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Does Retirement Offer a "Window of Opportunity" for Lifestyle Change? Views From English Workers on the Cusp of Retirement

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Abstract

Objective: Improving health behaviors can delay or prevent lifestyle diseases. Previous quantitative studies suggest that interventions at retirement may be particularly effective. This study introduces the voices of older people to explore the potential of retirement as a change point. **Method:** This qualitative study of current and anticipated health behaviors among 55 people approaching retirement in England reports thematic analysis of semi-structured interviews. **Results:** Many respondents expected improved health behaviors whether from conscious changes or simply as a beneficial side effect of retiring, while a smaller group felt retirement carried inherent health risks, with a need to guard against these. **Discussion:** The retirement transition can potentially establish positive health behaviors, but interventions need careful targeting to maximize their benefit. Further research is required to explore how far intentions translate into practice and the barriers and facilitators to doing so.

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Introduction

In a significant shift from post-war narratives of retirement as an achievement or a "reward", retirement has, over the past two decades, increasingly come to be presented as a "risk" for individuals, whether in terms of adequacy of incomes or because of the potentially negative impact on well-being, physical, and mental health. In Great Britain, an extended working lives (EWL) policy agenda has become firmly embedded with cross-party support (Department for Work and Pensions [DWP], 2005, 2006a, 2006b, 2014a). Alongside the fiscal arguments and business case, a key rationale of government strategy relates to the suggested beneficial health effects for individuals: "There is a strong evidence base showing that work is generally good for physical and mental health and well-being. Overall, the beneficial effects of work outweigh the risks of work" (DWP, 2014b, p. 16).

In relation to lifestyle diseases, a Department of Health (DH; 2013) paper sets out the range and scale of behavioral risk factors in England including poor diet, excessive drinking, physical inactivity, and smoking,[1] which are variously linked to type 2 diabetes, certain cancers, high blood pressure, liver disease, stroke and osteoarthritis, and premature mortality. There are several mechanisms through which stopping work may influence health behaviors and outcomes negatively, with evidence to suggest an association between retirement and reduced physical activity (Berger, Der, Mutrie, & Hannah, 2010), diminished social interaction (Dave, Rashad, & Spasojevic, 2008), and challenges to well-being (Black, 2008; Sahlgren, 2013). Reduced incomes in retirement may also be a risk for diet as those on low incomes consume fewer fruit and vegetables and more high-fat and high-sugar foods than recommended (Age UK, 2015; Bates, Lennox, Prentice, Bates, & Swan, 2012). Econometric studies have also suggested that employment, as a component of "active ageing" and social inclusion, can promote physical and mental health benefits (Waddell and Burton, 2006; Behncke, 2009; Bonsang et al., 2007; Hartlapp & Schmid, 2008): This perspective is not, however, uncontested, and other studies have found that extending working life may, instead, carry health risks and that "retirement" is therefore protective (Charles, 2002; Mein, Shipley, Hillsdon, Ellison, & Marmot, 2005; Neuman, 2008; Westerlund et al., 2009).

As noted by Heaven et al. (2013, p. 223), "Despite the variation in how and when people retire, the transition is typified by multiple lifestyle

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adjustments, many of which affect health and well-being, including the level and form of physical and social activities." Although retirement is a critical transition point with significant implications for lifestyle change, knowledge about people's expectations and aspirations on a range of health-related behaviors remains sketchy. The majority of studies examining change to date have used quantitative methodologies that provide little evidence on the motives, meanings, and intentions of individuals, which might explain and lead to deeper insights into the direction of change or continuity at this transitional point. This article seeks to introduce the voices of older people making the transition to retirement to establish whether the transition is anticipated or planned to include changes in health behaviors.

This article focuses on retirement planning in relation to health behaviors in general, and specifically regarding diet, physical activity, and alcohol consumption among 55 individuals living in England who have self-identified as intending to retire within 12 months. A main focus was to investigate what influences people's plans or anticipations, while acknowledging the potentially wide gap that may exist between plans and eventual outcomes. The study examines whether, and under which circumstances, shifts to more positive health behaviors form part of people's "anticipatory planning," whether the transition to retirement is expected to lead to a significant break with past habits and lifestyles as opposed to continuity, and to what extent individuals are open to change. The article is based on findings from a study designed to follow individuals as they make the transition from work to retirement and presents findings from the baseline year, with a focus on individuals' retirement expectations, motivations, plans, and concerns while still employed.

The article begins by providing an overview of the existing evidence relating to health-related behavior change over the retirement transition period, followed by a discussion of the potential for applying a "habit discontinuity" framework to the study of retirement transitions. The article then sets out the methodological approach taken, describes the findings, and, finally, discusses their implications in relation to social policy and intervention opportunities.

Health-Related Behavior Change Over the Retirement Transition Period

Health-related lifestyles in later life do not necessarily align with public health recommendations. A number of studies have examined the mechanisms through which diet, physical activity, and alcohol consumption may be affected over the retirement transition period.

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Diet. The need to improve intake of fruit and vegetables at older ages has been emphasized in response to observed weight gain and increased abdominal obesity (a key risk factor for heart disease) among people retiring from active jobs (Lara, Hobbs, et al., 2014). Evidence on dietary change over the retirement transition period is scarce and conflicting; one review (Conklin, Maguire, & Monsivais, 2013) found that studies demonstrated positive, negative, or no impact of retirement in relation to food spending and food intake, therefore no overall conclusions could be drawn. Studies on time use such as Verlarde and Herrmann (2014) highlight increased home production and consumption of food and associated shopping after retirement but cannot determine changes in the quantity and quality of food consumed. Summarizing the barriers to healthier eating patterns, Lara, McCrum, and Mathers (2014) identify limited time, taste preferences for less healthy foods, and a desire for convenience as key obstacles to improvement. Cost is also an important constraint on eating more healthily, with price and value being identified as key influences on food choice among lower income groups (Bates et al., 2012). Given the significance of time and cost in predicting healthy eating practices, the impact of retirement is hard to anticipate given that it is associated not only with an increased availability of time but also, for most, with decreased income.

Physical activity. Longitudinal analysis of English Longitudinal Study of Ageing (Banks, Nazroo, & Steptoe, 2014) has shown that the majority of older adults did not change many of their lifestyle behaviors over the period 2002-2013. The transition to retirement, however, was found to be associated with moving to lower activity levels. Focusing on a Scottish cohort of men and women making the transition to retirement, Berger et al. (2010) found that a lack of time was a key barrier to physical activity while employed. It was therefore expected that retirement would increase physical activity, but in reality, there was very little increase in non-work physical activity after retirement and notably not enough to compensate for loss of work-related physical activity. In accounting for their findings, Berger et al. noted that those in physically demanding jobs had less leisure physical activity and therefore less experience (and habit) from which to build. It was further speculated that cultural expectations and norms of "taking life easy" in retirement were relevant.

A more mixed picture emerged from analysis of the U.S. Health and Retirement Study (1996-2002; Chung, Domino, Stearns, & Popkin, 2009)—it was found that physical activity decreased over the retirement transition among those who had previously been employed in physically demanding jobs and in lower wealth groups. By contrast, those from a background of

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sedentary work and in higher wealth groups experienced increases in physical activity. Chung et al. (2009) concluded that economic constraints may have a greater impact on physical activity than the increased availability of time in retirement.

Alcohol consumption. The literature on retirement and alcohol consumption is mixed, with some studies suggesting a positive effect and others suggesting no effect or a negative impact (Bamberger, 2015); work experiences and the circumstances of leaving work may be more significant influences than retirement itself (Kuerbis & Sacco, 2012; Zins et al, 2011), but levels of problem drinking among older adults are known to be increasing (Bamberger & Bacharach, 2014). Involuntary retirement, strong attachment to and enjoyment of work, and high levels of work stress are all associated with increased levels of drinking in retirement (Bacharach, Bamberger, Biron, & Horowitz-Rozen, 2008; Bamberger & Bacharach, 2014); while the link with involuntary retirement and strong work orientation may be understood in terms of loss of role, the link with stress is a more counterintuitive finding and suggests that coping habits acquired during working life may prove difficult to change. Moving into or out of social networks that are permissive of heavy drinking at retirement is another potential influence on alcohol consumption (Bacharach, Bamberger, Cohen, & Doveh, 2007; Bamberger, 2015) and there is also some evidence that partial retirement and "bridge" work is associated with higher levels of drinking than complete retirement (Bamberger & Bacharach, 2014).

Theorizing the Retirement Transition

Several studies have suggested that policies and interventions targeting people on the cusp of retirement for health interventions may be particularly effective because this life transition involves other behavioral changes (Pittman, 2013; Lara et al., 2014; McNaughton, Crawford, Ball, & Salmon, 2012) associated, in part, with shifts in social networks, income, and time sovereignty. Such "moments of change" temporarily disrupt patterns of behavior in everyday life and open the possibility of modifying habits before new routines become established. As a major life event, retirement has been described as a turning point that presents a critical "window" for encouraging good dietary practices (Lara et al., 2014) and physical activity (Barnett, van Sluijs, & Ogilvie, 2012), presenting an opportunity to embed new and improved lifestyles (Verplanken & Wood, 2006). As such, it represents a key point in time when individuals may be more receptive to interventions.

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Many behavior change models (such as the theory of planned behavior and the transtheoretical or "stages of change" models; Ajzen, 1985; Prochaska & Di Clemente, 1986) give explanatory primacy to cognitive processes, arguing that change needs to be deliberative and intentional. The potential impact of context, circumstance, and structure on individual behaviors are accordingly downplayed (Weyman, Wainwright, O'Hara, Jones, & Buckingham, 2012). The habit discontinuity perspective (Verplanken, 2006), by contrast, focuses more squarely on circumstances, arguing that "moments of change" interrupt the context of behavior, and therefore, "The need for some degree of conscious direction returns—and once this has happened, the behavior may be more susceptible to change" (Thompson et al, 2011, p. 21).

Alternatively, continuity theory (Atchley, 1989, 1999; Richardson & Kilty, 1991) conceptualizes the retirement transition period in terms of maintaining continuity of lifestyles and core values. Lost roles in the workplace are often substituted by new roles (Hooyman & Kiyak, 2000), and the transition is seen as more of a rebalancing than an abrupt breach. Continuity is argued to promote well-being and help individuals to adjust to their new life without a sense of loss or distress.

In light of warnings that retirement is a health risk, a key focus of our study is whether individuals plan significant change to their health-related behaviors, or anticipate an experience of continuity, with implications, whether positive or negative, for longer term health outcomes.

Design and Method

Sample and Data Collection

As the research is a study of changes in well-being and health behaviors in the transition to retirement, it was important to be able to capture a baseline position when the respondent was in work, against which future changes occurring in retirement can be measured.

Participants were recruited by a social and market research agency[2] on the basis that they were employed, working full time (30 hr or more, or at least 4 days per week), and intending to retire voluntarily in the next 12 months. Using a screening questionnaire, the agency deployed a variety of recruitment methods, including social media platforms as well as more traditional methods such as on-street recruitment (around half the sample came from each of these methods). The main challenge was to find individuals planning to retire in the next year. The recruitment company provided a sample of 70 individuals, of whom 15 were excluded because their retirement plans had

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changed or because we already had sufficient respondents in the desired sampling category.

Respondents were sampled purposively to include sedentary, physically demanding, standing, and stressful (based on self-report) jobs, as the impact of work on current health was felt to create an important and varied context for the potential health implications of retirement. Those retiring as a direct result of a major health problem were excluded, because the association between health and retirement was already clear-cut, and the potential benefits of lifestyle changes are also more likely to be limited in situations of existing ill-health. Secondary sampling criteria (via telephone screening by the research team) included income level, gender, partnership status, and age, as these were anticipated to affect opportunity structures and attitudes. Respondents were also selected purposively by interviewers to include urban and suburban areas, with varying levels of labor demand and different facilities, but this was not a key sampling criterion.

Our sample of 55 people were mainly (75%) living with a partner and/or children, with one in four living alone. Sixty percent of our interviewees were men and 40% women, and their ages ranged from 54 to 70 years at the time of their first interview. Close to half (48%) had a net household income in excess of £30,000, 13% were in a low-income group (household income less than £20,000), and the remaining 39% had incomes between £20,000 and £29,999.

In terms of their employment, 45% of our sample was in sedentary work, 33% in jobs that involved standing for most of the day, and 22% in physically demanding work. More than half (55%) described their work as stressful (i.e., had scores of 5 or more on a 7-point self-report Stress Scale). One in five would have already reached age 65 by their anticipated retirement date, while 44% were intending to retire at, or approaching, state pension age (60-64). A further 39% were intending to retire earlier than this, between ages 55 and 59.[3]

The study is not one which raises major ethical concerns, as it does not cover a vulnerable population or inherently sensitive issues. The methods were approved by the University of Westminster Ethics Committee prior to commencement. Interviews were carried out by the three authors, who are all specialists in later life work and retirement transitions. A pre-interview questionnaire (completed by telephone or email) collected data on current diet, exercise, physical activity, and emotional well-being. Qualitative interviews, using a semi-structured topic guide, then explored the motivations and intentions around the decision to retire and its relationship to work, financial circumstances, and other factors. Participants were asked to identify areas where they anticipated or planned to make changes; for instance, in relation to their

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social activities and health behaviors, and their hopes, plans, and potential concerns in relation to their impending retirement were explored. A time-use grid was also completed to capture daily and weekly routines and their links to work. The interviewees' prospective intentions and views regarding their health behaviors are the primary focus of this article.

Analysis

All interviews were digitally recorded (with interviewee permission) and transcribed verbatim. Data management and analysis was initially conducted using NVivo to thematically code interview transcriptions, using both deductive categories from the literature and inductive categories arising from the data itself to develop coding frames, which were then used independently by coders and checked (e.g., for missing/overlapping categories and consistency in allocating data to categories). NVivo lends itself to rich contextual detail and offers flexibility in creating and adapting coding schemas iteratively as the analysis progresses. Broad themes were identified at the preliminary stage of coding, such as "retirement motives," "worries," and "plans." Subsequent rounds of coding were informed by existing theoretical frameworks to examine how well accounts of the anticipated retirement transition supported a path of continuity or discontinuity. This was followed by a further phase of repeated comparison to refine our conceptual schema.

During the final stage of our analysis, the data were reduced and a framework matrix approach used (Ritchie, 2013) to seek out patterns in the responses. A data matrix was created with research themes comprising the columns and respondents comprising the rows. A summary of respondent data was entered into each cell. The advantage of this visual platform is that it enables systematic comparison of differences across respondents, including easy identification of missing data on particular issues.

Results

The motivations and circumstances associated with planned change or continuity in relation to future lifestyles and specific health behaviors (including physical activity, diet, and alcohol consumption) were varied. Influences included gender, occupational background, and partnership status, while expected income was also a factor in some instances.

In conceptualizing plans for changes to health behaviors, two broad orientations were apparent, those who saw retirement as a time for change and those who expected it to make little difference. These are discussed in more detail below.

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Retirement as a Time for Change

These people viewed retirement as a time to introduce positive lifestyle changes. Individuals in this group expressed dissatisfaction with specific health behaviors and expected to see changes following retirement, or they were concerned that retirement presented risks to their health-related behaviors. This group was further subdivided into three types, according to the motivations for change:

- *Retirement is a solution*. Those who see a direct link between work and specific negative health behaviors and expect retirement to alleviate health problems and improve health practices.
- *Opportunistic change*. Those who see a link between increased leisure and specific health behaviors and so expect a positive change in retirement.
- *Retirement is a risk*. Those who see a direct link between retirement and potentially negative health behaviors and plan to actively address these.

Retirement as a solution. Some of our sample reported that work had become increasingly stressful for them, whether because of work intensification (such as long working hours, extensive travel, frequent and/or out-of-hours electronic contact, or a target-driven performance culture), conflict at an organizational or interpersonal level, or simply because their own tolerance for the demands of the job had declined over time. People in this group recognized that their work had encroached on their personal lives to the extent that they felt constantly stressed and so had lapsed into unhealthy behaviors. They reasoned that only by stopping work could they make changes to their satisfaction, seeing retirement as essential to their health, although health had not initially been reported as the main motivation for their decision to stop working. This attitude was generally associated with poor work–life balance, shift working, and/or a health condition (e.g., diabetes, high blood pressure, stress). In one case, a person in high-stress sedentary work felt retirement would enable her to improve her physical activity for the benefit of her health:

> The problem I've got is I'll work later and later because I've got nobody to go home to . . . I got to the point, nearly a burnout I suppose is the best way of putting it . . . it's not the right balance at the moment and I'm just thinking . . . just wait until you've retired and then go and do your swimming and go and do stuff . . . I had the five weeks off last year and I've got Wii Fit . . . and that was really good, I started to get into it on a daily basis . . . but I don't do it when I'm working, I've got my two and a half hour little box of an evening and the last

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> thing I can be bothered to do is get that out and do anything. (Female, 55-59, lives alone, stressful, sedentary occupation)

Another person in sedentary work wanted to address his limited physical activity and over-reliance on packaged meals. He summed up the trade-off of being on a lower income when retired as having "fitness and hopefully health." In the following account of poor dietary practices, there was a strong workplace culture around sharing sweet foods, which was viewed as problematic:

> At work if there's any biscuits I grab them, every time there's a birthday people are leaving chocolates and cakes, the patients occasionally bring in chocolates and cakes for us a thank you, they're the good ones. Easter time they brought in Easter eggs . . . So I just ate anything there was, just eating, eating, eating. I think part of it was stress and part of it I think, "To hell with it, I'm fat now, I'll get a bit fatter." (Female, 60-64, lives with son, sedentary occupation)

Opportunistic change. For people in this category, the motivation for, and timing of, retirement were not directly related to health or the negative impact of work, but the transition into retirement was nonetheless viewed as an opportunity to make positive changes, whether by proactively targeting health behaviors respondents felt could be improved or, more passively, simply expecting that changes would occur naturally, given the availability of more time and energy. It was common for retirement to be viewed as providing the opportunity to introduce new lifestyle interests and pursuits.

Physical activity was cited as an area where change was expected, given more time. People did not necessarily anticipate qualitative changes to their physical activities; instead, without the constraint of work, they expected to expand their usual activities such as walking the dog, golfing, or cycling. More generally, people seemed to assume that there would simply be a natural increase in their physical activity, because they would have more time, and be less tired, once they were no longer at work. For example,

> During the day, you're naturally going to do more, you're naturally going to get up more. I will take the dogs for a walk because they're there to be taken and if you're with them all day long you've got to get them out. (Male, 55-59, lives with partner, sedentary occupation)

Diet and eating patterns were a frequently cited area for planned change. People attributed bad habits such as skipped meals, unhealthy meals, and snacking to work-related constraints (e.g., long hours, shift work, and extensive travel), as well as work stress and boredom. In retirement, it was

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anticipated that meals would become more regular, varied, healthy, and interesting:

> I'd like to think that I would . . . prepare more, rather than sharing a pizza or something that is quick and convenient, not necessarily nourishing. I'd like to think that I could spend more time prepping and . . . I've got some wonderful cookery books and I look at them and I think I haven't got time to do all this so that sort of thing, it's making your own and preparing your own [costs] a lot less than buying it ready made. (Male, 65+, lives with partner, standing occupation)

Retirement as a risk. Based on their own self-knowledge and the behaviors of retired people they knew, people who saw retirement as a risk were conscious that an undesirable behavior or unhealthy habit could develop, and they were keen to avoid this.

A relatively small number of our interviewees voiced concerns about increasing the frequency or amount of alcohol consumed and were conscious of wanting to avert this. Without the structure of work, there was a feeling that daily drinking could easily become habitual, even among those who did not usually drink heavily:

> I think it's something I've got to be very careful about because I can see myself thinking, "No work tomorrow, I'll have a drink every night." It's just about habit . . . Yes, I think I could slip into it and then it could become "It's half past six, time for a drink." (Female, 55-59, lives alone, standing occupation)

Similarly, the extra time at retirement was viewed as a potential danger in terms of over-eating for some people, as this was a pattern they had identified in relation to holidays and unstructured time off at home:

> I eat a load of rubbish. If I'm around the house, I make sandwiches and cakes and all those. (Male, 55-59, lives with partner and children, manual occupation)

More broadly, people were also motivated to avoid more generalized patterns of behavior they considered undesirable, mainly based on their own observations of retirees:

> There's such a danger, when people retire they do nothing, they just vegetate. That's a big concern to me, that's the last thing on earth I'd want to do. (Male, 65+, lives alone, sedentary occupation)

These attitudes revealed negative stereotypes about the retirement lifestyle as involving an excessive amount of time spent shopping, at the pub, or

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watching TV, characterized by another interviewee as "slowing down and entering into a vegetative state." These activities were seen as something to be avoided and helped to instill a desire for an active retirement:

> One thing about going to work is it keeps you going, it gives you a routine and targets. If you're not careful when you retire you can drift. I think you need to work at retirement actually. (Male, 65+, lives with partner, stressful, standing occupation)

It should be acknowledged that although some individuals were very concerned that they would slip into a state of inactivity, others, especially those in stressful work, positively embraced the idea of "winding down" and described this as their ideal:

> Stopping in bed till ten o'clock of a morning, get up and if it's lovely I'll sit in the garden with a cup of tea, I wish I could do that . . . a slower pace. (Male, 55-59, lives with partner, stressful, standing occupation)

While many interviewees expressed a strong commitment to avoiding lifestyle "risks," acknowledging their personal agency, a smaller group believed they faced structural barriers to achieving their preferred lifestyle. For instance, physical activity was seen to be limited by living alone, cold wet winter weather, no longer having sporting companions, reduced incomes in retirement, and mobility difficulties. One woman was concerned that living alone, she may struggle to keep herself motivated to achieve her goals and live the retirement she was hoping for:

> There is a park and there are canals, there are some walks. I did get a book and I have done a couple of them . . . that's going to have to be me saying to myself right, come on. Because I'm not going to have anybody else to spur me on so that's where it's going to be difficult. (Female, 55-59, lives alone, sedentary occupation)

Several men, in particular, expressed a desire to play more sport but viewed their options as limited. In explaining reductions in physical activity over the past 10 years, one man described the need for companions and the fact that these were less-readily available than in the past:

> People I played football with don't play anymore because we're all getting a bit older now, yeah, most people stop. (Male, 60-64, lives alone, sedentary occupation)

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The cost of sporting and leisure pursuits was raised as a concern by both men and women, one of whom explained, "Cost will come into it . . . money really will play a big part in decisions," while another indicated, "I really want to enjoy the time I've got left . . . some of my negative feeling is 'Am I going to have enough money to do it?'"

Retirement Is Expected to Make Little Difference

People who expected retirement to have little impact on their lifestyle were satisfied with their existing health behavior(s) and so did not wish to make changes. These could be broadly divided into two sub-groups:

- *Pre-retirement change*. Those who had already made substantive changes to their health behaviors prior to retiring, often in response to a specific health issue.
- *Habit continuity*. Those who intended to continue existing patterns of behavior, out of enjoyment or habit, whether because their behavior is already healthy or in defiance of health advice.

Pre-retirement change. Some respondents did not view their impending retirement as a significant life transition that would affect their behavior because it had been pre-empted by another life-changing event such as bereavement, serious illness or health condition, or specific health concerns. These people had already introduced lifestyle changes and fully intended to continue on the same path in their retirement.

Improved eating patterns in the years prior to their retirement had usually been adopted in response to a health issue (such as heart problems, diabetes, or high cholesterol) or being substantially overweight. These respondents hoped to maintain or extend these new patterns into retirement.

Earlier changes to alcohol consumption tended to be identified with a gradual reduction in drinking over the years as interviewees' taste and tolerance for alcohol had declined. Workplace cultures were also noted as having changed over time, so that there was far less lunchtime and after-work drinking than in the past. The need to drive to social events also meant that alcohol consumption was reduced.

Some of those who have been bereaved had experienced large weight gains or losses as part of their reactions to grief, which they had subsequently addressed by changes to their diet. Some women also mentioned changes in their eating habits, usually positive, as a result of being alone, rather than in a couple.

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Habit continuity. Respondents who did not intend to make changes to health behaviors at retirement included both people who had long-standing healthy habits and those who were aware that their health behaviors were sub-optimal. The former group included people who had cultivated well-rounded healthy lifestyles in terms of diet, alcohol consumption, and physical activity and felt that retirement would simply make it easier to maintain their lifestyle choices, without having to fit activities around their work schedules.

The latter group of individuals recognized problematic health behaviors but anticipated it would be difficult to break these habits, for example, because of a lack of interest in terms of physical exercise, because they had pessimistic or fatalistic health beliefs, and/or because they valued immediate gratification over possible health problems in the future, as this overweight respondent commented about his high-fat/high-salt diet:

> I eat anything really, I love my food really and I just eat what's cooked up. If [wife] has cooked something I eat it. We try and live healthily but we'll do it for a bit and then we'll go back to where we were. I love sausages, I love bacon, I love a fry up, chips. I love fish and chips and I have got high blood pressure and high cholesterol . . . But I'm on tablets and I still eat that. I'm not one of these people to look at things like that, you've got to be careful, but I think, at the end of the day, life's for living as well and I enjoy what I eat. (Male, 60+, lives with partner, stressful, physically demanding occupation)

Discussion

Our assumption was that retirement (such as the birth of a child) is a classic example where one could expect habit discontinuity theory (Verplanken, 2006) to have traction, as it represents such a major break in daily and weekly routines, both for the individual and for the household as a whole.

Our findings suggest that although retirement may potentially present a window of opportunity for positive habit change, heterogeneity in attitudes and circumstances underpinning health behaviors need to be taken into account when interpreting change or lack of change post retirement. One group in the sample saw retirement as an opportunity for change, supporting habit discontinuity theory (Verplanken, 2006), whether due to the expectation of more time to take care of oneself or as a solution for poor health behaviors associated with their working lifestyle. However, the intention not to alter health behaviors in retirement, supporting continuity theory (Atchley, 1989, 1999), may be a function of changes that predate the retirement period (negating the need for change) and/or the perception that current lifestyle practices (whether good or bad) do not require changing. These findings shed light on

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previous quantitative studies by highlighting individual attitudes toward and concerns around health-related behaviors, providing explanations for change and continuity at this transitional point.

Our qualitative study has implications for the extended working-life agenda, promoted by the British government as a key means to achieve positive health outcomes in later life. Although the structure and routines provided by paid employment are a resource for well-being (providing social contact, income, activity, and a meaning structure), they are also a constraint, which limits the available time and emotional and physical energy to address other lifestyle areas such as exercise and healthy eating. Both the quality of the work and the work–life balance need to be taken into account here (Smeaton and White, 2015). The health implications of retirement are therefore complex and context-dependent.

The fact that people saw retirement as representing an opportunity for positive health change means that the transition to retirement does potentially offer scope for improving health. Government's Active Ageing and Healthy Ageing campaigns (DH, 2010) and measures to improve health among younger older people (EuroHealthNet, 2012) can build on this momentum. Given the findings, policy interventions in this area would need to be nuanced and include measures aimed at increasing motivation to change, as well as working with those who are already motivated. For example, policies that promote healthy lifestyles could target the retirement transition with messages about using this life stage as a time to develop and embed new habits.

In England, local authorities, with designated responsibility for health and well-being, have a key role to play here in providing good-quality sport and leisure facilities and ensuring that these are affordable and accessible.[4] For bridging the transition between work and retirement, there are employer-organized retirement clubs and activities to encourage social connectedness and physical well-being, a service that more employers could be encouraged to offer (Bazalgette, Cheetham, & Grist, 2012).

In our research, people varied considerably in their motivation to change. Respondents' health beliefs were often strongly influenced by the premature deaths of people in their social circle, whether these were contemporaries or parents who had died young. This tended to reduce their belief in the power of health behaviors to improve health outcomes and encourage a tendency to "live for today," what Prochaska and Di Clemente (1986) would identify as the "pre-contemplation" stage of change, where interventions will not be taken up even if offered. Motivation was also related to existing health behaviors; some people had long-term healthy lifestyles that did not require change, but simply continuation ("maintenance," in Prochaska and Di Clemente's terms), while others were motivated to change situations that they could see

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might have negative consequences over the longer term—Prochaska and Di Clemente's "contemplation" group. Each of these stages implies different strategies for intervention, with those in the contemplation stage being more immediately ready to respond and take up healthy living interventions while those in the pre-contemplation stage first need to be motivated to change by educational interventions and/or behavioral incentives.

The group most strongly motivated to change were those who saw their work as having a directly negative impact on their health and well-being. Although this was a small group in our sample, because we had deliberately excluded those for whom health was the primary motivation for retirement, it is a large group in population terms and so of concern to policymakers. However, turning this intention to change into a new set of health behaviors is potentially more challenging. Where people have been coping with stress and health issues over a long period, their psychological resources may be diminished, reducing their determination and "staying power" in making lifestyle changes. Targeted health and well-being interventions, such as exercise and weight loss programs, both during working life and at retirement, may be beneficial for these groups.

Limitations

A key limitation of the study is how far our findings and the range of issues which emerged will apply to the wider population of retirees. The small sample of 55 older people is not ethnically diverse, and the number of people from very low-income backgrounds was small, limiting the extent to which issues of class and culture could be addressed. Second, it is acknowledged that there can be a considerable gap between plans and eventual outcomes. However, the findings do point to the range of issues under consideration by individuals as they leave their working life behind and start to make choices about their lifestyles over the coming years.

Conclusion

This qualitative study has contributed new insights into healthy and unhealthy lifestyles in retirement. By examining the plans of workers on the cusp of retirement, the study found that people divided into two broad groupings: those who expected retirement to be a time for change and those who expected little difference in their day-to-day lifestyle. For the former group, time was an important element as people reasoned that some of the time previously spent in working would be used to care for themselves, something that had been neglected during a busy working life. Of those who anticipated no

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change in their health behaviors, some had already introduced positive changes following a life-changing event (e.g., a health scare or the death of a spouse). Another group lacked the motivation or financial resource to introduce healthy habits, and it is these individuals who would most benefit from public health interventions during the retirement transition.

Further research is needed to inform the development of effective policy tools for promoting healthy lifestyles among people at the retirement transition. More longitudinal research is also warranted to track changes over the longer term to identify both bridges and barriers to positive health behaviors.

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Notes

1. Smoking is not discussed in our findings as the incidence of smoking in our sample was too low.
2. Both the agency and the wider research team adhere to the ethical guidelines set down by the Social Research Association (http://the-sra.org.uk/research-ethics/ethics-guidelines/).
3. The availability of occupational pensions was sometimes a factor in the timing of retirement as was the ending of large financial commitments such as a mortgage.
4. Ageing Well was a national program to promote age-friendly spaces. One example was the offer of free swimming in public pools for over 60s. See http://www.local.gov.uk/ageing-well.

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