

# VALUES, LIFESTYLES INFLUENCING ACTIVE LONGEVITY *ROLE OF PREVENTIVE BEHAVIOR AND SOCIAL FACTORS IN AVOIDING RISKS ASSOCIATED WITH OLD AGE (THIRD AGE) RELATED MULTIPLE COMORBIDITIES*

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**Abstract.** Aim of this work is identifying the role of preventive behavior and influence of socio-cultural factors in avoiding multiple comorbidities risks specific of the third age. Materials and methods: In parallel with literature search on this topic, a questionnaire was given to 61 elderly who benefitted from healthcare services at the NIGG. Elderly were divided in two groups of subjects who were using nutritional supplements and those who were not. Use of statistical instruments pointed out relevant differences between median values and ranks, depending on case and significant correlations. Results: Statistical analysis showed that women have certain healthy habits (concern for not self neglecting, avoidance of alcohol, coffee consumption and smoking) which could confirm some theories according to which, preventive behavior is adopted to a larger extent by men than women (motherhood duties, concern for family safety, grandsons and granddaughters). Adopting preventive behavior for avoiding multiple comorbidities' risks in the third age, has not been related only with genetic and anthropological factors but also cultural ones (education, social milieu, consuming ways). Hence, those living in urban areas, but also those born in the cities have been consuming more often nutritional supplements, have been better informed about supplements, were having regular meals including breakfast and sorting out labels before buying supplements. Persons aged under 85 years old have been more aware of nutritional supplements' consumption but consuming ways were also related with certain social and economical factors (lacking money, poor family support, which severely limits consumption). Those having less diseases agreed that it was “better to eat healthy”, while those with five or more diseases reported that they had meals late and also sleep pattern related disorders. Conclusions: Heritage of cultural habits with regard to consuming ways has been preserved to a great extent even though surroundings have changed and nevertheless without totally excluding acculturation, namely the fact that some consuming behavior patterns typical of those born in the cities were adopted through mimicking by those born in the rural. Pointing out some statistical correlations suggested that frequent intake of nutritional supplements is not accompanied by much trust in the market of supplements, potential adverse effects of supplements being as well taken into account. This fact calls for better information and awareness from those in charge.

**Key words:** preventive behavior, pathology, social factors

**Rezumat.** Scopul lucrării este acela de a identifica rolul comportamentului preventiv și influența factorilor socio-culturali în evitarea riscurilor asociate unei polipatologii specifice vârstei a III-a. Material și metoda: În paralel cu apelul la literatura de specialitate, a fost administrat un chestionar unui esanțon de 61 subiecți care au beneficiat de serviciile INGG Ana Aslan București, împărțit în două loturi (cei care utilizează suplimente alimentare și cei care nu utilizează aceste suplimente). Prin instrumentele statistice utilizate au fost evidențiate diferențe relevante între medii sau ranguri – după caz, respectiv corelațiile specifice semnificative. Rezultate: Analiza statistică a semnalat că femeile au anumite obiceiuri sanatoase (teama de a nu-și neglija propria persoană, evitarea excesului de alcool, țigari sau cafea, responsabilitate maternă, preocupare pentru securitatea familiei, grija pentru nepoți), ceea ce ar putea confirma unele teorii (Papalia, 2010)(8) potrivit cărora comportamentul preventiv este adoptat în mai mare măsură de către femei decât de către bărbați. Adoptarea unui comportament preventiv în evitarea riscurilor asociate unei polipatologii specifice vârstei a III-a, nu ține numai de factorii genetici sau antropologici, ci și de cei culturali educație, mediu, comportament de consum (Anderson, E., 1990) (1). Astfel, cei care locuiesc în mediul urban, dar și cei născuți „la oras”, consumă mai des suplimente alimentare, le cunosc mai bine, obișnuiesc să ia mesele după un orar regulat (inclusiv micul dejun) și să consulte etichetele produselor înainte de adoptarea deciziei de cumpărare. Persoanele de până în 85 de ani (inclusiv) sunt mai responsabile în ceea ce privește consumul de suplimente alimentare, dar comportamentul

de consum tine și de anumiți factori economici și sociali (lipsa banilor, susținerea familială precară limitând drastic consumul). Cei care au suferit de mai multe boli sunt de acord că „e bine să mananci sănătos”, iar cei care au suferit 5 sau mai multe boli afirmă că iau masă târziu și au tulburări legate de programul de somn. Concluzii: „Zestrea” de obiceiuri (culturale, de consum) se păstrează în mare parte chiar dacă habitatul s-a schimbat, fără a exclude însă în totalitate aculturarea – anume faptul că anumite comportamente de consum tipice „omului născut la oras” sunt adoptate prin mimetism, cu repeziune și de cei proveniți din mediul rural. Evidențierea unor corelații statistice induce ideea potrivit căreia consumul frecvent de suplimente alimentare nu este însoțit de o încredere foarte mare privind piața suplimentelor, tinând cont și de potențialele lor efecte adverse – fapt ce reclamă o mai bună informare și conștientizare din partea factorilor responsabili.

**Cuvinte cheie:** comportament preventiv, patologice, factori sociali

Without pretending the following to be a whole inventory of values and specific lifestyles, this work's start-off point has been the identification of preventive behavior patterns and influences of socio-cultural factors in avoiding risks for multiple comorbidities of old age. On this analytical basis, investigation of relationships among cultural and behavioral aspects and axiological ones (behaviors, lifestyles, values), will be carried out in-depth, in view of becoming aware of the importance of adopting a healthy lifestyle and approaching aging as a stage of life continuing that is characterized by balance and dynamics.

This work's **aim** is providing scientifically based arguments for the importance of adopting socially desirable values and lifestyles in order to assure active longevity for old persons.

## MATERIALS AND METHODS

In view of this aim, at first we defined key concepts found in specialized literature (values, lifestyle, active longevity) and in the end we pointed out those factors that influence health condition of elderly.

### *Definitions in use*

Given the dominantly applicative type of this work, within this section, we limited ourselves to establishing definitions and operating with a distinct terminology in order to ease understanding and obtain in-depth results, conclusions and study-recommendations.

Values: according to DEX, values represent „characteristics of things, facts, ideas, phenomena that make them appropriate to social needs as well as ideals that these

needs generate”. Values actually represent explicit or implicit concepts with regard to what is (considered) desirable. Values are relatively stable in time, one thing (an idea) that was valued in the past can at present be taken into account as non-value or fake (pseudo) value.

Lifestyles represent a distinct model of personal or social behavior of a person or group. The concept of „lifestyle” can be considered an alternative to the concept of „social class”, lifestyles being patterns of values, good taste and behavior that the person is not forced to choose because there are other multiple options (at the three levels enumerated above). Generally, lifestyles tend to be focused in a certain part of the society and get the role of a symbol of that social circumstance. It follows that lifestyles tend to be class particularities (Zygmunt, B., & colab. 2008) [13]. Consequently, when discussing about third age related lifestyles, we must refer to values, habits and behaviors of this social class (regarded in the sense of the sociological notion of social class).

Behavior in fr. *comportement* is ways to act in certain situations and circumstances, behaving, acting. With regard to our study, preventive behavior is those modalities to act, attitudes adopted in view of preventing or avoiding unpleasant events, situations, personal states which could lead to risking health or life of an old person.

Risk in the sense of operating is the probability high or low that a person is injured or subjected to suffering due to a danger (situation). As associated to risk, we have found out the term of vulnerability which relates to characteristics of a person that makes him being subject to risk

(threat). In the case of old persons (but also for other vulnerable groups- young people, women, minorities), we may discuss about social vulnerability; this type of vulnerability is determined by factors such as poor health conditions, poverty, social injustice, marginalization, limited access to resources, dependence on resources, difficulties in accessing infrastructure, inadequately residing.

In specialized literature *the old age (third age)* has been defined according to three criteria: chronology, functionality and cycles. „ Aging of the human body is affected by social influences but certainly determined by genetic factors (Giddens, A. 2001)[5]. At individual level, in a larger sense meaning, aging has been considered a multi-dimension phenomenon that encompasses both morphological, functional changes of the human organism after adulthood and also a psychological change that shows in mental abilities as well as social changes through ways in which a person is regarded, his expectations and other people's expectations from him. It follows that the age at which a person starts to be called an old person differs depending on cultures and times in history (Sorescu,M., 2005)[11]. Culture plays an important role in dealing with aging as culture influences perceptions on old (third) age, attitudes towards old people's roles, rights and responsibilities and systems of support and assistance. Old age image which is circulated within a society is extremely important for ways in which others think about old people and also the old persons' own self-images.

*Aging, active longevity* according to World Health Organization, aging, active, as well as healthier longevity is the process of optimization of health related opportunities, social participation and old people's safety in order to improve quality of life of old persons.

Strategies and public policies A strategy is documenting on public policies on long and median? terms and defines in the main, governmental politics with regard to a

certain domain of public policies in regard with which decisions must be taken covering a large range of aspects. A strategy is elaborated in view of stating new public policies in that domain and also in case those politics have to be updated, hence necessitating significant improvement. It follows that public policies represent all activities that specialized central public administration carries out in order to solve identified problems regarding public policies and assure necessary development of these aforementioned in that certain domain.

### ***Methodological reference standards and statistical tools***

Detailed statistical processing (collected information by use of questionnaires regarding roles of preventive behavior and social factors in avoiding risks for third age related multiple pathology) was accompanied in parallel by a secondary analysis (studies, reports) and a documenting analysis (legislation, public policies). Actually, through mixing methods (which represents an innovative paradigm orientation), we managed to create a pertinent basis of relationships among social, cultural aspects on one side and those regulatory and desirable, on the other side.

At first, a questionnaire was designed, elaborated, pre-tested and given to a population sample of 61 subjects, carefully selected, admitted in clinics of the NIGG Ana Aslan And who benefitted from healthcare services while they were in-patients and who were divided in two study-groups (those who use nutritional supplements and those who do not use these supplements. The questionnaire was structured on the following dimensions:

- socio- demography data (including a primary diagnose with regard to medical histories of the patients);
- degree of satisfaction with regard to their health conditions and services provided by NIGG Ana Aslan, Bucharest;

- frequency of accessing services provide by specialists (family physician, geriatrician specialist, pharmacist);
- social, cultural and behavioral factors (pointed out in a set of twenty four items through which subjects were evaluated on ascale from one to ten);
- self-esteem and adopting a preventive behavior (a set of ten items through which degree of accord/disagreement in relation to valuing himself, was measured).

Data were collected in Excel, version Microsoft, 2008 and analysed by use of SPSS (*Statistical Package for the Social Sciences* version 16), in order to point out significant differences between average values and ranks, depending on case and statistically significant corellations, respectively.

#### **Limitations of the study**

Small size of the population sample, which was heterogeneous from the point of view of age groups ( the population sample was oversized as regards longevals over 85 years old); lack of data at national level for validation under circumstances that normalcy of distribution of relevant socio-demography variables (gender, age, education, income classes) had to be assured, so this was one reason for addressing in parallel both parameters' statistics and non-parameters statistics.

## **RESULTS**

Analysis of data of socio-demography pointed to the fact that women have certain healthy habits (concern for not self neglecting, avoidance of alcohol, coffee consumption and smoking) which could confirm some theories according to which, preventive behavior is adopted to a larger extent by men than women (motherhood duties, concern for family safety, grandsons and granddaughters). Adopting preventive behavior for avoiding multiple comorbidities risks in the third age, has not been related only with genetic and anthropological factors but also cultural ones (education, social milieu, consuming ways). Hence, those living in urban areas (regardless it is Bucharest or a country town), but also those born in the cities have been consuming more often nutritional supplements, have been better informed about supplements, were having regular meals including breakfast and much agreed as regards the need to read labels before deciding to buy them.

Between the two study groups (those who take nutritional supplements and those who do not) there are significant differences in relation with health concerns and related associated actions, as shown in the table below:

| Study-groups' subjects      | Mean    | Std. Dev. | Std. Error Mean | Status variances | F (testul Levene)           | Sig.  | t    | df    | Sig. (2-tailed) |      |                            |         |      |       |      |                             |       |      |       |       |      |         |      |       |      |                            |         |      |       |      |                             |       |      |       |       |      |         |      |       |      |                            |         |      |       |      |                             |       |      |       |       |      |         |      |       |      |                            |         |      |       |      |                             |       |      |       |       |      |         |      |       |      |                           |         |      |       |      |                             |      |      |       |       |      |         |      |       |      |                           |         |      |       |      |                             |      |      |       |       |      |         |      |       |      |                           |         |      |       |      |                         |      |      |
|-----------------------------|---------|-----------|-----------------|------------------|-----------------------------|-------|------|-------|-----------------|------|----------------------------|---------|------|-------|------|-----------------------------|-------|------|-------|-------|------|---------|------|-------|------|----------------------------|---------|------|-------|------|-----------------------------|-------|------|-------|-------|------|---------|------|-------|------|----------------------------|---------|------|-------|------|-----------------------------|-------|------|-------|-------|------|---------|------|-------|------|----------------------------|---------|------|-------|------|-----------------------------|-------|------|-------|-------|------|---------|------|-------|------|---------------------------|---------|------|-------|------|-----------------------------|------|------|-------|-------|------|---------|------|-------|------|---------------------------|---------|------|-------|------|-----------------------------|------|------|-------|-------|------|---------|------|-------|------|---------------------------|---------|------|-------|------|-------------------------|------|------|
| Frequent supplements intake | Group 1 | 8,77      | 1,55            | ,305             | Equal variances not assumed | 4,61  | 0,04 | 24,03 | 27,79           | 0,00 |                            |         |      |       |      |                             |       |      |       |       |      |         |      |       |      |                            |         |      |       |      |                             |       |      |       |       |      |         |      |       |      |                            |         |      |       |      |                             |       |      |       |       |      |         |      |       |      |                            |         |      |       |      |                             |       |      |       |       |      |         |      |       |      |                           |         |      |       |      |                             |      |      |       |       |      |         |      |       |      |                           |         |      |       |      |                             |      |      |       |       |      |         |      |       |      |                           |         |      |       |      |                         |      |      |
|                             | Group 2 | 1,23      | ,426            | ,072             |                             |       |      |       |                 |      | Eat healthy                | Group 1 | 7,73 | 2,63  | ,516 | Equal variances assumed     | 3,87  | 0,05 | 3,03  | 59,00 | 0,00 | Group 2 | 5,43 | 3,14  | ,532 | Regular meals              | Group 1 | 7,88 | 3,12  | ,614 | Equal variances not assumed | 4,48  | 0,04 | 2,61  | 57,55 | 0,01 | Group 2 | 5,63 | 3,61  | ,611 | Adverse effects            | Group 1 | 7,23 | 2,83  | ,556 | Equal variances assumed     | 2,63  | 0,11 | 3,60  | 59,00 | 0,00 | Group 2 | 4,29 | 3,37  | ,570 | Excessive alcohol drinking | Group 1 | 1,92 | 1,52  | ,298 | Equal variances not assumed | 19,93 | 0,00 | -2,74 | 51,72 | 0,01 | Group 2 | 3,60 | 3,15  | ,533 | Food for pleasant taste   | Group 1 | 7,92 | 2,53  | ,496 | Equal variances not assumed | 4,84 | 0,03 | 2,14  | 58,80 | 0,04 | Group 2 | 6,34 | 3,22  | ,545 | I feel hungry, I eat      | Group 1 | 3,15 | 3,171 | ,622 | Equal variances not assumed | 9,56 | 0,00 | -2,52 | 58,35 | 0,01 | Group 2 | 5,43 | 3,860 | ,652 | Market of supplements not | Group 1 | 7,04 | 3,026 | ,594 | Equal variances assumed | 0,35 | 0,56 |
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|                             | Group 2 | 6,34      | 3,22            | ,545             |                             |       |      |       |                 |      | I feel hungry, I eat       | Group 1 | 3,15 | 3,171 | ,622 | Equal variances not assumed | 9,56  | 0,00 | -2,52 | 58,35 | 0,01 | Group 2 | 5,43 | 3,860 | ,652 | Market of supplements not  | Group 1 | 7,04 | 3,026 | ,594 | Equal variances assumed     | 0,35  | 0,56 | 5,17  | 59,00 | 0,00 | Group 2 | 3,20 | 2,742 | ,463 |                            |         |      |       |      |                             |       |      |       |       |      |         |      |       |      |                            |         |      |       |      |                             |       |      |       |       |      |         |      |       |      |                           |         |      |       |      |                             |      |      |       |       |      |         |      |       |      |                           |         |      |       |      |                             |      |      |       |       |      |         |      |       |      |                           |         |      |       |      |                         |      |      |
| I feel hungry, I eat        | Group 1 | 3,15      | 3,171           | ,622             | Equal variances not assumed | 9,56  | 0,00 | -2,52 | 58,35           | 0,01 |                            |         |      |       |      |                             |       |      |       |       |      |         |      |       |      |                            |         |      |       |      |                             |       |      |       |       |      |         |      |       |      |                            |         |      |       |      |                             |       |      |       |       |      |         |      |       |      |                            |         |      |       |      |                             |       |      |       |       |      |         |      |       |      |                           |         |      |       |      |                             |      |      |       |       |      |         |      |       |      |                           |         |      |       |      |                             |      |      |       |       |      |         |      |       |      |                           |         |      |       |      |                         |      |      |
|                             | Group 2 | 5,43      | 3,860           | ,652             |                             |       |      |       |                 |      | Market of supplements not  | Group 1 | 7,04 | 3,026 | ,594 | Equal variances assumed     | 0,35  | 0,56 | 5,17  | 59,00 | 0,00 | Group 2 | 3,20 | 2,742 | ,463 |                            |         |      |       |      |                             |       |      |       |       |      |         |      |       |      |                            |         |      |       |      |                             |       |      |       |       |      |         |      |       |      |                            |         |      |       |      |                             |       |      |       |       |      |         |      |       |      |                           |         |      |       |      |                             |      |      |       |       |      |         |      |       |      |                           |         |      |       |      |                             |      |      |       |       |      |         |      |       |      |                           |         |      |       |      |                         |      |      |
| Market of supplements not   | Group 1 | 7,04      | 3,026           | ,594             | Equal variances assumed     | 0,35  | 0,56 | 5,17  | 59,00           | 0,00 |                            |         |      |       |      |                             |       |      |       |       |      |         |      |       |      |                            |         |      |       |      |                             |       |      |       |       |      |         |      |       |      |                            |         |      |       |      |                             |       |      |       |       |      |         |      |       |      |                            |         |      |       |      |                             |       |      |       |       |      |         |      |       |      |                           |         |      |       |      |                             |      |      |       |       |      |         |      |       |      |                           |         |      |       |      |                             |      |      |       |       |      |         |      |       |      |                           |         |      |       |      |                         |      |      |
|                             | Group 2 | 3,20      | 2,742           | ,463             |                             |       |      |       |                 |      |                            |         |      |       |      |                             |       |      |       |       |      |         |      |       |      |                            |         |      |       |      |                             |       |      |       |       |      |         |      |       |      |                            |         |      |       |      |                             |       |      |       |       |      |         |      |       |      |                            |         |      |       |      |                             |       |      |       |       |      |         |      |       |      |                           |         |      |       |      |                             |      |      |       |       |      |         |      |       |      |                           |         |      |       |      |                             |      |      |       |       |      |         |      |       |      |                           |         |      |       |      |                         |      |      |

|  |         |      |       |      |                             |      |      |      |       |      |
|--|---------|------|-------|------|-----------------------------|------|------|------|-------|------|
| (sufficiently ) regulated                |         |      |       |      |                             |      |      |      |       |      |
| Food products I read the label           | Group 1 | 7,58 | 3,088 | ,606 | Equal variances assumed     | 2,56 | 0,12 | 3,53 | 59,00 | 0,00 |
|  | Group 2 | 4,49 | 3,584 | ,606 |                             |      |      |      |       |      |
| Habit of having breakfast                | Group 1 | 8,73 | 2,426 | ,476 | Equal variances not assumed | 4,36 | 0,04 | 2,11 | 58,18 | 0,04 |
|  | Group 2 | 7,29 | 2,916 | ,493 |                             |      |      |      |       |      |
| I know about the nutritional supplements | Group 1 | 6,65 | 3,162 | ,620 | Equal variances not assumed | 7,45 | 0,01 | 6,24 | 42,84 | 0,00 |
|  | Group 2 | 2,11 | 2,246 | ,380 |                             |      |      |      |       |      |

Subjects of the study group I ( who take nutritional supplements) reported that they were eating healthier, generally they were used to have breakfast and meals on regular schedules (they were not eating compulsively whenever they felt hungry), they were appreciating a pleasant taste, were avoiding alcohol abusing and were used to read product labels before taking the decision to buy products. In spite of this, subjects were afraid of adverse effects of nutritional supplements and considered that the nutritional supplements' market was insufficiently regulated in our country.

Moreover, there was a positive bidirectional correlation between frequency of nutritional supplements consumption (vitamins, minerals) and „strength” of beliefs that these supplements' market was insufficiently regulated in our country( $r = 0,63$ ,  $p = 0,01$ ). In other words, with 1% risk of being wrong, we may say that a frequent nutritional supplements' consumption was (nevertheless) associated to the belief that supplements' market was not adequately regulated in our country and also conversely (as the correlation was bidirectional).

| Bravais-Pearson Correlations (Test)<br>$r = 0,633$ , $r^2 = 0,40^*$ |                     | Frequent consumption of supplements | Market of supplements not (sufficiently) regulated |
|---|---------------------|-------------------------------------|--|
| Frequent consumption of supplements                                 | Pearson Correlation | <b>1</b>                            | <b>,633**</b>                                      |
|   | Sig. (2-tailed)     |                                     | <b>,000</b>  |
|   | N                   | <b>61</b>                           | <b>61</b>  |
| Market of supplements not (sufficiently) regulated                  | Pearson Correlation | <b>,633**</b>                       | <b>1</b>   |
|   | Sig. (2-tailed)     | <b>,000</b>                         |  |
|   | N                   | <b>61</b>                           | <b>61</b>  |

\*The correlation was relatively strong as  $r^2 = 0,40$ .

\*\*The correlation was significant,  $p = 0.01$  (bidirectional).

With regard to the same topic, a recent study [17] showed that nutritional supplements containing vitamin C and beta-caroten that were initially considered useful to delay the aging process of the organism (due to their antioxidant effects), could actually accelerate this process. Without excluding usefulness of nutritional supplements for improving health

conditions of elderly, it seems that these products also have effects from a psychological perspective: it was found out that self-esteem was generally higher among persons who were taking these supplements (based on comparison of ranks associated with the ten items that define self-esteem, as shown separately for the two study-groups). Despite that, the only

significant difference was found out in relation to the issue „I have a positive attitude towards myself” and agreement with this item was stronger in the case of subjects of the study-group I who reported that they were taking nutritional supplements (inversed scale from 1 to 4 Rank<sub>1</sub> = 24,25; Rank<sub>2</sub> = 36,01, Rank<sub>1</sub> < Rank<sub>2</sub>, Mann-Whitney U = 279,5, Asymp. Sig. (2-tailed) = .007).

On the other side, frequency of medical events (expressed by number of diseases as „quantitative” medical history of subjects) was not significantly different between the two study-groups, meaning that good health is not exclusively due to taking supplements, but to a cluster of factors and preventive behaviors (p = 0,072 > 0,05).

| Ranks              |  |    |           |              | Test Statistics <sup>a</sup> |                    |
|--------------------|--|----|-----------|--------------|------------------------------|--------------------|
|                    | Study –groups of subjects                | N  | Mean Rank | Sum of Ranks |                              | Number of diseases |
| Number of diseases | Study-group1(take supplements)           | 26 | 26,42     | 687,00       | Mann-Whitney U               | 336,000            |
|                    | Study-group 2(does not take supplements) | 35 | 34,40     | 1204,00      | Wilcoxon W                   | 687,000            |
|                    | Total                                    | 61 |           |              | Z                            | -1,802             |
|                    |  |    |           |              | Asymp. Sig. (2-tailed)       | ,072               |

a. Grouping Variable: Loturi subiecti

A general picture of preventive behavior is illustrated in the table below:

| Degree of satisfaction as regards: (S1-S5):   | Study groups; 1,2 | Gender m,f | Age groups      | Number of children | Marital status | Lives in the urban, rural (U,R); | Born in the urban, rural (U,R)  | Number of diseases | Last disease diagnosed |
|---|-------------------|------------|-----------------|--------------------|----------------|----------------------------------|---------------------------------|--------------------|------------------------|
| S1_Health condition (at present)  |                   |            |                 |                    |                |                                  | U>R                             | bp>BM              |                        |
| S2_Quality of life  | L1>L2             |            |                 |                    |                | U>R                              | U>R                             |                    |                        |
| S3_Social relationships   |                   |            | vm>VM           |                    | C>V            |                                  | U>R                             | bp>BM              | recent>old             |
| <b>S4_NIGG healthcare services</b>  |                   |            | <b>VM&gt;vm</b> |                    |                | <b>R&gt;U</b>                    | <b>R&gt;U</b>                   |                    |                        |
| S5_Future of your health  |                   |            |                 |                    | C>V            |                                  | U>R                             |                    |                        |
| Habit to address to the : (A1-A3)   | Study groups; 1,2 | Gender m,f | Age groups      | Number of children | Marital status | Lives in the urban, rural (U,R); | Born in the urban, rural (U,R)  | Number of diseases | Last disease diagnosed |
| A1_Family physician   |                   |            |                 |                    |                |                                  |                                 |                    |                        |
| <b>A2_Geriatician specialist</b>  |                   |            | <b>VM&gt;vm</b> |                    |                | <b>R&gt;U</b>                    | <b>R&gt;U</b>                   |                    |                        |
| A3_Pharmacist advices   |                   |            |                 |                    |                |                                  |                                 |                    |                        |
| Issues, disagreement vs agreement (E1-E24)  | Study groups; 1,2 | Gender m,f | Age groups      | Number of children | Marital status | Lives in the urban, rural (U,R); | Born in the urban, rural (U,R)  | Number of diseases | Last disease diagnosed |
| E1_ I suffer from insomnia (I cannot get to sleep, I wake up during the night)      |                   |            |                 |                    |                |                                  |                                 |                    |                        |
| E2_ Many times I eat because of actually being greedy, without being hungry at all. |                   |            |                 |                    |                |                                  |                                 |                    |                        |
| E3_As regards money for food, I am a big spender.                                   |                   |            |                 | cp>CM              |                |                                  |                                 |                    |                        |
| Issues, disagreement vs agreement (E1-E24)  | Study group; 1,2  | Gender m,f | Age group       | Number of children | Marital status | Lives in the urban, rural (U,R); | Born in the urban, rural (U,R); | Number of diseases | Last disease diagnosed |
| E4_Sometimes I have dinner after 8 in the evening.                                  |                   |            |                 |                    |                |                                  |                                 | BM>bp              |                        |
| E5_During the day hardly find I time for myself.                                    |                   | F>M        |                 |                    |                |                                  |                                 |                    |                        |
| E6_I'm used to taking often nutritional supplements (minerals, vitamins)            | L1>L2             |            |                 |                    |                |                                  | U>R                             |                    |                        |
| E7_I'm used to sleeping after   |                   |            |                 |                    |                |                                  |                                 |                    |                        |

Values, lifestyles influencing active longevity

|  |       |     |       |  |  |     |     |       |            |
|--|-------|-----|-------|--|--|-----|-----|-------|------------|
| having lunch .   |       |     |       |  |  |     |     |       |            |
| E8_ At my age I have an appetite one can envy me   |       |     |       |  |  |     |     |       |            |
| E9_ I'm used to eating healthy   | L1>L2 |     |       |  |  |     | U>R | bp>BM |            |
| E10_ I'm used to having regular meals  | L1>L2 |     |       |  |  | U>R | U>R |       |            |
| E11_ I feel like doing nothing and burned out  |       |     |       |  |  |     |     |       |            |
| E12_ Sometimes nutritional supplements can have adverse effects                          | L1>L2 |     | vm>VM |  |  |     |     |       |            |
| E13_ Sometimes I have bad dreams at night  |       |     |       |  |  |     | R>U | BM>bp |            |
| E14_ Sometimes I drink more alcohol than it is good for me                               | L2>L1 | M>F |       |  |  |     |     |       |            |
| E15_ A pleasant taste of food is the most important quality for a meal                   | L1>L2 |     |       |  |  |     |     |       |            |
| E16_ I love to eat each time I'm hungry  | L2>L1 |     |       |  |  |     |     |       |            |
| E17_ I feel stressed about daily base issues   |       |     |       |  |  |     |     |       | recent>old |
| E18_ In Romania market of nutritional supplements is inadequately regulated.             | L1>L2 |     | vm>VM |  |  |     | U>R |       |            |
| E19_ If I do not eat enough in the evening I cannot sleep                                |       |     |       |  |  | U>R |     |       |            |
| E20_ Smoking and drinking coffee reduce my appetite.                                     |       | M>F |       |  |  |     |     |       |            |
| E21_ When I choose a food product I always look at its label (what it contains)          | L1>L2 |     | vm>VM |  |  | U>R | U>R |       |            |
| E22_ I got used to having breakfast  | L1>L2 |     | vm>VM |  |  | U>R | U>R |       |            |
| E23_ Lately I had to deal with problems  |       |     |       |  |  |     |     |       |            |
| E24_ I know very well about the nutritional supplements I'm taking (contents, benefits). | L1>L2 |     | vm>VM |  |  | U>R | U>R |       |            |

Abbreviations:

**L1** – study-group 1 (take nutritional supplements); **L2** – study-group 2 (does not take nutritional supplements);  
**M** – men; **F** – women;  
**vm** – average age inclusive of under 85 years old; **VM** – average age over 85 years old (as regards age groups);  
**cp** –with no children or one child at most; **CM** –two or more children;  
**C** - married; **V** – widow;  
**U** - urban, **R** - rural (for Living in ”, “N for Born in respectively”);  
**bp** – between 0 no and 4 four diseases inclusively; **BM** – more than four diseases  
**recent** – diseases diagnosed after 2007, **vechi** – old diseases, diseases diagnosed before 2007

Specifications with regard to reading the table: Symbols written in the table were pointed out after application of the t test for independent samples (Independent-Samples T Test), which point to those significant differences between average (medium) values (bidirectional  $p < 0,05$ ). Cells in which there are no symbols point to the fact that between the score variable (items of the first column in the table) and category

variables (Group 1, 2; gender, age-groups, etc) there were no significant differences (pointed out)

Example given: for reading in case **S4\_NIGG Healthcare Services** (row 4, column 1 in the right, issue ” Please express your degree of satisfaction with regard to services provided by NIGG”, from mark 1 to mark 10, where 1 – is very low level , 10 – is very high level):

- Those aged over 85 years old have a higher degree of satisfaction as regards services provided by NIGG (compared with inclusively those under the age of 85);
  - Those who answered the questionnaire and were living in rural areas and were born in these areas expressed a **higher degree of satisfaction** as regards services provided by NIGG (compared with those born in urban areas);
- Note:* interpretation was identical in the case of frequency of accessing assistance provided by a specialist geriatrician (those aged 85 and over address themselves more often to the specialist geriatrician and it was the same for those born/living in rural areas). Interpretations were not cumulative but sequential.

Moreover, we found out that:

- Those with high incomes had a higher degree of satisfaction regarding quality of life ( $M = 8,44$ ,  $AS = 1,078$ ,  $t = -2,50$ ,  $df = 59$ , bidirectional  $p = 0,015$ ) than those with low incomes, under 1200 lei ( $M = 7,74$ ,  $AS = 1,095$ ).
- Subjects with lower incomes had a higher degree of satisfaction regarding quality of services provided by NIGG ( $M = 8,22$ ,  $AS = 3,52$ ,  $t = 2,33$ ,  $df = 58,8$ , bidirectional  $p = 0,023$ ), compared with higher incomes that is more than 1200 lei ( $M = 5,91$ ,  $AS = 4,22$ ).
- Also, those who answered the questionnaire and had low incomes addressed more often to the specialist geriatrician ( $M = 8,00$ ,  $AS = 3,43$ ,  $t = 2,30$ ,  $df = 58,9$ , bidirectional  $p = 0,025$ ), in comparison with those with higher incomes that is more than 1200 lei ( $M = 5,76$ ,  $AS = 4,16$ ).

Persons with lower incomes, to a greater extent agreed to the issue according to which „Many times I eat because of being greedy and without being at all hungry” (low  $M = 4,89$ , high  $M = 3,06$ ,  $t = 2,24$ , bidirectional  $p = 0,03$ ).

Instead, those with higher incomes that is more than 1200 lei can be described as follows (by comparison with subjects with lower incomes less than 1200 lei):

- took more often nutritional supplements;
- were used more often to having regular meals, including breakfast;
- recognized to a greater extent the fact that nutritional supplements can have adverse

effects and supplements’ market in Romania is insufficiently regulated, respectively;

- were to a greater extent more careful to products’ contents and read information on products’ labels before deciding to buy them.

Relevance of this analysis consists in demonstration of differentiation between groups of subjects which is due to social, economical, cultural and environmental factors. In other words, this study does not attempt to be contradictory to some evidences in that it is a well known fact that an adequate nutrition, regular visits to physicians, avoiding abuses, getting regular rest are healthy „habits”. These aforementioned habits define a preventive behavior which assures reduction of risks associated with old age related multiple pathology (without considering these risks exclusively for the old age segment).

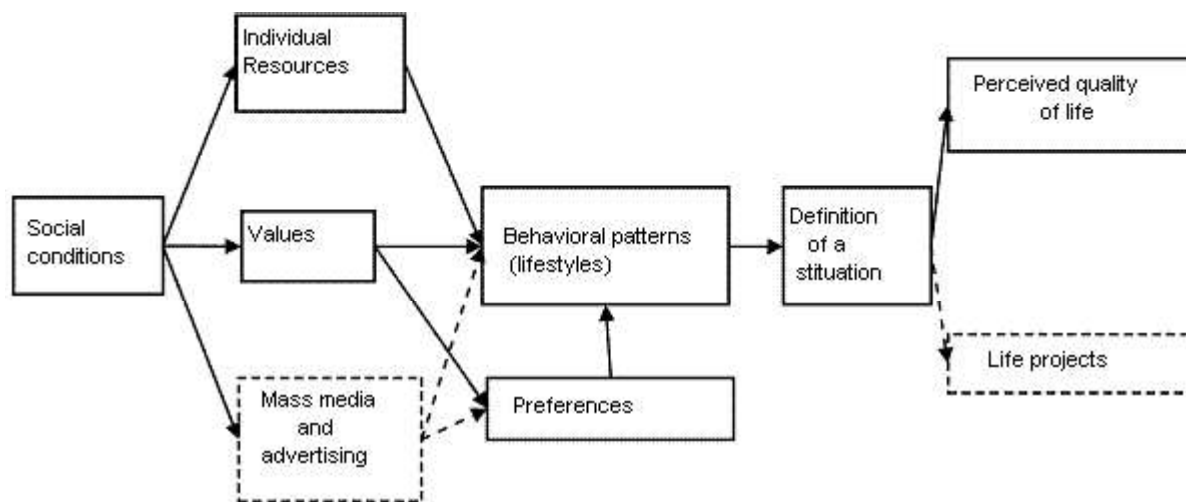
On the other hand, the fact that eating healthy rather characterizes persons who are used to take nutritional supplements (vitamins, minerals), who live in urban areas and have less medical history (have less diseases, has been a relevant element for future policies regarding education and active longevity. Similarly, heritage of cultural habits with regard to consuming ways has been preserved to a great extent even though surroundings have changed and nevertheless without totally excluding acculturation, namely the fact that some consuming behavior patterns typical of those born in the cities were adopted



through mimicking by those born in the rural. Pointing out some statistical correlations suggested that frequent intake of nutritional supplements is not accompanied by much trust in the market of supplements, potential adverse effects of supplements being as well taken into account. This fact calls for better information and awareness from those in charge.

### *Values and lifestyles*

From the beginning, it has to be specified that in Romania there are few studies and researches regarding lifestyle specific of the third age. In spite of this, we cannot deny that there have been researches (some of them representative for the national level) dedicated to the Romanians' lifestyles. Most of the identified analyzes operated by a scheme that is shown below:



Each lifestyle is a challenge in its own way. If we find that lifestyle attractive, our current lifestyle starts to lose its attractiveness (charm) and not bring us satisfaction it once used to. To the extent that mechanisms of production and consumption are tampered by frantic activity watching over dangers of self complacency, apparently there is no obstacle hindering efforts directed towards finding an appropriate lifestyle. Lifestyles exhibited in public are not only numerous and varied but also representative for various values and hence, they have varying power to differentiate among those who embrace them (Zygmunt&colab.2008)[13]. A relatively recent research (Vasile M., 2010) [12] identified eight lifestyles which we could define in a generic way, hence:

A. „**Modern style**” –of persons who highly regard post-material values and implicitly, distance themselves from the traditional

signification of family and work, as well from religious beliefs; for these persons, social relationships are important but also self-expressing themselves. According to the above author, persons with such a profile, are involved with social and intellectual activities together with friends and apart from their families.

B. „**Sociable, daily basis style**” of persons who equally regard standard values (family, work, religion) and values concerning self – expressing activities. Persons of this categorization prefer activities inside or outside their household, but value most a peaceful living (taking walks, having discussions), their good taste being at a medium level on a scale of knowledge (they get the information from mass media, news on TV and radio, therefore their critical abilities are reduced).

C. “**The family style**” – of persons oriented exclusively towards family activities; they

have a small social group which moves back and forth from the football game to reading books.

D. “**The solitary style**” – of persons who do not embrace certain values but probably have a high level of knowledge the anonymous (not necessarily in the sense meant by E. Durkheim, but rather as **detaching themselves from widely accepted social regulations**).

E. “**The tradition keeper style**” – of persons who are informed on social life, prefer spending time outside their household (usually with friends and relatives, probably the category of typical Romanians (seen at TV news) who do not miss” the barbecue and spending time outdoors”.

F. “**The cultural style**” – of persons, who highly value self-expression, have a high level of knowledge and relatively various, heterogeneous best taste. We may say that these persons critically experiment using cultural products of high quality.

G. “**Plain people**” – have rather post-material values and are oriented towards having discussions and taking walks.

H. Persons – who have **high-level of information and knowledge**, post-material values and are socially active.

It may be noticed that the last two styles (categories G and H), namely of plain people and those with high-level of information and knowledge can be added to the other styles already depicted (A-F) ( for instance, family style – C, cultural style- F, respectively).

As regards old age related values and lifestyles, we can promote a hypothesis according to which there are elderly (taken into account as statistical population sample) that can actually be ascribed to one of the eight styles above depicted. Moreover, in our opinion there are no “pure”, “exclusive” lifestyles, but rather a flow of values, good/bad tastes and behaviors (more precisely, a person can be described by elements of the daily-basis and those of family- type styles). To support that “X”

lifestyle is typical for elderly is a risky approach because of two reasons:

- Lack of legitimacy of studies and resources for scientific validation and
- Multitude of factors (social, economic, cultural, environmental) because of which this (group of elderly people) has great heterogeneity.

We can presume that persons living in urban areas, with higher than average incomes and education levels, who benefit from family and an extended social group’s support may adopt one of the sociable (B), cultural (F) or even modernist (A) lifestyles, as well as persons living in rural areas with low (modest) incomes and educational levels may rather have a “tradition keeper” or plain people lifestyles (but oriented towards sociable lifestyle).

It follows that caution is needed when identification of certain values and lifestyles is being based exclusively on data collected from questionnaires that were given to the two study-groups.

Statistical analyses of data provided the following **work hypotheses**:

**I** – Values, good/bad tastes and behaviors (the three foundations that define lifestyles) are created/developed/generated and influenced socially and by culture (family, group of friends, mass media, family/social background) and sometimes regulated by systemic constraints (incomes, habits of the community, etc).

**II** – As unique example given, it is interesting that those born in rural areas (regardles the fact that at present they live in urban or rural areas) strongly agreed with the issue of „Sometimes I have bad dreams at night”. It is possible that these bad dreams come from a set of archaic beliefs that are interpreted in traditional ways.

Satisfaction people got from services of geriatrics and gerontological healthcare, higher in the case of subjects living in rural areas has a possible cultural and behavioral explanation in that people from the rural pay respect to educated people (specialists) and gratitude to those who care for their health.

**III** – Incomes, sometimes low (modest) (eventhough our population sample did not seem to be the most disadvantaged) could regulate/restrain some good/bad tastes, hinder adopting some healthy habits (consumption of nutritional supplements, healthy food- bio products, regular meals, etc.)

**IV-** Social influence (mass media, family, group of friends) may influence in turn some good/bad tastes and consuming ways. Application of qualitative methods (for instance semi-structured or in-depth interview) could establish if opinions such as „supplements can have adverse effects”; „supplements” market in Romania is insufficiently regulated” were personal experiences or some specialists advices or opinions shared with friends and mass media.

For the old age, as regards the most important lifestyles, we could operate with dichotomies like rich-poor (economic factor), „optimistic-pessimistic” (psychological factor, selfesteem) or concerned – indifferent (behavioral factors, concern for own health in a preventive sense versus indifference, apathy, non-mistrust).

**In conclusion**, exactly for this reason, we may say that lifestyles depicted as various categorizations in specialized literature do not totally apply to old age persons. Hence, in-depth studies are necessary and need to be extended to identify and analyse clusters (classes) of elderly and carry out specific diagnoses (according to rigorous criteria, validated at national level).

### ***Active longevity***

As we mentioned in the section dedicated to definitions of key-concepts, active and as possibly healthier longevity, is the process of optimization of health related opportunities, social and safe participation in order to improve quality of life of old persons.

This concept has also an European demeanor [15] as there are projects aiming at supporting old persons (the same way

there is the concept of life –long continuing learning or *Life-Long Living* – (active longevals all life-long).

In this study we have been not aiming at an elaborated history of these concepts, nor a review as regards projects and initiatives carried out within this concept. Nevertheless, it is clear that there are consistent actions in the domain –proved by the fact that 2012 was the year exclusively dedicated to active longevity [14]. As regards Romania and as results from the official page of the Ministry of Work, Family, Social Assistance and Elderly, attributions and mechanisms involved in social assistance, pensions’ and compensations’ system have been already stipulated together with assuring equal chances and treatment, assistance of vulnerable persons and those with disabilities. Hence, we may say that there are implicitly legal and institutional frameworks dedicated to elderly.

An inventory of public policies however shows that there are no policies and strategies dedicated to active longevity, in spite of dedicated events (2012) and there are projects whose topics are on assuring active life-long involvement of vulnerable persons (elderly included).

On the other hand, we have found out that this activism [16] is rather in view of the economic component (hiring persons aged 65 and over, for instance) and less in view of valuing elderly socially (common concerns for the old persons, civil and social involvement, creating informal social networks, elderly collaborating with institutions in view of organizing actions in common.

A selective documenting analysis has shown that development of elderly skills in information tehnology, founding clubs for elderly, forming support committees [14] (in collaboration with local authorities) are still examples of good practice, which may be multiplied.

At present time, in our opinion, existing policies and strategies with regard to active longevity have to be more coherent and in a

strong relation with human resource assignment, material and financial allocations (at local level) to enable support for policies in view of active longevity in a welfare country (the way the European view is shared and heading at other countries outside the EU-for instance, Norway). That is why a larger, strategic framework encompassing true actions of all actors in charge (administration, non-profit organizations, specialized assistance, mass media, professional associations, unions).

## RESULTS AND DISCUSSIONS

Results of the present study were the following:

- a clarification of the key concepts which were used;
- a diagnose of preventive behaviors and associated factors;
- an analysis of the context within which we may dissent on values and lifestyles in case of old age persons;
- a brief review of recommendations in view of active longevity together with some pertinent recommendations regarding future actions;

It is worth discussing to what extent future studies and analyses will go in-depth with each topic presented in this study, namely: preventive behavior, factors influencing behavior, values and lifestyles typical of the Romanian elderly [(8), comparative analyses (Romania and other EU countries) that target previously mentioned cultural and axiological aspects.

## CONCLUSIONS

At the end of each section we have presented several conclusions and

recommendations specific of the topic analyzed. Overall, together with these results (out-put), the following four major conclusions can be drawn:

- The study did not propose verdicts as regards situations of old persons, their preferences, behaviors, lifestyles which our grandparents and parents. However, we consider this study a start-off point in approaches on subjects of major interest that can translate in further initiatives, actions (at level of institutes) or policies (local, national) dedicated to persons of the third age.
- Resources and cooperation are needed (among institutes of health and social assistance, research institutes, non-profit organizations) to enable extending analyses and studies on which to base meaningful strategies for needs of the age-group analyzed.
- Adopting a preventive behavior preserves a (good) health condition through diminishing risks to develop age related diseases superposed (adding to) on pre-existing comorbidities of old persons. This type of behavior is the premise (base) of active longevity. Not by chance old people's wisdom took good health as the most valuable thing in life (of a person).
- Embracing desirable social values (moderation, optimism, self-esteem and consideration for others, ceilalți, good understanding and communication, self concern and concern for others, involvement and civic engagement, as well as adopting a healthy lifestyle appropriate for the old persons' needs, actually represent ways to manifest oneself during active longevity.

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