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Original research article

Health in the context of healthy ageing among people aged 65+ in South Bohemia

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Abstract

Goals: This research aims to clarify the relationships between healthcare use and availability, preparation for active ageing and ageing, and involvement in the care of one's health among people aged 65 and over.

Methods: Qualitative research (grounded theory) was used to achieve the goal. This study was conducted from the beginning of February to the end of April 2024. The informants were people aged 65 and over who lived in South Bohemia. Semi-structured interviews were used.

Results: Health was the central category. Other categories were care availability, GP services, active ageing, alternative medicine, and hospitalisation. The connections found show that health is the key to fulfilling the idea of healthy ageing and is closely related to self-sufficiency. Self-sufficiency is essential from the point of view of active ageing. They pay attention to maintaining it from the point of view of planning the future. On the other hand, illness is a factor influencing thoughts about the future, the availability of care, and the need for information. Communication becomes an essential element, which is intertwined with the entire concept of successful ageing.

Conclusion: The results suggest that paying more attention to examining the expectations of patients and healthcare professionals regarding care aimed at maintaining and restoring health, or possibly implementing changes, is going to be necessary.

Keywords: Active ageing; Adult General Practitioner; Ageing; Health; Information

Introduction

Health is fundamental for realising one's potential and ensuring healthy ageing. Its definition depends on the paradigm through which it is viewed (Payne, 1983). According to the WHO (1948), health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. In 1978, it was declared that health is a fundamental human right. Achieving the highest possible level of health was identified as the most important global social goal. It was newly defined as a resource for everyday life (not just a life goal), a positive concept reflecting a person's social and personal resources and capacities. It was emphasised that health promotion is not only in the hands of the healthcare sector but is also a responsibility given by a healthy lifestyle and the concept of well-being (WHO, 2024a).

In the context of health and ageing, the WHO (2011) emphasises that many diseases and health limitations are rooted in early life experiences and living conditions. It is in the hands of each person how they will approach their health, old age, and ageing. It is true that ageing, as a genetically determined involutional process, cannot be prevented, but the qualities it acquires can be influenced. In practice, successful ageing is considered to be accompanied by physical and mental fitness concerning socioeconomic level, cultural factors, health level, etc. (Čeledová et al., 2017; Ptáčková et al., 2021). In the context of successful ageing, it should be added that, according to available statistics, Czech men will spend 13.4 years of their lives with a health condition and women 18.1 (Ministry of Labour and Social Affairs of the Czech Republic, 2021).

According to the projection of the Czech Statistical Office for 2023–2100, the Czech Republic will show a trend of population ageing. It is estimated that the share of seniors (i.e., people aged 65 and over) will increase significantly. Specifically, the number will be around three and a quarter million (for comparison, we note that, at the beginning of 2023, this number was 2.2 million) (Czech Statistical Office, 2023). This brings with it inevitable changes associated with how healthcare is provided to this part of the population and planning aimed at supporting active ageing. The strategic framework for preparing for an ageing society for 2021–2025 (Ministry of Labour and Social Affairs of the Czech Republic, 2021) aims to ensure dignified and fair financial security in old age, achieve accessibility of barrier-free housing for seniors, strengthen activities related to preventive healthcare, a healthy lifestyle and

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specialised geriatric care, ensure sufficient support for informal caregivers, improve the situation on the labour market for older people and increase their mobility, and strengthen the sense of security (including fighting disinformation). In addition to the involvement of several public health entities, all the goals mentioned earlier also require the active participation of recipients of care and services, and in particular, an effort to take personal responsibility for their health and quality of life in old age. To accept this responsibility, a person needs sufficient knowledge and the ability to use it in everyday life.

Self-care refers to the ability of individuals, families, and communities to maintain their health, prevent disease, and cope with this condition in the event of illness, with or without the support of health professionals. Self-care interventions include issues related to medicines, medical devices, and digital equipment. In the concept of self-care, individuals are perceived as active agents responsible for managing their healthcare and health promotion (including disease prevention and control). Throughout life, they naturally move along the axis of dependence–independence, comfort–discomfort (WHO, 2024b).

In line with this idea, the objectives of the study are as follows:

- To determine how citizens of South Bohemia aged 65+ use healthcare in the context of active ageing.
- To determine whether and how they prepare for their old age.

Materials and methods

Study design

Given the research objective, the grounded theory method (Corbin and Strauss, 2015; Urquhart, 2022) was chosen, which helped to clarify the relationships between healthcare use, its availability, preparation for active ageing, and involvement in the care of one's health. At the same time, it allowed us to view the obtained data without distortion and to focus on identifying what is significant in this area.

Sample

The research sample consisted of residents of South Bohemia aged 65+ who agreed to conduct a semi-structured interview. These citizens were selected using the snowball method, where one of the informants recommended another informant for the interview. The sample size was determined using the recommendations of the theoretical saturation criterion. That is the state when conducting another interview would not bring any new findings (Corbin and Strauss, 2015; Urquhart, 2022). A total of 45 people were addressed; 13 refused to participate, and two were excluded because they were not fully informed. The criteria for selecting informants were age 65 and over, willingness to participate, and their awareness of space, time, and themselves. Demonstrating such awareness was necessary concerning the target group because confusion would lead to distortion of the obtained data. The final size of the research group, at which theoretical saturation was achieved, was 30 people (10 men and 20 women) aged 65 to 81. They were all retired. Five informants were also employed (full-time, part-time, or work agreement).

Data collection

Each researcher conducted 10 interviews. The interviews lasted from 30 to 180 minutes. In the case of the most extended interview (180 minutes), the interview was divided into two sessions due to its complexity. The interviews were conducted in an informal setting (mainly in the informants' homes or in a quiet place in a restaurant). Based on informed consent, the interviews were recorded on an audio device. The answers were written down if the informant disagreed with the interview being recorded.

The content of the semi-structured interview was based on (1) the objectives set by the research, (2) the information obtained from the available literature, (3) the experience of the multidisciplinary research team. The team revised the interview questions several times, and their clarity was pilot tested before the study began. The final form of the interview consisted of four sets of questions. The first set of questions included 16 open-ended questions supplemented with sub-questions, which aimed to describe the healthcare issue through the informants' eyes. The second set of questions focused on disease prevention and one's involvement in such prevention. This set included 13 questions with sub-questions. The third set included 13 questions with sub-questions and focused on prevention and one's own preparation for old age. The fourth set contained eight socio-demographic questions to characterise the informants. The questions were open-ended to achieve the highest possible yield.

Ethical considerations

The final form of the semi-structured interviews and the research proposal were approved by the Ethics Committee of the Faculty of Health and Social Sciences of the University of South Bohemia, ref. No. 01/2024. This research did not contain any ethically controversial issues and respected the Regulation of the European Parliament and the EU Council 2016/679. All activities related to the involvement of participants in the research were carried out under the Declaration of Helsinki from 1975 and its last revision in 2024, and they followed national ethical standards and regulations.

Data analysis

The grounded theory method was used to analyse the qualitative data. Following the recommended procedure (Corbin and Strauss, 2015; Urquhart, 2022), open, axial, and selective coding were used during the process. The MAXQDA 24.6.0 program was used for the actual data analysis. After the interviews were transcribed verbatim into MS Word, they were transferred to MAXQDA 24.6.0. Subsequently, open coding was carried out in the program. The result of open coding was the initially identified categories and subcategories, which could not be considered final. At this stage, 1,340 segments were marked, and 132 codes were identified, which were divided into 15 categories and 23 subcategories. The next step was axial coding, when, based on a deeper analysis of the data and the search for connections, the data was composed in a different way using the determination of conditions. 97 codes expressing a causal connection, seven categories, and eight subcategories were identified. The last step of the analysis was selective coding, which allowed us to identify a central category and related subcategories. As a result, six categories and eight subcategories were identified. Health was identified as the central category. Other categories identified were accessibility of care, general practitioner services, active ageing, alternative medicine, and hospitalisation.

Results

Story identification

Health is an important attribute necessary for healthy old age and ageing. Healthy old age and ageing is defined as a state

associated with self-sufficiency, the possibility of an active life, and an active way of spending free time. With increasing age, the number of diseases (including pain) that affect a person's quality of life increases. Health is a factor that determines the method and frequency of using the services of a general practitioner and the need to seek further care. It is a significant determinant influencing the assessment of the availability of services. When informants are healthier, there is no great need to use the service, and there were no complaints about its availability. When the health condition of the informants required a higher frequency of visits to a doctor or seeking a specialist, the informants' attitude towards the availability of care also changed (it tended towards a negative or problematic assessment). A similar connection was seen when transferring information about the disease and regimen measures directly to the patient or next of kin. It turns out that those who are already sick are more likely to think about sharing information. On the other hand, those who do not suffer from a disease that would reduce their quality of life are more likely not to think about these issues and do not have information about the options in this area. Sharing information about the patient's health with them is preferred, who should determine whether and to whom this information can be passed on. The area of socioeconomic influences can also be considered very interesting in maintaining health, but according to the informants, it is not sufficiently monitored by doctors. The informants are aware of the importance of socioeconomic influences and the connection of this factor with the level of health.

Resulting categories

Health

Health was identified as a central category. Most informants rated their overall health as good. Eight informants responded that their overall health was not good (mainly due to pain, most often back pain): *"It's not exactly good, I often have pain, but I don't have an illness"* (I7). This was also reflected in the perception of physical health: *"I'm overweight, so I have problems with movement, my knees and back hurt"* (I6); *"I have pain, I often feel nauseous when I eat something bad"* (I2). Concerning physical health, informants mentioned using compensatory aids: *"I have mobility limitations. I have trouble walking up the stairs, I have to choose trains where the stairs are not so high. I can't pull myself up that well anymore, and I can't lean on my leg at all. I also wear glasses"* (V8); *"I have a walker and crutches. I have fallen many times at home, the firefighters were here too"* (I9); *"… when I go out, I take a walking stick, just in case… The social worker keeps recommending a button, but I don't have one"* (I3). It can be considered positive that 18 informants did not use compensatory aids to facilitate movement and did not experience any physical limitations.

In the area of mental health, the informants agreed that its level is directly related to their health status: *"My health status affects my mood, sometimes I feel good, sometimes worse"* (S9); "*The strength of the pain of the disease affects my mental mood quite a bit, and the same applies to the problem with the permanent use of medication, and the current weather condition also has a lot of influence"* (S6); *"My moods change, I am anxious, sometimes I am sad"* (I9). Fifteen informants denied their level of mental health had deteriorated. Social interaction, especially with grandchildren, proved to be protective in terms of maintaining mental health: *"We have a grandchild, a great-grandchild, that's great, I like looking after her so much"* (V5); *"I don't have time for that, I'm taking care of my grandchildren"* (S10).

Polymorbidity was noted in many informants. Only seven informants stated that they were not being treated for anything. The diseases reported included diabetes mellitus, hypertension, depression and anxiety, respiratory diseases (e.g., asthma and COPD), being overweight, or prostate disease. S6 stated: *"Yes, I have been suffering from a degenerative spinal disease for about seven years, I solve my problem by combining visits to doctors: a neurologist, an orthopaedist, and the pain centre. Accessibility at the orthopaedist and the pain centre is good, but not at the neurologist."* V6 also mentioned leg ulcers: *"I have diabetes. A year ago I had an ulcer on my left leg."*

Concerning the incidence rate of various diseases among informants, their activities to maintain and restore health appear significant. It is shown here that the most common activities include taking prescribed medication, following the regimen, attending prescribed rehabilitation, resisting symptoms of the disease, attending regular check-ups, and trying to limit smoking. *"I take medication, and now a rehabilitation nurse has started coming here, we exercise to lose weight, then maybe my back and joints won't hurt so much in general"* (I9); "*I exercise regularly – I ride a bike, go for walks, don't overeat and go to the doctor if I feel unwell"* (I10). The most frequently mentioned physical activities were walking, bike riding, or exercising at home. The quality of sleep was variable among the informants. Some reported sleep problems: *"I sleep badly, I take half a sleeping pill every night, I sleep about seven hours a day"* (S2); *"I don't sleep during the day, I go to bed around 9:30, and I have to take sleeping pills, then I sleep until 7 o'clock"* (I4). Some only observed changes in the length of sleep.

The level of risk behaviour (in the area of alcohol abuse and tobacco use) can be perceived positively. Among the informants, only seven people mentioned tobacco use. Only a small number of informants also mentioned alcohol use (beer or wine in smaller quantities): "*Here and there wine, here and there beer after lunch or after dinner"* (S7). It can also be stated that in the event of illness, some informants turn to their general practitioner immediately, and others only when they cannot cope with the symptoms of the disease themselves: *"To the doctor. So, when I am sick, I make an appointment with the doctor. Even if it is acute, I usually call there first, it is better, then she is not so unpleasant"* (V3); *"To the closest person, a friend, in the case of acute problems, to the emergency room"* (S1); *"Before I visit the doctor, I try to solve it myself so that I don't go there with every problem"* (V8).

Accessibility of care

The category Accessibility of care contained two subcategories: Compliance and Geographical accessibility. The Compliance subcategory brings together information related to factors that can influence patient and healthcare system compliance. The information obtained indicates that the doctors informants had visited in the last 12 months included general practitioners for adults, dentists, and, in the case of women, gynaecologists, as well as urologists, neurologists, orthopaedists, ophthalmologists, gastroenterologists, nutritionists, or doctors in a pain clinic. I2 provided a detailed list of visits: *"… I go to a general practitioner because of high blood pressure and now for follow-up treatment after discharge from the hospital, gynaecologist and dentist – prevention, hospital – internal medicine and ICU, ophthalmologist – intraocular pressure control."* I8 added a psychiatrist to the list: *"… an internist to check blood pressure, a diabetologist to check blood sugar, an orthopaedist to check hip pain, I go to a psychiatrist for regular consultations."* According to the informants, the reason for visiting doctors was not always only prevention but also the use of chronic medication. The use of medicines is associated with the issue of over-the-counter drugs and nutritional supplements. The informants mainly

buy these medicaments at the pharmacy, where they receive advice: *"I buy oyster mushrooms and vitamins in the winter, I buy them at the pharmacy and get advice from the pharmacist"* (I5); *"Of course we buy. For many things, you just have to go to the pharmacy. If there is a reasonable pharmacist there, they will advise you and you don't have to go to the doctor"* (V7). In some cases, the doctor is also a source of advice. It is certainly worth mentioning the possible obstacles to taking medication that stemmed from the financial situation: *"I don't buy it, I really don't have the money for it, I can hardly pick up the medication with a co-payment. Now I got prescriptions from the hospital, and I had to borrow money from a friend"* (I4).

During doctor visits, the line connected with monitoring fundamental health indicators was also followed, such as measuring blood pressure, blood cholesterol levels, etc. The informants' statements indicate that this monitoring takes place more during visits to the doctor than in the home environment: *"The doctor measures my blood pressure; once a nurse came to measure it at my home, I don't measure anything myself. The doctor takes my blood samples, but I don't know the values"* (I4). In addition to the possibility of monitoring fundamental health indicators, one's compliance with the doctor's recommendations and motivation to follow these recommendations are essential for compliance. Here it is shown that the informants make a considerable effort to follow the recommendations, albeit with varying degrees of success: *"Well, I try, but I don't lose weight, probably mainly because I don't exercise and eat a lot..."* (I9); *"He doesn't mind that I smoke, but that won't change. I'm too old to quit"* (V5); *"I mostly follow the diet, but I break it – for example, I eat a lot of sweets at Christmas or when we have a party. I just can't help it"* (I1). The level of support corresponded to the level of compliance with the recommendations. The fact that doctors regularly repeat the importance of adhering to the prescribed measures (during visits) to patients was repeated in the statements. Another source of motivation cited was family and their awareness, which is when patients motivate themselves and do not require external intervention or support.

The subcategory Geographical accessibility brings together information related to the availability of doctors. The data obtained indicate differences in the subjectively perceived availability of general practitioners for adults and specialist surgeries and the availability in cities and villages. V1 and V2 summarized the issue of accessibility of care in villages: *"As long as I can drive, I am satisfied. I can drive everywhere. But when they take away my driver's license, I hope I won't live to see it, I wouldn't get anywhere"* (V2); *"Everything here requires commuting. We used to have doctors, dentists, practices, and a gynaecologist in the city, but not anymore. The municipality tried to lure them by giving them an apartment, but no one wants to come here"* (V1). The availability of dental care and emergency medical services was considered the most problematic.

General practitioner's services

The General practitioner's services category contains four subcategories: Information, Creation of a treatment plan, Monitoring socio-economic conditions, and Organising general practitioner's services. The Information subcategory combines information about diagnosis, treatment, and health status from the patient to the doctor and from the doctor to the patient (or their family). It turns out that the informants obtain most information about their health status and treatment regimen from their general practitioner. They generally evaluate this information as understandable. If there are ambiguities, they usually do not hesitate to ask the doctor: *"He will explain it to me and tell me what I should do... The nurse is not very involved, she sometimes asks how I am or answers when I call for medication"* (V5); *"... I understand when they tell me, if I don't understand, I ask. Sometimes I don't understand the findings"* (S3). In addition to asking the doctor directly, they also use other available sources of information, such as the Internet or people close to them. However, some did not dare to ask the doctor in case of uncertainty: *"You don't even dare to do that, I usually ask my daughter or someone who had a similar disease"* (S4). In addition to doctors, informants obtain information from nurses: *"From the district doctor. The nurse told me how to follow a diet for diabetics"* (I9). The statements about obtaining information on improving their health status can be considered interesting. Here, the transfer of information is not unambiguous. Many informants were not instructed by health professionals about this issue. They instead obtained information on their own: *"I was not informed, but I know about it myself"* (S10); *"I was not instructed, but I know about it from the mass media"* (S7). At the same time, it was noted that the informants were less interested in this issue or their motivations for obtaining this information.

The informants' statements also indicate that they wish to be fully and truthfully informed about their health status. However, they often do not discuss this wish with doctors but rather expect it to be automatic: *"I have never talked to the doctor about it, I did not know that it would be possible. As far as I am concerned, he should talk to me"* (V5); *"I would like to know the truth, but I have never talked to the doctor about it..."* (I1). They also mentioned consent to providing information to another person; specifically, close relatives (husband/wife, children) were mentioned, but only if the informant's consent was met: *"With my express consent. I am informing my wife"* (S5). A particular discrepancy was noted in the information provided by specialists. In cases where informants visited multiple doctors, they usually provided information to their general practitioner by forwarding a report from a specialist: *"I send the information I get from specialists to the district doctor by email"* (S9); *"I don't tell him, I don't remember anyway. I give him reports"* (V4).

The Creating a treatment plan subcategory gathered information on the extent to which informants can participate in creating a treatment plan. It can be stated that informants have this opportunity but do not fully use it. Some encounter positive reactions from their doctor: *"Yes, if I don't want something, he respects it"* (I10); *"He is not directive in any way, I can decide on the proposed treatment"* (I5). On the contrary, some did not know about the possibility of participating in creating a treatment plan or encountered an adverse reaction from the doctor: *"No, I have never interfered in it, and I didn't know that I should or could"* (V6); *"No. He usually tells me what to do and doesn't ask what I think about it"* (I1).

The Monitoring socio-economic conditions subcategory aims to describe the attitude that informants take towards this issue and, at the same time, that their doctors pay attention to it. It turns out that many informants are convinced that their general practitioner is familiar with socio-economic conditions. The reason for this belief is that patients have been under their care for many years and should, therefore, know them: *"My doctor has known me all my life, so he knows everything"* (I6); *"My general practitioner knows all these things. For example, an orthopedist asked if someone could care for me after my discharge. The doctor should find out this information. It also shows that they care about people"* (I8). A similar positive experience was also described by I3: *"Yes, the hospital dealt with me staying there because I live alone."* However, many informants had a negative experience connected with the fact that the doctor was not interested in this issue and did not specif-

ically ask about it. They may ask when registering the patient for care but do not address it. Nevertheless, informants are convinced that socio-economic conditions are an important area that doctors should be interested in (especially in cases of suspected reduced self-sufficiency): *"They don't care. They should be interested in it when they suspect that the person won't be able to cope"* (I10).

The Organization of GP services subcategory indicates overwhelming satisfaction with the organisation of the care provided. According to informants, the weak points of the organisation of care are long waiting times spent in waiting rooms, lack of time for the patient, lack of interest in prevention on the doctor's part, the necessity of making an appointment, and the availability of a doctor's visit service in the home environment. *"The organisation is good, but before, I didn't have to make an appointment with the GP, but he took care of people according to the waiting list"* (S3); *"I miss the doctor's interest in prevention"* (S10); *"… OK, the wait could be shorter, sometimes there are a lot of people there"* (I7).

Active ageing

The Active ageing category contained the subcategories of active age, ageing, and preparation for the future. The Ageing subcategory gathers information about informants' active age and ageing ideas. According to the statements, this is mainly associated with the level of self-sufficiency, the ability to provide for one's own needs, keeping the mind in good shape, the ability to live a socially active life, continuing to participate in the work process depending on one's capabilities, the effort to maintain physical fitness, and the ability to move. *"It's in the way of thinking, it should be positive"* (S9); *"Every person should live so that their surroundings do not rest after their death. They should not live only for themselves and should live a full life according to their family, physical, mental and financial capabilities"* (S5); *"Probably work as long as possible. Always do something so you don't sit at home in a chair…, sometimes go to work and keep your legs in order so that you can move and maybe even drive a car"* (I1).

The Preparing for the future subcategory covers informants' thoughts related to the future of an ageing person. In this case, the necessity of physical preparation and maintaining the body's condition was repeatedly mentioned: *"Yes, I want to remain self-sufficient for as long as possible, so I try to move. And mentally – I am in contact with friends, I read, I go to social events"* (I10). However, there were also more frequent answers indicating that the informants do not prepare for the future because they live more in the here and now or do not know how to prepare for the future: *"I don't prepare, I don't know how, I just live now"* (I8); *"I don't even know. I should prepare, but I can now manage everything at home. I don't know what will happen if I can't make it. I don't want to end up like others who had to go to a nursing home and died there. I want to be at home. If I can't make it, I'll deal with it"* (V6).

Alternative medicine

The Alternative medicine category is associated with how much alternative practices are used and the preferences of informants in this area. Analysis of the responses showed that 16 informants do not use or trust alternative practices. The other informants had experience with acupuncture, the use of herbs, gemmotherapy, Chinese medicine, and psychotherapy: *"For gemmotherapy, I use a medicine created and infused in alcohol; otherwise, I do not use any other supportive means"* (S4); *"Repeatedly, Chinese medicine and herbal drops… I also have experience with acupuncture"* (V3); *"For Chinese medicine. Needles for weight loss, I did not inform the doctor"* (S1); *"Yes, but it was an attempt to reduce spinal pain, for example, acupressure, which took about one to two days"* (S6). It is certainly worth mentioning that most of them do not inform their doctor about the use of alternative methods of therapy.

Hospitalisation

The Hospitalisation category covers information about experiences with hospitalisation (during the last five years). Ten informants did not have direct experience with hospitalisation in the previous five years. Some informants had a transferred experience when someone from their environment was hospitalised. Positive experiences prevailed in the informants' responses, which stemmed mainly from the quality of care provided, the approach of the staff, and the abundance of information: *"I was in cardiology, and I was satisfied; I was hospitalised – knee surgery – less satisfied, as well as the subsequent check-ups"* (S10). In one case, a somewhat negative experience was recorded, which stemmed from poor communication: *"It was terrible in the hospital; they told me that I had gastritis, but they didn't tell me why it happened to me"* (I4).

Discussion

The presented study describes how citizens of South Bohemia aged 65+ use healthcare in the context of active ageing and how they prepare for old age. Analysis of the obtained data indicates that health is crucial for fulfilling the idea of healthy ageing. At the same time, it shows the significant influence of communication, which is intertwined with the entire concept of healthy ageing.

Health as the key to fulfilling the idea of healthy ageing

Health is a fundamental human right. Achieving its highest possible level is the most critical global social goal (WHO, 2024a). Concerning predictions related to the ageing of the Czech population (Czech Statistical Office, 2023) and the length of life that people in the Czech Republic will spend with a health condition (Ministry of Labour and Social Affairs of the Czech Republic, 2021), it is necessary to address the highest possible level of health in the context of healthy ageing. It is natural that the level of health changes with advancing age. These changes are influenced by environmental factors, genetics, lifestyle, efficiency, and healthcare quality (Kebza, 2005; Manavgat and Demirci, 2024). Our informants frequently mentioned polymorbidity. Some did not perceive the presence of a disease as an "illness" unless their health condition significantly affected individual areas of quality of life. They were more burdened by the presence of pain from various causes. This had an impact on their physical and psychological state. Differences in pain perception are mentioned by Rokyta et al. (2018), who add that it is necessary to perceive two significant factors involved in the perception of pain in old age. The first is that the sensitivity of pain receptors dulls with age. The second is the fact that some reactions that are used to regulate pain are limited. Fricová (2020) considers the period after 75 the riskiest period for pain syndromes.

The issue of self-sufficiency appears to be essential when it comes to health. It is also significant in the context of active ageing. The informants indicate that self-sufficiency is characterised by the ability to provide for one's needs independently (including the ability to drive a car), to be able to function within individual areas of human life (including social life), and to maintain good mental condition. Informants also

prepare for old age and carry out activities to improve their health. Specifically, they try to be active, stay outdoors, take care of their social and family life, maintain contact with society, train memory, etc. These activities align with the Manual of Preparation for Old Age for Citizens (Ministry of Labour and Social Affairs of the Czech Republic, Charles University, 2020). In the context of active ageing, Joukl et al. (2022) point out the importance of maintaining seniors' mobility (including using cars, bicycles, and other modes of transportation). In the study's conclusions, Hátlová et al. (2017) point out that seniors who became used to living actively earlier have a higher tendency to live an active lifestyle in the present, compared to other groups of seniors. However, despite their active lifestyle, they still may face health and social problems in old age (Hátlová et al., 2017).

Communication as an element interwoven with healthy old age and ageing

Communication is a specific connection between people to transmit and disseminate information. In the context of providing healthcare, communication functions include informative, instructive, persuasive, operative, and entertaining (Tomová and Křivková, 2016). The interviews show that communication is intertwined with the entire concept of healthy old age and ageing. Our informants perceived general practitioners, nurses, other healthcare professionals, and the patient's environment as a source of information and motivation but also as obstacles to taking care of their health and active ageing. Informants used communication to transmit (and conceal) information, communicate wishes and needs, and acquire new knowledge if the existing ones were insufficient. However, expectations appear problematic, e.g., in the case of the doctor's communication of information and the investigation of the patient's socio-economic situation. Informants often stated that they expect the doctor to know their preferences and needs without asking or telling them about them. These expectations arose because they had been under the general practitioner's care for a long time, so he or she should also know them. However, in reality, such expectations and wishes may not be fulfilled, and the care provided may appear poor in patients' eyes. Alternatively, situations that are not well handled in terms of communication may arise. Such situations become a source of conflicts and complaints. Several studies point to a closer examination of patient expectations in primary care (Abdulrahman, 2003; Oster et al.,2024; Williams et al., 1995). The conclusions of Oster et al. (2024) indicate that in the case of short-term expectations, both parties (doctor and patient) are almost aligned. However, in the case of long-term expectations, patients tend to hope for a more personal approach and communication, which reflects long-term contact with a general practitioner. On the contrary, doctors' preferences remained more on the professional and organisational level (Oster et al., 2024). As mentioned earlier, the discrepancy may be problematic in the future concerning determining the patient's socio-economic situation related to compliance with the recommended treatment regimen and the possibility of purchasing necessary equipment, etc.

Conclusion

The presented research contributes to understanding the expectations of active ageing among people aged 65+. It shows how these people perceive old age and ageing, and how this is reflected in healthcare and disease prevention. The results touch on the importance of self-sufficiency, which is essential for active ageing, even in the eyes of the informants. Health is a factor that is constantly interacting with the level of self-sufficiency. It also influences the level and need for healthcare and the desire to obtain and share further information. On the other hand, illness can make a person think about the availability of care, the level and method of communicating information, and planning for the future concerning advancing age and the development of the disease. Communication thus becomes an element in this process that permeates the entire concept of old age and ageing and influences its successful course. These results show the need for greater attention in the future to explore the expectations of patients and healthcare professionals (physicians and nurses) in relation to ensuring sufficient information, support, and motivation to maintain and restore health or to make a change. We must not forget the influence of scientific and technological progress, and the possibilities that patients, nurses, and physicians can use.

Data availability

The source data is available in the National Repository under DOI: 10.48700/datst.mqf1k-5ar65.

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Ethical aspects and conflict of interest

The authors have no conflict of interest to declare.

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