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# Physical capability and the advantages and disadvantages of ageing: perceptions of older age by men and women in two British cohorts

SAMANTHA PARSONS*, CATHARINE R. GALE†, DIANA KUH‡, JANE ELLIOTT* and THE HALCYON STUDY TEAM

***ABSTRACT***
In an increasingly ageing society, its older members are receiving considerable political and policy attention. However, much remains to be learnt about public perceptions of *older* age, particularly the views and experiences of older individuals themselves. Drawing on qualitative interviews carried out with members of two British cohorts (N = 60) who have reached the 'third age', this paper discusses perceptions of age, focusing particularly on how perceived advantages and disadvantages differ by respondents' self-reported physical capability. The interviews were carried out in 2010 as part of the HALCyon (Healthy Ageing across the Life Course) collaborative research programme. Findings suggest there is some difference in the way older people view aspects of ageing by capability and that although advantages are widely perceived, physical decline and associated health concerns were the overwhelming theme across the conversations. The article concludes by making tentative suggestions to inform the positive ageing agenda and its related policies.

***KEY WORDS*** – ageing, capability, cohort, third age.

## Introduction

Much political and scientific effort has been put into addressing the 'problem' of ageing. The focus is not just on living longer, but on living better (Tulle 2008). In the United Kingdom (UK) in 2007–09, life expectancy at birth was 77.7 years for men and 81.9 years for women and for those aged 65, men could expect to live a further 17.6 years and women 20.2 years. However, men could expect to experience 14.6 of these years

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with a limiting persistent illness or disability. For women this increased to 17.7 years. Living longer has been achieved, but not necessarily living well for longer (Office for National Statistics 2010). With the ageing of the baby-boomers, the 'ageing well', 'successful ageing' or 'positive ageing' agenda has received renewed interest (Chapman 2006; Phillipson *et al.* 2008; Rowe and Kahn 1987; Scott and Nolan 2005). Much of this is driven by economic rather than social concerns, in particular, the increasing imbalance in the dependency ratio of the vast majority of Western societies. The dependency ratio is an age–population ratio of those typically not in the labour force – children and adults age 65 plus – (the *dependent* part) and those typically in the labour force (the *productive* part). It is used to measure the pressure on productive population. If the ratio increases due to falling or stabilising birth rates and the size of the older population increases (Eurostat 2010; Lanzieri 2006), an increased burden is placed on the productive part of the population to maintain the upbringing and pensions of the economically dependent (Taylor 2002; The Pensions Commission 2004) and health care (Suzman, Willis and Manton 1992; Wanless 2002). Economic attention is also directed at the new consumer opportunities that have arisen with the changed demands of older age groups, with much market research highlighting their increased buying and negotiation power (*see e.g.* www.babyboomer-magazine.com).

However, the 'ageing well' concept has gathered its critics as it excludes certain groups within society, requiring an individual to have access to certain levels of resources, health and active engagement (Biggs 2001; Holstein 2000) whilst ignoring the diverse ways in which people might perceive they have aged 'well' (Chapman 2005). There remains much to be learnt about how age expectations are constructed, learned and then adapted, at both an individual and societal level when circumstances shift and change (Elder 1998). The boundaries between the different stages of life are also blurring – for example entrance to the labour market is now often not until a person has reached their early to mid-twenties, both men and women become first-time parents at increasingly older ages and turning 60 is not perceived as old and time to take things easy – and this has an impact on how age is perceived and ultimately how these perceptions are adjusted (Featherstone and Hepworth 1991; Gubrium and Holstein 2001; Moynagh and Worsley 2009).

At a societal level there remains a substantial mismatch between the negative associations and stereotypes that are attached to older age in the West and the increasing representation of a richly rewarding, positive life following retirement in the media (Lumme-Standt 2011; McHugh 2003; Rozanova 2010; Sinding and Gray 2005). At a time when jokes and negative remarks about race and gender have greatly diminished from the public

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arena, at least overtly, ageism is still largely permitted (Kirkwood 2001). These negative social stereotypes mean that few older people identify themselves as old (Itzin 1990; Jones 2006), describing getting older as remaining the same person but with a mask of an older person on their face (Featherstone and Hepworth 1989, 1991). As highlighted by Scott and Nolan (2005), 'there is much to do to boost more positive attitudes both towards and among older members of the population', despite the numerous international and national strategies that have emerged with the growth of the 'positive ageing' agenda (*e.g.* Andrews 2002; Dalziel 2001; Davey & Glasgow 2006; HM Government 2005; World Health Organization 2002).

Retaining good health is widely viewed as the cornerstone to ageing well, and as something individuals should strive to achieve (Crawford 2006). Poor health or 'suffering' disrupts daily life and an individual's ability to manage simple, routine tasks (Black 2009). As the medicalisation of ageing (Estes and Binney 1989; Moynihan 2011) has taken hold in Western society, ageing is increasingly constructed as a process of inevitable decline with age being an ally of illness, dependence, loneliness and, ultimately, death (Black 2009).

However, by going back to writings in Ancient Greece, Gilleard (2007) shows that the old have always in some way been depicted in a negative light. He discusses how a distaste and often disgust for old age ran as a constant theme in ancient Greece and its literature. An old man was portrayed as someone who has lost the power he used to have (*e.g.* Oedipus) and old women were either presented as supportive matronly figures or figures of ridicule (Pratt 2000). The striking exception to this cultural tradition was Sparta, which was the least literate state in ancient Greece. Respect for age and authority were indoctrinated from an early age (Cartledge 2001). In Sparta, all the young were soldiers and only when they became too old to be in the army did they become eligible, if they survived, to serve on the council of elders, the *Gerousia*. Once chosen, this was a job for life, one that could only begin after reaching the age of 60 (Gilleard 2007).

Today, it is not so much that there is distaste for old people *per se*, but for people who *look* old. Being described as old is evidence that a person has not 'aged well' (Torres and Hammarström 2006; Wolpert 2011). So, while there is every reason to think that perceptions of the ageing process will be less positive among older age groups and the less capable, it is vital to learn more about how self-perception at a particular life-stage is viewed among those within different capability, age and gender groups. By carrying out interviews with older men and women from two different age groups with differing physical capability, we aimed to explore whether the belief that good health is the cornerstone to healthy ageing is widely held. This research will build

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on recent findings that show that there is actually great heterogeneity in how the ageing process is viewed within any group of individuals, reflecting different experiences and changing life circumstances (Baltes and Baltes 1990; Scott and Nolan 2005). People are frequently masters at finding meaning and fulfilment in life even in very difficult times, when faced with reduced capability (Thompson 1992). This adaptability to changing circumstances may be triggered not just by the experiences of older age, but also by poor health, disability and loss of capability over the lifecourse (Brandtstädter and Renner 1990; Brandtstädter and Rothermund 2002).

Drawing on qualitative interviews carried out with sub-samples from two British cohorts (N = 60) who have reached the 'third age', this paper discusses perceptions of age, focusing particularly on how perceived advantages and disadvantages differ by respondents' self-reported physical capability.

## Methods

### *Background to the study*

This study is part of the HALCyon (Healthy Ageing across the Life Course) collaborative research programme, which brings together an interdisciplinary group of 23 scientists and nine UK cohort studies to understand different aspects of healthy ageing.[1] There are eight different research strands within HALCyon, each investigating how individual factors such as early development, lifetime health, personality and nutrition, and characteristics of areas in which study members have lived, influence a particular indicator of healthy ageing. Few studies have used qualitative methods to study capability or wellbeing, yet a focus on subjective experiences and beliefs can provide insights not obtainable by quantitative methods alone. The 'Life History and Healthy Ageing' work package within HALCyon carried out qualitative interviews with 30 members of the 1946 British Birth Cohort Study, known as the Medical Research Council (MRC) National Study of Health and Development (NSHD), and 30 members of the older Hertfordshire Cohort Study (HCS) who were born between 1931 and 1939. Of the nine available cohort studies, comparable data were available for participants in these two studies as both had carried out a self-completion postal questionnaire on health and wellbeing in 2008–09. For comprehensive details on the background and design of this study, together with some initial exploratory analyses and content of the topic guide, *see* Elliott *et al.* (2011).

### *The data sources*

*National Study of Health and Development.* The NSHD, also known as the 1946 British Birth Cohort Study, was the first of the national birth cohort

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studies. The sample was drawn from the first national maternity survey of all the babies born in one week in March 1946 in England, Wales and Scotland, which was undertaken to learn about the social and economic costs of childbearing. Funding was secured to follow up 5,362 of the single legitimate babies, so far on more than 20 occasions over their life. The focus of the study has shifted to reflect the lifecourse stage of the study members. During childhood, the main aim was to investigate how the environment at home and at school affected physical and mental development and educational attainment. During adulthood, the main aim was to investigate how child health and development and lifetime social circumstances affected adult health and function and its change with age. Now, as respondents reach retirement, the research team is developing the NSHD into a lifecourse study of ageing. For more information on the study, *see* Wadsworth *et al.* (2006),[2] and for an updated profile that outlines the most recent data collection at age 60–64 years, *see* Kuh *et al.* (2011).

*Hertfordshire Cohort Study*. The HCS is part of a group of unique studies of men and women born in the English county of Hertfordshire between 1911 and 1939. Details on these people's birth weight, early growth and health had been recorded by health visitors as part of a scheme originally set up by Miss Ethel Margaret Burnside in an attempt to improve the survival of infants in the county. In 1998–2004, men and women born in Hertfordshire between 1931 and 1939 and still living in the county were recruited to take part in a cohort study to evaluate interactions between the genome, the intrauterine and early postnatal environment, and adult lifestyle in the aetiology of chronic disorders of later life. A description of the setting up of the HCS has been published previously (Syddall *et al.* 2005). Of 6,099 people invited to take part in the initial survey, 3,225 (53%) agreed to be interviewed. In 2008–09, surviving participants were invited to take part in a postal survey. Of 2,689 people approached, 1,417 (53%) returned a completed questionnaire to measure how happy or satisfied individuals are with their lives, and provide new information about factors that may affect wellbeing.

## *Analysis strategy*

The interview was conducted on the basis of a semi-structured topic guide, which consisted of asking 34 questions across six main subject areas. This paper reports on key themes that emerged from analysis of responses to the question 'What are the main advantages and disadvantages of being the age you are?', which was part of the 'Identity and Perspectives on Ageing' section. Figure 1 details the questions included within this section, and their context within the overall interview.

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**SECTION 5: IDENTITY AND PERSPECTIVES ON AGEING (15-20 minutes)**

We are interested in **how you see yourself as a person**, and whether and in what ways this might have shifted or changed over the course of you life.

**Q22**. Do you think of yourself as **belonging to a social class**?

Probe for:
**If so, which one, and why? If not, why not?**
Have you always felt this way? *Did you feel you belonged to a particular social class when you were growing up?*
Have particular experiences ever made you more or less aware of yourself as belonging to a class?

*Note: if respondents refer to themselves as 'ordinary', they should be asked to expand on what they mean by this.*

**Q23.** Do you think of yourself as **belonging to a particular generation?**

**Q24.** What are the **main advantages and disadvantages** of being the age you are?

Probe for:
Health and physical factors

**Q25.** Compared with someone the same age as you would you say that your health is (Excellent, very good, fair, poor, very poor). What goes through your mind when you say that?
Has your health stopped you doing anything that you would still like to do?
Has it has any other impact?

**Q26.** What about your husband/wife/partner's health? How would you say that their health is? ((Excellent, very good, fair, poor, very poor).
Has their health stopped you doing anything that you would still like to do?
Has it had any other impact?

**Q27.** What would you say it means for someone your age to have **very good or excellent** health?
What would you say it means for someone your age to have **poor or very poor** health?

**Q28.** Why do you think some people are healthier than others?

**Q29**. Can you tell me the things you do to help keep yourself healthy/well?
*Note: Probe 'why' they are done – what specific reasons for an 'activity' or 'diet', etc.*

**Q30.** Are there things you do that you think are bad for your health?
*Note: Probe 'why' they are they bad – why continue to do them –*

**Q31.** Still thinking about your health, if you could go back in time and change some of the behaviours/things about your life (e.g. what you ate, how much physical activity you did, the work you did), do you think that would affect the health you're in now? Would it have been worth changing those things?

Figure 1. Questions in the 'Identity and Perspectives on Ageing' section of the interview.

The analyses were carried out across all transcripts after they had been imported into the qualitative data analysis program, NVivo 8.[3] In addition to providing an overview of the main issues that arose when asking about advantages and disadvantages of ageing, we focus on exploring differences between individuals with differing levels of self-reported physical capability in the ways they answered this question.

## *Physical capability*

Eligible participants from each cohort were selected into the qualitative study based on a measure of their physical capability. This was derived using six comparable questions in each study, which were part of a self-completion questionnaire, carried out in 2008–09 in both studies. Table 1 shows the six questions which were part of the Medical Outcomes Study Short Form (36) Health Survey (SF-36; Ware *et al.* 1993) in the NSHD and the Townsend scale (Townsend 1979) in the HCS. The two sets of questions had three similar answer categories, which made data harmonisation possible. Responses were summed and scores ranged between 6 and 18, with a high score indicating poor capability. For the main sample of respondents with complete information in both cohorts (N = 2,253 NSHD[4]; N = 1,416 HCS), the mean scores were 8.49 in NSHD and 8.61 in HCS, indicating that physical capability was very much skewed towards 'good' capability. The scores were split into quartiles of the distribution, with scores in the bottom (6) and top (11–18) quartile indicating 'good' and 'poor' capability, respectively. Cohort members with scores in the middle two quartiles (7–10) were classified as having 'average' capability.

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TABLE 1. *Physical capability questions*

| National Study of Health and Development[1] | Hertfordshire Cohort Study[2] |
|---|---|
| 1. No, not limited at all<br>2. Yes, limited a little<br>3. Yes, limited a lot<br>• Bathing and dressing yourself<br>• Bending, kneeling or stooping (similar to cutting toe nails?)<br>• Moderate activities (moving a table, vacuuming, bowling or playing golf)<br>• Vigorous activities such as running, lifting heavy objects, participating in strenuous sports<br>• Climbing one flight of stairs<br>• Lifting or carrying groceries | 1. No difficulty<br>2. Yes, some difficulty<br>3. Yes, unable to do alone<br>• Washing down<br>• Cutting toe nails<br>• Doing heavy housework<br>• Running to catch a bus<br>• Going up or down stairs<br>• Going shopping and carrying a full basket in each hand |

*Notes*: 1. Questions are part of the Medical Outcomes Study Short Form (36) Health Survey (SF-36; Ware *et al.* 1993). 2. Questions are from the Townsend scale (Townsend 1979).

### *Timing of interviews*

An equal number of respondents from within each of the three capability groups were initially invited for interview. All HCS cohort members, by definition, lived within Hertfordshire, the sub-sample of NSHD cohort members were drawn from those who lived in Scotland or London and the South East.[5] An equal split by capability was achieved in the HCS sample, with ten interviews being carried out in each capability group. There was a bias towards 'good' capability in the NSHD sample (six poor, 12 average, 12 good), which reflected a higher non-response rate among those with 'poor' capability and the reduced numbers with 'poor' capability available for selection.[6] All interviews were carried out between March and September 2010. The NSHD cohort members were 64 years of age at the time of their interview; HCS cohort members were aged between 71 and 79 years, mean age 74.7 years. The interviews averaged around two hours, though there was much variability in length.

### *Physical capability and social disadvantage*

Previous analyses of the main quantitative datasets for both studies have provided much support for the links between poorer health or wellbeing and social disadvantage (*e.g.* Birnie *et al.* 2011; Strand *et al.* 2011; Syddall *et al.* 2009, 2010). Table 2 (based on the participants from whom we drew our sample for the present study) shows that in comparison to respondents with good or average capability, more respondents with poor capability had left full-time education at an earlier age, had a father who worked in a partly skilled or unskilled occupation, or they themselves worked in a partly skilled

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TABLE 2. *Characteristics of the National Study of Health and Development (NSHD) and Hertfordshire Cohort Study (HCS) cohorts by physical capability*

| | NSHD | | | HCS | | |
|---|---|---|---|---|---|---|
| | Poor | Average | Good | Poor | Average | Good |
| | | | *Percentages* | | | |
| Father social class I or II | 17.3 | 27.5 | 28.2 | 8.7 | 9.2 | 11.4 |
| Father social class IV or V | 29.3 | 23.4 | 20.6 | 39.8 | 35.6 | 27.8 |
| Left education by age 15 | 59.0 | 41.2 | 38.5 | 68.7 | 63.4 | 58.5 |
| In education 18+ | 23.5 | 26.1 | 27.4 | 3.2 | 7.2 | 7.9 |
| Own social class I or II | 35.2 | 51.6 | 50.9 | 26.8 | 36.7 | 39.5 |
| Own social class IV or V | 19.5 | 12.4 | 9.8 | 22.4 | 16.8 | 10.6 |
| Home owner | 84.0 | 92.8 | 92.3 | 71.1 | 86.2 | 89.8 |
| Rent home | 16.0 | 7.2 | 7.7 | 28.9 | 13.8 | 10.2 |
| N (variable dependent) | 452–545 | 1,091–1,189 | 458–507 | 286–301 | 652–695 | 349–371 |

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or unskilled occupation in the later stages of their working life. More of those with poor capability also lived in rented accommodation. Among the 60 participants in the qualitative study, the same patterns were in evidence. For example, five of the 15 participants who were interviewed with poor capability lived in rented accommodation compared to none of the respondents with good capability. When looking at how participants discuss disadvantages of ageing, it is important to bear in mind the wider context of their life and its relationship with their self-reported physical capability.

## Findings and discussion

The aim of the qualitative, biographical interviews was to help us understand more about capability, wellbeing and ageing from an individual or lay perspective. This paper has focused on reporting the impact physical capability had on responses given by two groups of older respondents in the 'third age' of their life to the question 'What are the main advantages and disadvantages of being the age you are?' Respondent quotes are used throughout to illustrate some of the key findings, with the unique number assigned to each respondent included after each quotation. A number starting with a 'D' indicates the respondent is a member of NSHD, a number starting with an 'H' indicates membership of HCS. For descriptive purposes the numbers of respondents discussing specific issues are also provided.

The advantages and disadvantages expressed by the respondents in the two cohorts will be discussed in turn in detail. What was immediately apparent from the transcripts, however, was a disjuncture between the way individuals perceive the ageing process and the upbeat messages of freedom and new opportunities that are delivered by the 'positive ageing' theorists, such as Laslett (1989) who sees the 'third age' as a time of great fulfilment, or indeed, as the very pinnacle of life. The question asked respondents to think about the advantages first, so it was no surprise that two-thirds of all respondents began their answer to the question in a positive light, with such comments as 'I've learned a lot, I've seen a lot' (D004). However, a third began their response in a more negative light, with comments centred around feeling old, physical and health decline or on not perceiving any advantages to do with age: 'I don't know what advantages there are…' (H029) or 'Well, is there an advantage to being 64?' (D019).

Responses to this particular question, and indeed others throughout the whole interview, suggest that ageing and getting 'old' is associated far more in people's minds with illness and decline than it is with freedom and new opportunities. The freedom discourse was undeniably apparent in the interviews, in different guises and contexts, but the main thread throughout

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centred on physical decline and the ageing body. Those with poor capability were no more likely to focus on the disadvantages of age *per se* in comparison with responses from those with good capability, but there were differences in which particular aspects of life were perceived as either an advantage or disadvantage.

### *What are the advantages of being the age you are?*

The most often cited advantages across all interviews were financial security or being free from financial worries (22 out of 60 interviews), having life experience (16), freedom to do what you want when you want (15), enjoying grandchildren and family (11), being in good health (ten), having a bus pass (nine) and more leisure time (nine), not working (eight). Individual cohort members also mentioned being more tolerant, feeling more confident in who you are and less need to do things that you do not really want to do, and feeling respected by others as advantages of their age.

Financial security, being comfortable or free from money worries was the single most cited advantage, mentioned equally by respondents irrespective of physical capability, age or gender. However, this did embrace different perspectives, from an acknowledgement of certain 'benefits', 'You get the old age pension and you get your heating allowances and my husband gets his care allowances, so they're all advantages for the elderly' (H016), 'I'm lucky in as much as I've got a good pension, I've got no money worries' (D011), to feeling better off than at any other age previously as financial commitments and obligations had ceased or at least decreased. 'I'm very fortunate that, in a sense, I'm better off financially than I've ever been in my life...' (H028).

The value of the years lived, be it in terms of experience, confidence or tolerance, came across in many of the interviews. Life experience and being wiser with age – '(*Laughs*) Obviously you're a bit wiser obviously aren't you? The older you get the wiser you are' (H013) – was mentioned by more respondents with good capability and featured the least in conversations with respondents who had poor capability. Likewise, feeling 'lucky' or 'fortunate' about some part of their life was mentioned by seven respondents, but by just one with poor capability. Ten respondents overall, but notably by six with good capability and just one with poor capability, mentioned having good health as an advantage.

The advantage of age, in terms of providing more freedom and scope for spontaneity was mentioned by both women (nine) and men (six). As one woman said:

Well, I think that a lot of advantages for me is in the simple fact that you can almost do what you want to do without any ties. So if you want to do absolutely bloody nothing,

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or (*laughs*) watch the whole second week of Wimbledon, that is my entitlement to do that... (D028)

Having more leisure time and an appreciation of the 'now' was also valued by a number of respondents (five men and four women), but more by those with better capability, being mentioned in just one interview with a respondent with poor capability. Conversely, older men with (somewhat) diminished physical capability were, however, most likely to speak of the benefits of not working or being retired from work, 'Plus side, it's nice not to be in the rat race' (H017). Just one respondent who had good capability specifically mentioned not working as an advantage.

More women than men, particularly those in their sixties, mentioned the enjoyment of grandchildren and family, 'Having time to be with grandchildren if you're lucky enough to have them' (D008). This was mentioned less by respondents in their seventies which could reflect that their grandchildren were now no longer young children and had perhaps moved away from the area they grew up in for education, work and also family formation or disruption reasons. It should be remembered that all of the respondents in their seventies in the HCS cohort still lived in the same area in which they had been born. Fewer respondents with good capability mentioned grandchildren as being an advantage, perhaps reflecting that they were able to have a more active social life with friends.

More women in their seventies mentioned the advantage of having a bus pass, 'Well having a bus pass is a great advantage' (H011) or 'The main advantage, can travel on the bus everywhere, that's one main one (*laughs*)' (H026). Fondness for the bus pass among older women could be their only way to get around – either because they did not learn to drive when younger or they did not own a car due to the expense or that they had given up driving due to age-related impairments. However, it could also reflect a liking for public transport to help avoid problems of congestion and parking in town centres, *etc.* Fewer respondents with good capability raised the advantage of having a [free] bus pass, perhaps because they had more financial resources at their disposal to help them get around. (Refer to Table 1 for the relationship between socio-economic indicators and physical capability.)

Given the differences in how people age, it is important for all parts of society, and policy makers in particular, to acknowledge that the freedom and opportunities that come with life free from paid work and, possibly, reduced family and other commitments are not, however, available to all. As in all stages of life, take up of opportunities is very dependent upon resources – health, financial or otherwise. As such, the successful ageing agenda can therefore penalise or stigmatise those who are unable to fulfil the criteria of staying healthy, consuming new lifestyle products, having long

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and extended holidays, learning new skills, *etc.* (Chapman 2005; Katz 2008; Laliberte Rudman 2006).

*What are the disadvantages of being the age you are?*

The overwhelming disadvantage that people perceived, mentioned in 41 of the 60 interviews, was general physical decline, slowing up and being less able to do things than previously. Other specific disadvantages mentioned were being closer to dying (12), having less energy and feeling tired (11), problems with joints and arthritis (11), not being respected and being treated as 'old' (six), fear of the future in terms of unknown health problems (five), being left behind as friends and family die off (five) and having a poor memory (five).

Given the vast body of literature on the subject, it was no surprise that physical decline featured in two-thirds of the conversations on the disadvantages of ageing. It was discussed by participants across capability groups, even among the physically very able who spoke about decline in general and not of specific personal problems, 'old age doesn't come alone, hmmm, it brings with it all sorts of physical reductions' (D002). Comments on physical decline embraced awareness of an increasing number of general aches and pains, 'well, you do seem to get more aches and pains than when you're younger' (H008), restrictions on what can be achieved, 'you can't do the things that you'd like to do ... You think you can do them, you try and do them but the body lets you know' (H030) and having a slower recovery rate, 'I slipped over twice in that icy weather before Christmas and pulled the same muscle twice (*laughs*). So it's, for instance that's not fully recovered yet, I don't know if it ever will' (H003). The younger NSHD respondents and, in particular the younger women, also spoke of having less energy and feeling tired, 'and I do get very, very tired' (D026), but this was not always seen as a problem *per se*, 'if you get tired, you just have a little nap, don't you?' (D025).

The conversations gave recognition and support for the view that whilst being old was alright, looking old or physically infirm was not acceptable (Carrigan and Szmigin 2000; Karpf 2011; McDaniel 2005), and that this was in fact also associated with the withdrawal of respect and of being treated as a fully paid up member of society. In the words of one participant:

> I have noticed though, definitely, that if you walk with a limp, or you've got a crutch, or you have a wheelchair or something like that, or you have one of these noddy-head things that older people tend to get, that all the respect goes immediately and they think you're a bloody idiot just because you're older. And I fear that. (D002)

It was those with better capability who feared or worried about the impact of future health problems, 'I just hope, you know, it doesn't get much worse really...' (H027) and 'it's a bit frightening the prospect of losing my

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mobility' (D016), whereas 'future' problems were not mentioned by any participant with poor capability. This suggests that once physical decline goes beyond normal 'wear and tear', health concerns and any associated lifestyle changes had already materialised and were thus a present worry. In the words of H019:

> No. I don't like it . . ., it's very difficult to cook. I can't crack an egg or –, and I have to eat with a spoon and a fork –, he [husband] keeps wanting us to go out to eat, but, I, you know, I feel a bit self-conscious really. . .

Arguably, when faced with a real health concern or challenge, the future is not a major focus. When an individual is battling cancer or negotiating the health care needs of a partner with dementia, worries centre on getting through the next stage of treatment or the next week. It is almost a luxury to be worried about what might happen in a few years' time.

In terms of specific physical restrictions, problems with knees, hips and/or arthritis were mentioned by six of the 16 respondents with poor capability, 'the knees are a bit of a problem, I can't bend down very easily and I find a job getting up and down stairs and that sort of thing' (H011). This compared to just one respondent who had good capability, which provided some clear validation for the measure of self-reported physical capability used to select and classify the respondents in this study.

Diminished mental capacity was not directly referred to in many conversations, and was not talked about by anyone with poor physical capability. It was sometimes spoken of quite lightly, 'I can't run anymore and I forget things' (H014), but also with some fear over what the future might be like with a changed mind:

> So, I won't have the ability to do what I've been able to do or have the control, the mental control maybe over the things that I've been able to do in the past. And that is going to be an issue because I've always been very much, I believe, in control of what –, situations and when I'm not that is going to be difficult to deal with I would have thought. (D022)

The mismatch between the age participants felt and their actual age 'I mean, I'm 64 but inside I'm 46' (D015), and how others perceived them was a repeated theme across conversations irrespective of capability, 'But you see, I'm not 21 anymore, I'm not supposed to do those sort of things, you're not supposed to do them when you're 77 they tell me and you've had heart attack (*both laugh*)' (H030). However, very few expressed a desire to be young – rather that they did not feel they were old and wanted more 'good' years free from debilitating health concerns. This was not related to capability, and could perhaps in some way partially reflect the growing number of older role models that have a visible presence in many facets of our lives, for example, Dame Joan Bakewell, Sir Trevor McDonald, Fauja Singh (oldest

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marathon runner), Daphne Selfe (oldest model). Older HCS members expressed a dislike for being treated as 'old', 'well once you've hit 70 I think everybody looks –, oh poor old soul, can I help you?' (H014), which supports the view that no-one in the third age really considers themselves as old, and are not treated as old by others unless they are perceived to have aged 'badly' and succumbed to a health problem (Torres and Hammarström 2006). It seems that it is with the advent of health problems that older members of society enter the 'fourth age', the 'oldest old' or the final stage when aged 80+, when they are no longer in the active pensioner phase of their lives.

Dwelling on age itself when more of life lies in the past than the future can, obviously, be dispiriting: 'and old age is associated with you know, disease, dementia and death and none of those are very nice to think about or going through. So that's very negative, you know' (D017). Respondents with poor capability were the most likely (five of 16) to mention their own mortality, of being and feeling closer to dying. This was expressed in a number of ways, such as an acknowledgement of time passing and the age that had been reached, 'I can't believe it. It seems no time at all since I was doing all these other things, that I left school, the years are just gone. I can't believe I'm 64, I'm not 64, I can't believe it' (D004), and recognition that time in the future was limited:

> I'm closer to dying, you know, I mean please God I live another 20 years . . . I'm 65, three score years and ten the bible tells me so I'm only five years away from popping off there, so –, but say, the way things are, the average age is 80 plus so. . . (D018)

Five respondents also talked of having a reduced network as friends and family members start to die off, though this was not related to physical capability: 'One of the disadvantages is you look around and you see all your friends going down like nine pins, with this illness or that illness, and you think, oh dear' (H028) and 'You know, half the people I knew are dead' (D018).

But perhaps, as ever, it all depends on outlook. In the words of one respondent:

> If you're prepared to sit down on your backside and give in to old age, you'll not get any place. And being old is something I'll not give in to. It's a challenge being old. (D001)

## Conclusions and key messages for the positive ageing agenda

This research on the perceptions of age among two older age groups with different levels of physical capability has shown that ageing and getting 'old' was associated far more readily with aspects of physical decline than it is with

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the enhanced freedom and opportunities purported by the 'positive ageing' literature (Laslett 1989) together with the international (World Health Organization 2002), national (*e.g.* Andrews 2002; Dalziel 2001; Davey and Glasgow 2006; HM Government 2005) and local strategies that have evolved to promote 'positive' and 'active' ageing. However, when looking at the full response an individual gave to the specific question, two-thirds of all respondents did see some advantages to being the particular age they were, with men and women in their seventies as likely to see advantages as the baby-boomers in their mid-sixties.

However, it is also important to stress that although physical decline and changing capability were by far the main perceived disadvantage for respondents in the study, they did not dwell on a specific limitation, but rather accepted them as being part of their age (Torres and Hammarström 2006). Even when a certain amount of physical decline had occurred, those with relatively 'poor' physical capability were as likely to see some advantage to being the age they were as those with 'average' or 'good' capability. However, there was some difference in what was perceived as an advantage or disadvantage by respondents' level of physical capability, with more disparity in opinion being recorded for the advantages than the disadvantages.

Among the advantages and disadvantages discussed, more respondents with good physical capability cited being wiser, lucky, enjoying more leisure time and good health as advantages and a worry of future health problems as a disadvantage. Those with poor capability were more likely to talk of not working, having grandchildren and a bus pass as advantages, with problems with joints and arthritis and being closer to dying as disadvantages. As discussed, there was an overwhelming consensus of opinion for the perceived disadvantage of general declining physical health and capability.

Somewhat against the messages put forward by the positive ageing agenda, the conversations lend support to the literature that show ageing has become heavily associated with decline, and decline of health in particular (Crawford 1980, 2006; Featherstone and Hepworth 1991, 1995; Katz 2000). In their review of how successful ageing has been operationalised in analyses of quantitative data sets, Depp and Jeste (2006) found that although there was much variability across studies, they were all based, in part, on the absence of physical disability or reduced performance and that age was significantly associated (statistically) with successful ageing across studies. That is, being part of the 'younger old' meant you had aged more successfully. Health and capability are undoubtedly very important: 'And because I've got good health I can do … I can do all the things I want to do' (D011) – but ageing, or rather successful ageing, needs to be viewed across different domains of life.

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Being resourceful and thinking positively, or at least not thinking negatively, can help turn the challenging experience of growing older into something more manageable (Baltes and Baltes 1990). If there is an acceptance that growing older is accompanied by a change in what can be achieved, then this does not have to be perceived as a disadvantage. This supports the 'activity' theory of ageing which emphasises the need to remain actively engaged in society in order to adapt successfully to older age (Havighurst and Albrecht 1953). After all, 'it's no good complaining about it and calling it a disadvantage, you've just got to accept it . . . you can't do anything about it so why bother (*laughs*)? That's my philosophy anyway' (H007).

For the positive messages attached to 'successful ageing' or life in the third age to take hold in the perceptions of both older and younger members of society, the narrow concept of successful ageing needs to be challenged. Positive ageing is about far more than not looking your age and not succumbing to illness (Scott and Nolan 2005).

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## NOTES

1 For further information, *see* www.halcyon.ac.uk.
2 For further details on response rates, *see* http://www.nshd.mrc.ac.uk/data/response_rates.aspx.
3 For further details on NVivo8, *see* http://www.qsrinternational.com/products.aspx.
4 This number is limited to the NSHD participants who have been recently interviewed *and* had their information coded at the time of writing. The data entry process is currently ongoing.
5 Scotland and the South East of England were selected to match two of the three regions where a similar interview with 1958 cohort study members had been carried out. For further details, *see* Elliott *et al.* (2010).
6 Only cohort members who had been able to make the journey to a clinic for an assessment rather than have a home visit were available at the time the sample was drawn.

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