclusionary character of the strictly economic focus and the missed opportunities following from its application. By assigning first priority to the labour-market objective, educational benefits are restricted to the younger old who are still working or looking for work, while the beneficial effects of lifelong learning may reach beyond this limited group. Because learning in later life may play a crucial role in developing social contacts and postponing mental problems associated with ageing, education may offer active-ageing opportunities for *all* age segments (Phillipson and Ogg 2010).

Fourth, unidimensional approaches illustrate that active ageing is often 'little more than empty rhetoric' (Clarke and Warren 2007: 466), thereby contributing to the entanglement of terms. An exclusive focus on employment essentially reduces the discourse to its precursor, productive ageing, especially in the case of the most narrow vision, emphasising only supply-side factors (ActiAge Consortium 2005). Although many different definitions exist for productive ageing, most are restricted to the promotion of economic contributions by older adults through labour-market participation (Davey 2002). The active-ageing concept was introduced in order to

overcome exactly this type of narrow scope. Some authors, like Rowe and Kahn (1997: 434), apply a broader definition, by labelling an activity as productive ‘if it creates societal value, whether or not it is reimbursed’. In addition to paid labour, this definition includes such socially important activities as care and voluntary work. Even in this broader interpretation, however, many activities – which we will further on attribute to active ageing – do not qualify as productive.

Type 2: Multidimensional approaches

Some authors envision active ageing as a concept referring to the continuous participation of older adults in several domains of life. In this case as well, a more detailed differentiation is appropriate. Following the discussions on active ageing at the 1997 Denver Summit (US Department of Health and Human Services 1997), several authors (*e.g.* Castolo, Ferrada and Camarinha-Matos 2004; McKenna 2008) focus on both economically and socially productive activities.

Others additionally include leisure activities in their active-ageing definitions. Houben, Audenaert and Mortelmans (2004) consider activities that require *physical* and/or *mental* effort and that occur largely outdoors (*social* activities). Building upon these criteria, they developed an active-ageing index consisting of five indicators: paid labour, care and voluntary work, but also sports and active recreation outdoors (*e.g.* participation in club life). Avramov and Maskova (2003) describe the concept as a socially and individually designed combination of continuous labour-market participation, active contribution to domestic tasks (including care for others), active participation in community life (*e.g.* voluntary work) and active leisure activities (through hobbies, sports, travel and creative activities). For the European Commission, active-ageing practices include lifelong learning, working longer, retiring later and more gradually, being active after retirement, and engaging in capacity-enhancing and health-sustaining activities (Oxley 2009).

Rigidity of indices? Multidimensional approaches help to raise awareness regarding the various domains of life through which older adults can age actively. Although this partially addresses the weaknesses of unidimensional perspectives, it does not impede many researchers and policy makers from defining activity from a youthful, middle-aged perspective (Clarke and Warren 2007). These conceptualisations thus appeal primarily to the young-old, while deviating from the day-to-day reality of many of the old-old. This is especially clear in definitions restricted to productive activities. Several studies indicate that the old-old tend to focus more on

non-productive leisure activities than on productive ones. While external structural (*e.g.* upper age limits for volunteers) and situational (*e.g.* grown-up grandchildren no longer in need of care) constraints may contribute to this tendency, changes in health and preferences apparently play a key role in advanced old age (Broese van Groenou and van Tilburg 2012; Gauthier and Smeeding 2003; Gill 2006). After all, while current cohorts of older adults generally remain fairly healthy during early old age, their probability of experiencing sizeable losses in cognitive and physical potential increases substantially in the fourth age (Baltes and Smith 2003). Even for the young-old, for whom productive activities are usually within the range of capability, ongoing productive engagement is not necessarily beneficial. Siegrist and Wahrendorf (2009) find positive effects of socially productive activities on wellbeing only insofar as reciprocity in exchange (*i.e.* effort–reward balance) is experienced. High-investment activities such as long-term care (LTC) for an ill person may even hamper psychological wellbeing. Freed from certain responsibilities, such as work or caring for family members, and being able to enjoy leisure activities, many older adults re-engage with life (Clarke and Warren 2007). An exclusive focus on productive activities, mainly driven by a desire to reduce the 'burden' on society (Ranzijn 2010), thus neglects the alternative pathways through which older adults can age actively.

Authors who include leisure, hereby acknowledging its importance for older adults' personal wellbeing, encounter another difficulty. They tend to restrict their indices to 'active' leisure activities – a seemingly logical choice, were it not that the distinction between active and passive leisure is inherently ambiguous (Katz 2000). 'To one, an activity may seem active, to another passive' (Parker 1996: 69). It is also context-dependent. For instance, both Avramov and Maskova (2003) and Houben, Audenaert and Mortelmans (2004) regard television-watching as a passive pursuit, even though some programmes offer informative and mentally stimulating content. This general argument is particularly problematic when discussing the time use of older adults, as the activities often omitted tend to be those that contribute considerably to their involvement with life, especially for the old-old. For example, the emphasis on outdoor social activities included in the definition by Houben, Audenaert and Mortelmans (2004) excludes solitary leisure activities while the old-old do not only devote significantly more time to home-based leisure (Gauthier and Smeeding 2003; Verbrugge, Gruber-Baldini and Fozard 1996), but also attach high value to this allocation of time (Kelly 1997; Pettigrew and Roberts 2008). In contrast, sports, travel, participation in club life and similar activities – which are traditionally included in active-ageing definitions – are prevalent and perceived as satisfying amongst the young-old, but are less salient amongst the old-old (Jacobs 2005; Kelly 1997). Combined with the fact that

the choice to include or exclude particular activities is necessarily arbitrary, the fact that older adults themselves refer to a great diversity in activities that allow them to live engaged lives (Clarke and Warren 2007) calls into question the utility of constructing an active-ageing index.

Such limited focus on a predetermined number of domains, which does not fully consider ‘the discontinuity and qualitative differences between the “ages” of old age’ (Baltes and Smith 2003: 125), may fuel unrealistic expectations, amongst ageing individuals as well as at societal level. Given the importance for wellbeing of downward (relative to upward) social comparisons in the face of adversity, older adults who are not capable of meeting these expectations may be disappointed in their own abilities, experiencing lowered self-esteem as a result (Kessler, Rakoczy and Staudinger 2004). This may discourage further participation in society or, alternatively, result in a struggle to stay young and active for as long as possible. Active ageing should not be reduced to such a melancholic battle. Instead, being happy and maintaining engagement with life *despite* limitations should be encouraged. At the societal level, this may entail a type of victim-blaming towards those not ageing ‘actively’ in the traditional sense, by overly emphasising individual responsibility: if frail older adults had made the right choices and engaged in the right lifestyle, they would not be in this vulnerable situation (Martinson 2006-07). After all, if active-ageing policies exist and provide health-promoting physical activities in a supportive environment, there is ‘no excuse’ for not being active in old age (Ranzijn 2010: 717). In summary, this approach harbours the risk that a focus on the young-old will exclude the old-old and further marginalise vulnerable segments of the older population (Ranzijn 2010; Walker 2006).

Type 3: Transcending the behavioural level

The definitions discussed so far emphasise *behaviour*. Some authors supersede the mere behavioural component and include such aspects as health and economic circumstances. Bowling (2005: 230) conceptualises active ageing as ‘continuing physical, psychological, social health, participation, independence, autonomy, control for the enhancement of quality of life’. Mayhew (2005: 455) defines it as ‘allowing people to remain independent and achieve their potential regardless of age’. Cloos *et al.* (2010) focus on three components of active ageing: economic circumstances, social support, health and social services access and use.

Constituents or determinants of active ageing? The inclusion of health and independence is particularly prevalent in these definitions of active ageing.

In our view, the authors of such definitions fail to make a clear conceptual distinction between the constituents of active ageing and its determinants. While health may positively influence participation in several of the activities included in the indices discussed above, it should not be equated with ageing actively. The underlying argumentation draws upon a number of issues. First, health can be understood as a *potential* for some types of activity. What individuals can do, however, does not necessarily correspond to what they actually do. Active ageing transcends potential; it requires active involvement with life (Rowe and Kahn 1997).

In addition, there are hazards related to this approach. Where the indices mentioned earlier could be criticised for their bias towards the youngest and healthiest older adults, this is even more applicable to current definitions that treat health and independence as 'ultimate goals'. Unintentionally, this discourse further excludes the most vulnerable older adults as – under the present phrasing – active ageing seems unattainable for many of those who are already frail and dependent. Such conceptualisations could thus be responsible for the increasing criticism of the active-ageing idea 'for offering no alternative to less able or seriously ill persons' (Perek-Białas, Ruzik and Vidovićová 2006: 568). These definitions also fail to correspond to older adults' views on active ageing. In their opinion, health is no prerequisite for ageing actively (Clarke and Warren 2007). On the contrary, refusing help when offered and perceived as necessary in an attempt to retain independence is strongly discouraged by many older adults (Townsend, Godfrey and Denby 2006). In sum, health may be a means to active ageing, but it is not the end.

Finally, these definitions contribute to the increasing obfuscation of concepts, thereby negating the specific potential of the active-ageing discourse. Definitions including health and independence cross the boundaries with healthy ageing, as the latter concept implies a focus on the maintenance of health (Davey 2002). For example, the Organisation for Economic Co-operation and Development (OECD) defines healthy ageing as 'maintaining the elderly in good health and keeping them autonomous and independent over a longer period of their remaining years' (Oxley 2009: 6). In our view, healthy ageing and active ageing emphasise different aspects in the inter-relationship between health and activity. Some physical, mental and social activities are beneficial to personal health. Good health, in turn, may positively influence personal activity levels. The central focus of active ageing is on an active, involved lifestyle. The maintenance of health is a potentially beneficial consequence. In contrast, healthy ageing stresses the identification of programmes to enhance older adults' health. Successful policies in this area may increase labour-market participation and the performance of other activities (Oxley 2009). At first sight, this difference may

seem negligible. It is precisely because of the shift in emphasis away from health and independence, however, that the active-ageing discourse allows for a crucial question: How can the active-ageing ideal be realised under circumstances of declining health? How can active ageing be fostered under circumstances of dependence? Herein lies the key difference with healthy ageing. It is precisely this discrepancy that enables policy makers to create a more inclusive society than is possible with healthy ageing (WHO 2002).

The explicit attribution of health and independence to definitions of active ageing introduces a component that is also encountered in many definitions of ‘successful ageing’. While successful ageing is approached differently by various authors, the most frequently occurring component involves measuring disability and/or physical functioning (Depp and Jeste 2009). One of the most cited definitions stems from Rowe and Kahn (1997) which includes low probability of disease and disease-related disability, and high cognitive and physical functional capacity in addition to active engagement with life. In light of our critical discussion, the important point is that precisely this component of disability/physical functioning plays a major role in the unattainability of the ideal for many older adults. A review by Depp and Jeste (2009) shows that the mean proportion of successful agers amongst studies with this component in their definitions is 27.2 per cent, while studies excluding this component achieve 63.8 per cent successful agers. Ranzijn (2010: 717) expresses the issue aptly as this finding ‘calls into question the utility of a concept which implies that two-thirds of older Americans somehow “fail” at ageing’.

While the emphasis on health and independence are the most common examples of overlap between constituents of active ageing and influencing factors, other variations occur. For example, Cloos *et al.* (2010) consider economic and financial circumstances components of active ageing, but they do not explicitly discern what they understand by ‘components’ and how they relate to ageing actively. In our view, economic resources should be interpreted as determinants of active ageing. For instance, financial situation determines the ability to afford certain forms of recreational entertainment. The term ‘components’, however, may be erroneously interpreted as an essential part of active ageing. Such an interpretation brings the active-ageing concept dangerously close to that of ‘quality of life’. For example, Bowling (2005: 232) considers quality of life ‘a multi-level and amorphous concept, broadly defined as encompassing the individual’s perceptions of, and satisfaction with, physical health, psychological well-being, independence, social relationships, social and material circumstances and the natural and built environments; ultimately dependent on the perceptions of the individual’. As such, quality of life is clearly broader than active ageing, comprising economic wellbeing.

It would nonetheless be a misunderstanding to infer from this line of reasoning that such factors as health and economic circumstances play a minor role in the active-ageing discourse. On the contrary, profound knowledge of the determinants of active ageing contributes to the design of policies and programmes that are well-founded and therefore able to make a difference in practice (WHO 2002). From this perspective, studies like the one by Cloos *et al.* (2010), which discusses variations in economic conditions between and within countries, are certainly relevant within an active-ageing framework. In addition to the introduction of measures aimed at improving adverse circumstances, such research could incite a search for alternatives for the less fortunate.

Towards a comprehensive strategy

Despite our critical reflections on current conceptions of active ageing, we do acknowledge that the diffusion of the discourse may have been meaningful and empowering for the healthy young-old by supporting them to remain active, and by providing them with the opportunities to do so (Kribernegg, Maeirhofer and Mörtl 2011). Moreover, several of the activities traditionally emphasised in definitions of active ageing have preventive characteristics. For example, physical activity and socio-cultural participation have been shown to positively influence mental and physical health (Carstairs and Keon 2008). Due to the public health burden of sedentary lifestyles, involvement in such activities can be meaningful for both individuals and community. Active-ageing policies should therefore be forward-looking and promote such activities from childhood. This implies adopting a lifecourse perspective, which acknowledges that an individual's path to old age is not predetermined and that earlier life experiences exert an important influence on the way individuals age (Malanowski 2009; WHO 2002). As such, active ageing affects people of all ages, not just old people (Walker 2006).

Unfortunately, policies on ageing are often characterised by a dichotomy, targeting either healthy older adults by promoting active participation and self-responsibility or dependent older people by viewing them primarily as recipients of care (Angus and Reeve 2006). In our view, however, being engaged in life and being dependent are not mutually exclusive. Also Walker (2002, 2006, 2010) underscores this viewpoint by emphasising the importance of a broad perspective, which includes all groups and all meaningful activities. In the same regard, Jacobs (2005) points to the challenge of adapting the active-ageing concept to situations of frailty and dependency. In response to this challenge, we propose three principles that

can shape active-ageing policies throughout various phases of life. Our ambition is not to offer an exhaustive list, but rather a basis for further exploration and debate.

The power of adaptability

Current models on active ageing set relatively high standards and do not fully consider structural inequities and changing circumstances (Martinson 2006). Throughout life, and especially in later life, the pursuit of traditional activities may be impeded by circumstances outside an individual's control. In these cases, obstinately holding on to them may cause psychological distress (Burmedi 2001). In fact, not accepting the inability to perform valued activities one used to do substantially increases the odds of 'feeling old' – a state of mind that older adults tend to equate with giving in and which can thus be regarded as the antithesis of active ageing (Jacobs 2005; Townsend, Godfrey and Denby 2006). Active-ageing policies should therefore encourage people to accept these changes and integrate them into their lives (Jacobs 2005). This can be accomplished by searching for new ways to remain engaged. For the young-old, fostering adaptability may help those who feel forced into retirement (*e.g.* due to health problems or mandatory retirement) cope with this transition. From this perspective, policy could focus on optimising the role of pre- and post-retirement counselling programmes in increasing interest in non-work-related activities and helping retirees to rearrange their personal goals such that they can be fulfilled in a non-work context. For this purpose, programmes should be comprehensive in nature. They should not merely deal with financial elements, but should incorporate broader lifestyle issues and address individual participant needs, as multiple factors influence people's experience of retirement (*e.g.* ethnic background, family responsibilities, work history) (Richardson 2003).

This line of reasoning can also be extrapolated to the older old. Qualitative research shows that many of them consider 'ordinary' activities such as reading, solving crossword puzzles and gardening as a more important indicator of their involvement with life than highly social or physical, 'youthful' activities (Clarke and Warren 2007; Pettigrew and Roberts 2008; Ranzijn 2010; Townsend, Godfrey and Denby 2006). Policy may support this re-focusing process by acknowledging these alternative ways of ageing actively and educating older people about their potential benefits. It also offers concrete opportunities for institutional settings. Given the value attached to gardening, ensuring access to gardens and providing age-adjusted gardening equipment may be beneficial for many residents (Pettigrew and Roberts 2008).

In addition to promoting new ways of ageing actively, policy can also help older people to integrate age-related changes into their daily lives by informing them about and providing them with tools to compensate for certain functional limitations. Besides training interventions (*e.g.* lip-reading training in the case of hearing problems) and modifications of the environment (*e.g.* increasing luminance in the case of vision problems), assistive devices (*e.g.* walkers, glasses and hearing aids) offer considerable potential (Schieber *et al.* 1991). The rise of Information and Communication Technologies (ICT) has greatly expanded the range of possibilities (*e.g.* robotics driven by speech recognition, memory assistance by digital watches). Policy should therefore stimulate further research on needs-based ICT applications in order to help people continue to engage in certain activities that are personally meaningful, despite health-related limitations (Malanowski 2009). Both traditional (*e.g.* work, social participation) and alternative activities (*e.g.* reading) could be positively affected.

The human factor

Participation in highly social activities may benefit the young-old. Throughout older adulthood, however, the meaning of social engagement may change. Previous research on the old-old established a shift from large social networks towards emotionally close relationships (Berg 2008), making participation in club life, for instance, a matter of lower priority. Also the importance of solitary activities should not be underestimated. Nonetheless, engagement in social life remains important, as quality of social contacts, rather than quantity, continues to affect life satisfaction (Berg 2008).

Policy should take this social nature of human beings into account, as such age-related changes as retirement and ill health can disrupt the maintenance of relationships in later life (Reed *et al.* 2003). Facilitating social contacts by providing local facilities which promote a sense of community could be valuable, especially for the young-old (Bowling 2005). Particular attention needs to be paid to care-giving settings, where older adults are often unable to maintain ties with family and friends to their satisfaction (Burmedi 2001). Since LTC-residents perceive such contacts as particularly important, family should be encouraged to remain involved in the resident's life. In addition, the opportunities from residing collectively in a care facility could be exploited by providing socialising opportunities based on shared interests (*e.g.* crafts) (Edwards, Courtney and O'Reilly 2003). Sharing and enjoying experiences with others with similar interests and needs may enable residents to regain a dimension of their lives that they had lost (Reed *et al.* 2003). Positive interactions with staff through engagement in meaningful conversations are often valued as well. This calls for measures to counteract

the increasing pressure placed on residential care staff to do more in less time as ‘it is essential that it not be forgotten that, as well as being nursing care facilities, these places are also homes and residents need to feel they are more than just a patient on a nurse’s list’ (Edwards, Courtney and O’Reilly 2003: 42).

The primacy of agency over age-related structural barriers

In socio-psychological studies, agency is generally defined as the capacity of the individual to make his or her own choices and act correspondingly (Coleman 2011) – or as Stenner, McFarquhar and Bowling (2011: 474) put it ‘setting . . . one’s own norms rather than being “normed” by others’ – to which, according to qualitative research, older adults tend to attribute high value (Edwards, Courtney and O’Reilly 2003; Reed *et al.* 2003). In addition to the previously mentioned acknowledgement of alternative ways of ageing actively which presents the older person with a wider choice of active-ageing activities and thus leaves room for individual interpretations, particularly important in an active-ageing context is the removal of structural barriers which are exclusively based on age or dependency and which limit older adults in their ability to choose for a certain activity, or more generally, for continued engagement with life.

Despite the increased opportunities generated by the active-ageing discourse, certain domains of life still reflect remnants of the deficit-model of ageing, which impedes true choice. For instance, mandatory retirement ages continue to exist in many industrialised countries. While we commend initiatives that help older adults adapt to such external constraints, it does not exempt the State from its responsibility to look for ways to abolish mandatory retirement in accordance with the fight against age discrimination in the workplace. Uniform retirement ages ignore diversity amongst older adults by neglecting the substantial portion of people who are able to work well beyond the maximum age for retirement (Mayhew 2005; Walker 2002). An active-ageing policy should provide such people with the *choice* to continue working. To make this possible without endangering individual and public safety, a transformation from ageist, age-based criteria to a competence evaluation system is worth considering. To realise such reforms successfully, policy could stimulate information-sharing across disciplines and sectors regarding what is already known about competency, while complementing this knowledge by promoting new research on strategies for determining individual physical and mental capabilities (Carstairs and Keon 2008). In line with the principle of adaptability, there is also a need for strategies with which to compensate for any minor impairments (*e.g.* job re-design, training interventions) (Hansson, Robson and Limas 2001). The

same applies to upper age limits for volunteers, against which no legal protection exists in many industrialised countries. In addition to ignoring diversity amongst older adults, such age barriers divert attention from the possibilities existing for those older adults whose abilities have altered. One good example of creating volunteer opportunities for frail older people can be found in Camden, UK, where a telephone-befriending service was established to reach isolated and housebound older adults. Working as telephone volunteers fits within the abilities of even many frail older adults, thus providing them with the choice to volunteer (Gill 2006).

This line of thought provides valuable insight into the translation of the active-ageing concept to situations of care dependency. In this context too, there are structural forces at work that undermine older adults' agentic capacities. Many industrialised countries have a long history of service provision in which the care professional is the major power holder. Although this paternalistic model—which dominated care provision in the 20th century prior to the 1970s—has been challenged in recent decades by person-centred initiatives emphasising shared decision-making, certain subgroups are still more likely than others to be treated in a paternalistic manner (Smith, Flamm and Pentz 2009; Thompson and Thompson 2001). Especially the relationship between older service users and professional workers tends to remain characterised by power imbalance (Cavanna *et al.* 2009), thereby 'devaluing what the older person could bring to the encounter' (Thompson and Thompson 2001: 64). This approach is ageist as it stems from the assumption that older care receivers are incapable of making decisions in their own self-interest (Thompson and Thompson 2001).

Such lack of decision power may endanger older service users' potential for active ageing. Because beneficiaries of LTC-provisions represent a diverse group in terms of background, interests and level of frailty, their subjective interpretations of activities may differ. While we recommend research-based initiatives aimed at improving engagement with life (*e.g.* ensuring access to gardens, providing socialising opportunities), facilities should be wary of *exclusively* offering packaged programmes in which choices are expressed on behalf of the care recipients. Enabling older adults to contribute to decisions about activities may be fruitful (Edwards, Courtney and O'Reilly 2003). Even the mere act of decision-making may be a way for the heavily dependent to remain engaged with life: involvement in decisions, even in seemingly ordinary matters, can be contrasted with the negative affect associated with 'giving in' and losing all interest in life (Stenner, McFarquhar and Bowling 2011). Indeed, some of the older adults living in residential accommodation in the study by Reed *et al.* (2003: 17) did feel 'involved in decisions about their lives and they were supported to carry

them out by the staff... and this led to a more satisfying outcome.’ Their involvement in decision-making enabled them to be more than ‘passive recipients’ of circumstances (Thompson and Thompson 2001: 70). Active-ageing policies should try to turn these exceptions into the rule.

A decision to which older care recipients attach particular importance is the choice between institutional and home-care. Arranging life in such a way that optimises active engagement may be more feasible in one of the two settings, depending on one’s own priorities and needs. In the study by Reed *et al.* (2003), interviewees valued money as a means of ensuring this choice. Policy could enhance this choice, regardless of individual resources, by providing a universal insurance programme based on level of disability, in which LTC-benefits can be employed in the settings that older adults believe will best meet their needs. One good example can be found in Germany, where such measures have been implemented without spending substantially more than other OECD countries on LTC (Gibson and Redfoot 2007). Quality and efficiency of both institutional and home-care should be guaranteed in order to avoid undesirable situations (*e.g.* unacceptably long waiting lists), which could undermine the availability of a true choice once the demand for care becomes urgent (Larsson 2007). Given the important role the informal support network often plays for those receiving home-care, sufficient support should be provided to family care-givers, through such measures as training, pension credits or amelioration of the work–life balance (*e.g.* respite, teleworking, remote monitoring from the workplace) (Gibson and Redfoot 2007).

Once a setting for LTC is chosen, efforts should be made to ensure older adults’ ongoing involvement in decision-making. This calls upon care-givers to be willing to listen. They should continue asking care recipients about their preferences as long as possible (Jacobs 2005). The aim is to achieve a partnership in which two destructive extremes are avoided, *i.e.* expert-based decision-making without reference to older adults’ perspectives *versus* simply leaving older persons to express what they want in an unsupported way (Thompson and Thompson 2001). On the part of the care recipients, internalised oppression may pose a threat to the care-giving dialogue. Many of today’s older care receivers feel that it is not their place to have a say in what happens (Thompson and Thompson 2001). For instance, in a sample of older care recipients in Germany, Burmedi (2001) found a dysfunctionally high level of respect for medical authority, with such prevalent misconceptions as: ‘It is always better for the doctor to ask the questions and the patient to answer them, not vice versa’. Policy could take steps to cultivate a more constructive attitude amongst older care recipients by informing them sufficiently about their legal rights, hereby underscoring the contributions they are welcome to make to the care-giving dialogue. This

could be guaranteed by making such information transfers prerequisite for admission to nursing homes and home-care services. Good channels for addressing complaints would also be valuable. Regular contact with caseworkers is particularly useful, as it provides the opportunity to discuss current issues in personal care, thus enhancing older adults' feelings of involvement. Finally, care-givers should be informed about the tendency towards exaggerated respect for medical authority, so that they can respond proactively (Burmedi 2001). The implementation of such measures could create an environment in which the older care receiver is 'an agent rather than a patient' (Stenner, McFarquhar and Bowling 2011: 471).

Discussion

The long-standing tradition of framing old age merely in terms of losses was ageist, as older adults were systematically stereotyped and discriminated against solely based on their age, thus neglecting diversity amongst older people (Letvak 2002). In addition to corresponding to demographic reality, active ageing is a powerful discourse, as it is more consistent with older adults' actual capabilities. Previous research shows that many remain positive about their lives and actively involved in society (Jacobs 2004). To date, however, active ageing is too often understood in terms of traditional, 'youthful' activities (*e.g.* labour, sports, care), with a strong emphasis on health and independence. We should be wary of making the same mistake as activity theorists by becoming too idealistic once again. Overly ambitious conceptions of active ageing are problematic, as they may generate a form of 'new ageism', in which the generalised fear of ageing is replaced by fear of ageing with disability and in which *dependent* older adults suffer from discrimination (Angus and Reeve 2006).

Diversity-thinking is thus a two-way street, in which both extremes (*i.e.* an overly negative and an overly positive view of old age) should be avoided. To take diversity truly into account, we must discover how to promote and realise active ageing throughout various phases of life. A crucial point in this regard involves acknowledging that the meaning of an active life may change throughout the lifecourse and that gains might also be seen in the context of loss, as older adults may unfold unexpected substitute skills, collaborative relationships or creative strategies to overcome limitations (Hansson, Robson and Limas 2001). To gain further insight into the dynamic nature of active ageing, future research could consider four phases of old age: pre-retirement (with an additional distinction between those in good and those in poor health); independent living as a retiree; early dependent living (characterised by increasing limitations); dependent living up until death

(Malanowski 2009). Spending more attention to the multidimensionality of active ageing, and especially the interdependence of its components, is another viable venue. Avramov and Maskova (2003) focus on participation in particular activities *for each indicator separately*. Houben, Audenaert and Mortelmans (2004) operationalise the active-ageing concept by calculating the mean number of hours weekly spent on all considered activities *together*, subsequently relating this outcome to socio-demographic determinants. In our opinion, however, active ageing cannot be reduced to the sum of its indicators as various forms of activity are not necessarily complementary (*e.g.* possible tension between work and care responsibilities). Investigating further the *interplay* between different domains of life might hence be more interesting. Diffusion of these results at policy level calls for a central platform within which to integrate various aspects related to ageing. In most European countries, the various domains of active ageing have been separated into different public policy departments, each of which tends to focus exclusively on its own area of expertise (Perek-Białas, Ruzik and Vidovičová 2006; Piekkola 2004). Finland constitutes an inspiring example as three central ministries (*i.e.* Ministry of Social Affairs and Health, Ministry of Labour and Ministry of Education) co-operate with each other (Piekkola 2004). The European Union may use the ‘Year 2012 for Active Ageing and Intergenerational Solidarity’ as a framework for disseminating good practices.

Conclusion

Contemporary researchers and policy makers pay much attention to measures aimed at encouraging older adults to work longer. If demand-side barriers (*e.g.* age discrimination) are taken into account, incorporating attempts to raise actual retirement ages into an economic policy focusing on population ageing is – given the current demographic landscape – in itself not a bad thing. The same holds for the promotion of physical activities and health, which is also a topic of considerable attention. These tendencies, however, do become problematic when active-ageing policies are equated with the implementation of such measures. There is, after all, a difference between ‘a policy agenda centring on aging and an agenda centring around seniors’ (Carstairs and Keon 2007: 13). If one is truly concerned with how older adults can age actively, it must be recognised that there are multiple pathways for older adults to reach this objective. Converting active ageing into a dynamic concept by creating a facilitating climate for different sub-groups within society, including the frail and dependent, is an ongoing challenge. To include the latter, active-ageing policies should centre on

engagement with life in general, rather than reducing the concept to economic engagement or involvement in highly physical activities. Fostering adaptability, supporting the maintenance of emotionally close relationships and removing structural barriers related to age or dependency may further involvement with life throughout various phases of life.

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NOTE

- 1 The literature lacks consensus regarding the cut-off point between the young-old (third age) and the old-old (fourth age). Most studies place it somewhere between the ages of 75 and 85.

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