The State of Ageing and Health in Europe: Executive Summary

International Longevity Centre-UK and
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About this report:

The State of Ageing and Health in Europe 2006 is the fourth volume of a series that presents a snapshot of the entire health and ageing landscape in different regions of the world. This is the first time that the series has focused the international spotlight on the health of older adults in the European Union. It presents the currently available information and statistics on the health of older adults and presents specific *Calls to action* for policy makers based on these data. The Executive Summary of the report is presented here.

The State of Ageing reports are supported by The Merck Company Foundation and produced with various partner organisations that are recognised as leaders in the ageing field. A full copy of this report can be requested at *www.ilcuk.org.uk.*

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Europe's ageing population

Europe is the world's oldest continent in demographic terms. By 2050, one-third of Europe's population will be over 60, compared to 13% who will be under 16. The number of people over 60 will increase by 44% between today and 2050. The number of 'oldest old' aged 80+ is expected to grow by 180%.

Europeans enjoy amongst the highest levels of life expectancy in the world: 75.1 years for men and 81.4 for women. Life expectancy has been rising on average by 2.5 years per decade in Europe.

There is growing evidence that not only are we living longer, but we are also living healthier lives. Overall disability levels amongst older Europeans are decreasing, not increasing.

But because there are more older people overall, the absolute numbers of dependent older people may increase in future. Policy makers must take into account the needs of an ageing population in the planning, delivery and organisation of services.

A heterogeneous older population

There is a tendency to lump all persons over 60 together as a homogeneous group. In many ways, this is the equivalent of assuming that all people under 40 have the same health needs.

Lack of informative data on persons aged 60 and over exacerbates this tendency. There is a clear need for better health statistics stratified by age group within the older population. These data will better inform and guide future health policies.

Diversity within the older population must also be taken into account in policies and clinical practice. Care must address individual needs, preferences, social and cultural circumstances and always aim to be person-centred.

Regional diversity within the EU

Life expectancy (LE) ranges from 71 in Estonia to 80 in Italy. LE at birth is on average 4 years lower in the EU-10, with the exception of Cyprus and Malta, where LE rates are closer to those of EU-15 countries.

Most of the difference in LE is due to preventable and premature mortality. Men aged 35-55 living in Central Eastern European countries (CEE) have a 2-fold higher risk of death compared to men of the same age in EU-15. The average gap in LE between men and women is 8 years in EU-10 compared to 6 years in EU-15 countries.

Targeted public health campaigns may help reduce these regional inequalities. Lessons can be learnt from successes achieved in some countries and applied to others, whilst remaining sensitive to cultural contexts and specificities.

Important health inequalities

Important inequalities in life expectancy and overall health status are also found within European countries. Certain 'forgotten' groups of older people are at greater risk of ill-health than others. These include older women, members of ethnic and cultural minorities, socially isolated and disabled older people.

As in other age groups, poverty and lower socio-economic status increase the risk of ill health. Poor older persons have a 30-65% higher risk of almost all chronic diseases than those in more privileged social groups.

Further research is needed to understand the particular barriers in access, quality and outcomes of care that different vulnerable groups may face as they age across Europe. A stronger evidence base may help inform policy solutions.

Targeted actions are needed to empower these groups and engage them in their health and well-being. Equity of access to services is critical.

Forgotten groups: older women

It is often said that 'men die quicker but women are sicker'. Risk of mortality is higher for most chronic conditions in older men, however women present a much greater risk of disability as they age, mostly due to the presence of multiple conditions (co-morbidities).

In research, older women are often neglected as an important subgroup. As patients, they may take on a passive role. Many older women are carers and may devote their energies to caring for relatives at the expense of their own health. Women typically do not allow themselves time to convalesce in the same way as men.

The health care system has an important role to play in ensuring that the needs of older women are addressed in policies and service provision.

The shift towards chronic disease

With the ageing of its population, Europe has seen a major shift towards chronic illness. The prevalence of most chronic conditions rises with age, particularly stroke, heart disease, cancer, cataracts, risk of falls and incontinence.

In persons over 65, cancer and cardiovascular disease together account for around three quarters of all deaths in nearly every European country.

Many chronic conditions will occur at the same time in the older person, leading to significant disability and posing complex challenges to disease management. Integrated care models, which bridge across health and social care, are needed to help manage chronic conditions effectively in the community setting.

The rise of chronic illness also demands that policy makers recognise the needs of informal carers when developing long-term care policies. With increasing decentralisation of services across Europe the burden of informal carers is likely to increase. The vital role of this group cannot be taken for granted. Without support, many will fail to cope and the older people they are caring for will 'fall through the net'.

The burden of late-life depression

Only cardiovascular disease has a greater toll on morbidity and mortality than depression. Yet depression remains under-recognised and highly stigmatised across Europe.

Depression affects 10-15% of persons over 65. Older persons with depression are 2-3 times more likely to have 2 or more chronic illnesses and 2-6 times more likely to have at least one limitation in their activities of daily living.

Depression is the major cause of suicide in European older people. Rates of suicide and self harm are approximately 26% higher in Europeans over 65 than amongst the 25-64 age groups. In 90% of EU countries, the suicide rate is highest in those over 75.

More appropriate medical training, increased social awareness and better access to treatment options are needed to prevent, diagnose and treat late-life depression.

The higher risk of depression in older women and in persons of lower socio-economic status deserves particular attention.

Prevention is for older people too

Most health promotion and public health campaigns tend to focus on changing behaviours in younger people. Yet there is a need to ensure that the right public health messages are being given to all generations.

Prevention may help reduce the burden of some of the most common diseases of later life in terms of quality of life and health resource use. If implemented from midlife onwards, targeted actions may prevent and postpone the onset of cardiovascular disease, dislipidemias, stroke, hypertension, and dementia. Many preventive interventions in later life have been shown to be cost-effective.

Modifiable risk factors

Efforts to modify lifestyle behaviours should be targeted over the entire lifecourse.

Four main factors stand out as allowing people to enjoy better health in older age: a healthy diet, non-smoking, physical exercise and moderate alcohol use.

Good nutrition is of critical importance to people as they age. The risk of obesity in particular may accumulate over the lifecourse of individuals. An often neglected facet to nutrition is malnutrition. Malnutrition in older people is prevalent across all clinical and community settings. Persons over 80 admitted to hospital have a 5 times higher prevalence of malnutrition than those under 50.

Measuring disability and functioning in later life

As mentioned previously, there is encouraging evidence that disability levels are decreasing as the population gets older. Yet with the risk of multiple morbidity in later life, preventing disability remains a main objective of care.

On average, 18% of people 65-74, 28% of people 75-84 and 39% of people 85 and older have severe difficulties in carrying out their activities of daily living.

Disability-free life expectancy at 65 shows significant variability across Europe. Intra-country differences are difficult to interpret, however they suggest that older people across Europe may enjoy very different levels of quality of life as they age. Further research is needed to understand the reasons behind these differences.

'Objective' measures of functional ability have been developed to overcome the cultural biases inherent in self-reported measures of disability. Of these, walking speed and grip strength have been shown to be reliable measures of physical functioning in older people. They are also independent predictors of mortality.

Better indicators are needed to allow us to measure not only health status but quality of life and functional abilities of individuals as they age.

Special focus: Alzheimer's disease

Alzheimer's disease has been called the 'plague of the 21st century'. There are 5.5 million cases in Europe and more new cases per year than stroke, diabetes or breast cancer.

Too many physicians still adopt a somewhat nihilistic attitude towards treating Alzheimer's disease. Physicians across Europe need better training to recognise and treat Alzheimer's disease effectively. For example, a Polish survey estimated that only 10% of practicing GPs were able to recognise the symptoms of dementia.

There is currently no cure for Alzheimer's disease, however prevention and early diagnosis may play a huge role in delaying the onset of severe disease. Medicines are available but are often viewed as 'too expensive'. Significant barriers to access exist across Europe. Finding better treatment options remains a priority as is greater investment in research.

Stigma surrounding Alzheimer's disease needs to be reduced. Caring for a relative with Alzheimer's disease has been described as 'life changing, exhausting and stressful'. Support for carers is urgently needed.

Governments have a key role to play in raising awareness and improving outcomes for sufferers of dementia. Significant resources will be required to address the clinical and social aspects of Alzheimer's disease. New models of care that span across health and social care are needed. Budget projections need to take into account the magnitude of the costs borne by families.

Conclusion

By 2050, one third of Europe's population will be over 60. This will have significant implications for the state of health of Europeans and pose distinct challenges to health and social care systems.

The time is ripe to start addressing these challenges. Actions targeted at modifying lifestyle behaviours, for example stress, obesity and tobacco use, are useful over the entire lifecourse. If implemented from midlife onwards, these actions may prevent and postpone the onset of morbidity caused by such conditions as cardiovascular disease, stroke, cerebrovascular disease, and communicable diseases in older people.

When coupled with more sustainable, community-orientated models of care, better evidence on the health status and preferences of older people, and more attention given to issues such as later-life depression and dementia, these actions may help ensure that active ageing is a reality for future generations of Europeans.

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