Ageing and wellbeing: health in later life

Responses to Session 2 questions – Newcastle University (Tom Kirkwood and Karen Davies)

2.1 *How does healthy ageing differ for current older people compared to previous generations?*

It is hard to provide firm evidence because data were not collected in any reliable form for previous generations. It is known that death rates of older people have declined considerably over the last 50 years but information on healthy ageing is lacking. What limited data is available from previous generations is very patchy. Studies have not been representative of the population at large.

It was specifically to begin to fill this knowledge gap that the Newcastle 85+ Study was begun with funding from the Medical Research Council in 2006. This sought to recruit everyone registered with participating general practices in Newcastle upon Tyne and North Tyneside who had been born in 1921. A high level of recruitment was achieved including those in hard-to-reach categories (care home residents and those with dementia). This prospective study is still ongoing.

Baseline data reveal that 85 year olds experience extensive multimorbidity (75% have 4 or more medical conditions), yet 78% rate their health as “good”, “very good” or “excellent”.

When assessment was made of capacity to undertake 17 different Activities of Daily Living, there was great diversity. Some exhibited high-level dependency but almost 30% of men and 15% of women had no functional limitation in the 17 ADLs.

See Collerton et al *BMJ* 2009;399:b4904 and Jagger et al *BMC Geriatrics* 2011, 11:21 (link)

2.2 *Can and should we maintain our expectations and views of health in older age compared to younger age?*

It is not entirely clear what this question is asking. The experience of getting older involves certain changes in health and it is of course necessary to prepare for and adjust to these. However, the experiences of individual are extremely diverse. Scientific data indicates that there is considerable malleability in the personal trajectories of health across the life course. Therefore positive engagement in efforts to enhance health at any age is likely to be worthwhile.

2.3 *Should “ageing” itself be considered a disease or condition that requires remedy or should it be embraced as a positive stage of life?*

This is two questions rather than one.

As to whether ageing is a disease or normal part of the life course, the answer is that ageing is normal but brings increased vulnerability to a spectrum of diseases. Both intrinsic ageing and age-related diseases are amenable to intervention.

Older age should of course be embraced as an opportunity for further positive experience of life, despite its associated challenges.

The Commission may find it useful to refer to the recent UK Government Foresight project on Mental Capital and Wellbeing. The most relevant component is the report on Mental Capital Though Life, a copy of which is attached.

2.4 *What needs to be done to ensure that we remain healthy for as long as possible as we age?*

The main options, as informed by current evidence, centre around (i) avoidance of anything that causes the body to age prematurely (e.g. smoking, alcohol, drug abuse, saturated fats, sugar, inactivity, chronic stress etc) and (ii) promotion of actions that can enhance the body's intrinsic mechanisms for maintenance of health (activity, good nutrition, mental stimulus, social engagement).

2.5 *Are there cultural, ethnic or social-economic factors that help to promote or prevent healthy ageing?*

It has long been known that social-economic disadvantage is associated with shorter life expectancy and earlier risk of a spectrum of age-associated multimorbidity. This is consistent with the fact that social-economic disadvantage tends, on the average, to be linked with the adverse factors listed in the answer to 2.4 above. However, it is not yet clear exactly how the cause-and-effect relationships in this complex association play out. It should, in theory, be possible to follow healthier lifestyle choices even on low incomes; therefore the underlying patterns of low-esteem and reduced health aspiration need to be better understood. In terms of ethnic and cultural factors, these again are complex. The extent to which such factors contribute to poorer expectations of healthy ageing in some ethnic and cultural contexts, independently of social-economic factors is not well known. It is thought, for example, that immigrants who have significantly changed their nutritional environments may be affected by trans-generational adaptations that were suited to the environment of origin but which may be maladaptive in a different environment.