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Active Ageing and Effective Learning for Enhanced Quality of Life

Rona (Schwartzman) Bar-Netzer^{a*}, Musata Bocos^b

* Corresponding author: Rona (Schwartzman) Bar-Netzer, ronab11@hotmail.com

^a Doctoral School "Education, Reflection, Development", Babeş-Bolyai University Cluj-Napoca, 7 Sindicatelor Street, Romania, ronab11@hotmail.com

^b Babeş-Bolyai University, Faculty of Psychology and Educational Sciences, Sindicatelor Street, nr. 7, Cluj, Romania

Abstract

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Whilst promoting the European Year for Active Ageing (AA), in 2012, the European Union (EU) revised their definition to mean, growing old in good health. By this definition, no matter the person's age, the goal would be to enjoy a better quality of life as an active member of society. Three aspects which support promotion of Active Ageing are: employment, active participation in society and independent living (Hendrickx, 2012). Within the field of Gerontology, the essence of Active Ageing has taken many different names and forms. Many older adults have similar aspirations. In general, they want to be able to do the things that make them happy such as travel, spending time with family (especially grandchildren) and having the ability to maintain their household. The need to combine effective learning in the elderly, with the purpose of motivating intergenerational face-to-face interaction to encourage social support and accept the physiological changes, is a colossal issue.

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1. Introduction

One of the most pressing topics of our day is: the challenges associated with growing old. Until recently, primarily in developed countries around the world, there has been an antiquated "needs-approach" to ageing. The "needs-approach" refers to thinking of elderly as the people who just need care as a result of their limitations. That approach has been abandoned and replaced by a more positive 'rights-approach' (WHO, 2002), which emphasizes the fact that life doesn't end at some arbitrary point

in time between young and older adulthood. This approach highlights the fact that there is much more to life than the burden of physical limitations imposed by age. This change, is a global and cultural one, coming at a time when the world population is rapidly growing and is having a longer life expectancy rate. The World Health Organization (WHO) estimates that by 2025 there will be approximately 1.2 billion people over the age of 60 worldwide. That number of people should reach 2.0 billion by 2050 with 80% of them living in developing countries. Major economical and societal challenges to various social systems are expected as a result of such increases.

2. Rationale

As the number of older adults in the population goes up, more and more of them may seek college or university level educational opportunities, in local community educational programs or in their place of work (Johanson, 1991). Due to the downward economic trends of the past 10 to 15 years, business, industry, health and social services are restructuring their services and operations by retraining and cross-skilling their employees, many of whom may be older adults. For those who have already retired, increased longevity and better health provides more opportunity for interest and leisure education. Nonetheless, the risk of health problems substantially increases with increasing age. With the current trend in health care and its emphasis on health promotion and outpatient treatment, people will have to take more responsibility for their own health care and, as a result, will need to be more knowledgeable about their health. This may lead older adults to seek more opportunities for health education. Thus, whether for the purpose of job retraining or cross-skilling, interest and leisure education, or health education, growing numbers of older adults may soon be found in educational programs throughout all segments of the educational system. Naturally, it is increasingly important for adult educators to utilize teaching methods that will enhance their learning experience.

3. Ageing, Health and Quality of Life

Ageing is a process we begin at birth. In the beginning, people are busy growing, becoming physically stronger, and setting ourselves apart from others while building identities, increase experience and gain more knowledge. At around 20 years of age, physical, sensory, and cognitive aptitudes reach their highest point and stabilize until reach 50s/60s. While life experiences and knowledge (and perhaps wisdom) continue to grow, physical, sensory, and cognitive capabilities begin to decline. This decline depends on factors such as genetics, lifestyle, and social environment (Goldsmith, 2012). The exact reason of this decline is not yet entirely understood although some theories speak of a natural and programmed process that takes place in bodies. Other theories explain the decline as the result of damage amassed over time. Independent of the rationales which determine such decline, effects of ageing are unavoidable (Stibich, 2009).

Ageing often comes with the compounded risk of adverse health conditions that may affect physical functioning. The most common age-related health problems are related to mobility. The changes in

physical capability is often linked to disease. The rate of non-communicable chronic diseases increase in most societies (M.K.G, 1988) and have a negative effect on physical activity. Some examples of non-communicable chronic diseases are diabetes, cancer, and hypertension. Most health problems associated with old age are non-communicable chronic diseases (WHO, 2002), which require continual monitoring and care. Although research has shown that many of these conditions are seeded in early childhood, it is well known that behavioral factors considerably increase the risk of developing or intensifying non-communicable diseases. Independent of health, three macro-areas of manifestations of age which group different phenomena that affect quality of life and allows people to structure their analysis are: the capacity to perform physical activities; the capacity to capture and interpret information; and the capacity to process, reason and produce information (Concannon, Grierson & Harrast, 2012; Li & Lindenberger, 2002; Morrison & Baxter, 2012). Falls are the leading cause of injury-related hospitalization and death in older adults (Nevitt, Cummings, Kidd, & Black, 1989) yet the percentage of people 65 years and older who exercise is normally low. Strength and speed are diminished and there is a decrease in flexibility and range of motion. Causes for this can be: changes in energy levels, chronic diseases, neurological and morphological changes, hypertrophy, Sarcopenia, decreased motor activity, etc. There can also be blood circulation problems as well as osteoporosis. Loss of physical balance, equilibrium, incontinence, pelvic prolapse, motor disability and a lack of sleep are other possible determinants. Together, these factors diminish independence and quality of life. Furthermore, the fear of falling is associated with an increased risk of experiencing another fall (Cumming et al, 2000; Legters, 2002).

Research has also shown another key aspect of ageing that is sometimes disregarded or not mentioned when discussing the phenomena: the ability to get older and still experience happiness. Actually, there seems to be an increase in self-reported subjective well-being in individuals whom have passed their 50s (Stone, Schwartz, Broderick, & Deaton, 2010). The duality of ageing, whereas growing in some aspects (i.e., experience, wisdom, happiness) yet also face decline (i.e., physical, sensory and cognitive abilities) is the essence of Active Ageing.

4. Active Ageing (AA)

Within the field of Gerontology, the notion of Active Ageing has taken many different names and forms. In the mid-1990s, one of the first attempts to create a term to label these ideas was *successful ageing*. *Successful ageing* was defined as having a “low probability of disease and disease related disability, high cognitive and physical functional capacity, and active engagement with life” (Rowe & Kahn, 1997 Page 433). Later, other terms such as “healthy or productive ageing” and “ageing well” followed suit in defining desirable ideals about the ageing process (Mandin, 2004). This terminology represented an idealization of ageing but was not broad enough (Tesch-Roemer, 2012).

The Organization for Economic Cooperation and Development (OECD) defined AA as people’s ability to lead productive lives in society (OECD, 2000), focusing on the occupational dimension. The WHO’s definition of AA is described as the process of advancing opportunities for health, participation and security so as to improve the quality of life as people age (WHO, 2002). This definition, and those

that followed, focused on opportunities which represented a shift in how the concept was understood. The approach was the same differing only on which aspects or dimensions of quality of life other than health, security and participation, were emphasized. In addition to an emphasis on opportunities, the orientation of these definitions was almost always that of policy makers trying to implement AA through society's institutions.

For example, the United Nations, via its Economic Commissions for Europe (UNECE), emphasizes the promotion of *social integration* and *active involvement* in community as the key elements of AA(UNECE, 2002) while *autonomy*, *self-determination* and *choices* are the core dimensions (Mandin, 2004). The European Union's Institute for Prospective Technological Studies (IPTS) stresses the need for policies highlighting *independence* and *autonomy*.(Malanowski, Ozcivelek, & Cabrera, 2008). It outlines *AA policies* as those that allow people to lead independent lives (socially and economically) and make their own decisions as to how to shape their lives in every degree, as they grow older.

In conjunction with the European Year for Active Ageing, the EU widened their definition of AA to include issues such as good health, feeling more professionally accomplished, more independent and more involved as a full member of society. Employment, Participation and Independence have become the key scope in this definition (Paper, 2012).

4.1 Determinants of Active Ageing

How well both individuals and populations age is determined by a set of enabling factors (and the exchange between them) called the Determinants of Active Ageing. Each factor affects one or more of the three main aspects of AA presented before.

4.2 Health Services

This includes public or private health services to which a person has access. These services may include health promotion, disease prevention, curative and mental health services. Another part of this is equitable access to primary healthcare and long-term care by informal caregivers and/or healthcare professionals.

4.3 Behavioral Determinants

These are behavioral patterns which an individual regularly follows. Such behaviors as good nutritional health, active participation in ones own care, refraining from smoking or alcohol use and engaging in regular physical activity can all have a positive impact on AA.

4.4 Personal Determinants

These are characteristics which relate to a person's biological, genetic and physical limitations. These may include psychological factors such as intelligence, cognitive capacity, self- efficacy and self-esteem.

4.5 Environmental determinants

These are the conditions of a person's physical surroundings, which can affect a person's ability to age better. Transportation means, safe housing, clean water, air and safe food are all environmental determinants of AA.

4.6 Social Determinants

These are the conditions that define a person's social environment, including the amount of support a person receives from its social networks, how many opportunities for education and lifelong learning the person has access to and how much risk of violence and abuse the person is subjected to.

4.7 Economical Determinants

This refers to the different aspects of an individual's economic environment such as one's level of income, access to work and social protection services. Active ageing is about optimizing gains and minimizing losses. The aim of AA is about slowing decline as much as possible and increasing life experiences, wisdom and happiness (WHO, 2002).

Worldwide, adult education is one of the keys to the 21st century. (Schuetze, 2008). The way that an adolescent learns as compared to that of an adult learner, substantially differs and was specified in the principles of Andragogy. A "learner's need to know, the self-concept of the learner, the prior experience of the learner, a readiness to learn, an orientation to learning, and a motivation to learn" (Knowles et al., 2011, p. 147) should be taken into account when teaching students who are not the usual undergraduates. Additionally, one must identify the goals and purposes for adults' learning as "institutional, individual, and societal growth" (Knowles et al., 2011, p. 148). The motivation for adult learning is a direct result of a particular life situation. Furthermore, adult learners have a desire to advance their status in their place of employment, improve personal knowledge, or learn skills that will have an influence on society (Hardin, 2008).

Previous experiences of the learner represent the main difference between adults and children (Brookfield, 1988). Due to the fact that adults have more life experiences, these experiences may affect how they view a topic or how willing they are to listen to an instructor (Ababneh, 2012).

5. Life-long learning

Surveys and studies in Israel and elsewhere clearly attest to the fact that economic contrasts are mainly due to inequality in education. Adult education level has a dominant influence over two generations: both the adults and their children. Adults with low education and training levels earn minimum wages and are almost unable to propel themselves upwards due to their education level. The variable that most influences their children's ability to obtain a high-school diploma is parental education level (Paper, 2012).

The European Union has declared "life-long learning" a key means with the intent of making it competitive. Europe is leading the adult education revolution which, in turn, contributes to economic competition, social stability and unity. The commission's documents indicate policy and propose mechanisms of action and performance. The adult education departments invest by offering financing for competing projects, jointly operated by two or more countries (Przybylska, 2009; Rogers, 2009). The difficulties involved in financing adult education still has not been solved in Europe, more than in other parts of the world. For the past 15 years, the European Union has been addressing this issue in the Lisbon Strategic Program for European Economic-Social Development (MDG:Millennium

Development Goals, 2000-2015).

Learning throughout an individual's lifetime provides the opportunity to fulfill one's basic human rights: education, protection, freedom, meaning, influence and control over one's destiny (Global Report on Adult Education and Learning, 2010). The issue of adult education is the core of a global revolution. (Israeli, 2011). This global revolution is being led by two global organizations: UNESCO, the international cultural-educational umbrella organization for all countries in the world, and the International Council of Civilian Adult Education. Together with this, the report written in 2013, Financing the Adult Learning Sector, addresses the various entities that deal with adult learning. The report describes Europe as being at a crossroads. The labor market demands highly skilled manpower while the demand for uneducated manpower is on the decline. Due to demographic changes, the retirement age has been postponed. These developments have caused increased consumption of professional education and adult self-enrichment. Both, most probably will demand additional financing yet, at the same time, the economic crisis in Europe has caused education budgets in several countries to decline sharply in recent years (Bildungs & Erwachsenenbildung, 2013).

6. Israel's position in the global revolution

The revolution has bypassed Israel. Only a handful of people have and is taking part in international and global discussions regarding the above-mentioned issues. There are many professionals dealing with adult education but they are not organized in appropriate professional frameworks. The professionals in the academic world are a mere handful and are not involved in any of the international discussions mentioned above. State financing for adult education was brutally cut in early 2009. The state has no plans to address any of the proposals and recommendations described above nor is it represented or involved in the above-mentioned international and global forums. The state does not submit reports on some of the above-mentioned issues (Israeli, 2011). Israel did, however, take part in the global survey that concluded in late 2014 (Amir & Portnoy, 2014).

7. Conclusion

Considering determinants of Active Ageing, Andragogy and Lifelong Learning, older adults should take into account inherent morphological changes and the inescapable decline in motor disability, etc. when choosing their curriculum. In order to enhance their quality of life, older adults may incorporate physical exercise as a part of adult education programs discussed in this article.

Based on this information, the author suggests a future study to develop a model that engages in promoting improved quality of life through a daily operation intervention program of strengthening core muscles in older adults. This program may be implemented in different cultures and countries all over the world.

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