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Health Behaviour of People Over 60 and Their Dependence on Socio-Economic Factors

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Abstract

Health behaviour are human actions which directly or indirectly influence our health. The elderly are a group of people who should especially take care of their health. Taking up this issue is justified by the rising life expectancy of the society and the related increasing costs of social care. Considering the current situation, it seems required to provide the older generation with education in the field of health promotion and health behaviour. The study involved 689 individuals over 60 years of age from Poland. A diagnostic survey was applied in the research. A survey technique was used including the Health Behaviour Inventory (HBI) and own questionnaire. Elderly people have more health behaviour associated with prophylactic measures and a positive mental attitude, but least related to eating habits. Women, people over 75 years of age and better educated people with good financial standing adopt significantly more health behaviour. The subject concerning health behaviour of elderly people needs to be further explored and completed. This study may contribute to better quality of life in elderly population.

Keywords: health behaviour; socio-economic situation; elderly people; Health Behaviour Inventory

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Comportamiento de Salud de las Personas Mayores de 60 años y su Dependencia de Factores Socioeconómicos

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Resumen

Los comportamientos de salud son acciones humanas que influyen directa o indirectamente en nuestra salud. Los ancianos son un grupo que deben cuidar especialmente su salud. El aumento de la esperanza de vida y los costos crecientes relacionados con la atención social justifica la relevancia del tema, parece necesario brindar educación a las generaciones mayores en el campo de la promoción de la salud y el comportamiento de la salud. El estudio involucró a 689 personas mayores de 60 años en Polonia. Se aplicó una encuesta de diagnóstico, encuesta que incluyó el Health Behaviour Inventory (HBI) y un cuestionario propio. Las personas mayores tienen más comportamientos de salud asociados a las medidas profilácticas y una actitud mental positiva, pero menos relacionados con los hábitos alimentarios. Las mujeres, las personas mayores de 75 años y las personas mejor educadas y con buena situación financiera adoptan un comportamiento más saludable. Es necesario profundizar con el comportamiento de salud de las personas mayores. En este sentido, este estudio puede contribuir a una mejor calidad de vida en la población anciana.

Palabras clave: comportamiento de salud; situación socioeconómica; personas de edad avanzada; Inventario de comportamiento de sa

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3 Health Behaviour of People Over 60 – *Kuska et al.*

The rising life expectancy is one of the greatest civilization achievements. At the same time, the pace of civilization development poses a serious challenge to the modern world. It is estimated that there will be more than 2 billion people over 60 by the end of 2050 (Current Status of Social Situation, 2011). The basis of economic development is sustainable social development. Most European countries address active and successful ageing in the most important documents and strategies. These documents pay much attention to the promotion of physical activity among elderly people. An active senior is a support for economy (relieving health care, longer ability to do professional work).

Aging in the biological aspect is recognized as leading to a reduction in physical fitness and limited adaptability of the human body (Górski, 2011; Pędich, 1970). Aging relates to decreasing efficiency of particular functions and organs of the human body. This applies to all involution changes at the level of cells, systems and organs. Reduced physical performance mainly determined by biological factors as well as deteriorating health condition comprises an indispensable element of old age and aging (Steuden, 2011). People over 60 years of age are reported to frequently suffer from civilisation diseases and other diseases presumably caused leading an improper lifestyle (Gębska-Kuczerowska & Müller, 2009).

Health behaviour is defined as activities focussed on staying healthy or recovering. There can be distinguished health-strengthening behaviour – pro-health behaviour, anti-health behaviour and combined behaviour (Jabłoński & Wysokińska-Miszczuk, 2000; Słońska, 1994, Słońska & Misiuna, 1993; Woynarowska, 2008; Bendikova & Bartik, 2015). According to Łuszczyńska (2004) health behaviour means actions taken by an individual for health reasons or such with a well-documented impact on health. As Heszen-Niejodek (1995) claims, health behaviour relate to these actions which are concentrated on achieving health goals. The aim of actions taken by healthy people is to increase health resources, while sick people recognize an improvement in health as their key goal. The author distinguishes the following: behaviour aimed at maintaining well-being, health protective behaviour, and behaviour reducing the risk of health loss.

Polish literature most often quotes the breakdown of health behaviour developed by B. Woynarowska. Considering an individual's state of

consciousness and purposefulness of their actions, the following behaviour can be distinguished:

– health behaviour, that is, deliberate actions consciously undertaken by an individual in order to improve their health irrespective of the effectiveness of their actions.
– health-related behaviour that are not accompanied by a conscious goal, are adopted in everyday life, and can have positive and negative health effects (habits or reactions to a given situation).

The effects of behaviour on human health include:
– pro-health behaviour – conducive to health and enhancing health potential or intended to restore health (rational diet, physical activity, coping with stress);
– negative behaviour (anti-health) – posing risk and causing harm to health (use of psychoactive substances, aggressive behaviour) (Woynarowska, 2008).

The review of selected works written by authors dealing with the issue discussed in this paper (age, sex, education, occupation, income, physical activity of adults) suggests that different correlations exist between particular categories (Biernat & Tomaszewski, 2011; Trost et al., 2002; Wilcox et al., 2003). A higher level of physical activity and other health behaviour adopted in leisure time is characteristic of individuals with a higher socio-economic status whereas physical exercise they take in their free time may also supplement the shortages of exercise in other areas of life. People with lower socio-economic status are usually more physically active at work, home or while moving from place to place. Yet, they are less active in their leisure time. More and more research is focused on the impact of the socio-economic situation not only on health behaviour but also on early mortality especially caused by cardiovascular diseases. Coronary disease is the main cause of death among people with a low socio-economic status (Fiscella & Tancredi, 2008).

The aim of this study was to determine health behaviour (based on the Health Behaviour Inventory, HBI) of people over 60 years of age and the impact of selected socio-economic factors on these behaviours.

Materials and Methods

The studies were conducted on Third Age Universities in the Kuyavian-Pomeranian Voivodeship. The number of Third Age Universities (TAU) and their students in the Kuyavian-Pomeranian Voivodeship was established based on the analysis of documents and interviews. Consent was obtained from 16 Third Age Universities. Research was conducted before lectures which attracted the largest number of participants. The studies applied simple random sampling to have a highly representative sample. Surveys were given to volunteers. Students who refused to take the survey were not given one. People who wanted to quit during the survey could also do that. Every questionnaire had detailed instruction and was meant to be completed individually. Using the sample size formula with the finite population it was possible to calculate the necessary number of respondents required to participate in the specific research. Assuming that the population size is 7 600 subjects (the data from the Central Statistical Office), the level of confidence is 95%, and the permissible assessment error is 5%, the sample size should be 366 subjects. About 1100 questionnaires were distributed and 877 were given back (of which 708 were correctly filled out). 19 questionnaires were rejected as they had been completed by respondents under 60 years of age. The survey was held between October 2017 and March 2018. The study involved 689 individuals over 60 years of age from the Kuyavian-Pomeranian Region in Poland. Most of the respondents were women (n=585) and individuals covering an age range of 65-69 years (n=292). The average age in the examined group was 68.14. Detailed figures are shown in Table 1.

Table 1.
The number of respondents depending on sex and age (independence test χ^2)

Sex / Age range	F		M		Total N=689	%
	n	%	n	%		
60-64 years	139	20.2	16	2.3	155	22.5
65-69 years	262	38	30	4.4	292	42.4
70-74 years	127	18.4	38	5.5	165	23.9

(continued)

Table 1.
The number of respondents depending on sex and age (independence test χ^2) (continued)

Sex / Age range	F		M		Total N=689	%
	n	%	n	%		
75 years and over	57	8.3	20	2.9	77	11.2
Total	585	84.9	104	15.1	689	100
χ^2=23.27; df=3; p=0.0011; V Cramér=0.1812						

Note. F – females; M – males.

A diagnostic survey was applied in the research. A survey technique was used including the following research tools:

– Health Behaviour Inventory (HBI) – this tool is part of a set of tools used in health promotion and psychology (Juczyński, 2012). Internal consistency of HBI determined on the basis of Cronbach's alpha amounted to 0.85 for the whole HBI, and for its four subscales (CEH, PB, PMA, HB) the values were respectively: 0.65; 0.61; 0.60; 0.64. Test-retest reliability assessment (after six weeks) was 0.88. It contains 24 statements and determines four health-related behaviour and their severity. Individual behaviours covered four areas: correct eating habits (CEH) mainly concern the type of food consumed, such as vegetables, fruit, animal fats, sugars, salt, whole wheat bread; preventive behaviours (PB) include compliance with medical recommendations, avoiding colds, knowledge of emergency numbers, regular medical examinations; positive mental attitude (PMA) is about avoiding too strong emotions, depressing situations, stress and tension; and health practices (HP) include daily habits relating to rest, sleep, recreation, physical activity, maintaining proper body weight, using stimulants, and smoking. Each behaviour was rated on a five-point scale. Based on the frequency of indicated health behaviours, the general intensity of the particular categories of behaviours conducive to health was determined, as well as the level of intensity of individual categories. The general intensity of these behaviours was the sum of points from the individual categories, within the range from 24 to 120 points. A higher result denotes a greater

intensity of declared behaviours. The general index after the conversion into standard units is interpreted according to properties characterizing sten scores (results within 1 – 4 sten treated as low, 5 – 6 sten are medium, and 7 – 10 sten are regarded as high).

- Own questionnaire - containing questions about age, sex, body height and weight, place of residence, education, family situation, financial standing, and physical activity in particular stages of life.
- Methods of statistical estimation - the statistical analysis used the program Statistica 13 (for Windows, Kazimierz Wielki University in Bydgoszcz, Poland authorised). In all variables there was reported a distribution differing from the normal one, therefore, non-parametric statistics were used for calculations - rho-Spearman correlation and the Mann-Whitney *U* test used for checking the significance of differences. Variations for ranges were assessed (H Kruskal-Wallis Test, test *Z*). Statistical significance was accepted as $p = 0.05$ in the research.

The Bioethics Committee of the Nicolaus Copernicus University in Toruń (Collegium Medicum in Bydgoszcz) gave consent for the research (KB 577/2017).

Results

Respondents mentioned the most health behaviour relating to prophylactic measures (average=22.91) and a positive mental attitude (average=22.90) (Table 2).

Table 2.
Descriptive statistics for health behaviour (HBI)

Variable	M	Me	Min	Max	SD
HBI	90.73	93	36	120	14.06
HBIsten	6.99	7	1	10	1.91
CEH	22.40	23	7	30	4.29
PB	22.91	23	8	30	4.24
PMA	22,90	23	10	30	3,97
HP	22,51	23	9	30	4,09

Note. HBI – general indicator, HBI sten – general sten value, CEH – correct eating habits, PB – prophylactic behaviour, PMA – positive mental attitude, HP – health practices.

The analysis of the results in individual subscales (Table 3) allows for considering that respondents indicated the most behaviour relating to prophylactic measures and a positive attitude, and the least associated with eating habits. A slightly higher average score was achieved by female subjects (average = 91.36) whereas men had 87.18. When assessing the results shown in the table, women chose significantly more health behaviour connected with correct eating habits (Z=4.35, p=0.0001), prophylactic behaviour (Z=3.40, p=0.0012) and a positive mental attitude (Z=2.00, p=0.0451) than men. Furthermore, women also achieved a higher average score (Z=3.24. p=0.0011) and average sten score (Z=6.05. p=0.0001).

The most health behaviour were observed in people from the age group >75. An overall average score was 93.82 and average sten score was 7.31. In this age group, the subjects showed more behaviour related to correct eating habits, prophylactic measures, positive mental attitude, and health practices. The least health behaviour was observed in individuals aged between 60 and 64 (average=89.49). Thus, the intensity of health behaviour increased with age both in general and on an individual basis.

Table 3.
Descriptive statistics and significance of differences between health behaviour means of women and men (Mann-Whitney U test) (N=689)

Sex	F (n=585)					M (n=104)					Z	*p*
Variable	M	Me	Min	Max	SD	M	Me	Min	Max	SD		
HBI	91.36	93	36	120	14.02	87.18	86	48	120	13.85	3.24	0.0011*
HBIsten	7.17	7	1	10	1.86	5.96	6	1	10	1.92	6.05	0.0000*
CEH	22.68	23	7	30	4.25	20.86	21	10	30	4.20	4.35	0.0000*
PB	23.12	24	8	30	4.24	21.73	21	12	30	4.11	3.40	0.0012*
PMA	23.02	23	10	30	3.96	22.25	22	10	30	3.97	2.00	0.0451*
HP	22.53	23	9	30	4.14	22.35	23	12	30	3.84	0.68	0.4963

Note. *Significant differences at the level of $p \leq 0.05$. HBI – general indicator, HBI sten – general sten value, CEH – correct eating habits, PB – prophylactic behaviour, PMA – positive mental attitude, HP – health practices.

The result of general variation test H did not reveal any significant differences between health behaviour in particular age groups (Table 4).

Table 4.
Significance of differences concerning health behaviour of individual age groups (Kruskal-Wallis one-way analysis of variance ANOVA) (N=689)

	H (N=689; df=3)	*p*
HBI	4.70	0.1961
HBIsten	3.12	0.3731
CEH	1.13	0.7702
PB	4.58	0.2053
PMA	4.96	0.1754
HP	5.62	0.1310

Note. HBI – general indicator, HBI sten – general sten value, CEH – correct eating habits, PB – prophylactic behaviour, PMA – positive mental attitude, HP – health practices.

Health behaviours were assessed also in terms of marital status of respondents. More health behaviour were chosen by married individuals (average score 91.35; average sten score 7.11) (Table 5). These people also mentioned more health behaviour in individual groups (correct eating habits – 22,54; prophylactic behaviour – 23.03; a positive mental attitude – 23.09; health practices – 22.69). Yet, no statistically significant differences were found.

Table 5.
Descriptive statistics relating to health behaviour considering marital status (N=689)

	MARITAL STATUS											
Variable	married (n=318)					single (n=371)					*Z*	*p*
	M	Me	Min	Max	SD	M	Me	Min	Max	SD		
HBI	91.35	93	48	120	14.44	90.19	91	36	120	13.72	1.34	0.1790
HBIsten	7.11	7	1	10	1.94	6.88	7	1	10	1.89	1.78	0.0751
CEH	22.54	23	7	30	4.48	22.29	23	8	30	4.13	1.12	0.2631
PB	23.03	24	12	30	4.24	22.81	23	8	30	4.25	0.75	0.4532
PMA	23.09	24	10	30	3.99	22.75	23	10	30	3.95	1.19	0.2334
HP	22.69	23	11	30	4.20	22.35	22	9	30	4.00	1.41	0.1592

Note. Z – test result *Z; p* – significance level. HBI – general indicator, HBI sten – general sten value, CEH – correct eating habits, PB – prophylactic behaviour, PMA – positive mental attitude, HP – health practices.

It was also analysed whether having or not having children affected the choices of health behaviour. According to the data displayed in the table, slightly more health behaviour were reported by childless individuals (average score was 90.89; average sten score was 7.04). These people declared more health behaviour concerning proper eating habits (22.47), prophylactic measures (23.22) and health practices (22.60). Respondents who had children revealed more health behaviour within a positive mental attitude (22.94). The differences were statistically insignificant.

The most healthy behaviours were observed in people in a luxurious or very good financial standing (average score – 92.98; average sten score - 7.31) (Table 6). The least healthy behaviours were reported by respondents in a satisfactory and poor financial standing (average score – 86.35; average sten score – 6.38). The analysis of average scores for proper eating habits, prophylactic measures, a positive mental attitude, and health practices suggests that the lower score the worse financial standing.

Table 6.
Descriptive statistics relating to health behaviour considering financial standing (N=689)

	FINANCIAL STANDING														
Variable	luxurious and very good (n=209)					good (n=415)					satisfactory and poor (n=65)				
	M	Me	Min	Max	SD	M	Me	Min	Max	SD	M	Me	Min	Max	SD
HBI	92.98	95	36	120	13.16	90.27	92	48	120	13.98	86.35	89	48	120	16.13
HBIsten	7.31	8	1	10	1.74	6.92	7	1	10	1.93	6.38	7	1	10	2.17
CEH	23.15	23	7	30	4.01	22.20	23	10	30	4.31	21.34	22	10	30	4.71
PB	23.10	24	8	30	4.05	22.92	24	10	30	4.30	22.25	23	12	30	4.51
PMA	23.51	24	10	30	3.92	22.79	23	12	30	3.82	21.69	22	10	30	4.71
HP	23.22	24	10	30	3.83	22.37	23	9	30	4.06	21.08	21	12	30	4.64

Note. HBI – general indicator, HBI sten – general sten value, CEH – correct eating habits, PB – prophylactic behaviour, PMA – positive mental attitude, HP – health practices.

The analysis of correlation between financial standing and health behaviour has shown that the worse financial standing the fewer health behaviour (R=-0.13), especially within proper eating habits (R=-0.12), a positive mental attitude (R=-0.12) and health practices (R=-0.15). However, the level of these correlations was low (Table 7).

The number of health behaviour increased with rising levels of education. People with basic and vocational education achieved an average score of 88.02 (average sten score – 6.55), whereas those with higher education had 91.96 (average sten score – 7.14). the most health behaviour within proper eating habits as well as prophylactic measures were reported by people with general secondary education (respectively: 22.89; 22.98). More health behaviour within a positive mental attitude (23.16) and health practices (23.10) were observed in people with higher education.

Table 7.
Financial standing and health behaviour (rho-Spearman) (N=689)

Variable	R	t (N-2)	*p*
HBI	-0.13	-3.32	0.0011*
CEH	-0.12	-3.17	0.0020*
PB	-0.04	-1.07	0.2852
PMA	-0,12	-3,18	0,0021*
HP	-0,15	-3,94	0,0000*

Note. R – Spearman's correlation coefficient; t – significance tests; *statistically significant differences at the level of $p \leq 0.05$. HBI – general indicator, CEH – correct eating habits, PB – prophylactic behaviour, PMA – positive mental attitude, HP – health practices.

The analysis of correlations between education level and health behaviour has demonstrated that the higher education the more health behaviour within health practices (R=0.10). These correlations were at a low level (Table 8).

Table 8.
Correlations between education level and health behaviour (rho-Spearman) (N=689)

Variable	R	t (N-2)	p
HBI	0.06	1.66	0.0981
CEH	0.07	1.94	0.0531
PB	0.01	0.21	0.8312
PMA	0.03	0.68	0.4974
HP	0.10	2.55	0.0110*

Note. R – Spearman's correlation coefficient; t – significance tests; *statistically significant differences at the level of $p \leq 0.05$. HBI – general indicator, CEH – correct eating habits, PB – prophylactic behaviour, PMA – positive mental attitude, HP – health practices.

Discussion

The impact on aging processes is exerted not only by age, sex, financial standing, marital status, genetic factors, diseases, and injuries, but also by lifestyle. Health behaviour that allows for a significant improvement in the quality of life in different areas, and contribute to greater satisfaction with life and health, are important in the life of the elderly.

Women reported significantly more health behaviour relating to proper eating habits, prophylactic measures, and a positive mental attitude than men. Women also achieved a significantly higher average score and average sten score. Own research confirmed the results obtained by Muszalik et al. (2013). The correlation of sex with increased health behaviour was also demonstrated in the studies conducted by Zadworna-Cieślak (2013) and Ogińska-Bulik (2014). Women achieved a higher score in the Health Behaviour Inventory as compared to men. This means that women adopt healthier behaviour. This particularly concerned eating habits, prophylactic measures and, to a slightly lesser extent, health practices. Sex-related differences may be associated with social stereotypes which consider women to care more about health whereas men to take actions that are even risky for health. Additionally, own research results were also supported by the studies conducted by Sygit-Kowalkowska (2013), Zadworna-Cieślak and Ogińska-Biluk (2018).

Generally, the most healthy behaviour was observed in people from the age group >75. An overall average score was 93.82 and average sten score was 7.31. The least health behaviour was adopted by people aged 60-64 years of age (average=89.49). Health behaviour as a whole and in individual categories tended to increase with age. Own research confirmed the findings obtained by Kozieł et al. (2008). The authors analysed 197 students at the University of the Third Age, comprising the study group, and 197 elderly subjects who did not adopt this form of activity and accounted for the control group, using a diagnostic questionnaire. The analysis of correlations between age and the categories of health behaviour represented by students at the University of the Third Age revealed a statistically significant relationship only in terms of the general indicator of health behaviour and a positive mental attitude. Therefore, the general indicator of behaviour adopted by seniors and their positive mental attitude were better with age. Intellectually inactive people, that is not attending the course offered by the University of the Third Age, more often undertook health practices with age.

Health behaviours were also assessed about marital status of the subjects. The research carried out by Muszalik et al. (2013) showed that the elderly adopted a relatively high level of health behaviour. The same research suggested a significantly higher level of a positive mental attitude among married people. This was confirmed by own research studies which reported more health behaviour among married subjects. Beneficial effects of marriages on health behaviour were also proved by Williams and Umberson (2004). Umberson (1992) assumed in her research that marriage may have a positive impact on health, because numerous spouses monitor and try to control their spouse's health behaviour.

Respondents reported more health behaviour associated with prophylactic measures and a positive mental attitude, and the least with eating habits. The most health behaviour were observed in people in a luxurious or very good financial standing (average score – 92.98; average sten score - 7.31), and the least were reported by respondents in a satisfactory and poor financial standing (average score – 86.35; average sten score – 6.38). Hence, it can be concluded that a higher economic status facilitates pro-health behaviour through easier access to different forms of sport activity, and a healthy, often more expensive diet. The fact that older people pay less attention to eating habits may raise concern.

The studies of Suliga (2010) revealed that over 40% women and 75% men were not interested in gathering new information on food and nutrition, and health reasons determined the choice of food in 40% subjects. As indicated by the findings of some studies, only the diagnosis of a serious disease or its serious risk often influences a change in the diet to be more like dietary recommendations (Berg et al., 2008). Spanish researchers reviewed the articles dealing with proper eating habits of people aged 18 to 85 years of age from 15 European countries (De Irala-Estévez et al., 2000). The findings suggest that adult Europeans with a lower socio-economic status may have an unhealthy dietary model. Own research results were also supported by the studies conducted by Poortinga (2006). The author performed a survey of 7394 people living in England using a diagnostic questionnaire. It concerned the relationship between social capital and self-assessment of health together with health behaviour. A significant correlation was confirmed between the analysed factors. The studies conducted by Darin-Mattsson et al. (2017) on subjects over 60 years of age showed that low income was most closely connected with poor health condition of respondents and health behaviour. The authors analysed both the current and past financial standing of older people. The same conclusions were drawn by Scandinavian scientists who surveyed 748 women and men at the age of 75 (Avlund et al., 2003). The following two variables of the financial situation: high income and its duration turned out to be most connected with almost all health behaviour of older people. Own research results were supported by the studies carried out by Austrian researchers who intended to identify the perception of home environment and the relationship with self-assessment of health in the urban context. The study involved the citizens of Graz (a medium-size city in Austria) aged 15–60 years (n= 997). It was found that the high socio-environmental quality of the residential environment was associated with the higher level of health self-assessment (Stronegger et al., 2010).

Respondents with a higher education level reported more health behaviour than those with a lower level of education. It can be concluded that better-educated people are more aware of the need to care about own health and physical condition. Thus, the education level is connected with health condition. These findings were confirmed by the studies of Knurowski et al. (2005) and Ślusarska and Nowicki (2010). The analysis of declared health behaviour depending on the variable, which was the education level, found that individuals with a higher education level had a higher general indicator

of health behaviour as compared to people with secondary and basic education. The research studies performed in 2015 in the Iran city of Iranshahr (Mofrad et al., 2016) on 425 subjects at the age of 60 revealed a statistically significant correlation between health-promoting behaviour and the education level of older people. The findings are also supported by the studies of Khalaila (2017) and He (2016).

Conclusions

The theoretical foundations of the scope of health behaviour were proposed by Bond et al. who defined them as a form of human activity focused on health and as a lifestyle which consisted of two components: mental (self-control of the body, responsibility for health, positive attitude) and physical (diet, physical activity, rest, stimulants) (Bond, et al., 2004). This study used the division included in the Health Behaviour Inventory. The analysis included the following four categories of health behaviour adopted by people over 60 years of age: proper eating habits, prophylactic measures, a positive mental attitude and health practices. Based on the studies, the following conclusions were drawn:

- pro-health choices are conditioned by the socio-economic situation of old people. The higher education and the better financial standing, the more pro-health behaviour;
- older women revealed significantly more health behaviour than men, especially in terms of correct eating habits, prophylactic measures and a positive mental attitude;
- the most health behaviour were observed in people from the age group >75 and the least in 60 to 64 years of age. Health behaviour as a whole and in individual categories tended to increase with age;
- the elderly people indicated the most health behaviour relating to prophylactic measures and a positive attitude, and the least associated with eating habits.

It appears that with age the intensity of health behaviour is associated with medical recommendations concerning physical activity and proper diet. Among respondents, the lowest intensity of health behaviour was observed

just in the category of appropriate eating habits. Therefore, much greater attention should be given to this subject matter in national strategy documents. Another matter of concern is lower intensity of health behaviour in older men, which also encourages greater activation of this social group.

Limitations

The authors understand that the survey was given to a selected group and did not consider people that did not consider people that are not Third Age University Students. However, the objective of the study was to analyze health related activities of Third Age University students specifically. Undoubtedly it is peculiar that the participants are educated above average compared to the whole of Poland's population.

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