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Personal view

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Longevity and healthy ageing – Will healthcare be drowned by the grey Tsunami or sunk by the demographic iceberg?

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Abstract

Will healthcare be drowned by the grey Tsunami or sunk by the demographic iceberg? Or will new and radical, economic, medical, nutritional, exercise and life style developments, produce a better economic model for future healthcare. A properly funded Health Service rather than an over Politicised Failing Sickness service.

Keywords

Exercise, health economics, healthy ageing, lifestyle, longevity, nutrition

> The devastating impact of population aging in the decades to come is becoming like the proverbial weather: everyone is talking about it but no one is doing anything about it.

Predicted increases in demand for health and social care from 2010 to 2030 for people aged 65 and over in England and Wales include:

> people with diabetes: up by over 45%
> people with arthritis, coronary heart disease, stroke: each up by over 50%
> people with dementia (moderate or severe cognitive impairment): up by over 80% to 1.96 million
> people with moderate or severe need for social care: up by 90%.

The Nuffield Trust has recently estimated that under the current healthcare system, the NHS in England will see a funding shortfall of £54 billion by 2021/2022 if NHS funding remains constant in real terms.[1]

Life expectancy is going up by 6 h a day and the consequent lengthening of lifespan and the number of aged people, is perceived in very different ways. One school of thought regards this increase in ageing as a threat representing increased disability and illness which resulted in increased cost to the state and NHS. Indeed, it has been said that ageing in the developed countries is the biggest threat to the global economy because of the increased cost burden of all these old people who are chronically sick with prolonged illnesses of old age.

The alternative view is that this longevity represents an opportunity for improving the health and indeed lifestyles of all the people giving them increased health and happiness; reducing costs of healthcare by using innovative strategies of health prevention, so that, in this scenario, the very old tend to die from acute illness of relatively short duration.

This second view is rather similar to that proposed when the NHS was first founded in 1947, in that as healthcare improved and illness such as diphtheria, rheumatic fever and tuberculosis were successfully treated, then the total cost to the NHS would decrease over time.

This clearly did not come to pass and the reasons why this did not happen bears detailed analysis, especially at this moment in time, if we are to avoid financial meltdown healthcare.

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If this resource disparity is not very urgently addressed, then there will be a period of several decades where Government continues with current policies and healthcare system, increasing the burden of the retired population and the rest of the economy.

One model in *The Ageless Generation*,[2] suggests that biomedicine will transform our society forever by allowing people to live longer and to continue working and contributing financially to the economy longer, rather than entering into retirement and draining the economy through pensions and senior healthcare. Old age will become a concept of the past, breakthroughs in regenerative medicine will continue, and an unprecedented boom to the global economy, with an influx of older able-bodied workers and consumers, will be a reality.[2]

'This book, *The Ageless Generation*, shatters the illusion of retiring at 65, correlating the importance of research into repairing and slowing age-related damage with social security savings that will make even the most hardened policy maker sit up'.[2]

Another very important area, manipulation of human exercise, nutrition[3] and fasting[4,3] will have a massive positive effect on health, wellbeing and the economics of medicine in general.

The use of intermittent fasting (as popularised by Michael Mosley and the BBC Horizon programmes, book *Fast Diet*[4]) will have profound impact on healthy ageing, keeping individuals healthy, by avoiding the risks of metabolic syndrome, diabetes and cardiovascular disease improving cognitive ageing, reducing the risks of obesity. Intermittent fasting may well have benefits in terms of mood and reducing risk of depression.

Intermittent fasting works by reducing instantly insulin sensitivity with consequent beneficial medical effects.

Fasting can reduce the level of the hormone, Insulin Growth Factor 1 (IGF-1), reducing the risk of malignancy.[4]

Not only that, it has also been suggested that fasting regimes may enhance the efficacy of chemotherapeutic agents in treating malignancy, that is, fasting may well make chemotherapy more effective; trials are ongoing in this area.[4]

Attitudes to ageing[1]

For most people, living longer is to be celebrated. Many people now enjoy fuller retirements than ever before, or continue to work well into their later life. Older people make a considerable contribution to society, bringing maturity and varied life experiences to bear.

People's definitions of what it means to be 'old' have changed, along with ideas about how dependent older people are. For a lot of people, being 'old' is a state of mind related to health and the ability to remain independent. The public does not necessarily associate being 'old' with retirement or the earlier 60s. Yet this is still the age at which many public services, such as the free bus pass and winter fuel payments, are automatically handed out. Britons do not see themselves as elderly until they are approaching 70, and many in their 70s and beyond continue to be active and engaged in society.

If being 'old' does not begin at an arbitrary age, perhaps it should not be associated with birthdays at all. Society should move away from thinking about chronological age. Society should 'stop thinking about age itself as some sort of disease or handicap'.[5]

Employers often equate older age with retirement, and policy-makers tend to assume that when people reach traditional retirement age, they will need to be supported by younger taxpayers. Age UK considered that there is 'a tendency for people, including politicians and policy makers, to frame the debate on ageing within a dependency narrative which sees older people as a ''burden'' and a ''drain'' on the public purse'.[1]

Yet there is no reason why retirement and dependency should relate to a specific age. Much employment is physically less demanding than it traditionally was for many, and fewer people are incapacitated by diseases in later life. Society, the media and policy-makers should continue to rethink what they mean when they refer to 'old age'. Older age should be viewed as a spectrum, involving a smooth transition through different stages of life.

The Government have acted to legislate against age discrimination, through the Equality Act 2010 and the public sector equality duty which require equal treatment in access to employment and public and private services regardless of age. They have also abolished the default retirement age, so that retirement ages can only be set where they can be justified objectively.

While welcoming these positive steps, negative attitudes and discrimination towards the 'Stigma' of old age still abounds. Though the law has changed, attitudes will take time to catch up, as happened with previous anti-discrimination legislation.[1]

Rather than viewing ageing with horror, society should pay more attention to the large social and economic contributions that older people make, in areas such as volunteering, childcare, care of other adults, charitable giving and support for younger generations.

- 30% of people over 60 volunteer regularly through formal organisations
- 65% of volunteers are aged 50 or over
- 65% of those over 65 regularly help older neighbours and

- one in three working mothers rely on grandparents for childcare.

Age UK have estimated that people aged 50 and over make an unpaid contribution to the economy of £15.2 billion per year as carers,

£3.9 billion in childcare as grandparents and £5 billion as volunteers. These unpaid inputs reduce public expenditure, enable other people to work and help to make our society more cohesive.[1]

So many older people are anything but dependent

Increasingly, our growing older population are in good health, many will retire with a decent income and have strong social networks. These wise people have much to offer society, and will want to combine work with new activities, volunteering and caring.

One way to promote public understanding that ageing will be a positive experience for most will be for the Government to produce a clear guide to the key facts and trends about living longer.

There also needs to be a stronger recognition that older age, everyone from 60 to 120, covers a huge diversity of ages, levels of health and wealth and economic and social activity.

The Government should help people be better informed about how long they are likely to live in good health, the size of the pension that they are likely to receive, the likelihood of needing social care and its cost and how best to use their own assets.

By helping individuals and families analyse their own situation and make informed choices, the Government can give people some of the tools they will need to plan ahead.

Both public and private service providers need to meet the challenge of the ageing population. But acknowledging the changing role and diversity of older people puts new responsibilities on older people themselves: 'We should look at older people as the same as everybody else. If they are wealthy, tax them; if they are frail, they should be able to access services that support them just like anybody else at any age'.[1]

So it is not often helpful or even correct to consider older people as a homogenous group defined by chronological age. Age alone is not a predictor of health, wealth, employment status or activity in society, something Government needs to recognise when designing public services.

The Government should make everyone more aware of the truths about ageing. A better understanding of the needs and abilities of the older population should lead not only to better-targeted public services but also to a private sector that benefits from a growing market by producing goods and products that the older population really needs.

All political parties should be encouraged and expected to issue position papers on the future of health and social care within 18 months, and address these issues explicitly in their manifestos for the 2015 election.[1]

Plans for the long term must not be undermined by short-term budgetary cycles. The health and social care systems need to be enabled to plan more strategically and systematically for changing long-term needs. The Government should introduce a 10- and 20-year spending envelope for the NHS and publicly funded social care.

Those in middle age should be concerned about the quality of care that they may receive in the near future, because the current system is in very big trouble now. It will require substantial changes to address both present needs and future demand, and this challenge is combined with an impending catastrophic funding crisis. Nothing like enough is being done by those responsible, to face up or even recognise these challenges.

Developed countries such as the UK and EU must, as a matter of urgency, initiate plans to increase healthy productive lives of the two generations nearing retirement; failure to do this will result in the risk of severe economic decline. The need for co-ordinated programmes to encourage healthy ageing and lifestyle as well as common sense is also a vital economic necessity.

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As I see it

Post-reproductive health and lifestyle consultations

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The late lamented Brian Johnson ('Johnner's' of test match special fame) was once asked what his views on religion were, to which Johnson replied that he did not know much about formal religion, but that he had once been read Charles Kingsley's *The Water Babies*, in which there was a character, 'Mrs Doasyouwouldbedoneby' and Johnson said he felt that the world would be an infinitely better place if this role model was followed. It is my opinion that 'Mrs do-as-you-would-be-done-by' is perhaps a philosophy appropriate to the practice of medicine and medical consultation.

What makes an ideal consultation? People (patients) should feel relaxed and able to express concerns and fears about their symptoms in an unhurried fashion with a professional they know and have faith in.

There is evidence this is often not the case. Prescribed times for appointments in the UK National Health Service setting means that time is at a premium. Some years ago, a book on narrative-based medicine[1] looked at aspects of research into the consultation in general practice. It found that if a patient was allowed to speak, without interruption, after being asked 'what is the problem?' they would speak for 28.6 seconds, with the last 10 seconds containing the 'punch line' of what was really worrying them, i.e. 'could it be cancer?'. Unfortunately, the research showed that the average doctor would interrupt the patient after 18 seconds, so the punch line of the patient's story was never reached and the real fears were often left unaired and unanswered.

I heard from a colleague in an affluent area of the south of England who, in consulting with her general practitioner (GP), had the temerity to mention that she had a second problem, as well as the presenting symptom. Her GP promptly informed her that she could only discuss one complaint at a time, and advised her to make a further separate appointment at another time to discuss the second complaint.

The ideal consultation should have time. Time enough, in an unstressed atmosphere, to follow the principles inherent in narrative-based medicine. There is also a lot to be said for a patient having a friend or partner present, if wished.

Risk and its expression, especially with regard to estrogen replacement therapy, can be a difficult area to express to women in a way that is understandable, avoiding the fog of scientific jargon. The use of diagrams and graphics in this situation can be a great help, as can the use of the Internet and established websites such as Menopause Matters (www.menopausematters.co.uk) or search engines such as Wolfram Alpha (www.wolframalpha.com) for figures of individual life-expectancy.

After the conventional history examination, including body mass index and elucidation of issues, it is important to discuss broader issues relating to health and lifestyle, including exercise, diet, social factors, work/retirement plans, relationships and sexual issues. I find that quite a good introduction to discussion in this area is to ask, 'how long do you think you are likely to live for?'. It's a somewhat unusual question for doctors to ask and it usually excites a response.

I use the Wolfram Alpha website for life-expectancy projections as a good starting point for discussion on healthy lifestyle, osteoporosis, exercise and diet, and offer appropriate advice on these areas. The fact that one in three women over 80 will have an osteoporotic fracture or cognitive impairment makes the case for positive attitudes to health and lifestyle, rather than the alternative negative choice of having decades of life with years chronic incapacity. The time around the menopause is perfect for this discussion (as the Pennell report suggested) – changes occur leading to long-term health problems, and this vital opportunity for lifestyle intervention should not be missed.

There are now many other specific websites that perform life-expectancy calculations, some of which take into account lifestyle, demographic and health measurements, such as cholesterol and blood pressure. They even give suggestions as to how life-expectancy can be improved by positive changes. This type of calculation and advice is an invaluable tool in the modern person-orientated consultation and can be repeated every few years.

At the end of the consultation, it is useful to summarize key points. I find the use of a Dictaphone to

dictate the letter to the GP in front of the patient is invaluable in giving the patient a sense of ownership in the process. One can say: 'are you happy with the content of the letter? If not, it can be altered so that you are happy'. As the consultation finishes, it is helpful to recognize that questions may often arise later: 'what did he say?' or, 'what did he mean?' It is my practice to encourage patients to make a list of queries to bring to subsequent appointments. (It is my understanding many doctors refuse to allow question lists.) Questions should be encouraged as they empower patients and are an excellent starting point for subsequent discussion. I explain that the consultant (myself) is a resource (like the Internet), which can only be used properly if patients feel empowered enough to ask the questions they want.

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