

# Healthy Ageing

*A CHALLENGE FOR EUROPE*



# Healthy Ageing – A Challenge for Europe

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# Executive Summary

## *The challenge of Healthy Ageing*

The need for healthy ageing is a challenge to all European countries. By 2025 about one-third of Europe's population will be aged 60 years and over, and there will be a particularly rapid increase in the number of people aged 80 years and older. This will have an enormous impact on European societies.

There are powerful arguments for investing in health as an objective in its own right. Health is also an important determinant of economic growth and competitiveness. Investing in healthy ageing contributes to the labour supply, decreasing the likelihood of early retirement.

Co-funded by the European Commission, the three-year (2004–2007) Healthy Ageing project aims to promote healthy ageing among people aged 50 years and over. It involves ten countries, the World Health Organisation (WHO), the European Older People's Platform (AGE) and EuroHealth-Net. The goal is exchange of knowledge and experience among the European Union Member States, acceding countries and EFTA-EEA countries.

## **THE PROJECT'S DEFINITION OF HEALTHY AGEING**

*Healthy ageing is the process of optimising opportunities for physical, social and mental health to enable older people to take an active part in society without discrimination and to enjoy an independent and good quality of life.*

This Report brings together information from the Healthy Ageing project: literature on intervention, statistical data, examples of good practice and facts about policies and strategies for healthy ageing. It also proposes recommendations. National implementation will take place in the European countries.

## **Major topics and cross-cutting themes**

The Healthy Ageing project has a holistic approach and takes into account health determinants influenced both by society and its policies as well as the individual. The project partners have agreed to focus on ten major topics. Most are broad and interact with each other and with the following cross-cutting themes: *socio-economic determinants, inequalities in health, gender and minorities.*

- **Retirement and pre-retirement.** Employers and employees alike need to take responsibility for the health of the older members of the workforce so that these can work to higher ages. “Work ability” is a holistic concept including a balance between work and personal resources.
 

Anticipatory social interventions concerning pre-retirement have positive effects and contribute to empowerment.
- **Social capital.** A high level of social capital enhances a person’s sense of belonging and well-being. Providing opportunities for older people to do voluntary work among seniors improves the quality of life of the volunteers and those who receive the services. Low social capital correlates with mortality.
- **Mental health.** Ageing is a gradual process and there is much we can do to promote good mental health and well-being in later life. Participation in meaningful activities, strong personal relationships and good physical health are key factors, while age discrimination has a negative impact. Poverty is a risk factor for mental ill-health.
- **Environment.** Air pollution is responsible for a great burden of environment-related diseases and its effects are especially adverse on people already in poor health. Global climate change may have a widespread impact on the older population in the future, due to more episodes of extreme weather. Accessible green areas allow older people with poor mobility or disability to spend time outdoors, which is an important determinant of good health.
- **Nutrition.** Considerable gains in terms of mortality and function could be achieved if older people adopted a healthier lifestyle with healthy eating habits. Obesity and overweight are associated with unhealthy dietary habits and lack of physical activity.
- **Physical activity.** The broad benefits of physical activity for older people are well documented and associated with improved length and quality of life. People tend to become progressively less active as they get older.
- **Injury prevention.** The three leading causes of death due to injury in older people in Europe are self-inflicted injuries, falls and road traffic injuries. Exercising balance and strengthening muscles reduce falls in older people. Strained family relations are risk factors for the abuse of older people or for violence.
- **Substance use/misuse (tobacco and alcohol).** A majority of smoking-related deaths in the EU occur in older people. Smokers who stop at the age of 65–70 halve their excess risk of premature death. Smoking cessation remains the most effective method of altering the smoking-induced disease risk.
 

Health problems caused by alcohol use disorders are often under-detected and misdiagnosed among older people.
- **Use of medication and associated problems.** Older people are the largest per capita users of medication. The risk of adverse reactions increases with the number of individual drugs taken. Lack of overall knowledge of what medicines and treatment a patient is receiving is an important explanation of

drug problems. As well under-use, over-use and unsuitable combination of medication are other common problems. Some problems can be avoided through the inclusion of older people in clinical trials.

- **Preventive health services.** Older people with low socioeconomic status or from ethnic minorities may find access to health services difficult. They also may have low “health literacy”; that is, they may know significantly less than other people about disease and how to maintain good health. Health literacy is a more meaningful predictive factor than education for older people’s use of preventive services, and has implications for the design of interventions.

**Cross-cutting themes.** *Inequality in health* is best illustrated by the gap in life expectancy between people from low socioeconomic groups and those from high ones. Health inequality starts early in life and persists in later life. In healthy-ageing strategies, health promotion should give priority to addressing the health of the more disadvantaged older people.

Poverty is an important *socioeconomic health determinant*, with negative effects on health, life expectancy, disease and disability. Women living alone often risk poverty in later life because their lifetime earnings are less than those of men, as are their pension entitlements.

*Gender* has to be taken into account when planning and implementing health promotion. Women live longer than men in all European countries but report more psychological symptoms and consult health professionals more often and receive more treatment than men do. Men and women need to be motivated differently to participate in health promotion activities.

The relationship between belonging to a *minority group* and ageing and health needs more exploration.

### *Policies and strategies*

Most European countries have policies and strategies for healthy ageing according to a questionnaire designed by the Healthy Ageing project. The policies are either separate or included in general health policies. The majority of the policies was on health and promoting the health of older people, rather than care of older people. Most policies do not refer to health data. Policies seldom allocate funds for health promotion, which may hinder local implementation.

There is a need to involve older people in planning, and to promote positive images of ageing, avoiding any arbitrary focus on chronological age.

### *Good practice projects*

The sixteen ‘good practice’ projects presented in this Report indicate the importance of sustainability, i.e. transforming projects into programmes, and collaboration by people throughout the community. Most of the projects are considered suitable for implementation in other countries.

Social capital and physical activity are the most common major topics in the ‘good practice’ projects. Often in combination, they may lead to improved physical health and the alleviation of loneliness. The key issue is how to persuade people to change habits, especially those who for cultural, social and/or economic reasons are least inclined to do so. Gender has also to be considered: men are more difficult to motivate to participate in activities than women are. The ‘good practice’ projects suggest that

involving people from the target group in the planning and implementation phases may empower the less motivated and encourage their participation.

*Is health promotion for older people worthwhile?*

The usual cost-benefit model with consumption versus production discriminates against people with low incomes, such as pensioners. Including “senior production” (care of grandchildren, voluntary work etc) makes cost-effectiveness analyses fairer. Cost-benefit analyses of programmes relevant to older people indicate that the programmes lead to improved quality of life and decreased health care consumption. The potential health gains of a prevention programme are greater in the older population than among young people.

*Recommendations on policy, research and practice*

The recommendations in this Report on policy, research and practice are based on the findings of the project and on the following core principles:

- older people are of intrinsic value to society
- it is never too late to promote health
- equity in health
- autonomy and personal control
- heterogeneity

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