

# The concept of health in older age: views of older people and health professionals

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## Abstract

This study aimed to explore how older people and health professionals conceptualise health in older age. Thirty-six older people and 41 health professionals participated in 10 focus groups (five with older people and five with health professionals) and discussed concepts of health, the modifiable aspects of health, and barriers and motivators to undertaking health-promoting behaviour change. Both older people and health professionals were found to conceptualise health in a holistic manner. While health professionals tended to place the source of poor health on failures of social connectedness and poor service delivery, older people stressed the importance of taking ownership of one's own health and actively seeking out health promoting activities and services.

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HISTORICALLY, HEALTH in older people has been conceptualised from a medical perspective and focused on the absence of disease and disease-related disability.<sup>1</sup> Health is now understood to be more complex than the medical perspective suggests, defined not only as the avoidance of disease and disease-related disability but also the maintenance of high cognitive and physical functioning and active engagement with life;<sup>2</sup> that is, main-

## What is known about the topic?

The concept of health has been defined in terms of physical, mental and social health by the World Health Organization.

## What does this paper add?

This paper explores concepts of health from the perspective of older people and people working with older people to determine whether the World Health Organization's definition is salient to both older people and health professionals. Older people reported an empowered perspective where they were responsible and largely in control of their health and independence. Health professionals tended to describe external factors, such as poor transport or lack of access to services, as obstacles to achieving health and independence.

## What are the implications for practitioners?

Having a better understanding of how older people perceive their health can guide service delivery responses, including recognising the motivating factor of wanting to maintain independence. The importance of linking physical, social, mental and spiritual dimensions in service delivery is also highlighted.

taining the three dimensions of physical, mental and social health. This concept of health is embodied by the World Health Organization (WHO) Ottawa Charter for health promotion, describing health as a "resource for everyday life, not the objective of living" (p. 2). Health is thus defined as a positive concept that emphasises social and personal resources, as well as physical capacities.<sup>3</sup> A fourth dimension, not explicitly identified in the WHO Ottawa Charter, but which may be interpreted within the domain of personal resources, is spiritual health, which has recently been highlighted as an important aspect of healthy ageing.<sup>1,4</sup>

There is now vast literature on "successful ageing" from a theoretical perspective,<sup>1,5,6</sup> as well as from the perspective of older people.<sup>7</sup> This

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**Focus group questions****Service user questions**

- 1 What does health mean to you?/What does being healthy mean to you?
- 2 What affects your sense of health and wellbeing?
- 3 Do you believe that you (personally) can improve your health? Is there anything that you don't think you can change?
- 4 What motivates you to take action to improve or look after your health? What prevents/constrains you from looking after your health?
- 5 Are there any groups or individuals you may listen to who influence you taking action to improve or look after your health?

**Service provider questions**

- What does health mean to you?/What does being healthy mean to you?
- What things do you believe have an effect on an older person's health?
- What do you believe an older person can do to improve their health?
- What are the factors that motivate or prevent an older person from looking after their health?
- What things can you do to enable older people to improve their health? What role does your agency play in health promotion?

literature tends to refer to “health” as a uniform concept that is just one component of successful ageing, together with factors such as positive functioning or psychological wellbeing, physical and mental health, cognitive growth potential, high quality of life, high life satisfaction, adaptation to life changes, and social integration.<sup>4</sup> Few studies have focused specifically on the definition of “health” in older age, a sub-factor of the larger concept of successful ageing.

The main domains of health include physical, mental, social and spiritual health. Physical health involves the maintenance of high physical function — that is, an absence of deficits in activities of daily living, and minimal functional disability — as well as the prevention and control of chronic disease and illness.<sup>1,8,9</sup> Mental health is described as “the vitality necessary for active living, to achieve goals and to interact with one another in ways that are respectful and just.”<sup>10</sup> (p. 4) Social health is dependent on social connectedness as well as the extent to which communities value diversity, are supportive and inclusive, and provide opportunities for each person to participate in community life,<sup>11</sup> as well as the number and quality of social supports and relationships that a person maintains.<sup>12</sup> Crowther and colleagues<sup>1</sup> define spiritual health as the possession of a “developing and internalised personal relation with the sacred or transcendent

that is not bound by race, ethnicity, economics or class and promotes the wellness and welfare of self and others.”<sup>1</sup> (p. 614) While each of the above components of health contributes to wellbeing in older people, little research has explored the meaning and importance of the different aspects of health in older age; for example, what is meant when an older person refers to having good or poor “health”.

The expanding literature on the multidisciplinary demands of health in ageing would indicate that “health” is defined not by each domain of health in isolation, but by the interaction between one's social and spiritual connectedness, mental and physical wellbeing, and functional independence.<sup>13</sup> Older people are generally confronted with increasing losses of health, independence, roles, possessions, friends and family as they age, and therefore health priorities change throughout the ageing process.<sup>14</sup> Furthermore, the medical ailments experienced by many older people can be complex, often impacting on an individual's thoughts and feelings as well as physiological condition. Therefore, health needs in older age demand a holistic approach in medical management.<sup>14</sup>

While it is clear that health priorities change as people age, few studies have been conducted in Australia on how health is conceptualised by older people. One study by Knight and

Ricciardelli<sup>4</sup> found a high concordance between the older person's perspective on healthy ageing, and domains of healthy ageing; however, this study did not specifically address "health", but rather the more general concept of healthy ageing. As the Australian demographic is rapidly ageing, it is pertinent to understand how older people conceptualise health. The older person's concept of health will have important implications for implementation of appropriate health-promotion initiatives for older people. This study aimed to explore the concept of health in older people and health professionals who live in inner-metropolitan, outer-metropolitan and rural Victoria, Australia.

## Methods

A qualitative design based on a focus group methodology was adopted to obtain a rich source of data on people's experiences, values and beliefs.<sup>15</sup>

## Participants

Thirty-six older people with an average age of 76 (range: 62–90; 75% women) and 41 health professionals participated in the study. Participants were recruited from Home and Community Care (HACC) services (eg, Planned Activity Groups and Senior Citizens' centres) in three regions in Victoria, Australia — one inner-metropolitan, one outer-metropolitan and one rural region. HACC services include home help, food services, nursing, personal care and social support, which are provided in the home and community to young people with a disability, and to frail older people. Nineteen older people and thirty health professionals were recruited from these services.

The researchers recognised that focus groups are more likely to be attended by healthy older people, therefore, in an aim to recruit participants with more complex health concerns, 17 older people and 11 health practitioners were recruited from two falls clinics in the same targeted regions — the inner-metropolitan and rural regions. Falls clinics are an outpatient service in Victoria that provide multidisciplinary assessment, aiming to

reduce falls in the future for patients who have had multiple falls, and/or multiple risk factors for falls.

The falls clinic sample was significantly older than the HACC sample (mean, 79.3 v mean, 73.7;  $t(32) = -2.16$ ;  $P < 0.05$ ) and was also slightly more likely to live alone (52.9% v 36.8%; not significant). Self-rated health did not differ significantly between the older people in the HACC services and the falls clinic groups ( $t(33) = -0.82$ ; not significant). The health professionals who participated were allied health staff (18), managers (9), medical practitioners (6), assessment officers (5) and "other" (3).

## Materials and procedure

Ten focus groups were conducted: five with older people across the three regions (including two falls clinics) and five with health professionals across the three regions (including two falls clinics). These focus groups were conducted as part of a larger study that explored the enablers and barriers in achieving health-promoting behaviour change, described elsewhere<sup>16</sup> (Box). Focus groups were between 90 and 120 minutes in duration. Focus groups were conducted, where possible, within a community or health setting from which the participants were recruited, such as a meeting room in the health service where the falls clinic was located, or a centre where an HACC social support group met. All participants gave informed consent and local hospital human research ethics committees approved the study.

## Data analysis

A facilitator and a scribe conducted each focus group. Written notes (by the scribe) and transcribed tape recordings of the focus groups were cross-checked and verified by the facilitator. The researchers aimed to ensure the reliability and validity of the findings in accordance with the key aspects of research into human activity defined by Lincoln and Guba.<sup>17</sup> To ensure consistency and replicability of the findings, multiple focus groups were conducted with three researchers undertaking the content and thematic analysis of the transcribed reports. Themes extracted by each

researcher were compared. The study aimed to explore whether older people and health professionals conceptualised health according to dimensions that have already been identified in the literature. However, at no point were these concepts raised or pressed in the focus groups, and the thematic analysis did not aim to limit themes to those that have been previously identified.

## Results

Older people and health professionals attributed similar meanings to the definition of health. They identified health to be one, a combination, or all of the recognised dimensions of health: social, physical, mental and spiritual. Health professionals tended initially to describe health based on theory, for example that “the World Health Organization (WHO) says it’s not just the absence of sickness”, but then described their work-related experiences of health priorities in older people. Older people reflected on their life experiences to provide rich descriptions and examples of their concept of health. A holistic definition of health was shared among older people and health professionals, and was based on the belief that health is essentially related to “independence and quality of life”. Health professionals described health for older people as “being in control” and “being able to participate in your community”. Older people described health as being able to “get out and about, maintain independence, keep contact with friends and family, socialise, be able to participate in the things you want to do”.

Functional independence and the maintenance of social roles was of such importance to older people that they reported dreading the thought of having to go into care and losing their independence. Services provided by the council were recognised as providing older people with a level of independence that allowed them to continue living at home. One older person explained how the help he receives means that “we [older participant and his vision-impaired wife] can live a normal life. If not, we’d have to go to a nursing home, without the help that we get”. The impor-

tance of health was also complicated by the role of caring for a loved one. One older man described how “if anything happened to me, she [his wife] would have to go into a home”. One of the oldest participants in the study highlighted that stereotypes about older age can impact on one’s health and independence; for example, when she told people her age they treated her differently: “They tended to think I needed help at every step, and I don’t. I find that being independent depends a lot on your intention to stay independent.”

Older people and health professionals both described health in terms of the four main dimensions of health in the literature: social, physical, mental and spiritual.

## Social health

### Older people

Consistent with the literature, older people discussed the importance of social connectedness and social activity in maintaining overall health. Older people described how health and happiness were strongly associated with being socially active. One older person described how “Socialising is very important, otherwise you become a hermit in your own environment ... it [social activity] makes you happier, and if you’re happier you’re healthier”. Older people also commented that “Getting involved and meeting with people helps you” and identified that “Loneliness is the worst”.

### Health professionals

Health professionals also discussed the importance of social connectedness and social activity in maintaining overall health. Health professionals identified that “Health means being able to socialise with other people”. Health professionals also described facilities such as libraries and social groups as important because they give “a sense of belonging and encourage socialisation”. Loss and grief, on the other hand, were highlighted as having the potential to lead to high levels of isolation, which in turn put people at risk of poorer physical and mental health outcomes.

Isolation was noted by health professionals to be particularly problematic in remote or rural areas. One health professional described the difficulties faced by older people who settled in small townships when they were young adults when:

The town had services like banks and public transport and over the years all of those services have been stripped away. One of the towns I go to doesn't have any public transport to or from the town; so when the spouse can no longer drive or moves into residential care, all of a sudden the other one is left there with no transport or way to get out.

### ***Shared concepts***

Both older people and health professionals shared a similar understanding of the importance of social connectedness and happiness in overall health.

### ***Physical health***

#### ***Older people***

Older people discussed their experiences of poor physical health, and that gaining control over ailments was a concern, particularly when the disability resulted in reduced independence. For example, in describing the mobility and independence problems associated with arthritis, older people stated that "There are products you can't open: milk bottles, pill bottles . . . they don't put things out for people with arthritis". Older people described how the importance of their physical health became more salient after experiencing a health scare. One participant explained that after having open-heart surgery he "paid attention to the surgeon's lectures on the importance of physical programs to prevent heart disease in the future".

Older people indicated that their capacity to participate in physical activity was a fundamental marker of physical wellbeing. Being able to undertake activities such as walking, swimming, going to the gym and gardening was important to older people. For example, one participant described how "Health means going to the gym two to three times a week. I do pump aerobics. If

I can't do this, I'm devastated — don't know what to do with myself". Older people also commented on the value of the social aspects of physical activity. One participant, who did water aerobics twice a week, commented that "I look forward to the aerobics and the cuppa afterwards".

### ***Health professionals***

Health professionals identified that "absence of disease" and having "a 'normal' level of functioning" were important elements of health. Health professionals recognised the association between social health and physical health such that older people may rapidly decline physically when they are isolated and there is no one to "keep an eye on them". The potential impact on nutritional wellbeing following the loss of a partner was also noted. Health professionals discussed how "there are a lot of older people who tend to eat very badly because they haven't got the incentive to [eat better]". It was highlighted that sometimes when some older people lose a partner they think there is "no point in cooking a 'meal' for one person, so they don't". This was noted as particularly evident in widowers who may not have cooked before.

### ***Shared concepts***

Health professionals recognised the relationships between physical health and disease, social isolation and nutrition, and emphasised the need for others to "look out for" older people. In contrast, older people stressed the need to take ownership of their physical health, and placed greater emphasis on participation in physical activity to maintain their overall wellbeing.

### ***Mental health***

#### ***Older people***

Older people described how mental wellbeing was central to their overall health; for example, when one is "ill and housebound, depression sets in" and that "you've got no social life". This included having a positive outlook and "not feeling sorry for yourself" as well as using services that supported mental wellbeing, such as psy-

chology, and taking medication, such as antidepressants and sedatives, when necessary. “Mental attitude” was highlighted as an important aspect of wellbeing; for example, one older person described it as:

When you get out of bed in the morning and think “Well I’ll make sure I’m going to have a good day today” and you have it. If you’re going to get up and think “Oh God I’m down today”, you’re going to get around like that.

Another aspect of mental health, raised by some older people, was of maintaining cognitive functions. Fears about developing dementia and cognitive impairment were pertinent to some participants asking, “As I get older, could I lose my memory?”, associating memory loss with loss of independence and having to go into residential care.

### ***Health professionals***

Health professionals in each of the focus groups discussed the potential for mental health to deteriorate when older people are isolated from neighbours, friends and family. Poor access to health services was highlighted by health professionals to be an issue of particular pertinence, not only to physical health but also the mental health of older people in remote areas.

### ***Shared concepts***

Both older people and health professionals identified the link between social connectedness and mental health. Health professionals tended to associate poor mental health with failures of health service delivery and social connectedness, while older people emphasised the importance of taking control of their own mental health and seeking out services that promote and restore mental wellbeing.

### ***Spiritual health***

#### ***Older people***

Three older participants, in two focus groups, raised spirituality and spiritual health as important in maintaining overall wellbeing. One described his respect of Eastern philosophies and

his belief that “If you change your thought-set, you’ll probably be healthier than what you are now”. Another described the importance of maintaining a balance between different aspects of health:

I think we are concentrating a lot on physical [health] and I think it’s important to look after your spiritual welfare as well. I think that’s a very important part of my life — my church activities and my beliefs — and I think that always strengthens me. I do some voluntary work . . . I think it’s important to give something back to the community. I think that gives us a good feeling. That gives me a lot of pleasure. So I think those sorts of things maintain your equilibrium.

### ***Health professionals***

Spiritual health was raised in only one focus group with health professionals.

### ***Shared concepts***

A small number of older people and health professionals reported that faith and spirituality were integral to their overall health and wellbeing. While only a small number of participants discussed spiritual health, those who did stressed that it was a particularly salient aspect of their wellbeing.

In summary, older people and health professionals both acknowledged that health is a multi-dimensional concept that can be described in terms of the domains of physical, social, mental and spiritual health reported in the literature. These domains were not considered as independent, but as highly interconnected. The fundamental meaning of having “good health” was essentially to manage physical ailments, remain socially connected, have a positive outlook and, above all, to maintain independence during older age.

## ***Discussion***

Participants in this study, including older people and health professionals, identified the four dimensions of health reported in the literature

(physical, mental, social and spiritual health) as being the key dimensions for conceptualising health in older age. The interconnection of these dimensions was acknowledged as well as the importance of maintaining independence and quality of life. There was high concordance between the health professionals' and older persons' perceptions of health in older age, however, there were also some important differences.

An important difference between the perspectives of older people and health professionals appeared to be in how health was achieved and maintained. Older people reported an empowered perspective where they were responsible for, and largely in control of, their health and independence. Older people stressed the importance of taking control and ownership of one's own health by taking up health promoting activities and seeking out the relevant health services. Older people described maintaining independence and a strong desire to stay in their own home and avoid placement in residential aged care. The use of community services was perceived as facilitating such independence and avoiding the need for residential care. Thus, older people focused on adopting strategies for maintaining social health and keeping happy and connected. Health professionals acknowledged that an important aspect of healthy ageing was to maintain "normal" levels of functioning and to avoid disease and illness, consistent with the literature;<sup>13</sup> however, they discussed how poor health and lowered independence was associated with poor social connectedness within the community, and failures of service delivery. For example, health professionals contextualised social health in relation to isolation, reduced access to services in rural areas and dealing with loss and grief. These differences may reflect the role that service providers have in reducing external barriers for older people to maintain their health.

An aspect of health shared by some older people and health professionals was that of spiritual health. Spirituality was described as a very personal aspect of wellbeing. While spirituality was only raised by a small number of participants, those who did raise it described it as an

integral part of their overall wellbeing. This is consistent with previous research where spirituality has been described as significant in adjusting to the losses associated with ageing.<sup>4</sup>

While the ageing process is often accompanied by increasing levels of illness, disability and limitations, these physical aspects of health were not the focus of discussions about health and wellbeing among older people. The experience of a health scare was associated with improving vigilance in the maintenance of physical health as has been found previously,<sup>18</sup> and this is consistent with the Health Belief Model.<sup>19</sup> Concepts of physical health did not focus on elimination, but rather management of disease and disability. Challenges to independence encountered due to physical limitations, such as those caused by arthritis, were clearly a cause for frustration for some older people. Ranzijn and Luszcz<sup>20</sup> identified that acceptance of disabilities is a key element of wellbeing in older age. The priority for older people was clearly to be able to maintain physical abilities for as long as possible in order to continue living independently and, above all, to avoid going into residential care. An important aspect of physical health was the combined physical and social participation in activities, exercise, and social or community groups. Older people reported that losses in physical health were best accommodated by maintaining a positive mental attitude and supportive social structure. For many older people, social health and mental and spiritual wellbeing were discussed as being just as, if not more, important to overall wellbeing than physical health. In particular, loneliness was described as a terrible experience associated with poorer overall health. Ultimately, health in older age was equated with maintaining independence, not only so that an older person can function independently within their own home, but also to maintain their broader role within the community with family, neighbours and peers.

The findings are significant for two reasons. Firstly, the overall concept of health held by health professionals and older people appears to be broadly consistent between the two groups and with the literature; however, the factors

affecting health were biased by the vastly different viewpoints of older people — that is, of ownership of one's own health and independence — and health professionals — that is, of service delivery and tending to older people who may be more isolated or be less independent. Health professionals recognise that health in older age fundamentally means to live a meaningful and functional life. This is an important finding that can be used in practice with older people such that health professionals can work towards common goals in collaboration with older people. Secondly, it is clear that health in older age extends beyond merely maintaining physical health through the elimination of illness and disease. Health extends to social connectedness, mental wellbeing and, for some, spiritual wellbeing. It was recognised by both older people and health professionals, however, that a decline in one area of health is likely to have follow-on effects in other aspects of health. For example, a man who is consumed by grief at the loss of his wife may lose the motivation to eat well; depression, grief and poor nutrition may then lead to a decline in his physical wellbeing and lead to other physical, mental and social health concerns.

There are some potential limitations in the present study. It is likely that people who attend focus groups are more confident, socially active and positive about life. In order to counter this, two groups of participants were recruited: the potentially "more well" group of health service users, and the frailer, older group with multiple comorbidities from the falls clinics. In addition, the views of isolated people may not have been obtained, particularly considering all of the participants were linked into health services or community groups, to some degree. Some participants who had limited transport access, however, were able to attend focus groups using taxi vouchers. The findings from the sample may not be applicable to all older people, even though the sample comprised older people who were well-functioning and those at higher risk of poor health. Further research could explore concepts of health in community-dwelling older people who are not actively engaged in health and

community services. We found that older people accessing services tended to perceive these services as assisting them in maintaining independence and remaining living in their own home. People not accessing health services may have different perspectives in relation to using community services and their perceptions of independence. Older people living in residential care may also have a different perspective of health and how they perceive and maintain independence.

## Conclusions

The findings suggest that older people and health professionals have an understanding of health in older ages consistent with literature on concepts of health more generally. The key difference between health professionals and older people was how health is achieved and maintained in older age. While older people reported an empowered perspective in which they are responsible and largely in control of their health and independence, health professionals tended to describe external factors that created obstacles to achieving health and independence. This may reflect their roles as service providers in identifying and trying to overcome external barriers for their clients. It is particularly significant that maintenance of independence is a principle motivator in health promotion for older people. For this sample of older people, who have access to health and community services, these services facilitate independence and help prevent the need for residential aged care.

Future directions for health-promotion initiatives with older people could be to provide more opportunities for balanced participation in activities in the community that improve social integration, and assist older people to take personal responsibility for their own health. For example, current services that are important for older people include access to transport, meals, and health services — particularly GPs — as well as the combined access to social support and physical activity. As the Australian population continues to age, it is important that the health objectives of maintaining functional independ-



ence and quality of life continue to be acknowledged in policy and program development for older people. This is likely to lead to a greater uptake of health-promoting behaviours among older people, and therefore also lead to a better quality of life, and general wellbeing in older people.

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## Competing interests

The authors declare that they have no competing interests.

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