World Health Organization

REGIONAL OFFICE FOR Europe

Active Ageing
Good health adds life to years

Policies and priority interventions for healthy ageing

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Introduction

The median age of the population in the WHO European Region is the highest in the world and it continues to increase rapidly. Many people enjoy some of the longest life spans in the world: average life expectancy at birth for the 53 countries in the European Region is over 72 years for men and around 80 for women. But gaps in longevity and health experiences at higher ages continue to grow. The proportion of people aged 65 and older is forecast to almost double between 2010 and 2050, and no age group will grow faster than those aged 80 and over.

Combined with reduced fertility and population growth rates in many countries, increased average life expectancy is leading to higher old-age dependency ratios. While the average in the WHO European Region was almost 26 dependants (aged 65 and over) per 100 people of working age in 2010, it is projected to double to around 52 by 2050. But a static cut-off point at the age of 65 does not take into account increasing life expectancies, nor the growing number of people beyond this age who retain an active social life, support their families and engage in voluntary activities in their communities.

Fig. 1 shows the difference in projected dependency ratios, according to whether the age limit used is fixed or dynamic. The fixed age limit uses the ratio of the number of people 65 years and older, to the number of people aged 20 to 64. The dynamic age limit uses the ratio of the number of people at or above the age at which they can expect to live another 15 years, to the number of people aged 20 and up to that age. Dependency ratios grow substantially more slowly and follow different trends if the age at which people can expect to live on average another 15 years is taken as the age limit. This age limit increases over time and differs substantially between countries (Fig. 2).

Enabling a greater proportion of older people to stay healthy and active has become key for the future sustainability of health and social policies in Europe. The unfavourable fiscal prospects that affect many countries have added to the urgency to step up implementation of policies aimed at healthy ageing.

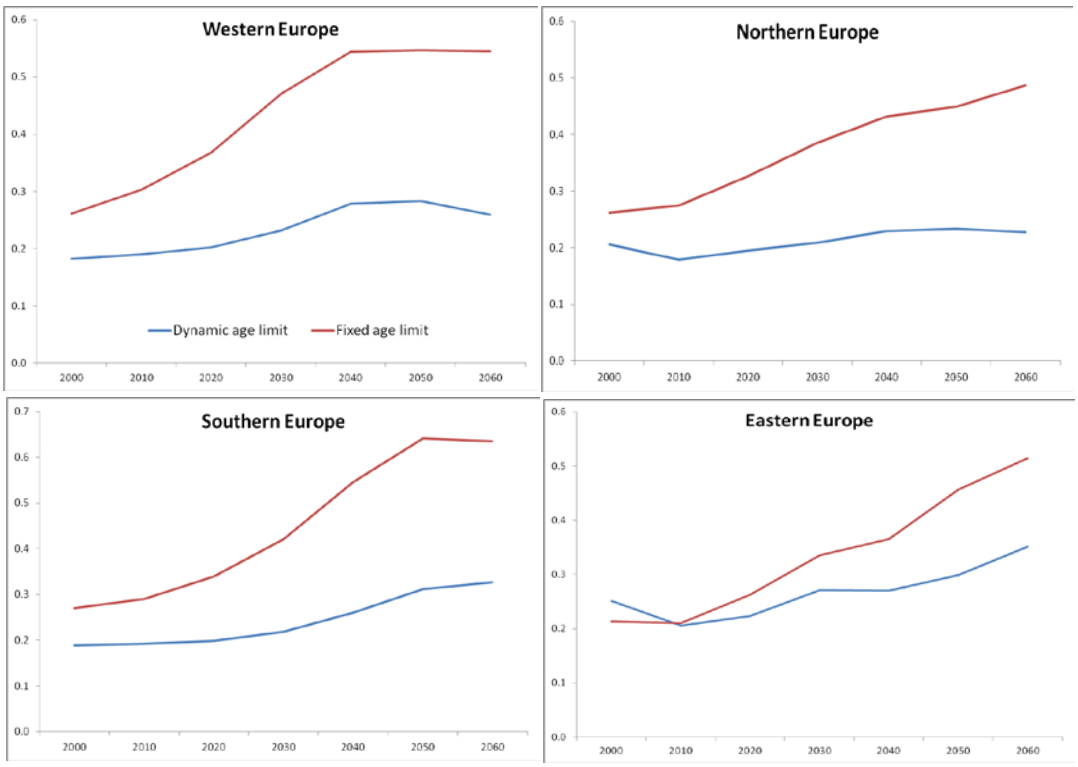
“Healthy ageing” is a short term for the broader concept of both active and healthy ageing. Active ageing is defined by WHO as:

> … the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age. Active ageing applies to both individuals and population groups. It allows people to realize their potential for physical, social, and mental well being throughout the life course and to participate in society according to their needs, desires and capacities, while providing them with adequate protection, security and care when they require assistance.[1]

Early interventions to promote an active life can reduce the proportion of older people falling below the disability threshold as illustrated in Fig. 3.

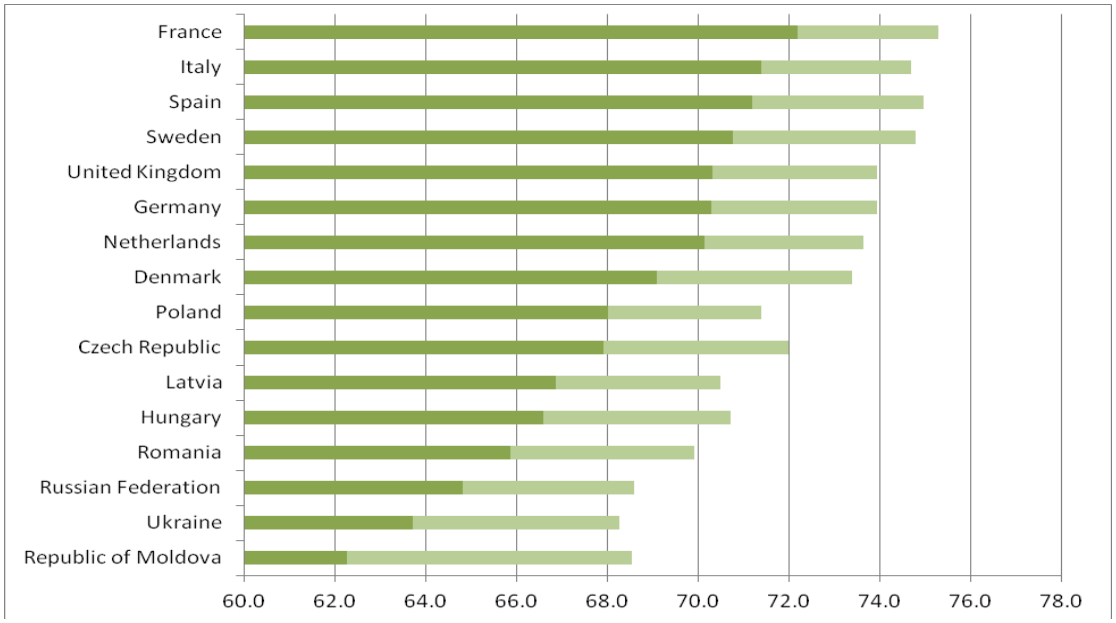
[1] *Active ageing. A policy framework.* Geneva, World Health Organization, 2002 (http://whqlibdoc.who.int/hq/2002/WHO_NMH_NPH_02.8.pdf, accessed 16 March 2012).

Fig. 1. Projected dependency ratios with fixed and dynamic age limits, by United Nations European subregions



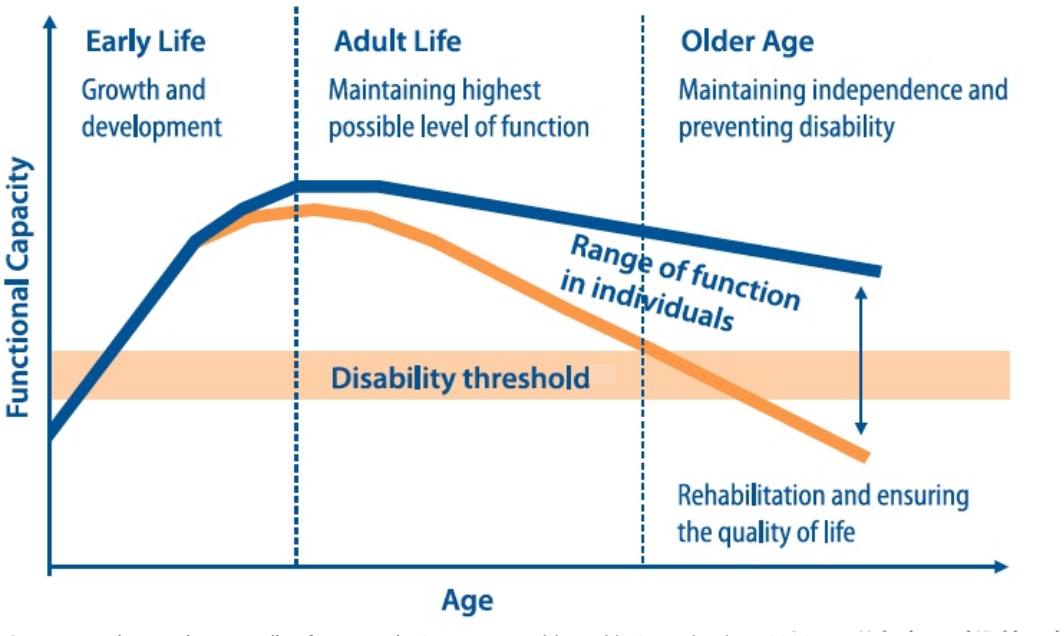
Source: European Centre for Social Welfare Policy and Research/WHO Regional Office for Europe, unpublished information, 2012.

Fig. 2. Age at which remaining life expectancy is 15 years, 2010 and 2050



Source: World population prospects, the 2010 revision. New York, United Nations, Department of Economics and Social Affairs, 2010 (http://esa.un.org/wpp/unpp/panel_population.htm, accessed 16 March 2012).

Fig. 3. Functional capacity over the life-course



Source: Active ageing. A policy framework. Geneva, World Health Organization, 2002 (http://whqlibdoc.who.int/hq/2002/WHO_NMH_NPH_02.8.pdf, accessed 16 March 2012).

Healthy ageing is high on the European and global policy agendas. The year 2012 marks the 10th anniversary of the United Nations Madrid International Plan of Action on Ageing. In the European Union, 2012 has been designated as the European Year for Active Ageing and Solidarity between Generations. Around 7 April, when WHO celebrates World Health Day 2012, campaigns throughout Europe will focus on ageing and health, raising awareness of how individuals and governments can contribute.

A core contribution for the WHO European Region is the action plan on healthy ageing in Europe for 2012–2016 that the WHO Regional Office for Europe is developing in consultation with its Member States and civil society. Allowing more people to lead active and healthy lives in their later years requires investment in a broad range of policies. The following four strategic priority areas map how integrated health policies can respond to rapid ageing in Europe.

Strategic priority areas

Healthy ageing over the life-course

Fighting the noncommunicable disease epidemic throughout the life-course is broadly agreed to be the key to further health gains at higher ages and for making health and social policies sustainable. Noncommunicable diseases account for the bulk of loss of healthy life years for people aged 60 and over. An individual's health and level of activity in older age thus depend on his or her living circumstances and actions over a whole life span. But more can be done to promote health and prevent disease, including among older populations, for whom access to prevention and rehabilitation may be impaired. A special concern is maintaining mental capacity and well-being into the highest age groups.

Health and long-term care systems fit for ageing populations

A second challenge is making health systems fit for ageing populations. How can the different levels of health and social care be better coordinated and provide better services for people with multiple chronic conditions and with functional limitations? The level of cost-sharing of the health bill is too high for many older people in Europe and public spending on long-term care varies enormously among countries. The evidence indicates that many people increasingly expect better access to high-quality health and social services, including public support for the informal care provided by family, friends and other volunteers.

Supportive environments

A promising development is the growing network of cities and communities that cooperate among themselves and with WHO to create supportive, age-friendly environments. This is a focus of the WHO Regional Office's contribution to the European Year for Active Ageing and Solidarity between Generations and to the European Commission's European Innovation Partnership on Active and Healthy Ageing.

Strengthening research and the evidence base

The Regional Office also strives to improve the evidence for policy, to facilitate the exchange of knowledge and to fill gaps in comparable data. Knowledge exchange and transfer will continue to be key for a European Region that is rich in innovative examples of best practice for healthy ageing, including at the local level.

Five priority interventions

Under these four strategic areas, the WHO Regional Office for Europe proposes priority actions to obtain measurable results within about five years. These are selected with a number of criteria in mind. They respond to questions often asked by politicians who want advice in the form of a limited number of policy recommendations, rather than comprehensive lists of actions. What interventions have a demonstrated capacity to achieve "quick wins", if adequately implemented? Are they politically feasible? Can progress be achieved and measured within a relatively short time span of several years?

The WHO Regional Office envisages working with countries at various levels of government to design and implement five priority interventions:

- prevention of falls;
- promotion of physical activity;
- influenza vaccination of older people and prevention of infectious disease in health care settings;
- public support to informal care giving with a focus on home care, including self-care; and
- geriatric and gerontological capacity building among the health and social care workforce.

Given that these interventions are already prominent in national or subnational plans related to healthy ageing, evidence is growing about their effectiveness and contribution to the sustainability of health and social policies. This evidence base provides a foundation for the further strengthening of international exchange and knowledge transfer.

Prevention of falls

The risk of falls increases steadily with age. About 30% of people over 65 and 50% of those over 80 fall each year. Older women are more vulnerable than older men as they tend to have less muscle strength and are more likely to have osteoporosis. Fall-related injuries in old age are more likely to be severe and, once injured, older people are more susceptible to longer-lasting ill health or hospital stays, or fatal complications. Fall-related injuries (mainly hip fractures) incur considerable costs for hospital admissions and rehabilitation interventions.

Environmental hazards account for between a quarter and a half of falls; other factors include muscle weakness, gait and balance disturbances, a previous history of falls and multiple medication. Convincing evidence reveals that most falls are preventable. Some preventive measures have been shown to be cost-effective, or even cost-saving and there are good-practice examples of how fall prevention strategies can be successfully implemented in different settings, when supported by public policies.

A combination of raising awareness of risk factors, exercise programmes, physical therapy and balance retraining can reduce falls and the number of injuries per fall. An increasing number of countries has programmes in place for home safety assessments and modification by trained professionals that can reduce falls. More specialized preventive measures for high-risk groups of older people have also been designed, such as the wearing of hip protectors. Falls prevention is prominent in quality management programmes for the health and social care of older people in various settings.

How does WHO contribute?

A number of publications illustrate WHO's contribution to advancing action on falls prevention. For example, the *WHO global report on falls prevention in older age* provides a set of recommendations.[2] For the European Region, the *WHO European Action Plan for Food and Nutrition Policy 2007–2012* includes guidelines for strengthening nutrition and food safety in the health sector. [3]

Under this priority intervention, the WHO Regional Office will work with Member States on a variety of objectives, including raising public awareness of risk factors and effective fall prevention measures; improving training and access to relevant information for informal care givers in the community; increasing access to preventive measures for high-risk groups; and incorporating fall prevention measures in quality frameworks in health and social care settings for older people.

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[2] *WHO global report on falls prevention in older age.* Geneva, World Health Organization, 2007 (http://www.who.int/ageing/publications/Falls_prevention7March.pdf, accessed 16 March 2012).

[3] *WHO European Action Plan for Food and Nutrition Policy 2007–2012.* Copenhagen, WHO Regional Office for Europe, 2008 (http://www.euro.who.int/__data/assets/pdf_file/0017/74402/E91153.pdf, accessed 16 March 2012).

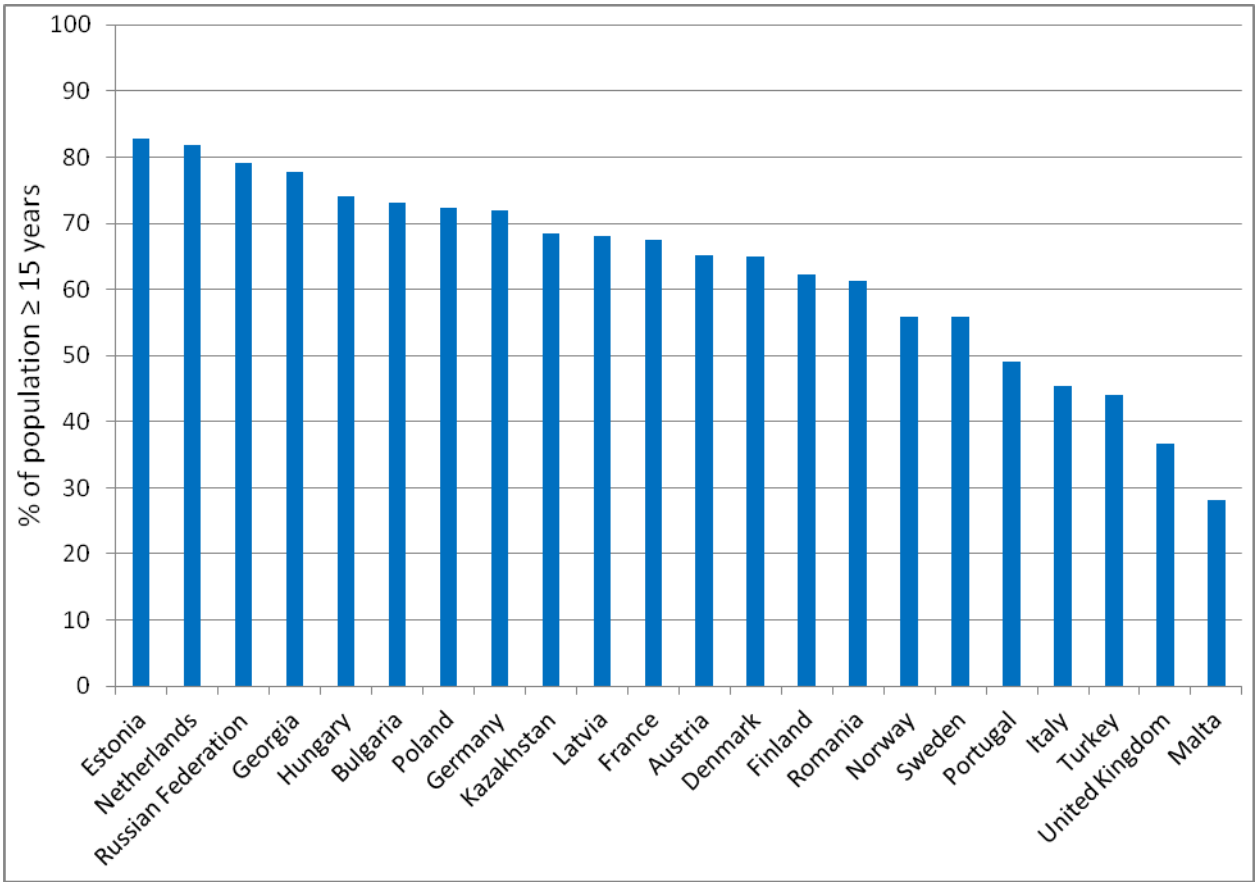
Promotion of physical activity

Physical activity is one of the strongest predictors of healthy ageing. Regular moderate physical activity promotes mental, physical and social well-being and helps to prevent illness and disability. Those who are physically fit when they enter old age tend to stay healthier for longer. For older people, physical activity is beneficial not only in preventing disease but also in lowering the risk of injuries, improving mental health and cognitive function, and enhancing social involvement.

The age-related loss of muscle mass can amount to 30–50% by the age of 80. Age-related muscle loss currently affects over 40% of men in the European Region aged 70–79, and over 50% of women.

Unfortunately, a large proportion of people in the Region, over half in some countries, is physically inactive; and evidence shows that physical activity tends to decrease as people grow older (Fig. 4).

Fig. 4. Proportion of population that is physically active, age-standardized estimates, 2008



Source: Global Health Observatory Data Repository [online database]. Geneva, World Health Organization, 2012 (http://apps.who.int/ghodata/, accessed 16 March 2012).

Policy interventions

Policy development in many countries now reflects the purgency of reversing the trend towards inactivity, including among older people. The causes of declining physical activity among older people vary by setting, necessitating tailored responses that address gaps in public awareness, urban planning, transportation, health financing, social welfare systems, among others. National

policies and plans on physical activity usually comprise multiple strategies aimed at raising public awareness, creating supportive environments for physical activity to take place, and supporting individuals to make a change. An effective approach will include steps to combat ageist attitudes and to work with older people to evaluate and redesign the urban environment. Investing in physical activity policies and programmes can achieve much more than better health: it can also reduce health care costs, make cities more liveable and attractive, reduce air pollution and revitalize neighbourhoods.

How does WHO contribute?

In *Steps to health. A European framework to promote physical activity for health*, the WHO Regional Office provides experts and policy-makers with guidance on designing and implementing policy and action that promote physical activity.[4] The Office will continue to support its Member States at various levels of government in fostering cooperation and the sharing of experience and good practice on effective measures.

Influenza vaccination of older people and infectious disease prevention in health care settings

Influenza is an acute viral infection of the respiratory tract that spreads easily from person to person. Influenza viruses circulate worldwide, causing annual epidemics in the WHO European Region during the winter months.

Although usually a mild and self-limiting disease, influenza can cause life-threatening complications including pneumonia and bronchitis or exacerbation of underlying conditions (such as pulmonary or cardiovascular diseases) resulting in hospitalization and death. Older people, in particular, are vulnerable to developing severe disease, which may result in prolonged and costly rehabilitation and recovery. During seasonal influenza epidemics, people aged 65 years or older account for more than 90% of influenza-related deaths.

Prevention

WHO recommends that people at risk of developing severe disease, including older people, are vaccinated annually before the influenza season begins. Such vaccination of older people also provides considerable economic benefits by reducing direct medical costs. Vaccines against influenza have been used for over 60 years and are considered safe and the best intervention available for preventing influenza-related morbidity and mortality. In healthy adults, vaccination may offer 70–90% protection against influenza infection. Nonetheless, the extent to which vaccination reduces influenza-related morbidity and mortality in older people, especially the frailest, is the subject of debate and calls for renewed studies on vaccine efficacy and investigation of alternative vaccination and other prevention strategies.

In addition, influenza outbreaks associated with infected staff in health care facilities and nursing homes are well documented. It is therefore critical that personnel working in these environments are vaccinated.

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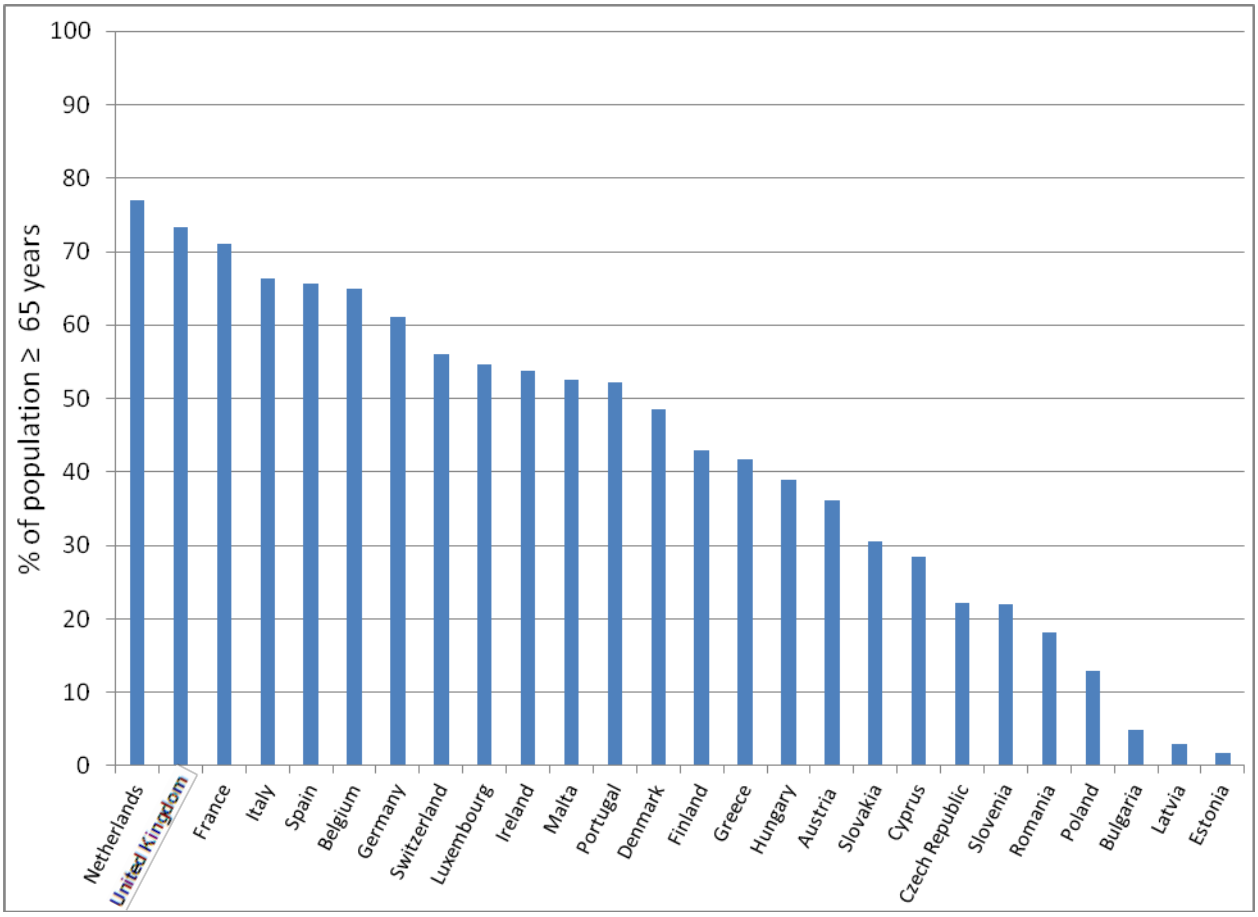
[4] *Steps to health. A European framework to promote physical activity for health.* Copenhagen, WHO Regional Office for Europe, 2007 (http://www.euro.who.int/__data/assets/pdf_file/0020/101684/E90191.pdf, accessed 16 March 2012).

In 2003, the World Health Assembly recommended that influenza vaccination coverage of older people be increased to at least 75% by 2010. This recommendation was reaffirmed by a European Parliament resolution in 2005. Some countries in the WHO European Region have made considerable progress in increasing seasonal influenza vaccination coverage of older people, but in most Member States coverage remains well below the 2010 WHO target (Fig. 5).

Fig. 5. Influenza vaccination rates, population aged 65 and over, 2009 or latest available year



Note: For Austria and Germany, the population is aged 60 and over.
Sources: OECD Health Data 2011 [online database]. Paris, Organisation for Economic Co-operation and Development, 2011; European Health Interview Survey [online database]. Brussels, Eurostat, 2012.

How can WHO contribute?

Key priorities for cooperation between the WHO Regional Office and its Member States include:

- initiatives to develop more effective influenza vaccines based on new vaccine technologies;
- continued support to increase influenza vaccine uptake among older people in countries with existing influenza vaccination programmes, and to introduce a seasonal influenza vaccine programme in countries where this does not exist; and
- increasing the evidence base to guide decision-making on introducing seasonal influenza vaccine for older people and to strengthen country capacities to monitor the uptake of influenza vaccine.

Public support for informal care giving with a focus on home care

As populations age in the European Region, an increasing number of older people with functional limitations need support with the activities of daily living. The growing prevalence of dementia will further increase the demand for this support. In all European countries, most care (in terms of hours) is provided informally at home (mostly by women). This is the case even in countries with well developed publicly supported elderly care sectors. Public support for informal care giving is one of the most important public policy measures for the future sustainability of health and social care in ageing populations.

This care is usually a response to multiple disorders and requires an evolving and tailored combination of acute care, rehabilitation, chronic disease management, social care, dementia care and finally palliative care. Where these services are available, however, they are often fragmented and may be prohibitively expensive.

Most people with chronic health or social care needs prefer the option of living at home and remaining independent as long as possible, over the alternative of assisted living in an institution. Access to adequate care at home can reduce the need for acute care in hospitals or other care facilities and is generally considered to be more effective and efficient in maintaining the quality of life.

But without public support, caring for a relative or friend can be associated with reduced workforce participation, a higher risk of poverty and the long-term loss of employment opportunities for the care giver. Lack of support can also have a negative impact on the relationship between care giver and recipient, and can potentially lead to mental and other health problems, the social isolation of both parties, or elder maltreatment.

Although most public funding of long-term care is still provided through institutions, in some countries in the European Region long-term care provided at home is seen as a preferred and cost-effective alternative to care provided in a nursing home or other facility (Fig. 6). In these countries, it has become an important component of publicly funded services.

How does WHO contribute?

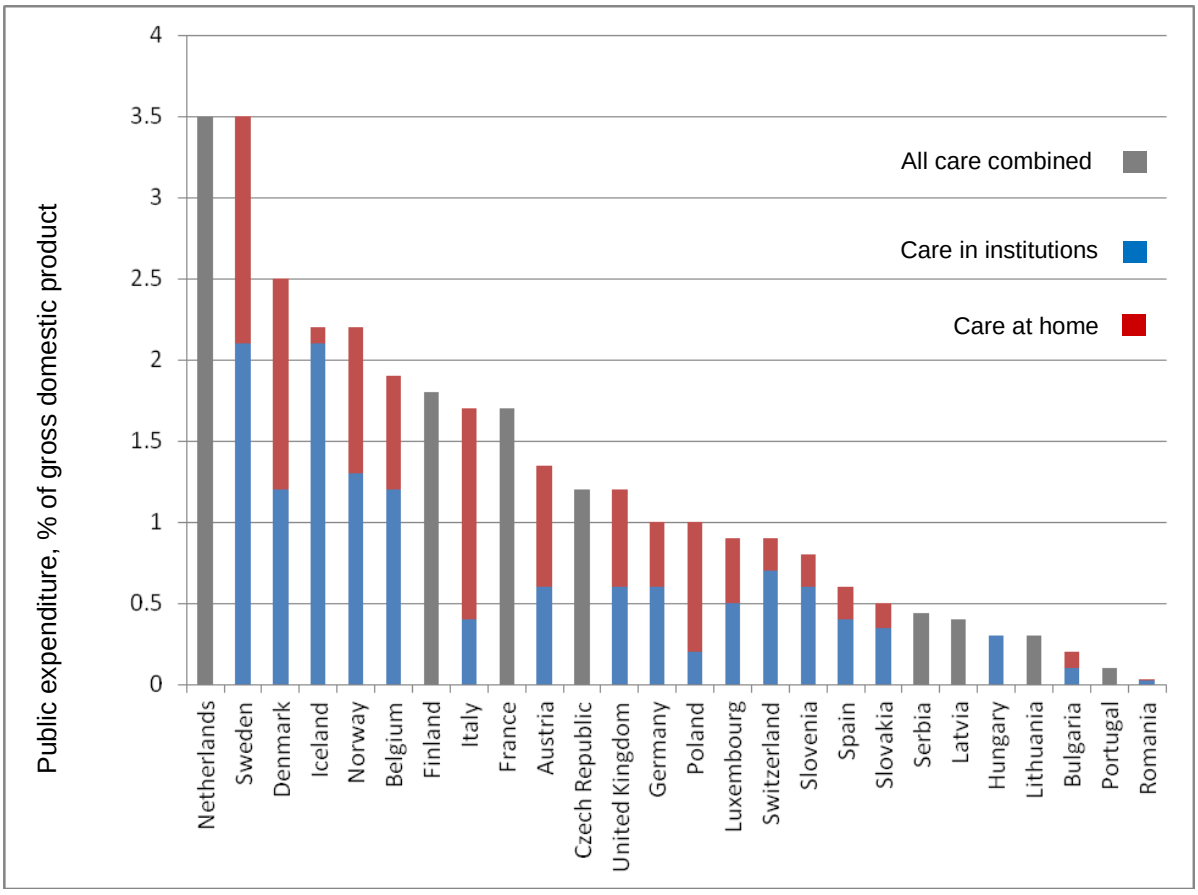
Finding the right balance between formal and informal care requires evidence on the health benefits and efficiency of and trends in informal care. In cooperation with other international organizations, the WHO Regional Office for Europe aims to strengthen the evidence base for informal care, such as on public and private home care usage, expenditures and outcomes, trends in informal care giving, and the living and family situations of older people. Through dissemination of good practice and international exchange, the Regional Office will continue to facilitate knowledge transfer and help in setting up basic packages of public support to home care, where these are currently missing or very fragmented.

Geriatric and gerontological capacity building among the health and social care workforce

Over the last 20 years, substantial progress in geriatric education has been made in many countries in the WHO European Region. Geriatrics has become a recognized specialty in medical schools, in undergraduate and postgraduate teaching, and in the continuous training of health care staff at various levels. Though progress has been uneven across the Region, surveys

conducted in 47 countries show that the number of established chairs for geriatrics has increased by more than 40% overall, and undergraduate and postgraduate teaching activities have increased by 23% and 19%, respectively.[5]

Fig. 6. Public expenditure on long-term care in institutions and at home, 2009 or latest available year



Source: European Centre for Social Welfare Policy and Research/WHO Regional Office for Europe, unpublished information, 2012.

But the growing number of very old people in the European Region has made it urgent to further strengthen national and subnational capacity for training in geriatrics and gerontology and to promote a stronger profile for geriatric training, including cross-specialty training. The greatest challenges are still gaps in the geriatric knowledge of general practitioners and other health care practitioners on the one hand and insufficient specialist training and a shortage of specialists in geriatrics itself on the other. Sound evidence points to access problems and shortcomings in the quality of care as a result of these insufficiencies. Although they were identified many years ago, progress in resolving these insufficiencies has been slow in many cases, increasing the urgency of action under this priority intervention.

How does WHO contribute?

To help close the gap in the capacity and training of health and social care staff, the WHO Regional Office cooperates with partners such as the European Commission and the Organisation for Economic Co-operation and Development in the international monitoring of the

[5] Michel J-P et al. Europe-wide survey of teaching in geriatric medicine. *Journal of the American Geriatrics Society,* 2008, 56:1536–1542.

health and social care workforce. It supports the international exchange of good practices in the evaluation and promotion of continuous training in competencies in health and social care for older people and will promote international networks in the European Region.

Supporting interventions

Experience from many European countries has shown that besides these five priority interventions, a number of supporting interventions can be important, particularly in linking healthy ageing to its wider social context. Among these are the prevention of elder maltreatment, social isolation and social exclusion. The WHO Regional Office for Europe addresses all three of these areas in its work with Member States.

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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