Active Ageing and Quality of Life in Old Age

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Related Processes

- **UNECE** Working Group on Ageing: „Quality of Life and Active Ageing“


  *Strategic priority areas for action*: Healthy ageing over the life course, supportive environments, health & LTC systems fit for ageing populations, strengthening the statistical evidence base and research

  *Priority interventions*: Falls prevention, promoting physical activity, vaccination of older people and infectious disease prevention in health care settings, public support to informal care giving with a focus on home care, including self-care, geriatric and gerontologic capacity building among the health and social care workforce

  *Supporting interventions*: Prevention of social isolation and social exclusion, quality of care strategies for older people including dementia care and palliative care for long-term care patients, prevention of elder maltreatment

- **European Year** of „Active Ageing and Intergenerational Solidarity“
Structure of the Presentation

1. The Argument
2. Early investments in active ageing
3. Late investments in active ageing
4. Investments in societal frameworks for active ageing
5. Some precautions
6. Policy recommendations
7. Questions
1. The Argument

– **Use a broad definition of active ageing**
  Active ageing embraces both individual processes and societal opportunity structures for health, participation and security. Goal: enhancing quality of life as people age.

– **Start early**
  Active ageing begins with investments early in life (e.g. education, health behaviour, volunteering in childhood and adolescence).

– **It’s never too late**
  Even in middle and late adulthood investments in active ageing are effective (e.g. health behaviour change, volunteering).

– **Improve societal frameworks**
  Health, integration, and participation in late life (level, diversity and association with other variables) can be fostered by good societal frameworks (e.g. strength of welfare state).

– **Don’t forget frail elders**
  Late in life a substantial proportion of the “old old” will need support because of multi-morbidity and frailty.
2. Early Investment in Active Ageing

Idealized Effects

Note: The figures shows hypothetical effects of early investments in active ageing.
2. Early Investment in Active Ageing

Overview of Results

- **Health**
  Lower socioeconomic status (education, income, occupational prestige) is related to worse health. Age as leveler or age as double jeopardy? Educational differences → onset of disease income/wealth differences → maintenance of functional health.

- **Social Integration**
  Low educational status: More often no confidant, no partner and lack of social support. But: No education differences in kin support.

- **Participation**
  High educational status: Higher probability of gainful employment during the last decade before retirement, higher probability of volunteering in late life.
Germany: The Effects of Educational Status in Functional Health Increase in the Second Half of Life

Wurm, Schöllgen & Tesch-Römer 2010: German Ageing Survey (DEAS)
Effects of Educational Status Are Also Clearly Seen in the Frequency of Physical Activities

Wurm, Schöllgen & Tesch-Römer 2010: German Ageing Survey (DEAS)
3. Late Investments in Active Ageing

Idealized Effects

Note: The figures show hypothetical effects of late investments in active age.
3. Late Investments in Active Ageing

Overview of Results

– **Health**
  Physical activity positively affects health outcomes, cognitive capacity and subjective well-being – up to very old age (80+ years).

– **Social Integration**
  Interventions against loneliness in very old people rely on the provision of opportunities to meet other people, training for social skills and social cognitive intervention.

– **Participation**
  “Employability” of older workers can be improved by employers (e.g. further training, job rotation) and employees (e.g. investing in skills and health). Volunteering can be stimulated by offering choice of voluntary activities, the ability to plan one’s own time table and compensation for the activity.
Effects of Physical Activity on Health in Old Age I

- **Intervention study**: N ~700 very old participants (mean age 87 years)
- **Strength training** over 10 weeks for muscles at hips and knees
- **Supplement**: protein-containing dietary supplement
- **Control group**: Placebo

Effects of Physical Activity on Health in Old Age II

- **Intervention study**: N ~700 very old participants (mean age 87 years)

- **Strength training** over 10 weeks for muscles at hips and knees

- **Supplement**: protein-containing dietary supplement

- **Control group**: Placebo

4. Societal Frameworks For Active Ageing

Idealized Effects

Note: The figures shows hypothetical effects of societal frameworks for active ageing.
4. Societal Frameworks For Active Ageing

Overview of Results

– **Health**
  Societal wealth related to good health in old age. In poorer countries stronger age-related decline in health satisfaction and rise in self-reported disability.

– **Social Integration**
  Cultural norms and societal wealth influence the relationship between social integration and well-being (e.g. effects of social integration may collapse when societal wealth is low and welfare state is weak).

– **Participation**
  Employment rates of older workers (55-64 years) high in Northern Europe, the British Isles, and North America, lower in Central, Southern and Eastern Europe. – Volunteering rates high in Northern Europe and relatively low in Mediterranean countries.
Healthy Life Expectancy in Europe: Large Differences between Countries...

Males

Females

http://ec.europa.eu/health/indicators/index_en.htm
Data from 2009
...but Frailty in Old Age Belongs to Life Everywhere

![Chart showing years in poor and good health for Males and Females across different European countries.](http://ec.europa.eu/health/indicators/index_en.htm) Data from 2009
5. Some Precautions I

Prototypical Life Course with Frailty Phase

**Compression of Morbidity:**
- extension of life span
- slowed rate of ageing
- no frailty phase

**“Shifting“ of Morbidity:**
- extension of life span
- unchanged rate of ageing
- frailty phase
5. Some Precautions II

- **Exclusion of frail elders?**
  An individualized focus on “successful ageing” could lead to the social exclusion of frail older people.

- **Inclusive policies**
  Policies for activating older people are necessary, but they should be complemented by policies on supporting frail and dependent older people to ensure their social inclusion and human dignity.
6. Policy Recommendations

- **Setting the framework for active ageing**
  - Investing in education
  - Providing security
  - Encouraging inclusive images of ageing

- **Fostering healthy biographies**
  - Promoting a healthy lifestyle
  - Providing effective services of health care and long-term care

- **Supporting social integration**
  - Strengthening diverse family types, extending social ties beyond family
  - Giving aid to caring families

- **Encouraging societal participation**
  - Reinforcing employability and stimulating employers
  - Creating opportunities for volunteering
7. Questions I

(1) How are responsibilities for active ageing shared between the individual and the society? Do individuals have a duty to make use of the opportunities provided for by the society?

(2) What should be done to avoid disadvantage to (older) people who cannot (or do not want to) invest in active ageing?

(3) Investing into active ageing: What should be done to promote life-long learning?

(4) Investing into active and healthy ageing: What should be done to change health behaviour throughout the life-course?

(5) What should be done to change working conditions settings for improved health of older persons?
7. Questions II

(6) What should be done to stimulate active ageing in different sub-groups (e.g. people with low education, people with low income, migrants)?

(7) What difference can new images of ageing make? How can images of ageing be changed?

(8) Bearing in mind that many ageing people – notably a high proportion of the very old – suffer from illness, chronic diseases, and frailty: What could be an inclusive understanding of active ageing?

(9) The proportion of ageing people without children is rising. If residential care homes are not a preferred option for such persons: What could be an equivalent to family care? And

(10) What should be done to help older people with functional limitations to live independently at home?