

RIGA STRADINS UNIVERSITY

Vents Sīlis

**HEALTH BEHAVIOR AND QUALITY OF LIFE OF LATVIAN
POPULATION**

Summary of Doctoral Thesis

Speciality – Sociology

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This work has been supported by the European Social Fund within the project „Support for the implementation of doctoral studies at Riga Stradins University”.

Riga, 2010

Research has been commenced in Riga Stradins University, Department of Humanities in period from 2005 to 2010.

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Presentation of the Doctoral thesis will take place on the March 16, 2011 at 3.00 PM in the Hippocrates Lecture Room of the Riga Stradins University, Dzirciema Street 16, Riga.

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1. The topicality of the paper

The topic of quality of life in Latvia has gained a special relevance in the last decade, when this country first experienced rapid economic growth which was then followed by even more rapid decrease. Such dynamic changes pose a question about the ways and extent of the impact they have laid on the quality of life and life satisfaction of Latvian population. As it is suggested by Baiba Bela and Tālis Tisenkopfs, “currently quality of life is not only the topic of philosophical discussions or individual’s personal matter, but it is more and more often the centre of social attention regarding the discussions about the goals and the meaning of progress, the tasks of economic growth and policy criteria, as well as developmental models of countries and their unions” (Bela, Tisenkopfs, 2006 b: 8). The wellbeing of Latvian citizens has thus become a subject of social research (Bela, Tisenkopfs et al., 2006 a; Indāns et al., 2006; Karnītis et al., 2007) and leitmotif of political documents, such as “Growth Model for Latvia: People First” (2005), “Guidelines for the Development of Latvia’s Economy” (Ancāns et al., 2006), “Latvian National Development Plan 2007–2013” (2006). Health and the issues related to it have a significant impact on the individual’s life on all levels; therefore sociologists are turning more and more attention to health, illness and risks created by the radical social change.

From the point of view of Latvia’s development it is very important that its population consists of capacitated individuals, who are generally satisfied with their lives, have certainty about their future, and are capable of exercising control over their lives in its various aspects. The concept of quality of life is defined by the authors of the Latvian National Development Plan (NDP) as follows: “Quality of life is a complex social, economic and political concept which encompasses a broad spectrum of living conditions of the country’s inhabitants. It is characterized by the consumer goods available to an individual, the range and quality of social services, opportunities for getting an education and **living a long and healthy life** (emphasis mine – V. S.); participating in the country’s political life, as well as by eliminating any kind of discrimination based on gender, ethnic origin, race, religion, physical disability, sexual orientation and age, thereby enabling an individual to realize his/her potential while helping to create society’s welfare.” (NDP, 2006: 10)

Health and health behaviour of Latvian population has become a topical issue because it is one of the essential domains of life and a fundamental component of the quality of life: “The quality of health is a significant human development indicator. (...) The value of health as a resource experienced a radical change in the post-Soviet period. In market conditions, health has turned into a scarce and valuable resource – to the individual as well as the country

in general.” (Latvia. Human Development Report, 2006: 36) In comparison to other European Union (EU) states, health statistics of Latvian population are significantly lower. For example, life expectancy for both men and women in Latvia is among the lowest: average number of expected life for women in EU is 82,2 years, while in Latvia it is 77,8 years; average number for EU men is 46,1 years, while for Latvian men it is 67,0 years. (Eurostat, 2010) This difference can be explained by the spread of causes of death related to unhealthy and risky lifestyles, namely, ischemic heart disease, lung cancer, cervical cancer mortality, alcohol-related mortality, as well as suicide rates and transport accidents (Cayotte & Buchow, 2009: 3). Distribution of unhealthy habits among Latvian population not only puts an additional burden on the health care system (thus raising the expense and making it less affordable for general population), “but also creates significant human-capital and productivity losses,” (Koroļeva, 2008: 89).

Recent research on health behaviour of Latvian people shows the tendency not only to gather the statistical data, but also to evaluate health problems associated with health behaviours, establish their geographic and demographic distribution, and to determine the priority for public health promotion and health education programs, (Koroļeva et al., 2008; Pudule et al., 2010). Current doctoral paper continues this trend; it is based on the assumption that by researching the relation between health behaviour and quality of life of Latvian population results in a better understanding of the causes of such behaviour, which in turn, could help to find the most adequate means to facilitate positive change towards a healthier lifestyle.

Special attention was paid to on one of the social groups – Latvian population aged 65–94. First reason for doing that is the fact that demographic data about EU countries shows a steady tendency of aging, which leads to conclusion that in 21st century ageing will be one of the main social and economic problems in EU, (see *Eurostat News Release*, 2006). Secondly, quality of life of elderly is already a problem in Latvia, where people at the age of retirement are marginalized or even discriminated, (see Stepčenko, 2007; CSP, 2007a and 2008; Eurobarometer, 2008b; Skrule, Rozentāle & Štāle, 2009). Current situation calls for taking urgent measures to improve their quality of life as it is stated in the *Target 5* of Public Health Strategy: “By 2010, people’s chances of surviving to old age and keeping quality of life should be increased and people in Latvia over 65 years of age should have the opportunity to enjoy their full health potential and contribute to social life,” (PHS, 2001: 13). Although the target has not yet been reached to full extent, (see Skrule, Rozentāle & Štāle, 2009: 29), work must be continued in order to reach the state where retirement means continuation of

good life, not its end. This should be done not only because it is set as a strategic goal, but also because it is a moral duty of a civilized society.

The novelty and scholarly and practical importance of the present research

Present doctoral paper seeks to contribute to the development of both the sociology of health and illness and the quality of life research in Latvia by adding several relevant theoretical and empirical aspects to the scope of current research in these fields.

1. Doctoral paper offers a most extensive critical review of the modern paradigm of sociology of quality of life that has been available in Latvian until now, which includes detailed analysis of such key concepts as ‘quality of life’ and ‘health-related quality of life’.
2. Paper also includes a broad review of the modern scientific paradigm of sociology of health and illness, which includes analysis of such key concepts as “health behaviour” and “health lifestyle” that has not hitherto been done in Latvian.
3. Closer examination is given to the quality of life of people at the age of retirement which, according to the recent statistics and estimates of demographic tendencies in Latvia, is one of the dominant social problems of both present and future.
4. Novelty of the doctoral paper consists in application of the health lifestyles theory to the empirical research of health behaviour.
5. Paper also discusses the problems related to the ethical review of social research, namely, the differences in standards of ethical scrutiny in Latvia and other countries.

Practical importance of the present paper is in helping to achieve a more thorough understanding of the problems related to both the quality of life and the sociology of health and illness. Research has revealed health behaviour patterns and interpretation of gathered data has allowed developing a theory of health behaviour of Latvian population thus continuing the scientific investigation in domains of health and quality of life. Results of the research are a useful resource for improvement of the educational programmes for medical students – it can be used to inform medical students of various specialities about the typical health behaviour models characteristic for particular groups of Latvian population (potential patients). Its conclusions can be applied in writing recommendations for policy makers and government officials working on improvement of health care system, as well as for public health specialists and health promotion/health education professionals who are planning the public health improvement campaigns.

2. The goal and tasks of the research

Object of the research of doctoral paper is quality of life and health behaviour of Latvian population. Subject of the research of doctoral paper is relation between the factors influencing the quality of life and health behaviour of Latvian population. Research population consists of members of Latvian population beginning with the age of 15 years.

The **goals** of the research of doctoral paper are:

- 1) to identify main objective and subjective factors, which determine the quality of life of Latvian population and influence their health behaviour;
- 2) to identify health lifestyles characteristic for different population groups.

In order to achieve the defined goals, the **tasks** are following:

- 1) to examine theoretical paradigms, models and conceptual definitions in the fields of quality of life research and sociology of health and illness,
- 2) to review the latest quality of life and health behaviour research about Latvian population in order to build a theoretical and methodological basis of research for the present doctoral theses,
- 3) to conduct an empirical research in order to achieve the defined goals of the doctoral paper and to elucidate health expert's and lay's subjective views on care for health,
- 4) to study health lifestyles characteristic for Latvian population and to characterize capability categories which influence their health behaviour,
- 5) to enquire the factors influencing the quality of life of Latvian citizens at the age of retirement and their subjective conceptions of health behaviour; to characterize their health-related quality of life,
- 6) to distinguish health lifestyles of economically active Latvian population as well as those at the age of retirement, to study their distribution and constituting health practices,
- 7) to assess health lifestyles of Latvian population against subjective and objective quality of life factors, and to establish statistically significant correlations.

Following **hypotheses** have been formulated regarding the research conducted for doctoral paper:

1. Health behaviour of Latvian population is influenced by the same factors that play a key role in their quality of life.
2. It is possible to distinguish several characteristic health lifestyles among the Latvian inhabitants at the age of retirement and at economically active age.

3. Health lifestyles of Latvian population result from the health practices of particular social groups, influenced not only by their socio-economic status, but also by other structural factors, such as age, gender, health status, etc.

3. The size and structure of the doctoral paper

Doctoral paper consists of three parts, introduction and conclusions, and its total length is 203 pages. The first part contains an overview of the development and the main concepts of contemporary paradigm of quality of life research. First chapter describes the problem of the definition of quality of life and its possible solutions, distinguishes between main types of definitions (global, component, focused and combination definitions), as well as examines several influential universal level definitions and their criticisms, and discusses the individual level approach to the definition of quality of life. Second chapter focuses on historical origins of the quality of life research which began in 1960s as social indicators research. Main conceptual problems of this area of sociology are the problem of subjectivity in methodology of measurement and analysis of results, as well as a question of how much the local context should be taken in account when defining quality of life. Two approaches dominate the field of social indicators research: objective approach, which uses criterion indicators and descriptive indicators of good life, and subjective approach, which measures happiness and life satisfaction of individuals. Solutions to the problem of subjectivity are discussed, as well as the question of whether the subjective evaluation of quality of life (happiness) should be considered a fixed trait or a variable state. Third chapter describes the concept of “health-related quality of life”, where the concept of quality of life is defined and analysed within a context of physical, psychological and social functioning. Fourth chapter shortly reviews quality of life research conducted in Latvia in past decade, where health appears as integral component of the good life.

Second part turns attention to theories and models of sociology of health and illness. First chapter describes historical development of sociology of health and illness, which is marked by emergence of four interpretations of its subject matter – biomedical, sociological, and post-modern and body theory. It is shown how this development took place in the process of applications of different sociological theories, such as functionalism, political economy, symbolic interactionism, post-modernism, phenomenology and feminism to the research of health and illness. Second chapter discusses the differences between two competing health models – biomedical and bio-psychosocial model, as well as definitions of health related to these models. It is followed by the outline of the theory of health lifestyles, developed by

William Cockerham, Thomas Abel and colleagues, where such concepts as health behaviour, health lifestyle and individual care for health are defined and explained. Third chapter contains of an overview of the research on health practices of Latvian population conducted in last two decades.

Third part of the doctoral paper focuses on empirical research analysing the relation between the quality of life indicators and health practices (everyday behaviours that bear an impact on health) of Latvian population. First chapter explains the methodological questions – methods of gathering and analysing data, stages of research, as well as criteria for selecting participants and other related issues. Second chapter discusses the results of the first stage of research, where the qualitative data is gathered in order to find out the different kinds of health lifestyles characteristic to Latvian population. Analysis of expert interviews allowed to identify the main factors influencing health behaviour of Latvian population, as well as to construct the definition of concept “care for health” and to distinguish set of categories. These categories, according to experts, are to be used to describe influences of the health behaviour of Latvian population. Third chapter reviews the second stage of the research: factors that influence the quality of life of Latvian inhabitants at the age of retirement. Objective and subjective indicators of quality of life are discussed, revealing the paradox of life satisfaction – unexpectedly high subjective evaluation of quality of life at the presence of low objective indicators of quality of life. In order to explain this paradox, coping strategies used by elderly people to adapt to the worsened living conditions are analysed. These strategies include lowering their standards of material wellbeing, using downward social comparison and psychological homeostasis. This stage of research also raises the discussion about ethical issues in social research. After that the attention is turned towards health-related quality of life and its impact on the health lifestyles of the Latvian population at the age of retirement, which reveals that respondents with relatively good health practice health improving lifestyle, while respondents with serious and chronic health problems practice health preserving lifestyle. Fourth chapter reviews the results of the third – quantitative stage of the research, which has been conducted as a telephone survey. Analysis of the gathered data allows distinguishing five health lifestyles characteristic to the Latvian inhabitants at the age of retirement: health promoting, health preserving, partial care for health, minimal care for health and noxious lifestyle. Each of the lifestyles is constituted by the particular health practices and therefore can be characterized by them. There is also a statistically significant relation between health lifestyles and such structural conditions or quality of life indicators as income, gender, employment, health status, education, age and place of residence. Third stage of the research includes also a face-to-face survey about the relation between the self-evaluated quality of life

and health behaviour of Latvian inhabitants at the economically active age (15-64 years). Analysis of the gathered quantitative data about this population group allows distinguishing the same five health lifestyles as with the elderly people. Data of this survey also reveals that health behaviour of this age group is strongly related to the main structural conditions (that can also be expressed in terms of quality of life indicators). This relation allows explaining why particular health practices, which in sum constitute their health lifestyles, are characteristic to particular social groups.

Last part consists of the conclusions drawn from the research about the relation between health behaviour and quality of life indicators, how this relation influences health lifestyle choices of Latvian population, why these lifestyles consist of both health oriented and health damaging behaviours, thus none of them can be called neither completely healthy nor completely unhealthy.

4. The theoretical foundation of the doctoral research

Present doctoral paper is using the bio-psychosocial model of health. This model defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity,” (Constitution of WHO). Contrary to biomedical model, which is based on a narrow interpretation of health in terms of the physical functionality, bio-psychosocial model is based on the holistic view of the human health, which is expressed in a following way: “Health and ill health is a consequence of interaction of social psychological and biological events,” (Bowling 2002: 13).

Theoretical foundation of the doctoral paper consists of the health lifestyles theory, authored by two distinguished medical sociologists William C. Cockerham (professor at Alabama University, USA) and Thomas Abel (professor at University of Bern, Switzerland), and their numerous colleagues. Their theory draws on the Max Weber’s conception of lifestyle, which is supplemented by Pierre Bourdieu’s conception of *habitus* and Anthony Giddens’s structuration theory. According to Weber, lifestyle consists of two components: life conduct and life chances. Lifestyle organizes individual practices and depends on both individual choices and the circumstances which allow fulfilling these choices. According to Cockerham and colleagues, Weber’s overall contribution to our understanding of contemporary lifestyles can be summed up as follows: first, lifestyles are associated with status groups and therefore are principally a collective, rather than individual phenomenon, second, lifestyles represent patterns of consumption, not production, and third, lifestyles are

formed by the dialectical interplay between life choices and life chances, with choice playing the greater role, (Cockerham, Rütten, Abel, 1997: 325).

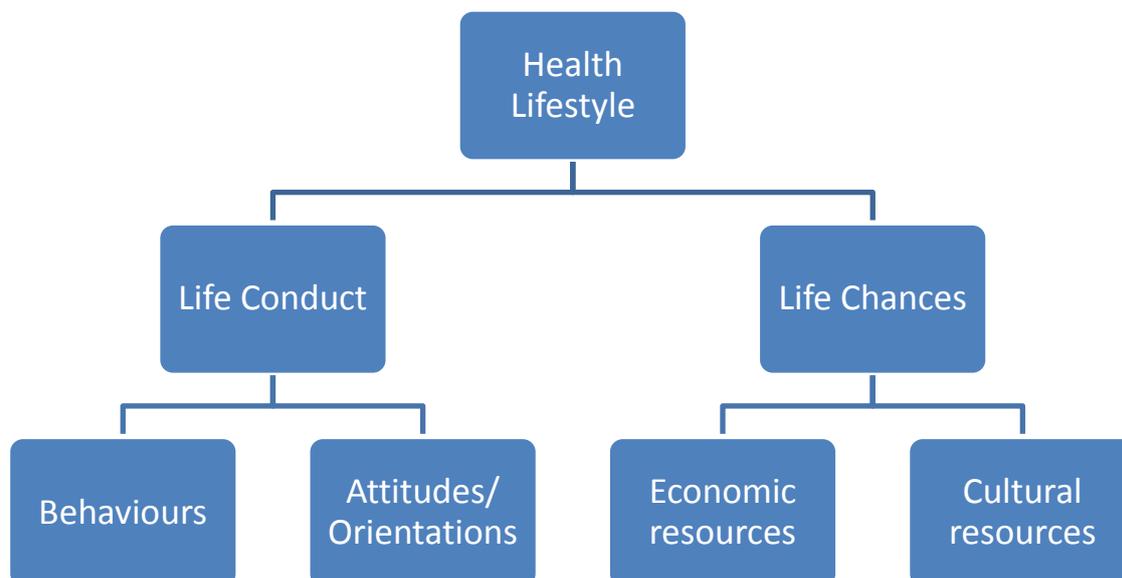
In order to gain a better understanding of how life choices are related to life chances it is necessary to turn to more recent sociological theories, in particular to Pierre Bourdieu's conception of *habitus*. Bourdieu defines *habitus* as "systems of durable, transposable dispositions, structured structures predisposed to operate as structuring structures, that is, as principles which generate and organize practices and representations," (Bourdieu, 1990: 53). Lifestyles have a tendency to become habitual. Knowledge of social structures and conditions produces enduring orientations toward action (daily routines), and when these orientations are realised in practice they tend to reproduce the same structures from which they are derived. This is a significant addition to Weber's conception, which explains why despite the individual differences in taste, dominant lifestyles are nevertheless reproduced by the members of social groups. Abel and colleagues conclude that Bourdieu's major contribution to the understanding of lifestyles is twofold: first, Bourdieu has demonstrated the role of *habitus* in creating and reproducing lifestyles, and, second, he has demonstrated this role by going beyond Weber to show how life chances (structure) determine lifestyle choices. Thus, "In Bourdieu's work, the gap between life chances and life choices in Weber's original analysis is significantly reduced through his concept of *habitus*, which incorporates both into a single entity," (Abel, et al., 2000: 62).

Giddens's views on the structural duality are in some aspects similar to those expressed by Bourdieu, but he is trying to avoid determinism of the latter: "A lifestyle can be defined as a more or less integrated set of practices which an individual embraces, not only because such practices fulfil utilitarian needs, but because they give material form to a particular narrative of self-identity," (Giddens, 1991: 81). Lifestyle and the individual are co-dependent – lifestyle as a structure cannot exist separately from individual's action, because by performing an action individual reproduces the circumstances that make this action possible: "The constitution of agents and structures are not two independently given sets of phenomena, a dualism, but represent a duality. According to the notion of the duality of structure, the structural properties of social systems are both medium and outcome of the practices they recursively organize." (Giddens, 1984: 25)

Actions chosen by individuals can have either positive or negative impact on physical and mental health, but they nonetheless form an overall pattern of health practices that constitute lifestyle (Cockerham, 1997: 124). Thus Abel, Cockerham and colleagues propose a following definition of health lifestyle: "Health lifestyles comprise interacting patterns of

health related behaviours, orientations and resources adapted by groups of individuals in response to their social, cultural and economic environment,” (Abel, 1991: 901). See Figure 1.

Figure 1. Structure of the concept of health lifestyle

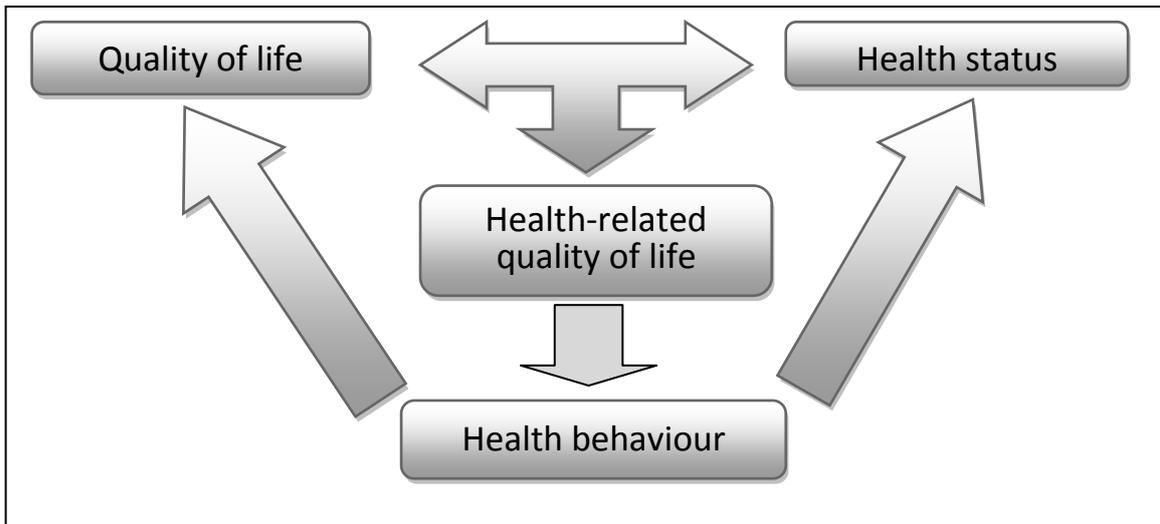


Source: Abel, Cockerham, Niemann, 2000: 63

This definition of health lifestyles has following qualities: first, it does not limit its scope to the behavioural aspects of lifestyle, but also includes individual and structural factors, second, this definition encompasses both lay and professional perspective on what behaviours, orientations and resources bear relevance to health, and, third, the definition allows that particular health practices can be either purposefully chosen by individuals explicitly for their effects on health (in which case their lifestyle can be characterized as *health oriented*) or they can be rather habitual. (Abel, et al., 2000: 63)

Main concepts employed in present doctoral paper are quality of life, health related quality of life, and health lifestyle. The relation between quality of life and health is a complex one. If this relation is addressed in context of quality of life as a multidimensional concept, then health appears to be one of its many domains. Individual health status can be seen as resulting from mutual interrelation of these domains. If, however, this relation is addressed in context of individual health status, then it is defined by the concept of health-related quality of life. The level of health-related quality of life, in turn, defines the scope of health-related everyday practices available to the individual and, consequently, determines individual's health behaviour. Relation between these concepts is illustrated in Figure 2.

Figure 2. Dynamic relation between quality of life, health status and health-related quality of life



Dynamic relation between these concepts is reciprocal, that is, health behaviour (physical exercise, eating habits, alcohol consumption habits and tobacco use, along with other behaviours that constitute health lifestyles) is influenced both by health status and quality of life.

5. Methods used for gathering and analysis of data

To achieve the defined goals of the research the combination of qualitative and quantitative methods was used in order to gain from the advantages and balance out the flaws of both methods. Conceptual differences between qualitative and quantitative methods should be understood not as an obstacle that forces researcher to choose one over the other, but as an opportunity to use both in order to gain a more complete understanding of the research subject. As it is stressed by Uwe Flick, “all research methods have the same source in everyday techniques; qualitative methods are the first and quantitative methods are the second level of abstraction from these everyday techniques,” (Flick, 2002: 67).

Thus, qualitative methods were used to gather data about the most important characteristics of research subject. Analysis of this kind of data includes deriving a set of categories, that, in turn, allows formulating hypotheses for quantitative research and creating a more precise survey instrument. This methodological approach is approved by Glaser and Strauss: “*In many instances, both forms of data are necessary* – not quantitative used to test qualitative, but both used as supplements, as mutual verification and, most important for us, as different forms of data on the same subject,” (Glaser and Strauss, 1967: 18).

In the light of these considerations, there were three types of interviews used in order to gather qualitative data: (1) structured interviews of Latvian inhabitants (quality of life forms); (2) semi-structured expert interviews of medical and medicine-related professionals,

(3) deep semi-structured interviews of Latvian inhabitants at the age of retirement. Quantitative data, in turn, was gathered via two types of survey: data about Latvian inhabitants at the age of retirement (65-94) was gathered by telephone survey, while data about Latvian inhabitants at the economically active age (15-64) was gathered by face-to-face survey.

Research conducted for the purposes of reaching the goals of the present doctoral theses consist of three stages and several methods of data gathering were used to increase the validity of results (see Table 1.):

Table 1. Characterisation of the Stages of Research

Stage	Project title	Methods	Author's contribution
Stage 1 (2005)	"Quality of Life in Latvia"	Survey of "Human Development Report 2004/2005" (n=1020)	Data analysis
		Quality of life forms (structured interviews) (n=79)	Data analysis
		Semi-structured expert interviews (n=6)	Data gathering and analysis
Stage 2 (2007-2008)	"Factors Influencing the Quality of Life and Life Styles of the Old People in Latvia"	Semi-structured deep interviews (n=28) Quantitative telephone survey (n=400)	Data gathering and analysis Survey instrument design and data analysis
Stage 3 (2008)	"Self assessment of quality of life and its relation to health behaviour of Latvian population"	Quantitative survey (n=999)	Survey instrument design and data analysis

Stage 1 was conducted in 2005 within the framework of a larger project "Quality of Life in Latvia", where the data was gathered by using quality of life forms. Quality of life forms are a type of structured interview, which was developed and employed by researchers of Advanced Social and Political Research Institute. Form consists of 64 open questions that encompass such domains as everyday life, employment, income, expense, housing, social participation and social bonds, family, health, mobility as well as subjective interpretation of good life and general level of life satisfaction. (Bela, Tisenkopfs, 2006: 9). The number of interviews was n=79, the age of respondents was 16-75 and they were selected randomly. Gender wise 21 were male and 58 were female. Distribution according to the place of residence was following: 35 resided in Riga, 26 in other cities, 14 in rural areas, and three respondents were residing abroad at the time of interview.

Answers to the questions were taken down in the form of ethnographic notes. Advantage of this method is that it allows getting more certain answers and information is better structured and therefore better to analyze. Content analysis of quality of life forms revealed how such notions as "health", "quality of life" and "care for health" are conceptualized by Latvian inhabitants, and what are the criteria they use in order to

characterize their care for health. Analysis of these criteria allowed making a rough distinction among several health lifestyles, such as care for health, partial care for health and careless attitude towards health.

For the purposes of health section of the research of “Quality of life in Latvia”, semi-structured expert interviews (n=6) were taken in addition to structured interviews of lay people. The strategy of theoretical sampling included interviewing general practitioners, mental health specialists and experts in medical ethics. Accordingly, four of the experts were GP’s, one expert was psychologist and yet another one – an expert in biomedical ethics. List of questions consisted of twelve questions, encompassing such topics as the meaning of the notion “care for health”, the practices of taking care of one’s physical and mental health, and to what extent care is influenced by the knowledge and competence regarding these matters. Analysis of the gathered data allowed finding out expert’s opinion on the problematic issues related to health practices of Latvian population, as well as what categories are used by experts to define key factors of “care for health”, and to construct an expert definition of this concept.

Results of the qualitative data were interpreted in light of the quantitative data gathered for “Human Development Report 2004/2005” about Latvia. Methodology section of the research informs that “A stratified random sample, calculated on the basis of the Population Register data of the Office of Citizenship and Migration Affairs of the Republic of Latvia about the population of Latvia, was used in the survey. In total, 1020 permanent residents of Latvia, aged 18-74, were surveyed. The composition of the respondents reflects the composition of the adult population of Latvia by gender, age, nationality and place of residence. (...) The survey was conducted by using the direct (personal) interview method at the place of residence of each respondent.” (Human Development Report 2004/2005, 2006: 124) Data of this survey was offered by the authors of Human Development Report to aid in writing publications of the results Quality of Life in Latvia research. The offer was gladly accepted thus making these data one of the empirical sources of present doctoral theses.

Stage 2 of the research was carried out as a part of research project “Factors Influencing the Quality of Life and Life Styles of the Old People in Latvia”, which focused on the population of Latvia at the age of retirement. It was conducted in autumn of 2007 within the grant program “Scientific development in Higher Education institutions” financed by Ministry of Education and Science (Nr. RSU-ZP 07-6/15). Qualitative part of this research consisted of semi-structured deep interviews, which provided information about how members of this age group understand such concepts as “quality of life” and “care for health”, and what, in their opinion, is relation between them.

Theoretical sampling strategy used to select respondents for this part of research, was based on the principle of maximal variation. The aim of this strategy is to uncover as many variations in the field of research, as it is possible. Statistical method was used in order to define the main criteria for selection respondents for interviews (Flick, 2002: 62). Three main criteria were gender, age and place of residence.

Task of the deep, semi-structured interviews (n=28) was to provide a more thorough insight into factors influencing quality of life of people at the age of retirement, so they contained open questions about the factors enhancing and diminishing the quality of life, health status and everyday health practices (in case of chronic illness questions were asked about the experience of chronic illness), questions about old age, its advantages and disadvantages, questions about social relations, and questions about subjective life satisfaction and happiness. Research group consisted of three interviewers (Vents Sīlis, Signe Mežinska un Ainārs Kamoliņš), and at the beginning of the data gathering process, several interviews were taken by two researchers at the same time, in order to improve the strategy and skills. Length of the interviews varied from one to two hours. Most of the interviews (23) were taken at respondent's place of residence; some were taken at public places, such as cafes (2) and some – at the place of employment (3). Usually respondents chose to speak in an isolated room, but in some cases they preferred to disclose themselves in an open environment, at the presence of their family members. This, however, did not influence the interview process in any significant way.

Form of semi-structured interviews allows to record free-style responses to the questions, which makes this method of collecting data closer to the normal conversation, than it is with the survey questionnaire. The advantage of this data collection method is that “interviewer can and must decide during the interview when and in which sequence to ask which questions.” (Flick, 2002: 92) To gain a better understanding of subjective attitudes, beliefs and behaviour of the interviewee, researcher can ask *ad hoc* questions that were not initially included in the list, which allows collecting more data about a particular category.

In the process of participant selection the main difficulty was to find older participants, especially males at the age of 80 years and more. However, these difficulties are related to the fact that the number of such individuals within general population is relatively small. According to the data of CSB, in 2007 among the citizens older than 65 males aged 80 and more constituted only 4%, while females of the same age constituted 15%.

Results of qualitative research were used to design an instrument for the second part of the research on Latvian elderly – to develop the *ad hoc* survey questionnaire for quantitative research. In 2008 a survey was conducted in order to gather data about quality of life and

health behaviour of Latvian population at the age of retirement. The chosen method was a telephone survey, which was carried out by researchers of Institute of Sociological Research (ISR) according to contract with Riga Stradins University.

To ensure the validity of survey instrument, a commonly accepted practice was employed in the measurement of the concepts. For measuring quality of life, health status and related variables the scales are used, where the “domain scores are scaled in a positive direction (i.e. higher scores denote higher quality of life), (WHOQOL-BREF, 1996: 10). Scales are used also used in cases where it is necessary to find out not only distribution, but also quantity-frequency of the measured phenomena, (see Koroļeva et al. 2008; Pudule et al. 2010). These scales are used in surveys to Doctoral Thesis to measure concepts linked to health behaviour. Concepts include alcohol and tobacco consumption patterns, medical check-up frequency and other day-to-day health practices.

Sample size was $n=400$ and it was constituted by permanent residents of Latvia aged 65–94. Representativeness of results was ensured by estimating sample size and data weighing. If general population is $N = 389\,900$ and maximal adapted sample error is 5%, then sample size $n = 400$ is representative,¹ (CSP, 2007). Participants were selected randomly according to criteria of 65 or more, gender and place of residence. Taking in account differences between general population and sample, a weighing method developed by Daniel Horovitz and Donovan Thompson was used (see Horovitz, Thompson, 1952).

Aim of this part of the research was to collect data about the distribution of particular health behaviours and about their relation to significant indicators of quality of life. Data was analysed with statistical analysis software *SPSS 16.0*. To distinguish health lifestyles a method of *k-means cluster analysis* was used. Algorithm requires specifying the number of clusters and group separation is based on the principle of maximum difference between the groups. Membership in one of the health lifestyle groups depends on the individual choice of particular health practices. Estimations included noxious habits (risky alcohol consumption², smoking and use of other addictive substances), health preserving behaviour which individuals chose either to prevent illness or to battle its symptoms (visits to health specialists, use of medication), food choices (depending on its impact on health, taste, price and nutrition value), and leisure time activities and amount of physical exercise. Qualitative

¹ To estimate the minimum sample size, a following formula was used: $n = \frac{1.96^2 W(1-W)N}{\Delta^2 N + 1.96^2 W(1-W)}$, where n

= required sample size, Δ = sample error (5% jeb 0,05), N = general population (389, 900), $W = 0,5$.

² Risky use of alcohol means to drink more often than 3 days per week, and to consume more than 5 doses per one time (day). One dose is estimated to be 10g of absolute alcohol or 30g of strong liquor, 150 ml of wine or 330 ml of moderately strong beer, according to educational material “Count your doses!” published by Public Health Agency of Latvia in 2007.

data about health behaviours among Latvian population allowed distinguishing five different health lifestyles: health promoting (care for health), health preserving, partial care for health, minimal care for health and noxious lifestyle (careless attitude towards health). Then the statistically significant correlations ($p < 0.05$) were estimated between the health lifestyles and factors influencing the quality of life.

Stage 3 of the research was carried out almost simultaneously with the survey of the elderly population. It was carried out as a part of the research “Self assessment of quality of life and its relation to health behaviour of Latvian population”, within the grant program “Scientific development in Higher Education institutions” financed by Ministry of Education and Science (Nr. RSU-ZP 07-6/15). Survey method was a face-to-face structured interview. According to contract with RSU, data collection and primary processing was performed by ISR researchers.

Survey instrument was *ad hoc* questionnaire developed in the light of the findings of qualitative research. People at the economically active age were asked the same questions about the quality of life and health behaviour that were asked to the elderly people. This instrument was added as a separate section to the questionnaire of the survey “Prevalence of Addictive Substance Use among the Population of Latvia”, that was carried out by ISR at that time. Research population was Latvian inhabitants at the age of 15–64 and participants were selected randomly and sample size was $n=999$. Representativeness of the sample was achieved by using the previously described formula for weighing cases (however, this time the size of general population was $N = 1\,572\,881$).

As with the elderly population, the same five health lifestyles were distinguished depending on the individual choice of health practices, and statistically significant ($p < 0.05$) correlations between quality of life factors and health lifestyles were sought out.

Research Ethics Issues

In the process of conducting research a critical reflection about the issues of research ethics, in particular, the risk assessment in human research, appeared to be necessary. Among the semi-structured deep interviews there was one interview, which showed how unprotected can be Latvian person at the age of retirement whose health status is bad and who has no relatives left to support her. While giving her answers to interview questions, at the very first minutes of the interview elderly lady mentioned the possibility of committing suicide and she did periodically burst into tears during the conversation. Thus, this interview resulted in

serious considerations about research ethics, particularly, the risk assessment in qualitative research.

Four ethical principles must be observed in when performing a qualitative research: non-maleficence, openness, honesty and careful conduct, (see Shank, 2005: 118 – 119). All of these principles were observed also in the case of aforementioned interview, and in addition to that a strategy of turning the participant towards more optimistic thoughts was employed when stirring the course of conversation in order to avoid the possibility of causing psychological harm. This strategy proved to be successful and emotional equilibrium was restored, however, it showed the relevance of ethical scientific conduct.

In the process of conducting qualitative research, ethical issues become especially relevant because it consists of “revelations about the construction of inner worlds of participants, which means encountering a very personal material,” (Kropļijs, Raščevska, 2004: 78). This research method, therefore, has a high potential of causing psychological harm to the participant. Thus it raises a question of whether the risk of participating in qualitative research is serious enough and if it is, whether it requires to be submitted for evaluation to the bodies responsible for ethical assessment of human research before it is commenced.

Lithuanian bioethicists Eugenijus Gefenas and his colleagues indicate, that it would be only logical to expect that legal acts regulating the ethical assessment of human research would be based on the principle of equal stringency of review: “research projects imposing equal or similar amount of risks and inconveniences on research participants should be subjected to equally or similarly stringent review procedures”, (Gefenas et al., 2010: 435). In reality however, in Latvia and in other two Baltic countries, the situation is quite opposite. Legal requirements that are currently in place do not prescribe this: “At the moment, according to law in the Baltic States, non-biomedical human studies do not fall within the scope of REC approval. Ethical review is not required for conducting sociological, anthropological or psychological research outside of healthcare context,” (Dranseika et al. 2010). Same idea is expressed in the description of research ethics system in Latvia: “some types of human research, for example, genetic research is reviewed very thoroughly by two institutions – Genome Research Council, and the Central Medical Ethics Committee, – while some others, such as sociological, public health or anthropological research, are not reviewed at all.” (Silis, 2010: 61) Therefore, the level of protection might differ depending on the type of human study – it is possible that participants of non-biomedical research are subjected to much higher levels of risk than participants of biomedical research.

A problem that is related to the specific nature of qualitative research is that it is very difficult to evaluate of the real risks before the interview is actually being taken. The more researcher finds out about the participant, the more adequately can risks be assessed. Thus, the main instrument of risk assessment in the process of conducting a qualitative interview are the professional qualities of the researcher, his understanding and communication skills. (Speck et al. 2005: 156) If it is revealed in the course of the conversation, that it may cause psychological harm, then the researcher has to use every skill to prevent it, because ethical requirements pervade all of qualitative research and are above its scientific goals. This was also true in the case described previously.

On the other hand, specific nature of qualitative research not only poses potential harm, but also benefits. This was confirmed by practical experience acquired in the process of research, because most of the participants reached a very good at the end of the interview. This fact illustrates how through the process of self-analysis and self-reflection participants can arrive to positive conclusions about their lives. So, one can agree to the opinion of Peter Speck and his colleagues that “disclosing one’s beliefs or moral narrative to self, or to an understanding other, encourages the development of meaning and understanding and is often therapeutic in itself,” (Speck et al., 2005: 157).

6. Summary of findings

6.1. Health expert’s and lay conceptions of care for health

Considerable part of Latvian population has assumed a following stance towards their health: a person can afford to think and to care for health only when he or she is not busy dealing with more important things. Because of such attitude Latvian people sometimes ignore their health even in situations where serious problems appear and there is an urgent need to pay attention to it.

At the first stage of research in the result of analysis of data gathered in quality of life forms it was established that depending on their answer to the interview question „Do you care for your health in your everyday life?” respondents can be separated into three large groups: (1) those who think that they care for their health, (2) those, who believe, that they care for their health at least partially, and (3) those, who admit, that they do not care for their health.

Those, who think they care for health, define this concept by describing their daily health practices. These descriptions show major differences in the number of categories among women and men. Men describe their health behaviour with practices like physical

activity, healthy nutrition, and lack of unhealthy habits, preventive health check-ups, use of vitamins, sufficient sleep and use of medicine. Women are more elaborate in their health behaviour description. Along with practices indicated by men, they also point to active lifestyle, sufficient sleep, regular visits to physicians, spending time outdoors, use of vulnerary remedies, hygiene, sauna, and other ways of avoiding illnesses and stress. Women's perception of care for health goes beyond mere physical activity. It is rather understood as a use of artificial and natural vitamins and healthy nutrition, i.e. health maintenance, not just health promotion. Men associate care for health mainly with physical activity and healthy nutrition. Moreover, female respondents claim that use of medicines is a part of care for health, and only few male respondents even mention medicines. Men are also more sceptical about vitamins, whereby women mostly perceive vitamins as crucial part of their care for health.

Those respondents admitting only partial care for health usually mention one or more of above care-for-health practices and recognise the undue frequency/intensity of those practices. The factors precluding better care for health according to them include lack of time and financial resources, bad habits that are difficult to quit. Some responses show different understanding of 'partial care for health'. For instance, one of respondents claims "there is no time [to take care of health], but I'm not letting health deteriorate, either". Another female respondent admits minimum care for health that includes regular dental check-ups and preventive health check-ups once a year. However, she has no physical activity and rather sedentary lifestyle. Such responses lead to an assumption of certain kind of lifestyle that can be labelled 'minimal care for health' where individual cares about health a little, without creating major harm to one's own health.

The third group of respondents is comprised of individuals that admit to exercise no specific care for health. These respondents recognise they are not making any direct efforts to improve or maintain health condition. However, their responses are not indicative of negligent attitude towards health. It is rather an indication of health behaviour that is not explicitly oriented towards care for own health. Scholars researching health lifestyles underline that health lifestyle encompasses all health-affecting behaviour, both deliberate and non-deliberate. Individuals ignoring the impact of their behaviour on own health are deemed to have chosen health lifestyle based on habitus. On the other hand, individuals deliberately choosing lifestyle with positive effect on health are attributed to health-oriented lifestyle populace (Abel et al., 2000: 63).

Lack of care for health may be an indication that respondent's health condition is good, so he/she does not have to specifically think or care about own health, i.e. "no, I do not

need [to take care of my health], I am a healthy woman”. On the other hand, as a pension-age female respondent points out, some may not take care of their health because of lack of means and bad health condition: ‘I do not have that kind of money to take care of my health. I have lived long and health is not that good, either.’ According to another pre-retirement age female respondent ‘when health condition is gone, there is nothing you can do, it’s gone. Nevertheless, you go to see a doctor, drink pills and try to get well.’ This leads to an assumption that there are also ‘health-preserving lifestyles’ where bad health condition requires attempts to avoid further deterioration of health.

A following definition of the concept of “care for health” was constructed from the data gathered in expert interviews: “care for health is realised as a holistic lifestyle (system of health behaviours), which is organized according to the place of health among the basic values and inclusion into the concept of quality of life; as well as knowledge about the structure and functions of human organism and awareness of available health care services, which guides individuals actions in case of illness (system of illness behaviours),” (Sīlis, 2006b: 187). Expert description of health behaviour of Latvians identifies three kinds of categories: (1) individual categories – values, health status, education; (2) social and cultural categories – consumer culture, advertisement, gender role, traditions; (3) capability categories (a mixed group consisting of both social and individual factors influencing the behaviour) – motivation, income, amount of free, choice between health care providers, level of competence in health care, as well as quality and availability of health care system. (Sīlis, 2006b: 201) Latvia is also described by the phenomena of social inequality in terms of health status, i.e. people with better education and higher income have better health that they take care of (Monden, 2003: 1).

Respondents-smokers recognise that smoking is incompatible with care for health, yet this contradiction is not motivating enough to quit smoking. Health lifestyle theory explains such attitude towards bad habits with behavioural standards that are adopted by the respective social group. Statistically smoking has become a norm among Latvian male population; almost half of men are smokers (see Pudule et al., 2010). The more of your friends are smoking, the less motivated you are to quit smoking. By quitting you risk excluding yourself from a group where everybody smokes, you can lose contact with them, become an outsider, behind the news discussed over a cigarette (see Koroļeva, 2008: 20). In other words, unhealthy lifestyle is rooted in habitus, based on individual’s past experience of socializing and depends on membership in a specific social stratum, age group and gender. “The result is an enduring orientation toward an unhealthy style of living that becomes routine and, when acted on continuously, reproduces itself over time.” (Cockerham, 1999: 120) Due to its

nature, qualitative data does not fully describe the scale of unhealthy habits in the Latvian population. It can only be determined through collection and analysis of quantitative data. According to Human Development Report 2004/2005 „health indicators reflect the state of the country’s health care system and the co-operation between this system and individuals. The lifestyle of Latvia’s population cannot be deemed healthy. Excess weight and obesity, insufficient physical activity, alcohol and drug use and smoking are all significant factors that influence the health condition of individuals. In the realm of public health, smoking is currently considered among the most dangerous causes of oncological and vascular disease, which can be prevented.” (Human Development Report 2004/2005: 127) This leads to an assumption that Latvian population uses another health behaviour model that could be called ‘health negligence’ or noxious lifestyle.

The analysis of the survey’s first stage results allows concluding that Latvia’s inhabitants have five health lifestyles: health neglect (noxious lifestyle), partial care for health, minimal care for health, health preserving and health promoting lifestyle (see Figure 3.).

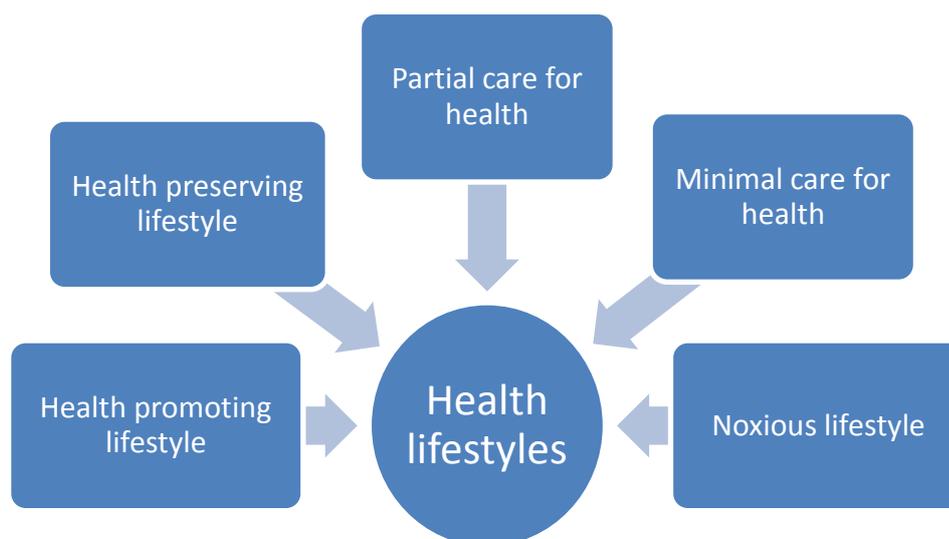


Figure 3. Health lifestyles of Latvian population

6.2. Factors influencing the quality of life of elderly people in Latvia

The second survey stage was designed to identify the link between life quality factors and health behaviour among Latvian population in pension age. The content analysis of the qualitative data collected during interviews shows that life quality of pensioners is translated into balance between wishes and needs, body and soul or harmonious social interactions.

When asked about the key factors influencing the quality of life, respondents named family and relations, relatively good health status and sufficient means as life quality

promoting factors. Among adversely-influencing factors they mentioned lack of sufficient means, bad health and negative effects of ageing like reduced functionality and appearance changes. The above factors are supporting the hypothesis that the life quality of population in this age group is influenced by the following three areas: social relationship with friends and family, health and functioning, as well as material circumstances (income). (Bowling, 2005 a: 7; Börsch-Supan et al. 2005: 18; AGE/inc, 2007)

Life quality is a holistic concept of overlapping notions that create mutual causal relationship: good health may be a precondition for higher income, higher income may be a prerequisite of better health. This puts Latvia's pensioners in a very unpleasant place. They say that the current old-age pension is not enough even to survive, never mind living the 'good life'.

Data of the Central Statistical Bureau (CSB) only supports the view of pensioners. In 2007 the majority of pensioners, 82%, received old-age pension of 138 LVL on average. At the same time, for December 2007 subsistence minimum **per capita** was 143 LVL, i.e. 5 LVL more than the average pension in the country. On the other hand, depending on the amount of pension, 88% of individuals in the retirement age made income of 140 LVL (CSP: 2008) That means almost 9/10 of Latvian population in retirement age were forced to survive on income that barely met their basic needs.

Analysis of link between objective quality of life and subjective well-being shows that in some cases people were pleased with their life, despite bad health and low income. This phenomena is known as the paradox of well-being: „the presence of subjective well-being in the face of objective difficulties which would be expected to predict unhappiness.” (Bowling, 2005a: 11) The paradox of subjective well-being lies in fact that the pensioners' needs and expectations are modest. They have adapted (psychological homeostasis) and created solid social relations where family provides them with financial support and emotional comfort.

Lower financial needs for sustaining quality of life are also linked to the fact that 65-year olds and older people have gone through the WW2 and post-war period. Compared to harsh conditions of those years, the difficulties of today may not seem all that relevant. Moreover, those having stronger religious beliefs specifically pointed out that people should lead a modest life, without excess luxury.

Psychological homeostasis is individual's ability to adapt to reduced quality of life in order to maintain positive self-attitude and life prospects. It engages compensatory mechanisms in cases when individual suffers from grave health complications (heavy sickness or loss of function) or severe financial pressures. General optimism, feeling hopeful about the future and enjoyment of life are not only widely recognized as having beneficial effect on

mental health, but also as offering protection against poor physical health and functioning, including reduction of risk of adverse medical events such as stroke or myocardial infarction, (see Bowling, 2005a: 138). Downward comparison is one of the most popular coping strategies. Well-being and life satisfaction are comparative concepts. When evaluating quality of life people tend to compare themselves against other individuals in the same social group. As living conditions worsen, social comparison with those having even harder life becomes a kind of cushion. Interviews with Latvian pensioners suggest that downward comparison is often applied to assess own health condition.

Respondent's choice of health-preserving practices to a large extent depends on the nature of his/her health problems. According to interviewees use of pharmaceuticals is a mandatory precondition to treat chronic diseases (high or low blood-pressure, heart failure) and maintain physical functioning. At the same time there are alternative approaches like use of vulnerary medicines, i.e. herbal tea. The use of alternative medicines is driven by both economic and health assumptions, stemming from rather ambivalent role of pharmaceuticals and their health effects. Many consider pharmaceuticals efficient, but are weary of adverse side-effects they may have.

Exercising and physical activity is an important part of health regimen among senior population. However, in some cases health condition may limit the type and intensity of a specific physical exercise. Some respondents point out that mental problems aggravated by illness or ageing can be eliminated by performing mental exercise. This statement, however, is directly linked to education degree. Mental exercise was mentioned dominantly by respondents with higher degree of education.

All these exercises are performed because of their positive health effects. Their aim is to possibly delay the overall loss of motor skills, the most frightening of all ageing scenarios considered by many. Respondents unanimously stated that the best motivation to care for health comes from the desire to avoid the state of complete loss of motor skills and having to spend the last years of your life in bed. Respondents specifically underlined their fear for not only facing these difficulties themselves but also becoming a burden to their relatives. Quite many respondents were proud to show that despite restrictions resulting from bad health condition they are participating in home chores, cooking and gardening as much as possible. Therefore, interviews revealed a distinct link between functioning, care for health and self-esteem.

Answers that were given to questions are indicating that one of the main care-for-health drivers is financial well-being. It largely determines the frequency and choice of medical professionals, services and food products for daily consumption.

The analysis of behaviour among elderly population discriminates two groups of respondents: relatively healthy individuals (n = 5) and individuals suffering from chronic illnesses (n = 23). Respondents at the age up to 72 years consider themselves relatively healthy. This is probably due to weaker indication of ageing effects at this specific age. Men mainly prefer health-promoting lifestyle; they try to avoid illness through lots of physical activity (work or exercise) and strengthening of immune system. They are reluctant to use medicines, waiting for the last moment, and instead engage in physical activities and try to eat clean food. When describing health practices such relatively healthy individuals talk about the importance of own capacity. One respondent, 62, with good health status practices a very peculiar lifestyle. His occupation is healer. At the same time he is a Franciscan monk and is obliged to lead ascetic life as much as possible. When describing his care for health he emphasised the holistic nature of health, its physical and mental dimensions, especially the role of praying.

Women, in turn, who admitted no health problems also mentioned they do not care for their health. One female respondent, 64, claimed her health status is good and has, so far, had no impact on quality of life. Another female respondent, 62, confessed to regular use of hypertension medication and herbal tea for insomnia only in later stages of an interview. She also made clear that ageing has been accompanied by gradual loss of physical function. She said it is important not to give up, otherwise physical collapse would come earlier. Respondent was certain that these health problems are nothing special and they have to be accepted. This is why she initially forgot to even mention that these are daily activities she does in scope of care for health.

Nevertheless, majority of respondents claimed to have serious health issues, in many cases pointing essentially toward chronic disorders (for the purpose of research, chronic health problems are issues that exist for at least 12 months). The health behaviour of sample unit is distinctly set around health-preserving practices. Otherwise their health condition would significantly worsen and that would have instant negative effect on quality of life. One of the most common care-for-health practices among elderly people is use of medical drugs. Some elderly people try to avoid excess activity and opt for more frequent rests, others routinely check their physical stats (weight, blood pressure, etc.), and some also try to avoid use of unhealthy food products.

There was one interview that was particularly vivid in describing the fragile state in which elderly population of Latvia is in. The health condition is bad and relatives are gone, there is no support, so, despite physical barriers, one has to work. A lady, 69, from one of the large cities started the interview by mentioning a suicide she is contemplating, she broke into

tears several times during the interview. Thus, this interview resulted in serious considerations about research ethics, particularly, the risk assessment in qualitative research.

Quantitative data collected through phone survey leads to a conclusion that senior population of Latvia chooses health lifestyle based mainly on objective life quality factors, i.e. lack of financial means, biological ageing and comparatively bad health status and specific nature of health problems. Subjective factors, including motivation to take care of health linked to understanding of healthy lifestyle, the ability to shape own health and will to keep up good looks are less inspiring.

Quantitative data confirmed the subjective well-being paradox revealed in analysis of qualitative data: although 87% Latvians who have reached retirement age think their income partially/slightly/insufficiently meets their needs, almost the same percentage, 85%, assessed their quality of life as satisfactory/good/excellent. This means that most of elderly people are to a certain extent adapted to financial pressure, they have minimised their needs or replaced them with family comfort. (Silis, 2010)

There is a clear statistical link between quality of life, health status, health satisfaction and ability to influence it. The higher is the quality of life, the better is health, the higher satisfaction with health and ability to influence it.

Firstly, health behaviour of elderly people is influenced by availability of finances. The level of income is one of the main factors determining the type of care for health. Finances are according to many the most important tool in handling the chronic illness and choosing food products, as well as decision-making with respect to emerging illness. As for unhealthy habits, individuals with higher personal income are more inclined to smoke and use alcohol. This leads to a conclusion that limited financial resources can also have positive impact on the health behaviour, i.e. lack of money can make individuals refrain from noxious habits. (Silis, 2010)

Secondly, biological ageing is objectively linked to deteriorating health, emerging of various chronic illnesses and their symptoms. This means that the quality of life of elderly people is dependant on their health status. So we can assume that almost all elderly are taking care for health to a certain degree. Data suggests that 99% of people in this age group are indeed conscientious about their health. Those who have serious health problems or are less satisfied with their health condition and those having higher self-assessment of quality of life, education degree, employment, higher income, valuing healthy lifestyle higher, better aware of own ability to influence health status and health knowledge are putting more effort in taking care of health.

Another factor having influence over health behaviour is the severity of health problems. Approximately $\frac{1}{4}$ of respondents recognise that they suffer from chronic health problems that last over a year. So, we can say this group of respondents exhibits higher care for health. 91% of sample unit showed profound and fairly appropriate care for health and only 9% cared less. The same applies to individuals with chronic health problems. The ratio is 74% and 24% correspondingly, with 2% that care less for their health. Chronic illness entails significant capacity limitation. If an individual would like to or have to work, it would limit employment possibilities. It would also limit mobility, self care or recreational potential. Thus chronic diseases also lead to various psychological problems, i.e. prolonged or constant dejection, bad mood or even depression. There were no respondents who would claim their chronic illness has no effect on their mood and well-being. There was a surprisingly high number (42%) of chronically-ill respondents who thought their quality of life would improve because of stronger will and determination. This means that, in case of chronic disease, life quality is equally tied to subjective and financial issues.

Analysis of specific health-promoting activities shows that majority of elderly people visit doctor at least once a year, usually it is a general physician more than other specialists. Despite common dejection and bad mood among those with chronic illnesses, their reluctance to visit psycho-therapist or psychologist can be attributed to discomfort and fear of stigmatisation perception such visits imply.

The most popular way of caring for own health is use of medicines. Almost 70% of respondents admitted use of pharmaceuticals in different proportions. Elderly mostly consume painkillers, vitamins and sedatives, and other medicine tackling specific chronic symptoms. More than 30% of pensioners drink herbal tea. More importantly, they do so without doctor's advice, on their own initiative. Less than a third have regular preventive health check-ups, $\frac{1}{7}$ use food supplements and almost each eighth is on diet. Usually respondents follow the advice of doctor on the type of practice. However, advised practices are coupled with other own initiatives. All in all, we can say respondents trust the tradition health care system. Only 10% of them also turn to alternative medicine.

The amount of daily physical activity also has a significant impact on health. Majority of sample unit (45%) move around quite a bit through the day. They spend more than one hour a day walking or cycling. Rural inhabitants walk and bike more than city-dwellers. Generally, intense physical activity required to complete everyday tasks is levelled out by rather inactive pass-time. $\frac{4}{5}$ of retired spend their free time sitting, each seventh retired engages in light physical activity, 10% are exercising and training or gardening.

6.3. Health lifestyles in relation to factors influencing the quality of life

According to the theory, “health lifestyles can be characterized as either generally positive or negative”, (Cockerham, 2005: 56). That, however, does not mean that they are homogenous, that is, consisting of only beneficial or only harmful practices. Health behaviours resulting from individual choices “can have either positive or negative consequences on body and mind but nonetheless form an overall pattern of health practices that constitute a lifestyle,” (Cockerham, 1997: 124). Research data confirms this assumption: none of the five health lifestyles distinguished among the Latvian population consisted exclusively of either healthy or unhealthy practices.

6.3.1. Health lifestyles of Latvian population at the age of retirement (65–94)

Retirement-age people in Latvia exhibit the following health lifestyles (in %): more than a third (or 36%) of respondents prefer health-preserving lifestyle, less than a third (or 31%) opt for minimal care for health, partial care for health is common to 12%, 15% neglect their health (by engaging in bad habits) and 6% of all support health-promoting lifestyle. The following table reflects only statistically significant differences ($p < 0.05$). Variables are dichotomised prior to aggregation. The mean values (cluster centre coordinates) in the table translate into reply-frequency in percentage (see Table 2).

Table 2. Distribution of health practices among Latvian population at the age of retirement (cluster centres)

	Noxious lifestyle	Partial care for health	Minimal care for health	Health promoting lifestyle	Health preserving lifestyle
Risky alcohol consumption – from 3-4 times per week up to every day	,28	,21	,03	,11	,02
Risky alcohol consumption – more than 5 doses per time (day)	,04	,00	,02	,00	,00
Smoking – both regular and irregular	1,00	,04	,03	,14	,01
Smoking – regular	,98	,04	,02	,09	,01
Seeking medical help within last 12 months	,82	1,00	,63	,95	1,00
Seeking medical help within last 12 months – 2 and more times	,57	,92	,30	,59	,99
– 4 and more times	,06	,04	,11	,00	,63
Use of medical drugs within last 7 days	,70	1,00	,39	,31	1,00
– against high or low blood pressure	,49	,80	,04	,00	,37
– against high cholesterol level	,00	,12	,04	,04	,37
– against high blood sugar level	,04	,07	,01	,00	,13
– against headache	,23	,52	,12	,03	,31
– against pain	,47	,49	,16	,03	,69
– against cold	,10	,14	,06	,10	,07
– tranquilisers	,05	,34	,22	,00	,79
– vitamins and minerals	,08	,38	,06	,24	,92

Actions taken for the sake of health – preventive check-ups	,08	,05	,17	,57	,73
– herbal teas	,06	,31	,09	,69	,92
– dieting	,00	,01	,01	,47	,29
– use of food supplements	,06	,02	,13	,56	,20
– hardening	,00	,00	,01	,10	,00
– aromatherapy	,00	,00	,01	,39	,03
– remedial gymnastics	,00	,00	,01	,34	,02
Choice of food with considerations of its impact on health – from “sometimes” to “always”	,47	,88	,43	1,00	,87
Choice of food is mostly affected by – taste	,99	1,00	,81	1,00	,98
– ecological purity	,85	,97	,60	1,00	,94
– nutrition value	,84	,97	,58	1,00	,96
Characteristic leisure time activities – reading, watching TV, other sedentary activities	,88	,58	,91	,16	,99
– walking, bike riding, other light physical activities	,07	,37	,00	,78	,01
– slow jogging or heavy gardening works	,05	,05	,09	,06	,00
– heavy training and competitions	,00	,00	,00	,00	,00
Free time physical exercise – from one time per week to every day	,05	,35	,00	,78	,02

1) *Health neglect (noxious lifestyle)*. The key feature of this lifestyle is strong presence of bad habits. However, respondents drink responsibly – frequently but in small (safe) quantities. The major health threat comes rather from chronic smoking, a very characteristic feature among people of this lifestyle. However, the daily count of cigarettes is relatively low, most respondents smoke less than 10 units a day. Almost all respondents with this type of lifestyle have sought medical help over the last year and have used some medication over the last weeks. They are not engaged in almost any kind of daily health-oriented activity, thinking less about the impact of food on health and choosing food products based on price and taste. In their free time, 88% of them prefer to sedentary activities, each twentieth admitted intense exercising at least once a week that usually lasts about 30-minutes, until breathless or sweating.

2) *Partial care for health*. Among respondents with this lifestyle every fifth person is using alcohol more than three days a week, however, none were drinking more than five doses per day and only few smoke. All respondents in this group have sought medical help over the last 12 months and majority have done so repeatedly. All admitted using medical drugs over the past couple of weeks and used a wide variety of pharmaceuticals. Partial care for health also implies lifestyle with some (few) daily health-oriented activities. Their choice of food products is based on its health effects, emphasizing ecological qualities and nutritional value. More than a half of these respondents spend their free time in sedentary activities, while more than a third prefers walking, biking, and other light physical activities.

3) *Minimal care for health*. Among the representatives of this group there are very few of those who practice noxious habits. As the name of the group suggests, its members exhibit

minimum care for health – only 63% have visited medical specialist during the year, and only 39% take medication. This lifestyle assumes only a few health-oriented activities that are performed by a small number of respondents. Supporters of this lifestyle care less about the impact of food on health and choose food based on price and taste. They spend their leisure time sitting, walking and biking is not practiced by anybody. On the other hand, 9% are involved in heavy gardening works and this type of outdoor activity is more common than in other health lifestyles.

4) *Health promoting lifestyle*. Respondents with this type of lifestyle have the third largest number of persons that consume alcohol more than three times a week, but there are none drinking more than 5 drinks at a time. Despite the name of the lifestyle, 14% of the respondents are a smoker, which proves the thesis that health lifestyles may also include contradicting practices. Almost all respondents go to see the doctor at least once a year but use much less pharmaceuticals (31%) than average (72%). Respondents with this lifestyle ticked all daily health-oriented activities in the questionnaire. Impact of food products on health is considered by all respondents of this group, they admit looking into aspects like price, taste, ecological purity and nutrition value. 78 % of all respondents spend their free time exercising and training, none of them indicated sedentary activities.

5) *Health preserving lifestyle*. This lifestyle is characteristic to individuals suffering from chronic health problems. Only 2% drink alcohol more than 3 days per week and 1% smoke on regular basis. Individuals with this lifestyle seek medical help and have more follow-up visits. All of them use pharmaceuticals, mostly sedatives, vitamins or mineral substances and painkillers. Many engage in some of daily health-oriented activities: 92% drink herbal teas, 72% have preventive check-ups, but other types of activity are ignored. Majority of people with this lifestyle do consider impact of food products on health. These people are rather inactive. Absolutely all spent their free time in sedentary activities and only 2% exercise at least 30 minutes once a week.

There is a statistically significant relation (Sig. = 0.000) between health lifestyle and factors like age, gender, health status, income, employment, education, place of residence and self-assessment of life quality.

Of those pensioners practicing noxious lifestyle, more than third (38%) of respondents evaluated their quality of life as good or excellent, 59% claimed it to be satisfactory, while 3% considered it bad and very bad. Satisfactory quality of life is characteristic to people under age of 84, mainly men, with average health. Their income is mainly above minimum and more than 1/3 are employed. These respondents have secondary or vocational education and mainly live either in the countryside or other small Latvian cities.

Of those partially taking care of their health 30% evaluated their quality of life as good or excellent, and 53% claimed it is satisfactory, while 17% called it bad. This lifestyle is practiced by individuals under the age of 84, mainly men with average health assessment. Two thirds of them have income below minimum and are employed. Majority have either secondary or vocational education. They live either in Riga and other bigger cities, or in small Latvian cities and countryside.

Data about adherents of minimal care for health revealed that 72% of them find their quality of life to be satisfactory. Almost all (99%) of them are under 84 and more than 2/3 are women. Majority evaluated their health status as satisfactory and one quarter as bad. For 90% of them personal income is below minimum despite the fact that each eighth is employed. Majority of this group has secondary or vocational education, and each third has only primary education diploma. Representatives of this group live mainly in countryside or in Riga and other big cities.

Unsurprisingly most of respondents (80%) that claim their quality of life is good or excellent are actively pursuing health-promoting lifestyle. Those are predominantly younger pensioners, up to 74, and two thirds of them are women. These respondents have better health self-assessment, higher personal income, better education, they are employed and live in Riga and other large cities.

The biggest number of individuals valuing quality of life as bad or very bad (20%) is among those practicing health-preserving lifestyle. 64% of this group claimed their life quality is satisfactory and only 16% think it is either good or excellent. Majority, 58% of this group are under 84 and 90% of them are women. More than half of this group said their health is bad, income is below minimum and the main source of income is pension, while 85% of the group have secondary, vocational or primary education. Pensioners of this group are distributed in almost equal proportions between Riga and other bigger cities, small Latvian cities and countryside.

The summary of telephone survey among Latvian pensioners is in line with key hypotheses of health lifestyle theory. Despite different conditions and contradicting practices, majority of inhabitants in this age group take care of their health more or less, depending on their life options, i.e. structural factors that determine their objective life quality.

6.3.2. Health lifestyles of Latvian population at the age of 15–64

This population group exhibited the following lifestyles: 25% pursue noxious lifestyle and 21% show minimal care for health. In contrast, 19% are practising health-promoting

lifestyle and the same percentage opts for health-preserving lifestyle. Little less, namely 16%, of sample unit exhibit partial care for health.

The following table reflects only statistically significant differences ($p < 0.05$). Variables are dichotomised prior to aggregation. The mean values (cluster centre coordinates) in the table translate into reply-frequency in percentage (see Table 3).

Table 3. Distribution of health practices among Latvian population aged 15-64 (cluster centres)

<i>Types of health behaviour</i>	<i>Noxious lifestyle</i>	<i>Partial care for health</i>	<i>Minimal care for health</i>	<i>Health promoting lifestyle</i>	<i>Health preserving lifestyle</i>
Risky alcohol consumption – from 3-4 times per week up to every day	,13	,06	,02	,02	,04
Risky alcohol consumption – more than 5 doses per time (day)	,45	,29	,24	,16	,12
Smoking – both regular and irregular	1,00	1,00	,04	,14	,06
Smoking – regular	,91	,89	,00	,05	,00
Smoking – more than 10 units (per day)	,98	,95	,00	,08	,03
Drug use – from few times to regular use	,16	,10	,04	,04	,02
Seeking medical help within last 12 months	,21	,89	,50	,46	,96
Seeking medical help within last 12 months – 2 and more times	,11	,79	,36	,30	,81
Use of medical drugs within last 7 days	,06	,73	,20	,31	1,00
– against high or low blood pressure	,00	,12	,03	,02	,41
– against high cholesterol level	,00	,02	,00	,01	,07
– against high blood sugar level	,00	,02	,00	,00	,10
– against headache	,02	,39	,03	,11	,68
– against pain	,00	,42	,03	,05	,52
– against cold	,03	,44	,06	,11	,43
– tranquilisers	,00	,09	,02	,00	,26
– vitamins and minerals	,02	,20	,02	,09	,52
– contraceptives	,00	,06	,00	,02	,10
Actions taken for the sake of health	,14	,50	,33	,41	,73
– preventive check-ups					
– herbal teas	,26	,84	,51	,64	,84
– dieting	,02	,18	,06	,20	,24
– use of food supplements	,03	,17	,13	,28	,33
– hardening	,13	,16	,12	,34	,13
– aromatherapy	,03	,11	,04	,22	,10
– remedial gymnastics	,03	,06	,07	,23	,17
– vaccination	,23	,35	,34	,36	,53
Choice of food with considerations of its impact on health – from “sometimes” to “always”	,46	,64	,65	,81	,75
Choice of food is mostly affected by	,88	,97	,96	,99	,98
– taste					
– ecological purity	,65	,76	,79	,90	,84
– nutrition value	,52	,62	,57	,84	,72
Characteristic leisure time activities	,74	,67	,96	,00	,85
– reading, watching TV, other sedentary activities					
– walking, bike riding, other light physical activities	,15	,24	,00	,80	,10
– slow jogging or heavy gardening works	,07	,06	,01	,14	,04
– heavy training and competitions	,04	,00	,02	,06	,00
Free time physical exercise – from one time per week to every day	,26	,50	,29	,67	,29

1) *Noxious lifestyle*. This lifestyle has stronger inclination toward bad habits (risky alcohol consumption, chronic smoking and drug use), therefore, the lifestyle may also be called health-harming lifestyle. Respondents of this kind are performing health-oriented activities less frequently and their daily routines assume less care for health. When choosing food products, less than half considers their health qualities and majority recognise that choices are made based on taste and price. The typical way of spending free time is sedentary activities: watching TV or reading. Each sixth respondent mentions walks, biking or other light physical activity. Each fourth person in this group does exercise (for at least 30 minutes, until breathless or sweating) once a week to every day.

2) *Partial care for health*. This controversial health lifestyle has stronger inclination toward bad habits that co-exist along with relatively active care for health and health-promoting activities. Majority of respondents with this lifestyle, 89%, have been to doctor over the past year, and 2/3 have used one or another medication over the past week. The health-oriented activities this lifestyle includes: drinking herbal teas, preventive check-ups, vaccination, dieting and/or using food supplements. When choosing food products, majority, 64%, consider their health impact. Two thirds spend the free time in sedentary activities, while each fourth prefers walking, biking or other light physical activity. Half of respondents (50%) indicated that they exercise for at least 30 minutes at least once or several times a week.

3) *Minimal care for health*. Respondents with this lifestyle are rather passive about their health; the absence of noxious habits is combined with reluctant attitude towards health care and health-promoting activities. Over the past year 50 % of people with this lifestyle have visited doctors and medication has been used in a past week by a one third of them. Two thirds, 65%, admit that their food choice is based on its influence on health, and the majority make this choice by taste and price. According to majority of respondents, the typical way of spending the leisure time is sedentary. Yet 29% of respondents do engage in physical exercise for at least 30-minute from one time a week up to every day.

4) *Health promoting lifestyle*. This lifestyle is characteristic to individuals who are in good health and engage in regular sports activities; however, noxious habits are also present among adherents of this lifestyle. Their health-oriented activities are rather moderate – they tend to avoid illnesses, not to treat it. Within last 12 months less than a half (46%) have paid a visit to the doctor, and about 1/3 have used pharmaceuticals. Their health-oriented activities include: drinking herbal teas, preventive check-ups, vaccination and hardening. When choosing food products, majority considers its health impact. None of them spends their leisure time in sedentary activities. Instead, 80% prefer to go walking, biking or other light physical activity, while 14% prefer jogging and other kinds of training, as well as heavy

gardening, while 6% indicated heavy physical training. Also, 67 % admitted exercising at least once (or several times) a week for at least 30 minutes until breathless or sweating.

5) *Health preserving lifestyle*. This lifestyle is characteristic of people with significant health issues, which is the main reason they focus the behaviour on preserving the health – they are least inclined towards practicing bad habits, but also least engaged in health-oriented activities. There is a comparatively small share of risky drinkers among this group and there are no regular smokers. Almost all respondents have seen doctor over the past year and 4/5, 81%, were scheduled one or more follow-up visits. All individuals have used medication over the last 7 days; 68% have consumed pharmaceuticals to treat headache, 52% to remedy other pain, 51% have used vitamins and mineral substances, 43% took cold medicine and 41% have had pills for high/low blood pressure. These respondents try to take significant care of their health on daily basis and four in five choose food based on its influence on health. The typical way of spending the free time, according to 2/3 of respondents, is sedentary. At the same time 29% of respondents do at least 30-minute physical exercises from one time a week up to every day.

Further analysis addresses the relationship between quality of life factors like personal income, gender, employment, health status, age, education, place of residence and life quality self-assessment. The first factor is personal income.

The analysis of typical features of respondents in all five lifestyles shows that majority of those careless about their health are men from 15 to 54 years old, employed and having secondary education. They have good health, living in Riga and other big cities most of them evaluate their quality of life as good or excellent, but more than a third, 37%, as satisfactory.

Partial care for health is common to almost equal shares of men and women. Supporters of this lifestyle are predominantly under 34 or in 45-54 age groups. Most of them have secondary education and are employed. Third of this group has satisfactory health status and 2/3 have good health. More than a half of this group live in Riga and other larger cities, most of them consider their quality of life to be excellent and good, while 37% see it as average.

Minimal care for health is slightly more characteristic for women (61%). Most of people within this lifestyle are under 45, employed (69%) or studying. Their health status is good or excellent (80%), they live mostly in Riga and other big cities or in countryside, and consider their quality of life either as good or excellent (66%) with 29% claiming it is neither good, nor bad.

Health promoting lifestyle is more popular among women (61%) under 45, employed (50%) or studying in school or university (30%). They have excellent health, live mainly in

Riga and other big cities and most of them (77%) consider their quality of life as good and excellent.

Health preserving lifestyle is more common in women (79%) after 45, either employed (50%), or on age/disability pension (18%). Most of these women have neither good nor bad health (46%), and 8% have bad health. This lifestyle group has the most number of individuals with higher education (24%) and most of them (56%) have secondary education. A slightly bigger share of respondents in this group (39%) lives in the countryside than in Riga and other big cities (31%). Little less than a half (45%), evaluated their quality of life as good and excellent, more than a third (40%) claimed it is satisfactory and each sixth mentioned bad or very bad health.

Distribution of health lifestyles across age groups

From a lifestyle distribution point of view, there are vivid discrepancies between the both age groups (see Figure 4).

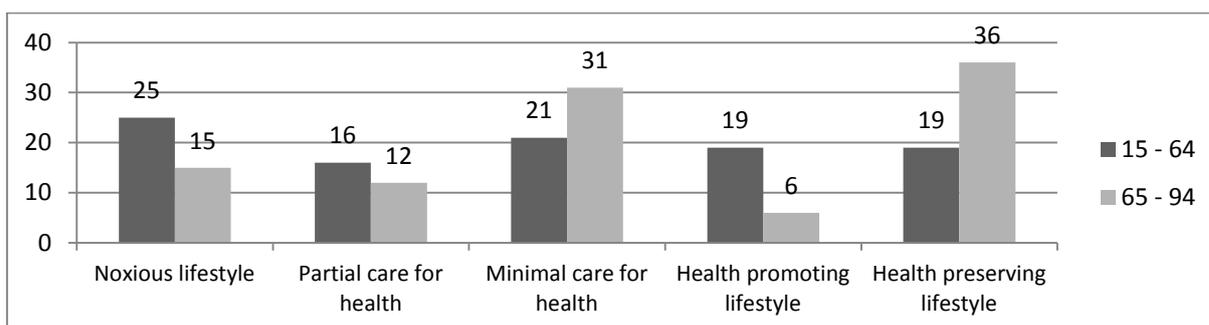


Figure 4. Distribution of health lifestyles across 15-64 and 65-94 age group (%)

Diagram shows that among older population the number of people not taking care of health and having noxious habits is diminishing – their proportion shrinks from 25% to 15%. However, the share of health-promoting lifestyle practising respondents also tends to go down from 19% to 6 percent. There is also a slight decrease (from 16% to 12%) of those who partially care for their health. But the number of respondents exhibiting minimal care for health increases from 21% to 31% as the age goes up. Most significant increase is in adherents of health-preserving lifestyle: from 19% to 36%.

Theoretical assumption that “age affects health lifestyles because people tend to take better care of their health as they grow older by being more careful about the food they eat, resting and relaxing more, and either reducing or abstaining from alcohol use and smoking,” is confirmed by empirical data (Cockerham, 2005: 58). According to the table below, these links are applicable also to Latvian population (see Table 4).

Table 4. Distribution of health practices in age groups 15-64 and 65-94 (%)

<i>Health practices</i>	<i>15-64</i>	<i>65-94</i>
<i>Alcohol consumption within last 12 months (yes)</i>	84	33
<i>Alcohol consumption 5 and more times per week</i>	6	1
<i>Alcohol consumption more than 5 doses per time</i>	27	3
<i>Smoking</i>	45	18
<i>Daily smoking</i>	37	16
<i>Visit to the medical specialist at least one time over 12 months</i>	57	86
<i>Use of medical drugs within last 7 days</i>	42	72
<i>Choice of food with considerations of its impact on health (from "sometimes" to "always")</i>	67	68
<i>Sedentary leisure time activities</i>	66	85
<i>Heavy training and competitions</i>	3	-
<i>Physical exercise for at least 30 minutes until slight shortness of breath or perspiration (at least one time per week)</i>	39	10

The data shows that bad habits, including risky alcohol consumption and smoking, are more widespread among 15-64 year olds, while health preserving lifestyle is more common among 65-94 year olds, the share of free time spent sitting also goes up along with declining physical activity. The only shared characteristic is attitude towards impact of food on health. Both age groups share the same ideas on this issue.

There is not only different distribution of lifestyles in both age groups, the practices employed by people of both ages also vary. The greatest variety is among those who practice partial care for health: all 100% with this kind of lifestyle in age group 15-64 are smokers (89% regular smokers), whereby in age group 65-94 the share of smokers partially caring for their health is only up to 2% (with 1% smoking regularly). This is probably due to the fact that, as the age goes up, the total number of smokers goes down radically and there are other, demographic changes that affect those with this particular lifestyle, i.e. in age group 15-64 almost 2/3, or 73%, of regular smokers are men and they make up the 43% of the whole lifestyle population, whereas in age group 65-94 men are constituting 88% of regular smokers with 16% share of the whole lifestyle group. The dynamic brings an increase of smokers among those having minimal care for health: in age group 15-64 only 6% are smokers (1% regular smokers), whereby in age group 65-94 their share goes up to 19% (18% being regular smokers).

Analysis of link between health lifestyles of Latvian population and life quality factors is in line with Cockerham and his colleagues' theory that health lifestyles of individuals in late modernism are driven not by substantive rationality where health is the ideal state and goal by itself, but rather formal rationality where health is a tool for achieving better quality of life (better looks, more physical pleasure, longer life and better functionality, etc.).

Formal rationality implies more individual control over your health. Therefore, when adapting a lifestyle equal importance is given to own abilities, subjective health perception, where health is treated as a resource, and the objective circumstance. At the same time quality factors have dual effect on health behaviour. On one hand, good quality of life is closely

linked to health-promoting lifestyle. On the other hand, high quality of life is to be blamed for almost half of respondents, 49%, neglecting their health or taking partial/minimal care of it. Relatively worse health condition with a rather negative impact on self-assessment of life quality forces individuals to choose health preserving lifestyles. That means Giddens's principles of 'structural duality' fully apply to relationship between quality of life and health behaviour among Latvians aged 15-64. In other words, quality of life is both the result of health behaviour and a tool for particular health lifestyle.

7. Main Conclusions

The overall conclusion is that goals of the research have been attained successfully. The key objective and subjective factors influencing the quality of life and health behaviour of Latvian population have been identified along with the characteristic health lifestyles of particular social groups.

Data collected through expert interviews in the first stage of the research lead to a conclusion that there are three categories driving the health behaviour of Latvian population: individual (role of health in value system), social and cultural (existing social norms) and capability (availability of resources and choices).

Inhabitant interviews showed that health as terminal value is relevant to those individuals that include it in their own life quality concept. The other perceives health as an instrumental value that helps to achieve and maintain the desired level of life quality. This proves the health lifestyle theory that claims that health lifestyles of individuals are driven not by substantive rationality where health is the ideal state and goal by itself, but rather formal rationality where health is a tool for achieving better quality of life (better looks, more physical pleasure, longer life and better functionality, etc.).

Firstly, health is necessary for normal everyday functioning – work, studies and household chores. Secondly, good health is necessary to enjoy life, even if that takes place at the expense of health. This is backed by the number of smokers, bad eating habits, increasing consumption of alcohol and drugs. Thirdly, modern Western society cultivates the image of beauty and sexuality that revolves around healthy looks. So, health is linked not only to good physical and mental state, but also beauty and sexual attraction.

Health behaviour of the Latvian population is affected by social norms, especially the ones related to gender roles. Due to this, the spreading of bad habits among Latvians, specifically the male population, remains high. Such social norms lead to significant differences in projected male and female life expectancy and contribute to Latvia's backward position in the EU. Reproduction of the social norms is linked to gradual strengthening of healthy lifestyles in the society. Health status and care for health are the top social status attributes in the consumer society.

The analysis of qualitative data in the first stage of the research showed that Latvian population exhibits 5 types of health lifestyle: health neglect (noxious lifestyle), partial care for health, minimal care for health, health preserving and health promoting lifestyle.

The analysis of qualitative data acquired in the second stage of research shows that upon comparing objective life quality factors and subjective life satisfaction among

pensioners a paradox transpires. In some cases, despite objective factors pointing to low quality of life, respondents admitted that they are happy with their life. This may be due to factors like modest financial needs, psychological homeostasis (protective mechanism that maintains positive self-assessment even when the life quality goes down by having a downward social comparison with backward social groups; frequently used to create health self-assessment) and good family relations. Respondents were unanimous that good family ties are more valuable than the availability of financial means. Interviews showed that family support can make up for the negative impact on subjective life quality by bad health and lack of sufficient financial means. Healthy social environment helps elderly maintain physical and mental stamina for longer, i.e. family support and caring motivates retired not give in on ageing and health problems.

Health behaviour of senior population in Latvia is based mainly on objective life quality factors, i.e. lack of financial means and comparatively bad health status, and subjective factors like motivation to take care of health have secondary role. Lack of financial means and accessibility of health care are some of the main obstacles in respondents' care for health. Life quality affecting the health is one of drivers behind health behaviour: elderly with relatively good health practice health promoting lifestyle or minimal care for health, while respondents with chronic health problems practice health preserving lifestyle.

Data on health behaviour of Latvian senior population (aged 65-94) confirms the hypothesis that there are 5 distinct health lifestyles with the most common of them being health preserving lifestyle and the least widespread being health promoting lifestyle.

Quantitative data on both age groups (15-64 and 65-94) showed statistically significant relation between health lifestyles and quality of life indicators like income, gender, employment, health status, education, age and place of residence. The strongest link is between health lifestyle and gender, health status, education, place of residence and life quality self-assessment.

- Neglect for health is characteristic for men under 84, with high or moderate assessment of quality of life, moderate health, income above survival minimum, having a secondary or vocational education, living predominantly in countryside or in small cities.
- Those who practice partial care for health are under 84, mostly men with high or moderate quality of life assessment, moderate health, half of them have income under the survival minimum, most of them have secondary or vocational education, and are living either in Riga and other big cities, or in the small cities.

- Minimal care for health is also characteristic for younger pensioners, predominantly women with moderate quality of life and health, income below the survival minimum, having either secondary or vocational education, every third one – only primary, living either in countryside or other big cities.
- Health promoting lifestyle is practiced by pensioners under 74, two thirds of them are women with high quality of life and health self-assessment, higher income, better education, having a paid job and living mostly in Riga and other big cities.
- Health preserving lifestyle is practiced by pensioners older than 84, women, who evaluate their quality of life and health either as moderate or bad, their income is below the survival minimum, they have either secondary or primary education, and live in almost equal proportions in Riga and other large cities, in countryside and in the small cities.

Ageing brings gradual deterioration of health status and reduced functionality, elderly are forced to seek medical assistance, use more medication and change their abusive substance consumption patterns. Ageing forces them to reduce physical activity and spend more free time sitting watching TV or reading.

The quantitative data on economically active population (aged 15-64) collected in the third stage of the research is also indicative of 5 types of health lifestyle. The most widespread is neglect for health (noxious lifestyle), which is followed by minimal care and health promoting and preserving lifestyles, with partial care for health being the least popular.

- Health neglect (noxious lifestyle) is characteristic to men living in Riga and other big cities. Most of them have secondary education, higher income and life quality self-assessment.
- Partial care for health is common to both sexes, mainly to individuals with low or mid-level income, satisfactory or good health, living either in Riga or other big cities or in countryside.
- Minimal care for health is more characteristic to women than men; it is popular among individuals with lower income and education level, living in countryside or small cities.
- Health promoting lifestyle is characteristic to younger people, who live predominantly in Riga and other large cities, who have good health and higher quality of life self-assessment.
- Health preserving lifestyle is popular among older women with bad or satisfactory health status, lower income and lower quality of life self-assessment. Adherents of

this lifestyle live in almost equal proportions in Riga and other big cities, in small cities and in countryside.

Quantitative data on health practices of Latvian inhabitants supports the health lifestyle theory that claims none of these lifestyles is perfectly healthy or absolutely unhealthy, that is, each of the lifestyles presented has includes both healthy and unhealthy behaviors.

8. Approbation of doctoral theses

Scientific publications on doctoral paper's themes in the quotable sources:

1. Sīlis, V. Rūpes par veselību un dzīves kvalitāti. Grām.: *Dzīves kvalitāte Latvijā*. Zin. red. T. Tisenkopfs un B. Bela-Krūmiņa. Rīga: Zinātne, 2006, 173.–216. lpp. (Quality of Life and Individual Care for Health).
2. Sīlis, V. Patība kā pievienotā vērtība. Grām.: *Patērniecība Latvijā: tendences un alternatīvas*. Galv. red. V. Zelče. Rīga: LU Akadēmiskais apgāds, 2006, 21.–33. lpp. (Self as an Added Value).
3. Sīlis, V. Latvijas pensijas vecuma iedzīvotāju dzīves kvalitāti noteicošo faktoru ietekme uz veselības uzvedību. Grām.: *RSU zinātniskie raksti: 2009. gada sociālo zinātņu pētnieciskā darba publikācijas*. Rīga: RSU, 2010, 142.–158. lpp. (Factors Influencing Quality of Life of Latvian Citizens at the Age of Retirement).
4. Sīlis, V. Latvijas iedzīvotāju veselības dzīvesstili: individuālās izvēles alternatīvas (*accepted for publication in collection of scientific papers in social sciences from RSU annual conference 2010*). (Health Lifestyles of Latvian Population: Individual Choice Between the Alternatives).
5. Sīlis, V. Research ethics system in Latvia: structure, functioning and problems. *Dilemata*, No. 2, 2010, pp. 55–69.
6. Gefenas, E., Dranseika, V., Cekanauskaite, A., Hug, K., Mezinska S., Peicius, E., Sīlis, V., Soosaar, A., Strosberg, M. Non-equivalent stringency of ethical review in the Baltic states: a sign of a systematic problem in Europe? *Journal of Medical Ethics*, No. 36, 2010, pp. 435–439.
7. Dranseika, V., Gefenas, E., Cekanauskaite, A., Hug, K., Mezinska, S., Peicius, E., Sīlis V., Soosaar, A., Strosberg, M. 20 years of Human Research Ethics Committees in the Baltic states. *Developing World Bioethics* (*accepted for publication*).

Publications in abstracts of international conferences:

1. Sīlis, V. Relation between health behaviour and quality of life in Latvia. Grām.: *Abstracts for International Conference "Bioethical Aspects of Human Health"*. Rīga, 2006, pp. 28–29.
2. Sīlis, V. Health behavior and quality of life in Latvia. In: *XXI European Conference on Philosophy of Medicine and Health Care "Ethics, Philosophy and Public Health"*. Cardiff: Cardiff University, 2007, pp. 94–95.

3. Sīlis, V. Application of principles of bioethics in moral education. In: *Abstracts of 22nd European Conference on Philosophy of Medicine and Health Care "European Bioethics in a Global Context"*. Tartu: Tartu University, 2008, pp. 76–77.
4. Sīle, V., **Sīlis, V.** Latvijas pensijas vecuma iedzīvotāju dzīves kvalitātes subjektīvais pašnovērtējums. Grām.: *RSU zinātniskās konferences tēžu krājums*. Rīga, 2008, 41. lpp.
5. Sīlis, V. Latvijas iedzīvotāju dzīves stili: individuālās izvēles alternatīvas. Grām.: *RSU zinātniskās konferences tēžu krājums*. Rīga, 2010, 379. lpp. (Perceived Quality of Life of Latvian Population at the Age of Retirement)
6. Sīlis, V. Health behaviour of elderly people in Latvia. In: *XVII ISA World Congress of Sociology "Sociology on the Move". Book of Abstracts*. Gothenburg, 2010, pp. 446.

Other publications:

1. Sīlis, V. Plastiskā ķirurģija: rūpes par veselību vai dzīves kvalitāti? *Kentaurs XXI*. Nr. 43, 2007, 94.–112. lpp. (Plastic Surgery: Care for Health or for Quality of Life?).

9. Presentations at international conferences related to the topic of the doctoral theses

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