THE “NEW” OLD AGE -  
CHALLENGING THE MYTHS OF AGING

Report of

Sixth Annual Conference of 
the Regions for Health Network

Katowice, Poland, 2–3 October 1998
EUROPEAN HEALTH21 TARGET 2
EQUITY IN HEALTH

By the year 2020, the health gap between socioeconomic groups within countries should be reduced by at least one fourth in all Member States, by substantially improving the level of health of disadvantaged groups

(Adopted by the WHO Regional Committee for Europe at its forty-eighth session, Copenhagen, September 1998)

EUROPEAN HEALTH21 TARGET 5
HEALTHY AGING

By the year 2020, people over 65 years should have the opportunity of enjoying their full health potential and playing an active social role

(Adopted by the WHO Regional Committee for Europe at its forty-eighth session, Copenhagen, September 1998)

ABSTRACT

The Conference explored the challenges posed by population aging in Europe, innovative efforts to promote and support healthy aging and how regions can add value to later life. There were presentations on the complexities facing policy-makers across Europe at a time of considerable political change, and on what employers, the health sector and the voluntary sector can achieve in raising awareness of the difficulties older people face and in using the talents and enthusiasm of older people for the wider benefit of society. Drawing on the presentations and on personal experience, working groups developed an action programme to promote macroeconomic and cultural change, strengthen communities, encourage the provision of responsive services and develop and support resilient individuals.

Keywords

AGING
HEALTH SERVICES ACCESSIBILITY
HEALTH SERVICES FOR THE AGED
HEALTH POLICY – trends
LOCAL GOVERNMENT
EUROPE

© World Health Organization – 1999

All rights in this document are reserved by the WHO Regional Office for Europe. The document may nevertheless be freely reviewed, abstracted, reproduced or translated into any other language (but not for sale or for use in conjunction with commercial purposes) provided that full acknowledgement is given to the source. For the use of the WHO emblem, permission must be sought from the WHO Regional Office. Any translation should include the words: The translator of this document is responsible for the accuracy of the translation. The Regional Office would appreciate receiving three copies of any translation. Any views expressed by named authors are solely the responsibility of those authors.
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td></td>
</tr>
<tr>
<td>Introduction and summary</td>
<td>1</td>
</tr>
<tr>
<td>Purpose</td>
<td>1</td>
</tr>
<tr>
<td>Context</td>
<td>1</td>
</tr>
<tr>
<td>Outcome</td>
<td>1</td>
</tr>
<tr>
<td>Presentations</td>
<td>2</td>
</tr>
<tr>
<td>What are the myths that need to be challenged, and why?</td>
<td>3</td>
</tr>
<tr>
<td>General discussion on regional experiences</td>
<td>6</td>
</tr>
<tr>
<td>Aging and inequities in health – the case of Lithuania</td>
<td>8</td>
</tr>
<tr>
<td>Aging and inequities – the case of North-West England (Peter Flynn)</td>
<td>13</td>
</tr>
<tr>
<td>Health care reforms and aging in Katowice (Dr Andrzej Sosnierz)</td>
<td>19</td>
</tr>
<tr>
<td>Preparing for growing older in working life and the community (Dr Anna Ritsatakis)</td>
<td>22</td>
</tr>
<tr>
<td>Advocates for older people – the example of Age Concern</td>
<td>26</td>
</tr>
<tr>
<td>(Ms Frances C Hunt, Head, Age Concern England ActivAge Unit)</td>
<td></td>
</tr>
<tr>
<td>Developing an action programme: discussions in working groups</td>
<td>29</td>
</tr>
<tr>
<td>Changing the perceptions of aging</td>
<td>29</td>
</tr>
<tr>
<td>Tackling failing health among older people</td>
<td>32</td>
</tr>
<tr>
<td>Preparing for growing older</td>
<td>37</td>
</tr>
<tr>
<td>What have we learnt and what should we do next?</td>
<td>40</td>
</tr>
<tr>
<td>Securing macro-economic and cultural change</td>
<td>40</td>
</tr>
<tr>
<td>Strengthening communities</td>
<td>41</td>
</tr>
<tr>
<td>Providing responsive services</td>
<td>42</td>
</tr>
<tr>
<td>Supporting resilient individuals</td>
<td>42</td>
</tr>
<tr>
<td>Annex 1. Participants</td>
<td>42</td>
</tr>
<tr>
<td>Annex 2. Résumé</td>
<td>46</td>
</tr>
<tr>
<td>Annex 3. Zusammenfassung</td>
<td>47</td>
</tr>
<tr>
<td>Annex 4. Резюме</td>
<td>48</td>
</tr>
</tbody>
</table>
Foreword

It is occasionally interesting to experiment – to try something new. For its 1998 conference the Regions for Health Network decided to take on a topic not because it was a regional issue but because it had captured the international limelight: the issue of aging. The subject was tackled not as a dry statistical affair, but as a social conundrum. Why is the reality of growing older so often misunderstood and, more to the point, what can be done to improve matters?

Of course, the focus was on the regional level and the Conference, magnificently hosted by the Voivodship of Katowice in Poland, gave an opportunity to compare the situation across Europe and share good ideas. These came aplenty and were collected in an “ideas basket” for analysis and action. They are summarized at the end of this report.

A distillation of the discussions is also presented much more briefly in a short report entitled “What regions can do to challenge myths about aging”.

It was a happy and productive occasion, graced at the opening by a Polish choir that included four generations in a living display of intergenerational unity. There followed excellent presentations and lively group discussions.

The Network’s thanks are due to the organizers, and particularly Dr Malgorzata Kucytowska, Provincial Methodical Centre for Health Care, Dr Andrzej Sosniers, Chief Medical Officer, Health Department of Voivoda Office, and Dr Krystian Oleszczyk, Director, “Repty” Gornoslaskie Centrum Rehabilitacji. But we should also thank the speakers and all participants, whose contribution helped to make this event a success.

The need now is for action.

Christopher Riley
Regions for Health Network and
Country Health Policy Unit
**Introduction and summary**

**Purpose**

The conference set out to:

- articulate the challenges posed by population aging in Europe
- identify how the potential offered by a longer life can be fully exploited
- explore how action by regions can add value to later life
- find and share innovative efforts to promote and support healthy aging.

It was hoped that a result would be that each region represented would have a more profound understanding of the issues and commit itself to launching at least one new initiative to promote healthy aging during the United Nations Year of Older People in 1999.

**Context**

This was the sixth annual conference organized by the Regions for Health Network (RHN). Each of the conferences has taken as its theme an issue of Europe-wide importance offering scope for valuable interventions at a regional level within countries. Regions have come together on these occasions to hear expert contributors, compare problems and talk through possible solutions.

This year a new approach was adopted in selecting the theme. The Network decided to link its conference to the fact that 1997 was to be the United Nations Year of Older People. This would be an occasion for the whole world to assess the implications of the extraordinary demographic shift that we are living through and the conference would be an opportunity to explore the issues as they relate to what regions might and should be doing.

The particular focus selected was to highlight the contradiction between the manifest success of so dramatically reducing premature deaths and the rather gloomy tone that so often dominates discussions concerning the “greying” of the population. The conference aimed to set out the facts, pin down some of the problems and identify how, by supporting older people and using their talents, life could be better for the whole community.

**Outcome**

It was intended that the conference should result in a menu of actions which regions could implement, either through using their own powers or through influencing or stimulating or collaborating with others to bring about changes. They could take action either alone or through joint projects.

Throughout the conference ideas and suggestions were generated by speakers, discussions and working groups, and these were collected and put in an “ideas basket”. The mechanism adopted was initially to write any interesting propositions on post-its and put them on one of four posters each dealing with a level policy-makers might target:

- the macro-economic level
- the community
- services
- the individual.
By the end of the conference a wide range of ideas had been collected on how life could be improved for older people in Europe, by action on all these levels. These were then analysed and used to prepare:

(a) the summary conclusions presented at the end of this report;
(b) a short booklet (cross-reference) setting out some of the main messages together with some real-life examples described by participants; and
(c) the checklist below against which regions can assess their progress in developing policies for older people:

\textit{Think about what the responsible authorities are doing in your area.}

1. Do your regional or local authorities have an agreed policy to support the health and wellbeing of older people?
2. Do your regional or local authorities have an information base of health and socioeconomic indicators relating to older people?
3. Do your regional or local authorities have a forum to bring together different agencies and groups to discuss the problems of older people?
4. Do your regional or local authorities support strong, well organized voluntary groups to speak for older people and encourage them to use their talents?
5. Do your regional and local institutions and services aim primarily to foster independence?
6. Do your regional or local authorities have policies making it easy for older people to meet, travel and get access to information?
7. Do your regional or local authorities have policies to give help to those who are carers for older people?
8. Does your regional or local education policy prepare everyone for old age and support older people?
9. Do your regional or local authorities have programmes to combat isolation?
10. Do your regional or local authorities have a well founded strategy to deliver proven preventive and clinical services to older people?

Those who attended the conference are now more aware of the principles underpinning the United Nations Year of Older People and how they and their regions might be able to promote its objectives.

\textbf{Presentations}

The meeting commenced with a presentation by Dr Anna Ritsatakis setting out the background to the conference and its objectives. This prompted a discussion to which representatives of the regions present contributed, reflecting on the problems and possibilities facing older people in their communities.

To throw a sharper light on people’s hopes and experiences and the disparities and similarities across Europe, two presentations from very different parts of Europe (Lithuania and North-West England – both RHN regions) gave more detailed insights into their local situations.
The host region, Katowice, described some of the complexities facing policy-makers in trying to manage difficult policy issues at a time of considerable political change. People’s expectations and abilities to manage as they near and enter retirement depend on their broader cultural, economic and social environments. These were discussed in a further presentation by Dr Ritsatakis which particularly identified what employers and the health sector can do to reduce some of the trauma of this time.

A final presentation by Ms Frances Hunt gave a powerful example of what a dedicated organization can achieve not only in raising awareness of some of the difficulties faced by older people but also how barriers can be broken down to allow the talents and enthusiasm of older people to be used for the wider benefit of society.

**What are the myths that need to be challenged, and why?**

**Background**

The most important pattern of progress in the world is an unmistakable trend towards healthier and longer life. The explanation for this trend lies in the social and economic advances of the late twentieth century. Food supply has more than doubled in the last 40 years. Per capita GNP in real terms has risen by at least 2.5 times in the past 50 years. Adult literacy rates have increased by more than 50% since 1970. Housing and the supply of clean water have been substantially improved and there have been unprecedented advances in health care and medical technology.

And are we celebrating these enormous achievements? Not really. Instead of rejoicing in these achievements we mainly talk of the burden of aging. Society has not yet caught up with the new reality that older people are an important resource. While technology is leaping into the twenty-first century, in its perception of aging society seems to be locked into the situation of 50–60 years ago. We have created an artificial limit to productive life and now seem unsure what to do as more and more people live beyond it.

So, we are faced with problems of:

- false perceptions
- growing agism
- social exclusion, and
- a failure to reap the benefits of longer life.

Unlike women or children, older people have no comprehensive international convention addressing their rights.

In the face of these challenges, 1999 has been designated United Nations International Year of Older Persons, with the double aim of dealing with the needs of older people within a society for all ages. A decision was taken that the RHN would use its 1998 Annual Conference to participate in this celebration and propose concrete action to promote healthy aging in the twenty-first century. The challenge is to change perceptions, and by combating agism and social exclusion, make the most of life after 60.

The conference title was “The ‘new old age’ – challenging the myths of aging”. It was intended to face the challenges on four policy levels:

1. macroeconomic and cultural change
2. strengthening communities
3. individual lifelong development
4. access to essential goods and services.

**Current situation**

People in Europe are growing older in a rapidly changing world. It is a divided society. A world dominated by cars, easy travel and communication can facilitate contacts but it can also encourage living at a distance, which often means living without the warmth of a family. It is a society where some have a world of information at their finger tips and others must queue for water.

The population is “greying”. In 2030, every third person in the OECD countries will be over 60. Within the WHO European Region, western Europe in particular is expected to age rapidly. Although the number of years that people in Europe can expect to live has increased considerably, not all have a fair chance at life. Life expectancy at birth in Sweden and in the newly independent states (NIS) differs considerably: for example, a boy born in Sweden can expect to live until 76 and a girl until 82. This compares with the NIS, where a boy can expect to live 16 years and a girl 10 years less than their Swedish counterparts. A short drive down the road can take you from an environment where older people can expect to live long and healthy lives to one where illness, pain and a shorter life are all too common.

Globally the situation is even worse. According to a popular saying “Life begins at 40”. But for people in some countries, that is when life ends. In Malawi and Uganda, for example, average life expectancy reaches only 41 years. Surely, such shocking inequities cannot be allowed to continue unabated into the twenty-first century?

Our health as we grow older is determined to a large extent by our whole life experience. The habits formed during infancy and throughout the life cycle greatly influence whether or not we are able to enjoy growing older. Where and how we work will both affect our health and the number of years we feel capable of working. Our social networks, those with whom we share our joys and our problems and with whom we give and receive support, are vital to our health, particularly as we grow older.

**Keeping lively**

We must be clear about what we mean by getting older. Do we mean chronological age, determined by the calendar, or biological age defined in terms of critical life signs and cellular processes, or psychological age – being as old as we feel?

Nothing holds more power over the body than the beliefs of the mind. We must challenge false perceptions. A productive member of society does not become a dependant with the passing of a birthday. For example the self-employed continue lifting, climbing and bending for as long as they feel fit. The decline in vigour in old age comes about largely because people expect to decline.

Some people break the stereotypes of aging and maintain or discover a new creativity in the fourth age. Michelangelo designed St Peter’s when he was nearly 90. Picasso painted, and Rubinstein played the piano at the same age. Creativity and talent do not diminish at 70. The quest for adventure remains, as for John Glenn – at 40 the first American to orbit the earth, and at 77 years once more ready to go into space.
The wisdom attained through experience can be put to good use: for Mary Wesley starting a successful writing career after she reached 70, for Tullia von Sydow in Sweden and Fred Tuttle in the USA, both at 79 standing for the first time as candidates for their national legislatures.

**What we can do and where we need help**

Many of the apparent problems facing older people are avoidable and can be offset in simple and practical ways, for example by drinking water. Chronic dehydration is a major cause of preventable aging. Muscle strength is important for overall vitality, as are regular routines (including breakfast), long-standing relationships and social bonds. Many of these preventive and health maintenance measures are in our own hands.

Much of our muscle strength can also be maintained. In the United States, frail 87 to 96-year-old residents of a nursing home were put on a weight-training regimen. Within eight weeks, wasted muscles had come back by 300%, coordination and balance improved, and an overall sense of active life returned. The message is clearly “use it or lose it” if intellectual, physical and emotional capacities are to be maintained.

Exercise is good for us and should be fun. A healthy diet should be both balanced and psychologically satisfying. Continuing contact with family and friends provides important support. Age is not a barrier to a zest for life. Dancing is one of life’s cheapest pleasures and forms of exercise.

But some issues need action from a different level – a decent and secure income, a safe and accessible environment, health services and personnel who care and who get there.

Sadly, whatever our position, wherever we live, we can all become the victims of the myths of aging. The conference examined some of the myths related to the four policy levels and looked for ways that have worked, or could work to dispel them.

**Challenging the myths**

At the level of macroeconomic and cultural change, there is a myth that after retirement people no longer contribute to society. This is not true. Older people have an evident and valuable role:

- in the family
- in voluntary work
- in business, and politics
- as transmitters of tradition and experience.

We need to recognize and value those roles, and by doing so will strengthen our communities. The same goes for the myth that older people are all the same. Again this is simply not true – we need to recognize and value diversity. We also need to counter the myth that provisions for older people are a burden on society. What is good for older people could be good for all of us, for example safe pavements, better lighting, easier working positions.

Other myths are that

- aging starts at 60
- mental and physical deterioration is inevitable
- you can’t teach an old dog new tricks.
These are also untrue. The behaviour of our parents and our own lifestyles from infancy strongly influence the quality of our later years, so that the process of aging is moulded by our whole life course. Examples have been given already to indicate that deterioration can be avoided and that people can and do continue to grow mentally and spiritually. We need to recognize the possibility and desirability of individual lifelong development.

Of course, older people can be ill and need help from organized community services. But here too there are myths. One is that spending money on services for older people is wasted effort, and once again this is untrue. Small amounts for chiropody, spectacles, hearing aids, correct use of drugs, advice on diet and exercise can keep people mobile, independent and active in social networks. It is also untrue that older people expect to put up with poor health. They are growing in numbers, better informed and increasingly vocal.

The most dangerous myth of all is that people, systems and society will cope in the end. This certainly is not true. The biggest threat is neglect, letting the myths dominate discussion and policy-making. To ensure that people now and in the future can enjoy the benefits of a healthy old age we must take action, and do it now, individually, in our families, workplaces and neighbourhoods, through our governments and the international community.

**General discussion on regional experiences**

Participants were invited to give their impressions of the PC presentation, and to discuss whether the myths of aging also applied in their regions.

Dr Lars Himmelmann (focal point for the western countries) gave his personal perspective in view of the fact that he is currently preparing for retirement in 1999. He gave some useful tips for others about to do the same. He said the transition to retirement can be made easier if people decrease the number of hours they work before retirement. This gives more time to explore other facets of life and what life will be like as a non-working person. He recommended that people due to retire should avail themselves of pre-retirement courses and plan their post-working life. Not all employers are so receptive to introducing these types of scheme and Dr Himmelmann proposed that more efforts were needed to make employers aware of the importance of pre-retirement courses, and of their responsibility to older workers.

A Polish participant highlighted retirement for men as being a particularly difficult time. Having spent virtually their entire lives as workers men often had more difficulty than women in finding their place at home. Women seemed to be better at developing and sustaining multiple roles over life.

Ms Frances Hunt (Age Concern, United Kingdom), said that it was particularly important to ensure aging policies were sensitive to both culture and gender. The perception of aging and older people varies between different cultures and communities, and between men and women.

Dr Lena Rydin Hansson stressed the importance of introducing public policies that are sensitive to socioeconomic differences between older people. Some older people are in a more advantageous financial position than others because of better pension arrangements. Retirement can be an anxious time for those with poor pension entitlements.
Dr Birgit Weihrauch (North Rhine-Westphalia) stressed the importance of bolstering older people’s confidence so that they looked forward to retirement with a sense of optimism and hope. She pointed out that many health promotion programmes are developed for young people, but health promotion was important for older people too.

Dr Jaroslav Volf (Northern Moravia) said that it was important to instil into young people a sense of respect and caring for older people. Nowadays, people are so busy that they consciously need to set aside the time for older people, including grandparents.

A Polish participant stressed the importance of preparing for growing older throughout life. As shown in the PC presentation, aging starts early. Planning for old age is just as important as for any other time of life. This participant proposed that better awareness of what growing older entails and a positive outlook put people in a much stronger position to realize their dreams.

Another Polish participant pointed out that although women generally are more positive about retirement, overall their health tends to be poorer than men’s. Self-perception can be a useful indicator of how people feel about getting older. Perceptions can also change as a result of critical life circumstances, for example the experience of older women who have outlived their spouses can be very lonely.

Dr Sosnierz (Katowice) said that the loss of a spouse often had a negative psychological impact on the remaining partner. He pointed out that although some people might live to be quite old, for reasons such as loneliness, poverty or social isolation, they might not really enjoy their lives. Quality of life was becoming an important issue in Poland.

Giving people opportunities to explore new facets of themselves or new roles in the family or community was seen as an important part of successful aging by one participant. This was supported by another participant who emphasized the importance of providing people with the skills to change behaviour and explore new dimensions of themselves.

While some older people are fortunate to have good health it was pointed out that aging is a very individual process. Some older people, because of poor health or disability may need additional care and support. One participant said that day centres fulfilled an important social function as well as providing basic health and social care. For example, giving people the opportunity to eat together strengthened social contacts and bonds.

Formal networks such as through-day care centres are not the only way of promoting social activities for older people. One participant told the story of how an old lady in her community, despite being frail and housebound, invited a group of friends to her home each week, providing an opportunity for them to meet. Being housebound is not always a reason to shut down and lead a lonely or isolated existence.

Building on the care theme, another participant suggested that sometimes rehabilitation is needed rather than care. Older people can be supported through rehabilitation to remain independent and carry out basic tasks so that their functional health is maintained.

There was a special mention for carers too. Very often older people are the ones who take on the real burden of caring. One of the myths not highlighted in the presentation was that older people are dependent. This was simply not true. Very often older people are the ones caring for others.
Depression can be a serious problem for older people. Policy-makers needed to be aware of this, particularly in relation to dislocation which inevitably affects all older people forced to move from their home.

Dr Weihrauch stressed the importance of finding ways to use older people’s experience in the community. In North Rhine-Westphalia, efforts had been made to tap into older people’s energy, experience and expertise by supporting the establishment of self-help groups for older people.

Ms Inger Helt Poulsen (Roskilde, Denmark) commented on a changing view in Denmark. Increasingly health and social workers were reaching out to older people and listening to their views before making an assessment of their needs. Talking to older people in order to establish which services they need can be more effective than simply delivering a general service package.

Moving on to exploring new dimensions, Ms Sue Evans (Wales) described an initiative from Wales called “The University of the Valleys” which both offers courses to older people and employs older people as teachers. Older people do not always need help. Sometimes they simply need opportunities to try out new activities.

The final comment came from Dr Szuszaanna Hangyal who described the situation emerging in eastern Europe where social systems have virtually collapsed and elderly people must continue in many cases to work beyond retirement age because pensions are too low –if they can even find suitable employment. Unfortunately this does not always prove to be the case.

**Aging and inequities in health – the case of Lithuania**

Dr Zilvinas Padaiga began by reporting on recent population trends in Lithuania where as a result of a falling birth rate and an increasingly aging population there had recently been a decline in the overall population (Fig. 1). Fig. 2 shows that improved life expectancy is increasing the number of older people at a time when the falling birth rate is reducing the number of young people. Fig. 3 shows the proportion of older people over 65 years living in different regions of Lithuania. The proportion of the population over 65 years is greatest in the north-east and south.
Fig. 2. Age structure of the Lithuanian population, 1959–2001

Fig. 3. Proportion of the population older than 65 years, by quintiles

Fig. 4 reveals sharp inequalities between different professional groups in terms of disposable income. Pensioners have substantially less income, for example, than businessmen or hired workers but are slightly better off than farmers and some other workers. Fig. 5 reveals a similar picture with evidence that some pensioners are spending up to 60% of their income on food, leaving little available for expenditure on other items.

Fig. 6 reveals the differences in living conditions of older people and other socioeconomic groups, with pensioners in a substantially worse position than workers.
The proportion of people rating their health as good or reasonably good varied with gender and by age group (Fig. 7). Women tended to perceive their health as worse than men, and this perception increased as they got older although for both sexes perceptions of poor health tended to increase with age.

Fig. 4. Total disposable income, by socioeconomic group of household head, Lt per capita per month

* Source of income: various allowances, stipends, income on property, etc.

Fig. 5. Proportion of consumption expenditure on food, by socioeconomic group of household head

* Source of income: various allowances, stipends, income on property, etc.
Fig. 6. Evaluation of living conditions (excellent and good), by socioeconomic group of household head

* Source of income: various allowances, scholarships, income on property, etc.

Fig. 7. Proportion of persons rating their health as good or reasonably good, by sex and age

Fig. 8. Proportion of persons using vegetable oil for cooking, by sex and age

Fig. 8 shows how lifestyle risk factors can vary according to age and gender. Use of vegetable oil for cooking is far less common among older people and at all ages women are less likely to use it than men.
Fig. 9 indicates that depression tends to increase with age, and is higher among women.

![Fig. 9. Proportion of persons who have experienced depression during the previous year, by sex and age](image)

* p<0.05, if compared with two youngest groups.
** p<0.05, if compared with the first group.

Older people are the biggest consumers of health services. Fig. 10 not only shows that pensioners visit outpatient facilities considerably more than other socioeconomic groups but also suggests that the likelihood of using these facilities has increased. The rise is even more marked in relation to hospitalization (Fig. 11).

![Fig. 10. Odds ratio for visiting outpatient department adjusted for age, sex and morbidity, by occupation, 1995 and 1998](image)

**-p<0.01, ***-p<0.001, if compared with other groups

Fig. 12 shows that older people seem to have increasing difficulty in making the journey to health care institutions.

![Fig. 12. Odds ratio for hospitalization adjusted for age, sex and morbidity by occupation, 1995 and 1998](image)

**-p<0.01, if compared with other groups
Mr Flynn referred to the latest population data which throw light on the likely workloads those working in health and social services will be facing. Fig. 13 shows the percentage of the population aged 65 years or older by ward. It is clear that the percentage of older people is very varied and particularly high in some areas. For example, in the Southport area on the coast, the percentage of people aged 65+ is as high as 39% of the total population. However, the most deprived group may be individuals in inner city locations.
Fig. 13. Percentage of population aged 65 years or older by ward


Fig. 14 shows a projection for age group changes in North-West England. This indicates that there will be a particularly sharp increase in the number of people aged 65–69 years between 2010 and 2015. It is estimated that if current trends continue the number of people aged 80+ years will be much increased between 2025 and 2030. Overall the number of people aged 65+ is set to increase by 20% in the next 20 years.
As a group older people are more likely to suffer from poverty. It is therefore important to identify priority groups and provide for their diverse needs. At present older people do not all have the same opportunities for aging well.

In North-West England, average life expectancy is significantly lower than average life expectancy for people living in other parts of England and Wales, and significantly worse for men than women (Fig. 15).

Source: ONS 1993-based projections.

Fig. 15. Life expectancy by age


Note: Data for ages above 80 not presented. Individual figures for the population of the North-West problematic above this age. Standardized mortality ratios (SMRs) in North-West England for all causes of death in the 65–74 year age group are highest for both men (116) and women (115) as compared with all other regions in England (Fig. 16) but this average itself conceals very wide differences across the region. As shown in Fig. 17, SMRs tend to be highest in large urban conglomerations.

Fig. 16. SMRs for all causes of death in the 65–74 year age band
calculated for the period 1993–1995

Source: Public health common data set, 1996.

Fig. 17. SMR for the 65–74 age group by health authority area in the North-Western region, calculated for the period 1993–1995

Source: Public health common data set, 1996.

Fig. 18 compares hospitalization rates for North-West England’s population aged 65 and over for accidents and heart disease and stroke. There are big differences between health authorities. The rate of accidents, for example, is substantially higher in Salford and Trafford than in other health authorities, while the rate of heart disease is substantially higher in the North Cheshire health authority than in others.
Older people’s incomes also vary widely. Although in the United Kingdom everyone is entitled to a state pension, there is a gap between those with good occupational pensions and those without, many of whom are women.

Causes of death are apparently income-related. In North-West England, SMRs for chronic obstructive pulmonary disease and lung cancer are clearly higher for low income groups (Fig. 19).

Women in the region live longer than men, but are also likely to have poorer health and lower incomes. How to meet the needs of lonely older women in poor health and often living on insufficient income will be a major issue for the future.
Mr Flynn stressed some of the key findings: the number of people aged 65+ will increase by 20% in the next 20 years; older people are more likely to suffer poverty, especially women over 80, living alone and disabled; there are high rates of accidents among the elderly, and people over 85 years were nearly 10 times more likely to be hospitalized through falls than those between 65 and 70 years.

But although older people as a group may have certain characteristics, it is important also to note the differences among them. These include:

- area differences
- urban/rural differences
- socioeconomic differences
- gender.

By taking account of the differences, policy-makers can identify priority groups and areas and target resources more effectively. Mr Flynn suggested that the needs of older people need to be integrated fully into strategies developed at national, regional and local level.

Mr Flynn also described recent policy developments in North-West England which will tackle some of these issues. He said that a national public health strategy, *Our healthier nation*, had been produced with the aims of:

- improving the health of the population, and increasing life expectancy and years free from illness; and
- improving the health of the worst off and reducing inequalities.

One of the important dimensions of the new policy was the framework for assessing health service performance which was based on:

- improvement in health
- fair access
- effective health care
- efficiency
- patient/carer experience
- health outcomes of care.

National service frameworks defining service standards were to be established for coronary heart disease, mental health and services for older people.

At regional level, a multidisciplinary and multi-agency Regional Task Force on Older People had been established in 1997 to promote:

- the health and wellbeing of older people
- the needs of carers
- networking and sharing information
- evidence-based prevention, treatment and rehabilitation.

The focus was very much on exploring opportunities for the health of older people. This would be the direction of a major national conference to be held on 26–27 November 1998, which
would also coincide with the launch of a report by the Regional Director of Public Health, *Health opportunities for older citizens of the north west*.

At local level, health improvement programmes based on partnerships of health authorities, local authorities, primary care groups and health care trusts, were high on the agenda. The local health strategies were designed to deliver:

- national health and social priorities
- local priorities
- reductions in inequalities in health and access to health and social care.

**Health care reforms and aging in Katowice (Dr Andrzej Sosnierz)**

Dr Sosnierz opened his presentation with a brief description of the region of Katowice, its principal industries and population breakdown. Katowice Voivodship is one of the 49 Polish voivodships. It is a very characteristic region – covering an area of 2.8% of the total area, it has 10% of the entire Polish population. It is an industrial area with dominant heavy industry – coal mining and steel. In recent years there has been a rapid development in the motor industry. In Katowice voivodship there are also influential and powerful scientific centres, including Silesian Polytechnics, the Silesian University and the Silesian Medical Academy, which in 1998 celebrated its fiftieth anniversary.

The region is highly urbanized with the ratio of urban population reaching 86.6%. Population density is 589 people per km². At the moment the mining industry is being restructured with the closing of some of the inefficient coal mines.

**Demographic changes in the population of Katowice Voivodship 1960–1996**

The leading subject of the conference is the phenomenon of population aging visible in the European countries. The following demographic changes took place in the Katowice Region between 1960 and 1996:

- the birth rate decreased from 12.1 in 1960 to 0.0 in 1995 and 1996;
- the percentage of the population aged 60 and more increased from 10.1 in 1996 to 14.5 in 1996, and the percentage of the population aged under 19 years decreased from 36.3 in 1960 to 28.8 in 1996;
- the percentage of the population aged 65 years and more was 10.1 in 1960 and 14.5 in 1996;
- looking at WHO’s definition of old age (starting at age 65 years), the population of Katowice can be described as old or aging;
- the number of women per 100 men grew from 103.6 in 1960 to 105.3 in 1996.

**The phenomenon of over-mortality of men in the Katowice Region**

One of the most worrying demographic phenomena is the over-mortality of men (higher mortality rate among men compared with women) observed in the various age groups. In the Katowice Region, this is especially visible among very young people; in 1996 over-mortality of men in the age group 20–24 was 303.1 in Poland and 434.8 in the Katowice Region, and in the group 25–29 it was 364.1 in Poland and 668.6 in Katowice Voivodship. Average life expectancy in Katowice Voivodship between 1996 and 1997 was:
Female 75.85 76.19  
Male 67.80 67.93

Over-mortality leads to an increase in the number of single women in the older age groups. It has social consequences: these single women need both social and financial support, as single households are the most expensive to run.

Reforms of the health care and the public administration – main assumptions of the planned reforms

Poland faces the challenge of the in-depth implementation of the reforms to health care and public administration. These reforms are of strategic and revolutionary importance. The changes concern administration structure, social security and health care. From 1 January 1999, 16 big voivodships will be created to replace the 49 small voivodships. The Katowice Voivodship will become the central part of the Silesian Voivodship, which will be created from the three regions of Katowickie, Bielskie and Czkstochowskie. The new Silesian Voivodship, with Katowice as its capital city, will be the second most heavily populated region (after Mazowieckie Voivodship), with 4.9 million inhabitants, but with an area of 12 300 000 km² it will remain one of the smallest regions. The Silesian Voivodship will be divided into 16 rural and 19 urban subregions. At the lowest level it will consist of 133 districts. 1 January 1999 is also the day the new law on social security is introduced. The new regulations dramatically change the system of financing health care from a state-funding system to an insurance-based system.

Sixteen regional health insurance offices will be set up corresponding with the new voivodships. In the new system the following roles will be divided:

- payers – the regional health insurance offices and the state
- organizers of health care – autonomous bodies at voivodship, subregion and district levels
- service providers.

The aim of the reforms is to increase the effectiveness of health care units as well as to improve utilization of the available resources.

Health care units in Katowice Voivodship – advancing the reforms

A major task facing the authorities is to prepare health care units for the changes. In 1992 new integrated software-hardware systems were introduced in the following areas with the aim of improving management of the units, which functioned as both organizers and payers at local and regional levels:

- finance, accounting, costs: to support financial management
- statistical record: system which gathers information concerning patients treated in hospitals;
- personnel and salary: to gather information concerning medical personnel and human resources management.

A system monitoring ambulatory care units and medication and drugs management was introduced from 1997. A programme of hospital restructuring and optimal utilization of available hospital beds is also being carried out. This aims to modify the structure of the hospital bed supply and match it to the changing needs of the population, as well as to make hospitals more

<table>
<thead>
<tr>
<th>Year</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td>75.85</td>
<td>67.80</td>
</tr>
<tr>
<td>1997</td>
<td>76.19</td>
<td>67.93</td>
</tr>
</tbody>
</table>
efficient in their use of beds. There will be fewer acute hospital beds and more rehabilitation and long-care beds, which is also connected with the problem of the population aging.

Two important elements of the reforms are changing the way health care policy is perceived and reorganizing the health care system so that health promotion and prophylactic measures will be given priority. A Health Promotion Team created by the voivodship authorities has prepared the health promotion programmes now being implemented in the region. This has allowed the introduction of further cooperation between many different institutions engaged in health promotion in hospitals, schools and cities.

**The impact of population aging on the changes to the health care system**

The reforms are being implemented in a period of demographic change. The process of aging, which will gradually reach the level of other European countries, has an impact on the structure of population morbidity, and therefore on the pattern of demand for hospital beds. Neoplastic diseases, osteoporosis and orthopaedic problems (e.g. hip fracture) are closely associated with aging. The growing prevalence of the above-mentioned health problems leads to increases in needs for a particular kind of hospital bed. As the result of demographic changes, the demand for paediatric beds is falling systematically while that for rehabilitation beds is increasing.

The next problem Poland faces is the overmortality of men, as mentioned above. This has, and will continue to have, social and sociological implications (a superiority in the number of women). The health care reform aims to improve health care efficiency, but the changes in the demographic structure will cause new demands and a resulting increase in costs. The number of working people is falling and those still in work will have to cover the costs of the social net system. These problems inflicting also other European countries and similar tendencies are visible within the Polish population.

Traditionally Katowice has been an area of heavy industry, particularly for the automotive/car industry. It was also traditionally a strong centre of scientific research.

The population density is 590 per km², served by a network of 93 hospitals. Dr Sosnierz described the changing demographic structure of the area: the percentage of the population aged 60+ years was increasing, the number of young people declining. Life expectancy is 68 years for men and 77 for women. The gender differences raised their own problems, most particularly the increasing number of lonely older women, often in poor health and living on insufficient income. In general, the mortality rate for both men and women was substantially worse than it was twenty years ago, and overall mortality for all causes was very high. Dr Sosnierz pointed to the difficulties in changing or reversing these trends.

In Katowice, measures to deal with the aging population need to be seen against the background of three major changes: (i) reforms at regional level, (ii) reform of the social insurance system, and (iii) reform of the health care system. The 16 new voivodships, which act for the central government at regional level, would take responsibility for health services. Changes in the health care system would include moves towards privatization of health care and the development of an insurance-based health care system as in many other countries of central and eastern Europe. Information systems were an important building block in the process of reform, and Katowice had already established an efficient computerized information system containing information on patients’ hospital stays and health care interventions.
Dr Sosnierz concluded with some of the problems confronting countries in a state of transition to democracy and a market economy. How, for example, could health insurance-based systems cope with the burden of an aging population and an increasing number of people with chronic diseases, in particular osteoporosis and lung cancer? Changing health care needs and demands were bound to have repercussions on health services, hospital beds and intergenerational solidarity as an increasingly larger number of people come to depend on a smaller working population.

Preparing for growing older in working life and the community (Dr Anna Ritsatakis)

Changing patterns in later life

As people grow older, their lives change. However, the pattern of changes is more complex than is sometimes thought. Some chronic disabling conditions become more common with increasing age, and many people increasingly lose their former role in life as neighbours, tenants / householders, people who go shopping, collect their own pension or buy postage stamps. However, when given the opportunity people do not withdraw or disengage from active life. Research into leisure activities shows that for those which take place in the house, the pattern or frequency appears equal for all adult age groups. Similarly, changes in sexual activity are affected more by the lack of a suitable partner and the role forced on older people by family and society. Where and how we live and with whom we live has a strong influence on our attitude towards growing older.

One of the myths about older people is that they have similar needs and wants. In reality the individual differences found in any human group appear to increase with chronological age. So the oldest population segment is in fact the least homogeneous.

One sharp change most people face is retirement from paid productive work. This is not something natural but an artificial break imposed from outside. Though people are generally living longer, in many instances working life has actually become shorter. For some people retirement can last 25 years or longer, and this raises important questions about how societies and individuals prepare for that time.

The importance of work

Until the time of retirement, employment has been a basic and important part of people’s everyday life, with people spending up to 60% of their time in their work environment. Work is a very important part of life not just for survival but also for ensuring social contacts and friendships, community life, a regular pattern and self-fulfilment and self-expression. Work is very often closely associated with a person’s identity. How many conversations open with the question – what do you do? Retirement means that this very substantial role and sense of purpose is often taken away, and it can happen when people do not want it, or at least not yet. In the United States, one study revealed that one third of respondents felt they were forced by circumstances to retire earlier than they wanted. In France, 57% of those still working said they would prefer to choose their retirement date.1

On the other hand, issues such as retirement cannot be looked at in isolation from other important social and economic trends and developments. Overall, what types of society are we creating? How equal are they? Some companies are currently adopting a policy based on the

---

“½ × 2 × 3” formula, half the people being paid twice as well to do three times the work. Is that what we want, having some people paid well but under considerable stress, while others perhaps have no work and little income? There is evidence that disabilities and accidents caused by stress due to speed-ups have already cost US industry $100 billion a year. A just society would ensure a better balance between family, friends, festivals, and fun and profit, performance, pay and productivity.

Perhaps we should be thinking more about productive aging. This means giving older workers the opportunity of a later and more flexible age of exit from the labour force, possibly with special conditions of employment appropriate to that gradual transition. Currently, the average age of retirement in Finland is 59 with levels of stress and burn-out particularly high for white collar jobs. Surveys have revealed that the majority of Finnish workers feel they have to work at too fast a pace. Municipal workers also complained of under-use of professional skills, neglect of the development of new skills, and susceptibility to age discrimination. According to the national programme on aging workers (1997–2001), “working life solutions are needed to ensure coping, working capacity, and constant updating of skills in the face of an increasingly accelerating tempo of change”. Flexible individual solutions recognize that older people/workers are not all the same, that some people may wish and be able to work longer, while others may wish to retire early. According to a recent survey, more than 80% of Finns doubt society’s ability to ensure adequate pension security.

The problem is particularly acute in countries where economies have collapsed, and few opportunities exist for those laid off when traditional industries become obsolete. In this case, unemployment becomes enforced retirement.

The institutionalization of retirement has meant that the mandatory retirement age has fluctuated in relation to fluctuations in employment opportunities for young and old. This has been supported by another of the myths of aging, that older people keep jobs which could be taken by young people. A survey carried out in Italy, however, showed that of every four jobs vacated by older people only one was filled by a young person.

Developing an alternative

Attitudes towards aging must change from negative to positive. Within work in general there could be:

- greater cooperation – shifting from a hierarchical pattern to teamwork and more participation;
- improved job planning – moving from a static to a dynamic approach which takes account of individual workers’ needs;
- active communication – disseminating information so that workers are briefed on impending changes before rather than after they come into practice.

Starting from the basic premise that older workers are valuable and a commitment to take concrete action to sustain their contribution, employers or managers have a variety of strategies available, including the following.

---

a. Flexible policies on retirement. These can let employers continue to reap the investment of older workers while not placing an undue workload on them. Employers who operate a rigid policy of early retirements and early redundancies may well be losing hard-won skills and experience, thereby destroying their own human investment.

b. Occupational health promotion programmes. Employers can promote their employees’ health by assessing fitness, matching capacity to demands, adapting the work environment to their needs, providing counselling and dealing with emergencies. They can offer health education, healthy food choices, exercise facilities, smoke-free zones and specific services such as physiotherapy and eye checks.

c. Career planning. This enables employers to match the competence of the worker over the longer term with the needs of the company, with particular attention to how those needs and competencies may change as people become older. Career planning recognizes the worker as an individual – for example, some people may wish to reduce their work commitment as they become older while others may be keener to strive after fresh goals. Such preparation does not begin as soon as people reach 45, but as soon as they begin their working life. It is important to nurture everyone’s working capacity in order to deal with change throughout their working lives.

As they grow older, people may experience a reduction in strength, agility, some physical functions, and the speed of absorbing information and response to high-level physical or mental demands. On the other hand, qualities such as professional experience, strength of judgement, ability to communicate, independent critical thinking and a sense of responsibility and maturity all tend to increase as people become older. Older people often have greater control of their lives, a more controlled use of language, high motivation to learn, high levels of commitment to work and loyalty to employers. They also tend to have fewer absences and, of course, more work experience.

d. Professional development and job training. In appropriate circumstances older workers are just as able to learn and grow as younger colleagues. Yet another of the myths is that “an old dog cannot learn new tricks”. Because of such myths older workers are frequently excluded from training schemes. Evidence has shown, however, that older workers can learn new tasks, although they may have to learn in a different way. When they can go at their own pace, when the course relies more on practice than theory, when they can assimilate new knowledge piece by piece and when they are allowed time for repetition, older workers perform just as well as younger workers.

Studies have shown that apart from teaching new skills or simply refreshing existing ones, training for older workers promotes better teamwork and higher levels of participation. Older workers respond much better in a supportive environment. Employers have perhaps been misled by myths about older workers losing productivity and ability with age; provided the learning environment is right, older people on balance are just as capable of absorbing instruction as younger people even with highly technical devices. Ensuring that older people are included in training programmes and that the particular characteristics of an aging worker are reflected in the content of training programmes can lead to more productive and fulfilled workers. One option might be to establish mixed training schemes for young and old. Special attention should be given to ensuring access for those in lower ranks, otherwise training programmes can actually exacerbate inequalities by widening the gulf between “knowledge haves” and “knowledge have nots”. Continuing training and lifelong learning have the additional
advantage of opening people to other opportunities which can broaden their range of interests both while working and as a foundation for when they retire.

e. Work design. There are two components in an approach ensuring a work environment that supports older workers: at the least, a work environment that does not adversely affect their health, and additionally if possible, dynamic work designs that accommodate workers’ changing capacity over time. This may entail adapting:

- premises, equipment, hours and pressures
- assessment criteria regarding qualifications
- work functions, for example by substituting one function for another where roles may be worse or better as a result of age.

Minimizing risks and monitoring exposure of workers to risks is an important part of work design.

f. Preparation for retirement. Retirement for most people represents a break in their life. For many it is the end of productive work in the sense of paid work. Others may wish to continue working later in life, perhaps on a self-employed basis – for example, turning hobbies and previous experience into work – or taking up a new career. But almost everyone could benefit from some advice, education and time to reflect. Some firms do offer such schemes but they need to be rather more than just a few weeks at the end of a long working life. The Swedish county of Östergötland set a target in its health for all programme that by 2000 all pensioners-to-be should have the opportunity of participating in pre-retirement programmes.

What the health and other sectors can do

The previous sections have identified a number of things that employers can do to support the health of older people. There are some other relatively simple actions that can be taken within the broader community to support people in growing older. Such actions can also benefit the whole of society, for example removing risks of accidents by ensuring better lighting, improving the instructions that accompany various appliances and designing homes that remain easy to manage throughout the whole life-course.

Many of the suggestions in this presentation can only be implemented by specific agencies – employers or those responsible for creating living and working environments. However, the health sector has several important opportunities to act for healthier aging.

First, it can encourage these other sectors to introduce such policies.

Second, the health sector is also itself an employer, and can provide a good example by “cleaning up its own house first”. Opportunities exist for the health sector to improve the health of its own workers, particularly those working in lower grades, many of whom are women.

Third, the health sector is responsible for collecting data on the health effects of poor living and working environments. An extensive body of work in these areas has been undertaken over the years. The health sector has not, however, been very effective in presenting such data to those who can initiate the necessary policy changes. More could be achieved through better analysis and dissemination of information demonstrating the possible harm caused by policies in other sectors or their potential for healthier aging. Much could be learnt from the way the private
sector undertakes and uses market research to target products. Some regions have begun to use such techniques, for example the household profiles created in North-West England are an innovative way of assessing socioeconomic differences in the community and targeting resources for health accordingly.

Giving information to policy-makers in a form they can use, and showing why the health sector is doing what it is doing and how other sectors can contribute will ensure that we all become part of a much wider health development process.

Advocates for older people – the example of Age Concern (Ms Frances C Hunt, Head, Age Concern England ActivAge Unit)

Age Concern England is a nongovernmental organization (NGO), although the term used in the United Kingdom is usually voluntary organization. It is a registered charity legally governed by the Charity Commissioners for England and Wales. Although it was established after the Second World War as a response to helping the many older people who were found to be living in abject poverty at that time, it has its roots firmly in the Middle Ages when hospitals and small local institutions (known as “parishes”) took responsibility for caring for poor and destitute people in their areas. Nowadays, Age Concern England is at the heart of a movement which consists of over 1400 local Age Concern groups throughout the United Kingdom supported by over 250 000 volunteers, most of whom are older people. There are similar subnational organizations in Wales, Scotland and Northern Ireland.

Activities carried out locally include the provision of day care; luncheon clubs; befriending, visiting and advocacy schemes; health promotion and intergenerational projects. Nationally, amongst a large variety of services, Age Concern England provides support to local groups in England through specialist and generic units and officers, offers low-cost insurance to older people, operates a substantial information service and runs various training programmes. It also works on the policy front – influencing government and other decision-makers in their work with older people.

Ms Hunt heads the ActivAge Unit, that part of Age Concern England which deals with positive and active aging. This unit, established in 1997, has offices in London, in the north of England and in the Midlands. Its role is to facilitate opportunities for people aged over 50 to continue to make a positive contribution towards the structure of their own lives, the lives of other older people and the life of their local communities. Currently, it operates two major nation-wide programmes: Aging Well UK, a health promotion initiative with and for older people, and Trans Age Action, an intergenerational programme based on the United States Foster Grandparent Programme. The work was shortly to encompass a wider schools programme working with disadvantaged pupils in secondary schools and a further project associated with older people and the arts. All the programmes seek to empower older people, putting them in the position of being able to make informed choices and their own decisions.

The background to the unit’s establishment lies in the phenomenon of longevity and a belief that this can be capitalized upon to bring real benefit to all sectors of society. It builds upon a desire by Age Concern England to develop work across generations and to service a sector of the older
population which does not necessarily need traditional care services but to whom life-enhancing opportunities might be offered.

The work of the unit sits within Age Concern England’s commitment at national level to act as advocate of all older people, ensuring that they are not forgotten, that they remain on politicians’ and decision-makers’ agendas, maintaining their rightful profile and ensuring that this is free of the stereotypical misunderstandings that so many people have about old age and older people – professionals included. Ms Hunt believed this to be one of her movement’s most important roles and one it could play well, thanks to its unique position outside government and its reputation for work of high quality with and for older people.

She felt that, sadly, in the United Kingdom today not all older people look forward to the second half of life. Though they might hope and expect to be able to participate, to have a feeling of self-worth, to continue to make a contribution towards their own lives and the life of the community in which they live, to exercise choice and to be recognized as human beings, this is not always possible.

There are many factors which touch on their quality of life, including health, an adequate income, employment, access to and standards of care, adequate housing, security and warmth, a clean environment, personal desires and relationships with family and friends – in fact all of those things that younger people accept as the norm and that we all – whatever our age – place great value upon. A major determinant (as throughout the rest of the world) is the dramatic shift in the age profile. In the United Kingdom in 1994 the population was 58,935,000. Of this figure, 18.2% (10,630,000) people were over pensionable age. Over two thirds of people aged over 75 were women, with 8,000 people aged 100 or over – by 2031 it is estimated that a staggering 34,000 people will be in this latter age group.

These figures cannot be ignored – nor should they be, for they demonstrate the tremendous advances that have been made over the years in the United Kingdom and elsewhere in the fields of health, housing and social care. Age Concern England has tried to harness and capitalize on them – countering any negative and burdensome connotations and creating a positive, dynamic force of older people which can be used for the benefit of the whole nation. In doing this the organization has not lost sight of those older people who need care and support – either now or in the future.

Ms Hunt gave some practical examples of how Age Concern is managing to achieve its objectives.

**Campaigning to combat age discrimination**

Over the years Age Concern has been at the forefront of campaigns to combat age discrimination. In February of this year it promoted a high profile Age Discrimination Week. This involved the release of a report and a Gallup poll, a briefing for the All Party Group (of Members of Parliament) on Aging and Older People, a free-phone line for people to report experiences of age discrimination and a poster designed to caricature a celebrated advertisement for Wonderbra. This secured 10 hours of television and radio coverage and 26,000 newspaper articles.

---

7 Government Actuary’s Department, 1994, based on national population projections.
column centimetres. Nearly 150 MPs signed a declaration of support and the organization was congratulated by present and former ministers, Members of both Houses of Parliament and the media, corporate partners and the general public. Sadly, the Government did not adopt all the organization’s suggestions but is introducing a code of practice which they are helping to formulate. The organization continues to fight for legislation which outlaws age discrimination along the lines of sex, race and disability and the event helped keep age discrimination firmly on the agenda. Also in respect of age discrimination the organization initiated and continues to service the Employers’ Forum on Age, which challenges discrimination in the workplace.

During the past year a substantial piece of work was produced entitled *Equal access to cardiac rehabilitation*. This disclosed how 40% of cardiac rehabilitation services in the United Kingdom operate explicit upper age limits, and called upon the Government to enforce the principle that health care be made available on the basis of clinical need and to ensure that the necessary funds are available to make sure that this happens. An earlier and extremely effective campaign was on breast cancer screening for women over 65, which began in 1996. Its aims are to bring a change in government policy on breast cancer screening so that older women are automatically invited to be screened on an equal basis to women aged 50–64; to effect change so that women aged 65 or over are aware of and encouraged to take part in breast screening; to raise as much media interest as possible; and to raise awareness among older women, the public, health professionals and policy-makers of the issue. Again, in support of the campaign there is a report *Not at my Age – why breast cancer screening is failing women aged 65 or over.*

**Working with older people to enable them to realize their potential as change makers: The Aging Well UK Programme**

The “ greying of nations” referred to earlier leaves us with some important questions.

- In adding years to life are we adding life to years? – in other words, will those extra years be quality years, or will they be spent in abject misery and ill health?
- Will our already stretched health and social care resources be able to respond to the needs of an aging population?
- What, if anything, can older people themselves do about the situation?

*Aging Well UK* was established to provide a practical and a strategic response to all of these questions and through it we expect to achieve

- improved general quality of life of older people, positively adding years to life and life to years;
- increased cost-effectiveness of medical and social interventions;
- improved mental health of older people by alleviating physical disability/chronic illness and social isolation.

*Aging Well UK* is the health promotion programme with and for older people, managed by *Age Concern England*, which enables them to take greater control of their lives and offers the opportunity to work with their peers to promote healthy aging. It is an excellent example of a partnership between the voluntary, corporate and statutory sectors. It currently has over 30 local

---


projects in the United Kingdom and the development continues in Europe and world-wide. One of the significant features of the programme is the way in which it works through trained older volunteers – senior health mentors. Since its inception in 1993 over 400 people over the age of 50 have been recruited and trained to deliver healthy messages to their peers, and the numbers continue to grow! In addition, over a million leaflets have been produced in support of the Programme and have been circulated widely throughout the United Kingdom.

**Bridging the generation gap – creating the “intergenerational contract”**

In 1995 a United Kingdom Foster Grandparents Scheme *Trans Age Action* was launched. This enables older people to play a supportive role in the lives of children from families going through difficult circumstances and allows older volunteers to give something back to the community as well as leaving children with a life-long understanding of the value of an older person.

Also in the intergenerational field, earlier this year the *Age Concern* Millennium Awards Scheme was launched. Under this programme grants and personal support are provided for older people (Millennium Fellows) to set up local projects and activities to assist children and young people under 25, thus helping to give them an opportunity to put something very valuable back into their communities, building on their own life skills and experience. Examples of the types of intergenerational project being undertaken include the creation of videos, art collections, local histories and gardens to commemorate the Millennium in towns and villages all over the country; the establishment of a programme of “Generation Games” and the setting up of an after-hours school club to teach children from Ireland living in England about their rich cultural heritage.

In conclusion, *Age Concern* cares about all older people and believes that later life should be fulfilling and enjoyable, but recognizes that for too many older people this is impossible. As the leading United Kingdom charitable movement concerned with aging and older people, it works hard to find effective ways of dealing with these issues. Years of policy analysis and research have established it as the authoritative voice on aging issues and given it a lead role in campaigning to influence policy and attitudes about later life. This helps it to plan for the future with a clear vision of the challenges to come. Wherever possible it enables older people to solve problems themselves, providing as much or as little support they need. Its innovative programmes promote healthier lifestyles and provide older people with the opportunity to put something back into their communities – preventing them from being made to feel that they are always taking something out of society.

**Developing an action programme: discussions in working groups**

Participants discussed specific topics in working groups. Each session opened with a keynote presentation and then participants were asked to give examples of programmes that had worked or that could work if given support. The following are reports from each of the groups.

**Changing the perceptions of aging**

**Changing the perception of aging in the community**

Dr E. Mesthenaiou gave an introductory presentation, indicating that there are considerable differences across Europe in the role of the family, e.g. family care of dependent members whether old, young or disabled. Attitudes to citizenship and voluntary bodies and the role of the
welfare state differ between northern and southern Europe. In the south, the reliance on the family and kin group and the centrality of these networks to social support and solidarity mean that informal relationships are more common while voluntary work has been less organized and extensive. Additionally, the present generation of older people in southern Europe include considerable numbers who have had almost no schooling and have lived considerable periods of their lives in absolute poverty.

There are some general trends that are having or will increasingly have a positive impact on older age in the community. Increasing numbers of older people do have a standard of living that allows them something beyond mere subsistence. Certainly in northern Europe there are increasing numbers and proportions with very high disposable incomes – new consumers who are beginning to demand special services and products that serve them such as travel, cars, home appliances, clothes and care services, and slowly advertisers are becoming aware of this group of older people. As a result there is a slow adjustment to the idea that they are a new market to be addressed which leads to new advertising images as well as new advertising.

Educational standards among older people have risen and continue to do so. More have secondary and higher education and this seems to be one incentive to continued learning in later life. Despite continued high numbers of hours spent watching television, more books are sold than ever before. On television very different images are presented – older people who are rich, famous, in positions of authority, glamorous, sexy – and the “rest”, regarding whom old age is associated with poverty, ill health, isolation and loneliness. The difficulty often lies in who are the journalists. If 20-year-olds write about older people their perspective can be quite different from that of someone who is older.

Family size has so decreased that being a grandparent and caring for children is no longer taking a significant part of women’s lives. Set against this, care of the oldest people is becoming a more significant issue and is often undertaken by “younger” old people. New forms of community structures are emerging to ensure that older people are less isolated and receive help if they need it in some countries – not traditional residential homes, but other services such as sheltered housing, respite care, home care services – all of these help older people remain in their own homes independently or with their families for a far longer period of time.

Geographical mobility has already effectively broken up any remaining notions of the traditional co-residential community as the main context within which people will grow up and age. Modern urban societies are highly mobile and are having to create new forms of social bonding typically based on common interests. People are judged less by their background than by what they are now, their interests, personality. However, there are major differences by social class and region in Europe, and older people are more stable geographically.

More older women have experience outside their family and community in the paid labour force. The implications for this are difficult to judge but creating links outside the family and local physical community, and participating in the wider economic, political and social life would seem to provide a stimulus to further development and social participation in later life.

People are learning at an earlier age – more flexible negative and positive aspects.

The group was asked to consider issues such as continued learning and the role of older people in the family, in voluntary work. They outlined a number of challenges:
how to ensure family support, and well organized social care for older people;
how to match policies to the circumstances in which people live and their political/cultural environments;
how to cater to people’s everyday needs, whether they live in urban/rural communities;
how to support older people who are caring for other older people;
how to ensure adequate financial support for older people.

Actions which could change perceptions of aging included:

- establishing workshops for older people to promote social contact and learning
- involving traditional partners such as the church in changing perceptions of aging
- intersectoral action to make aging more visible as an issue in communities
- coffee parties for all ages to support a positive view of aging in an informal atmosphere
- using the media, e.g. newspapers, to circulate ideas for older people
- tapping into older people as a resource, e.g. voluntary workers in schools and nursing homes
- developing activities for older people, e.g. educational or leisure activities
- establishing self-help groups in the community
- promoting more contact between older and younger people and children.

**Changing the perceptions of aging in the health sector**

The group was asked to consider issues such as maintaining independence, dignity, the right to make decisions, and the role of health professionals. They identified actions which could change perceptions of aging including:

- training in approaching/supporting older people
  - for professionals
  - for their families and others in the community
  - for elderly people;
- finding innovative ways to challenge the myth that aging is not a disease but a natural process;
- intersectoral cooperation, with health professionals acting as a bridge to promoting a more positive view of aging;
- tapping into older people as volunteers to support and care for other older people;
- fighting for older people’s rights to decide.

**Changing the perceptions of aging in the voluntary sector**

Ms Frances Hunt gave an introductory presentation (her more detailed paper is presented earlier in this report). The group was asked to consider issues such as how to gain attention for questions relating to older people, the position of older people as citizens, voters and consumers and the role of older people’s associations. They agreed that actions which could change perceptions of aging included:

- tapping into ethnic groups to produce leaders among older people;
- ensuring that government schemes to support older people are (a) known about and (b) used;
- helping older people to experience new activities;
• encouraging older people to participate in political processes not as tokenism but in a meaningful way, for example through political parties, trade unions, campaign and self-help groups;
• helping patients to form self-help groups supported by care professionals (e.g. people suffering from dementia);
• targeting government/local authority financial support to support voluntary efforts;
• the aim should be to support but not professionalize.

**Tackling failing health among older people**

*Tasks for the health and social care sectors*

Dr Birgit Weihrauch gave an introductory presentation on health and social care for elderly people in North Rhine Westphalia (NRW). She said that at present people aged 60 or over amounted to 22% of the NRW population, some 4 million out of a total of 18 million. The proportion was expected to rise to 26.5% by 2020 and 30% by 2040. Two significant social characteristics of this group are the number living alone (42% of older men and women live alone against 20% in younger age groups), and financial problems among older people, especially women. In terms of health the group experiences higher chronic diseases and handicaps, depression, dementia and mental disorder, multi-morbidity, and different and delayed courses in the healing processes. Symptoms of depression, dementia and mental disorder rise from 2.4–5.1% among men and women aged 65–69 years to 5.4–9.1% among those aged 70–74 and over 30% among those aged over 90.

The challenges to state and society include providing material security, equal chances and fair participation for older people and securing a high-quality infrastructure for health, nursing and social facilities.

The principle adopted in NRW under the 1990 *Landesaltenplan* is to maintain old people’s responsibility for themselves and independent activities and living as long as possible. This requires a health care system capable of meeting the special needs of older people and corresponding to their specific requirements. In NRW the necessary components are seen as a geriatric section in general hospitals, special units/sections in hospitals (stroke units, sections for cardiology and heart surgery, and geronto-psychiatric institutions), general practitioners (family doctors, specialists), inpatient, part-time inpatient and outpatient clinics for medical rehabilitation, outpatient nursing services, inpatient and part-time inpatient nursing, short-term nursing, outpatient and inpatient hospice services and self-help (referring to health and old age). Appropriately qualified staff are important – family doctors, geriatricians, geronto-psychiatrists, old people’s nurses and orderlies, geronto-psychiatric nurses, occupational therapists, physiotherapists and pharmacists.

To guarantee the quality of care and the efficiency of resource input, there needs to be coordination, cooperation and networking among all partners in the health care system. To sustain this, NRW in 1997 enacted a law regulating the rights and duties of the public health service, and has set up a State Health Conference with 10 priority health targets and Local Health Conferences to ensure local coordination of health care and social care. Local examples of the work of the latter include:

• a project to improve care for stroke patients (Düsseldorf)
• moves to establish a geronto-psychiatric advice centre (Coesfeld)
• an emphasis on diabetes in old age, gerontopsychiatry and stroke (Herne).

The group talked through these issues in terms of their local circumstances and identified a number of issues where action is needed to ensure better health care for older people, including:
• ensuring equal access to health services
• ensuring services are close to where older people live
• information and advice to empower older people and maintain their independence
• health promotion and health prevention programmes for older people
• outpatient prior to inpatient care
• rehabilitation prior to nursing
• support for self-help organizations and voluntary work
• training of health professionals
• cooperation, coordination, networking on all levels
• drug policy for old people
• active professional contact with old people.

**Maintaining fitness and eliminating debilitating symptoms**

Dr Sinead O’Mahoney gave an introductory presentation, which described a survey of the prevalence of breathlessness among older people in south Wales. A random sample of 1404 people aged 70 years and over living at home was approached and investigated via a postal questionnaire, home visit and clinic visit. The response rate was 87% and the prevalence of significant breathlessness was 32%. The conclusion of the survey was that breathlessness is common among older people living in the community, that it is measurable and that it is associated with significantly poorer function and quality of life. This in turn prompted questions about the causes – often specific diseases, which can be managed – and the need to identify and take action on these points.

Dr O’Mahoney identified a number of areas where evidence showed clearly that positive health outcomes could be achieved:
• preventive exercise programmes: improving healthy people’s mental outlook and participation;
• acute treatment, using ace inhibitors for heart failure;
• well organized multidisciplinary exercise rehabilitation programmes targeted at high-risk groups have been shown to work in improving quality of life in the fields of cardiac, pulmonary and stroke rehabilitation and preventing falls.

Ms Inger Helt Poulsen described a project in Roskilde in Denmark. This targeted people over 65 who had done no exercise in the previous two years. The setting was a locality selected as having many isolated individuals. Personal letters were sent out in an attempt to recruit 10 teams of 20 people. They were invited to two hours exercise a week with tea/coffee, and a meal once a month. Trained exercise instructors were provided. In fact 20 teams were recruited, and it proved very popular. About 60% had not exercised before. Isolated neighbours were put in contact with each other and 15 teams agreed to continue at their own cost after the programme finished.

The group discussed issues arising from these presentations and recommended:
• targeted programmes based on evidence;
• a broad approach to encouraging exercise including building on cultural practices (e.g. mushroom-picking in Poland) and targeting socially isolated elderly people;
• multidisciplinary teamwork – cross-sectoral issues at all levels involving all professions.

The potential of integrated social and health services

David Elwyn Jones and Marilyn Elaine Parfitt gave an introductory presentation in which they described an example of an integrated service package for older people from Dyfed-Powys in Wales, including:

• chiropody
• meals on wheels
• home help
• information
• GP services
• personal care
• day centre.

The group discussed this type of approach and decided that the advantages were:

• flexibility: care could be tailored to the individual and his/her circumstances and family situation
• potential for a balanced assessment of care needs
• better quality services,

but that the dangers included:

• dilution of responsibilities
• the need for a lot of planning
• interruption of information flow.

This group proposed that a holistic approach, which focused on the determinants of health, and which dealt with health and social care in an integrated way was fundamental to promoting better health.

A multidisciplinary approach to commissioning health services

Mrs Sue Davies gave an introductory presentation outlining the process. The challenge for this group was how to achieve an understanding within the groups of the term “commissioning” – which might be defined as a process through which an official body secures services of an appropriate quality for a population on the basis of identified needs. The group agreed that essentially people do not care who provides the service, as long as they get the services they need.

Actions which could ensure better quality included:

• mapping needs (people and communities) in terms of population statistics, health status, housing, transport, and current service utilization;
• giving information to those who responsible for meeting needs;
• joint assessment of needs, e.g. involving other sectors in needs assessment;
• trusting each other to carry out responsibilities.
Providing care to older people in rural areas

Dr Mesthenaiou provided a briefing paper focusing on Greece, where there have long been established agricultural rural surgeries manned by newly qualified doctors who are required to undertake a period of service in the countryside. There are also newer health centres, established in the late 1980s and strategically placed in rural areas which are supposed to provide comprehensive health services, but these are often inadequate and not fully manned. As with many countries in Europe the countryside is often disproportionately inhabited by older people and despite the existence of rural surgeries and health centres, many villages have no easy access to medical services (doctors, physiotherapy and nursing services). Lower incomes, poorer housing, a difficult physical environment and geographical remoteness have repercussions for older people and family carers, while local authorities do not have the resources to set up extensive and expensive medical or social care facilities in every village. There have been various attempts to overcome these difficulties through the creation of volunteer support networks, the mobilization of local organizations and institutions, e.g. the local authority, governmental bodies, the churches, women’s groups, and even the introduction of telemedicine in some areas. However, all these projects and programmes are experimental, partial and relatively rare and older people remain dependent in many rural area on old-fashioned neighbourliness and the care of whatever family is left.

An exception to this are the KAPIs (Open Care Community Centres for Older People) begun originally as pilot centres by volunteer groups using public financing and now under the auspices of the local authorities. The main objective of these centres is to help keep the elderly active and participating members of their local communities. There are over 243 centres in many rural areas as well as urban centres throughout Greece. The services offered are primarily recreational in character but include those of a full-time social worker and some medical services provided by a full-time health visitor, a part-time doctor and, in some cases a physiotherapist, the emphasis being on preventive health care. Chiropody and occupational therapy services are available in some KAPIs, as are washing machines which can be used by elderly members of the KAPI or their carers. The medical services are not integrated within the national health system, though there is cooperation with the agricultural insurance fund.

The KAPIs’ services are oriented more towards the well elderly, although some funding has now been found for the initiation of home care services in selected areas, including some of the rural areas. Although they are supposed to provide home helps, KAPIs have so far had difficulty in the implementing this programme with the result that the bedridden, the housebound and the dependent elderly in the community are least likely to benefit from the KAPI. While the KAPIs are aimed at the elderly, they frequently work closely with family members in such matters as drugs prescription and provision, advice and counselling, while also providing some relief care through limited supervision of elderly members on weekday mornings, or holiday care for those elderly people who go on annual camping holidays organized by the majority of KAPIs in association with the Ministries of Tourism and of Health and Welfare. It should be emphasized that the KAPIs do not take responsibility for the care of the dependent elderly in their area and in any case not everybody chooses to join a KAPI.

Finally, something should be said about the implications of new technology. Already there has been some development of telemedicine. While this may be excellent in acute cases and enable experienced doctors to supervise the work of junior doctors and nurses in the field, the often complex health problems faced by older people need good case management that may not be so easy.
One development already found in one study is that older people who become seriously ill or dependent are often forced to leave their rural homes for the urban apartments and facilities which can give adequate physical and medical care.

The group discussed a broad range of options that might help support older people in rural areas including:

- making multiple use of community buildings, e.g. schools;
- providing travelling health and social services e.g. libraries, dental services and chiropodists;
- ensuring appropriate housing e.g. improved phones, bathrooms;
- a village information centre to promote the use of information technology for all ages;
- telemedecine;
- telephone assessment of health needs;
- targeting resources for rural maintenance/development e.g. providing jobs to ensure young people continue to live in rural communities;
- providing elderly-friendly transport for long and short distance travel.

**The potential contribution of older health professionals**

The group felt there were considerable differences between east and west: in western Europe older health professionals tend to join voluntary groups after retirement, while in eastern Europe they have to find other jobs in order to survive financially.

Ms Lena Rydin Hanson gave an introductory presentation, saying that in Östergötland in Sweden over 10 years ago older health professionals formed a new voluntary group and have since participated in health care debates, health care development and in practical health care. They took an active part in the development of the Östergötland health for all programme and helped move it into action. They are at present working with hospital wards to make rehabilitation something that starts when older patients are still in acute care.

Such professionals have experience, skills and knowledge. These they can use to help health care organizations, and they also have time and sympathy for older patients and can win their confidence. But it is hard to persuade current health care professionals of the benefits of such collaboration.

In Sweden, by 2010 about 20% of health care professionals will have reached retirement age, matching the profile of the rest of the population, and that means a huge demand for health care. This underlines the need to look closely at the role that older health professionals can play.

The group considered the issues raised in the presentation and decided that actions which could enhance the role of older health professionals included:

- recognizing the benefits from collaboration between older and younger health professionals in caring for elderly people;
- when establishing teams, ensuring a balance between young and older doctors;
- strengthening care of the elderly as a component of medical curricula;
• encouraging health professionals to take up new activities after retirement (e.g. hospice work);
• providing continuing training for health professionals in geriatrics and social services;
• giving incentives to health professionals (particularly nurses) to stay in the profession up to retirement;
• improving the economic, political and professional conditions of health professionals in order to enhance their health and quality of life.

Preparing for growing older

Pre-retirement advice

Ms Lena Rydin Hansson gave an introductory presentation, explaining that the county of Östergötland in Sweden in its health for all strategy set four targets in relation to retirement. Target 8 said that everyone 65 years plus should be offered a health check every fifth year as an introduction to an active lifestyle – to be available countrywide by 1995; Target 11 said that by 1997 at the latest, study circles should be available to pensioners, combining instruction, preparing food and spending time together; Target 24 aimed to halt the rise in the number retiring early due to functional impairment in neck/shoulders/lower back by 1995 and Target 25 aimed to ensure that by 2000, all pensioners-to-be should have opportunity of participating in pre-retirement programmes.

Some larger firms were already taking action which would help achieve this last target, and the county wanted to encourage smaller firms to take a similar course. However, politically and economically, circumstances turned against the policy. Between 1990 and 1992 unemployment quadrupled and trade unions, employers and society in general were more concerned with unemployment than retirement.

When developing policies it is essential to consider how the best balance can be achieved in setting priorities which support older people and at the same time ensure fair opportunities for those in the workforce. Consideration of broader economic circumstances is important when assessing the feasibility of a target.

The group identified actions to support older workers as including:
• developing retirement policies in the context of broader social trends;
• paying particular attention to retirement in the light of life stages and working needs;
• making provision to tackle inequalities – for example the group recognized substantial differences between well paid white collar workers with good conditions, and low paid manual workers with poor working conditions;
• adapting the physical working environment to the needs of older workers;
• introducing more flexible working arrangements;
• appropriate services (health care/education) for older workers;
• pre-retirement and post retirement services.
**Unemployment/forced retirement of older workers**

Dr Malgorzata Kutycowska gave an introductory presentation offering some statistics on the changing situation. In discussion the group identified a number of actions to support older workers forced into unemployment or early retirement:

- recognizing those important elements of working life which might be lost on retirement:
  - money/income
  - status/recognition
  - social contact
  - freedom/new interests/new careers;
- maximizing choices so that people can still be fulfilled in those areas of their lives;
- the health sector influencing the development of social policy through information/data;
- ensuring identity does not just come from work but that people are able to develop and sustain various identities over their lives:
  - family identity/value
  - location identity/value
  - hobby/interest identity/value
  - community identity/value.

**Reducing accidents among the elderly**

A paper by Dr Antoine Casabianca was presented as an introduction to the session, describing a project in the Canton Ticino (300 000 inhabitants). In Switzerland, one of the most frequent causes of death of people over the age of 65 is unintentional injury. The high burden of suffering and the high cost of cure and care for these patients have created growing concern for the Ticino health authority and the population as a whole. The PIPA Project (PIPA stands for the Italian title – *Injury Prevention Programme for Elderly People*) was launched in May 1996 as a joint project between the Ticino Public Health Department and 26 organizations dealing with elderly people. A multi-agency steering group was co-opted with the main objective of coordinating and giving informing about existing activities and stimulating agencies to put injury prevention on their agenda. Working groups were created to deal with different aspects of injury prevention: personal factors, environmental factors and information/communication strategies, and to make proposals for action.

The main objective of the intervention is, through community participation, to decrease the level of injuries among elderly people. Intersectoral cooperation and community involvement are emphasized. The programme includes active and passive strategies.

Activities include education for members of the intersectoral groups, staff who are in contact with elderly people and risk environments in general, district nurses, home visitors, pensioner organizations, work supervisors, safety engineers, home associations, trade unions, political parties and others; services and facilities focused on easy access to safety equipment for older people, peer health counselling (both to help and to support customers) and activities organized and tutored by older people themselves; and elimination of risks in home and traffic environments.
Evaluation to date indicates that the participative process is going ahead, although it is slow. There are difficulties achieving community ownership of the project and as yet there is no compulsory surveillance system to measure changes in the injury rate.

Bibliography


Alternative roles after work

Dr Mesthenaiou gave an introductory presentation, focusing on voluntary work and education. Voluntarism, i.e. participating in an activity generally for altruistic purposes rather than for direct financial gain – a current centre of debate in Europe. Changes in work patterns, the cut-back in welfare provisions, growing demands from dependent groups for social and/or health support, and long-term unemployment are reasons why many governments in the European Union are showing such acute interest in the role of voluntary bodies as agencies that may be able to provide solutions to social needs and problems. On the other hand, voluntarism depends on notions of social solidarity which cannot be used for political and policy ends.

Among older people the problem lies often in the fact that during their childhood they were never exposed to opportunities for a variety of interesting and stimulating voluntary activities and in later age it is not easy to stimulate them into activity. However, political and self-help groups among older people defending their interests are likely to increase.

The role of tradition in voluntary work for older people should, perhaps, not be underestimated but this does not mean that more traditional organizations using NGOs can rest on their laurels, e.g. churches, Red Cross. Many have already begun to think in terms of modern management, targeting, project design and the training and management of volunteers.

Continuing education can involve similar problems, since those who have had little or unhappy experiences of education are not easily persuaded of the fun of continued learning. Programmes that are not classroom- or desk-bound, that use and develop as well as respect older people’s existing knowledge, are needed. Interestingly, though we have kindergarten teachers, we have not yet developed the profession of animateurs and managers for older people’s activities and education linking the generations – in many countries older people are able to offer time and real help with those who need special tuition and support in their learning. There are activities that involve older people as tutors to new managers, to the unemployed, to children with special learning difficulties, to those who want to learn new crafts. In reverse there have also to be opportunities where older people can learn from younger – computer training is one obvious example. There have been projects where one retired person and one unemployed person have been put together to the mutual gain of both.

The group discussed the issues raised. Within the voluntary sector, older people could play an important role in complementing health and social services and organizing self-help and pressure groups. They also discussed how older people can benefit from further education, and recognized
older people as making an important contribution to the promotion of culture. The advantages of engaging older people as voluntary workers included:

- an economic means of providing support to other older people
- keeping people active
- giving older people a social value
- providing social contact
- establishing regular patterns of life
- giving people an identity
- strengthening community life
- ensuring physical, psychological, social and spiritual wellbeing.

The disadvantage was that using older people as voluntary workers could become a way for health and social services to neglect their full responsibilities.

The group proposed that education for older people should be fun, experimental and practice-based rather than classroom-based.

**What have we learnt and what should we do next?**

Over the course of the conference, issues raised and suggestions made by participants were captured for the “ideas basket” and sorted into four areas of potential action:

- macroeconomic and cultural change
- community level
- services
- individual.

In the final session, Dr Christopher Riley and Professor Morton Warner synthesized the suggestions from the four posters with the objective of identifying a programme of work for individual regions and for the Network on the topic of aging.

**Securing macro-economic and cultural change**

**The task**

From the presentations and discussions a number of important issues concerning the relationship between individuals and society were raised which need some sort of high level response:

- the power of the break at 60 or 65, which can exercise such a psychological hold over both older people and the rest of society;
- job discrimination against older people;
- the reality of poverty for many older people;
- the fact that it is no longer true (if indeed it ever was) that the state is responsible for everything – this can, of course, free people to be more creative and open;
- the need to put people in a position where they are prepared for and are making choices;
- gender differences and cultural diversity;
- socioeconomic diversity within and between countries and between different parts of Europe;
• recognition that changes across Europe are creating victims of transition who will need attention, and that the same solutions will not apply everywhere.

**The possible responses**
These are big issues and will require mobilization of resources across society. Perhaps four groups and four tasks particularly need to be worked on:

• sensitizing employers to understanding what harm and good they can do
• reaching out to politicians, and bringing pressure on them if necessary
• using all courses available to raise media interest and activity
• building up community representatives to speak out.

**Strengthening communities**

**The task**
The presentations and discussions highlighted the great good that communities could do by making older people feel welcome and maintaining their health and wellbeing, but also underscored areas where concerted action is needed:

• efforts to counter social exclusion and make people feel that they belong
• support for families, to help those who can find no time and to encourage contact
• actions to counter an indifference and lack of neighbourliness towards others
• a programme of community preparation – we all hope to be old one day.

**The possible responses**
Three broad field of action were identified:

*Involve, integrate, empower people*

• assist, encourage and support people’s own efforts – don’t take over
• support self-help groups
• use older people as consultants/assessors
• provide meeting places for people to organize in
• be open to new ideas
• recruit, use and develop volunteers.

*Improve the availability and use of physical resources*

• use buildings in more ways for more groups
• encourage churches and other organizations to work with older people
• develop workshops
• open information centres
• provide elderly-friendly transport – short and long distance
• develop programmes to care for and repair housing stock for later life.

*Capture influence*

• encourage political membership
• develop and use leaders who reflect different groups within the community
• work positively with both men and women
• search out what people really need and make it known.
Providing responsive services

The task
Of course, the ideal would be for us all to live healthily into old age, but the reality is that many of us will need practical help. Our aspiration, backed by our taxes and the efforts of trained, dedicated staff, is to have the services needed to keep people as fit, health and happy as possible.

The possible responses
The services that result need to include a complete range of decent, effective and efficient services both in the field of health care and across the spectrum of social activity and support, including:

- excellent graduated, accessible and fully coordinated health services covering:
  - assessment of needs
  - promotion of good health and problem prevention
  - targeted programmes to find and help those with remediable health problems
  - accessible rehabilitation programmes for those who will benefit;
- imaginative social programmes to explain, demonstrate and encourage healthy living, including:
  - sound nutrition
  - natural activities (e.g. picking mushrooms and walking)
  - exercise throughout life
  - environmental adaptations
  - hazard reduction
  - information and advice via any appropriate channel.

Supporting resilient individuals

The task
The success of all these efforts will be judged by their effect on the health and experience of the individual. But we are not helpless pawns in this game; we all have our own aspirations, capacities and skills. Each of us needs to acquire through life the tools and assets that will take us through to a healthy old age; this does not mean piling up material possessions but engaging in a process of life-long learning. Programmes need to understand that people absorb lessons in different ways.

The possible responses
The process is life-long. It needs a programme with the government, the local community, families and individuals recognizing their common interests and engaging together to make it possible for the present and future generations to enjoy a more healthy old age than our forebears did, through:

- economic and social investment to give children a sound physical, nutritional and emotional start;
- action to reduce the long-term impact of smoking, drinking, poor food, stress and pollution on chronic diseases over the entire life course supplements a healthy start in life.
Annex 1

PARTICIPANTS

Czech Republic – Northern Bohemia

Dr Josef Richter
Head, RHN N.Bohemia
Regional Hygiene Office
Moskevská 15
400 78 Usti nad Labem
Tel.: +420 474 0159
Fax: +420 474 0160
E-mail: jrichter@khsulbukov.cz

Dr Eva Rychlikova
Moskevská 15
P.O. Box 78/U2
400 78 Usti nad Labem
Tel.: +420 474 8763
Fax: +420 474 8760

Czech Republic – Northern Moravia

Dr Jaroslav Volf
Director, Regional Institute of Hygiene
Partyzanska nam. 7
728 92 Ostrava 1
Tel.: +420 69 223 201
Fax: +420 69 611 8661
E-mail: khs.ostrava@vsb.cz

Germany – Nordrhein-Westfalen

Dr Birgit Weihrauch
Ministerium für Arbeit, Gesundheit und Soziales des Landes Nordrhein-Westfalen
Fürstenwall 25
40219 Düsseldorf 1
Tel.: +49 211 855 3556
Fax: +49 211 855 3239
E-mail: juergen.deckers@mags.dvs-nrw.dbp.de

Hungary – Bacs-Kiskun

Dr Klára Mihai
Public Health Officer
Szechenyi krt. 12
H-6000 Kecskemét
Tel.: +36 76 481 570
Fax: +36 76 481 570
E-mail: h8652sza@ekka.hu

Hungary – Gyor-Sopron

Dr Peter Abraham
Medical Officer for Health
Sallai ut 3
H-9200 Mosonmagyaróvár
Tel.: +36 96 216 066
Fax: +36 96 216 187
E-mail: antszgy@mail.datanet.hu

Hungary – Szabolcs-Szatmár

Dr Szuzsanna Hangyal
Public Health Office
Arok u. 41
H-4401 Nyiregyháza
Tel.: +36 42 438 316
Fax: +36 42 434 036
E-mail: hzs@antsz.szabinet.hu

Dr Sandor Kovacs
County Assembly
Kossuth ut 114
4232 Gezálered
Tel.: +36 42 361 161
Dr Marianna Penzes
Chief, Department of Health Promotion
Public Health Office
Arok ut. 41
4401 Nyiregyhaza

Lithuania

Dr Z. Padaiga
Department of Preventive Medicine
Faculty of Public Health
Kaunas Medical Academy
A. Mickeviciaus g. 9
3000 Kaunas

Poland – Katowice

Dr Malgorzata Kucytowska
Provincial Methodical Centre for Health Care
(Wojewodzki Zespol Metodyczny Opieki Zdrowotnej)
ul. Dworcowa 17
40-012 Katowice

Portugal – Madeira

Dr Miguel Stringer
Secretaria Regional dos Assuntos Sociais e Parlamentares
Rua das Hortas no. 30
9050 Funchal
Madeira

Sweden – Östergötland

Ms Lena Rydin Hansson
Director of Regional Development
Ostergotland County Council
Landstingets Kansli
St. Larsgatan 49 B
S-581 91 Linköping

Sweden – Västra Götaland Region

Dr Lars Himmelmann
Regional Health Planning Board – Western Region
Bohuslandstinget
Box 1508
S-40150 Göteborg

United Kingdom – North-West England

Mr Peter Flynn
Deputy Director of Public Health
NHS Executive North West
930–932 Birchwood Boulevard
Birchwood
Warrington, WA3 7QN
United Kingdom – Wales

Mr Tony Beddow
Welsh Institute for Health and Social Care
University of Glamorgan
Glyntaff Campus
Pontypridd
Mid-Glamorgan CF37 1DL

Tel.: +44 1443 483 070
Fax: +44 1443 483 079

Ms Sue Evans
Care Manager
Dyfed Powys IHA
P.O Box 13
Carmarthen SA31 3YH

Fax: +44 1267 222440

Mr David Elwyn Jones
Day Unit Manager
Ysbty George Thomas
The Mattie Collins Way
Treorchy, Rhondda CF42 6YG

Tel.: +44 1222 716989
Fax: +44 1222 711267

Dr Marcella Sinead O’Mahony
Senior Lecturer in Geriatric Medicine
Academic Centre
Llandough Hospital
Penlan Road
Cardiff CF64 2XX

Tel.: +44 1443 440440
Fax: +44 1443 775042

Ms Marilyn Parfitt
Community Psychiatric Nurse
Ysbty George Thomas
the Mattie Collins Way
Treorchy, Rhondda CF42 6YG

Tel.: +44 1443 440 440
Fax: +44 1443 775042

Professor Morton Warner
Director, Welsh Institute for Health and Social Care
University of Glamorgan
Glyntaff Campus
Pontypridd, Mid Glamorgan CF37 4BS

Tel.: +44- 1443- 48 30 70
Fax: +44- 1443- 48 30 79
E-mail mmwarner@wihsc.glamorgan.ac.uk

Temporary Advisers

Dr Katalin Bolvary
National Institute For Health Promotion
Andrassy ut 82
1068 Budapest, Hungary

Tel.: +36 1 332 73 80
Fax: +36 1 131 61 12

Ms Frances Hunt
Age Concern England
Astral House
1268 London Road
London SW16 4ER, United Kingdom

Tel.: +44 181 765 7701
Fax: +44 181 679 6997

Dr Elizabeth Mesthenaiou
SEXTANT CO
9A Aktaiou Str
GR-118 51 Athens, Greece

Tel.: +30 1 346 1742
Fax: +30 1 346 9070
Observers

Ms Margaret Ohr
National Institute For Health Promotion
Andrassy ut 82
1068 Budapest, Hungary
Tel.: +36 1 332 73 80
Fax: +36 1 131 61 12

Ms Inger Helt Poulsen
Department of Prevention
Roskilde Amt
Kogevej 80
4000 Roskilde, Denmark
Tel.: +45 46 30 35 17
Fax: +45 46 37 36 18
E-mail: cfihp@ra.dk

WHO Regional Office for Europe

Ms Patsy Harrington
Short-term Professional, Country Health Policies unit
Tel.: +45 39 17 13 02
Fax: +45 39 17 18 18
E-mail: pha@who.dk

Dr Chris Riley
Short-term Professional, Country Health Policies unit
Tel.: +45 39 17 1403
Fax: +45 39 17 18 18
E-mail: cri@whodk

Dr Anna Ritsatakis
Regional Adviser, Country Health Policies and Equity in Health
Tel.: +45 39 17 12 18
Fax: +45 39 17 18 18
E-mail: rit@who.dk

Ms Frances Ingels
Secretary, Regions for Health Network
Tel.: +45 39 17 12 59
Fax: +45 39 17 18 18
E-mail: fra@who.dk
Sixième conférence annuelle du réseau Régions-santé
Katowice (Pologne), 2 et 3 octobre 1998

Cette conférence a permis d’examiner les défis que pose le vieillissement de la population en Europe, les démarches novatrices axées sur le vieillissement en bonne santé et ce que les régions peuvent faire pour l’amélioration de la qualité de vie des personnes âgées. Des exposés ont été consacrés à la complexité des choix qui s’imposent aux décideurs dans l’ensemble de l’Europe en une époque de profonds changements politiques, aux résultats que les employeurs, le secteur de la santé et le secteur bénévole peuvent obtenir à travers une sensibilisation de l’opinion quant aux difficultés rencontrées par les personnes âgées et en mettant à contribution les talents et la bonne volonté de ces dernières pour le profit de l’ensemble de la société. S’appuyant sur ces exposés et sur l’expérience de chacun, des groupes de travail ont élaboré un programme d’action ayant pour but de favoriser les changements sur les plans macro-économique et culturel, consolider le tissu social, offrir des services adaptés à la demande et préserver l’autonomie des individus.

Autres documents

Outre le présent résumé, un rapport sur cette réunion est disponible en anglais.

BUT EUROPÉEN 2 DE LA SANTÉ 21 – ÉQUITÉ EN MATIÈRE DE SANTÉ*

D’ici 2020, l’écart de santé entre groupes socioéconomiques dans les pays devrait être réduit d’au moins un quart dans tous les États membres en améliorant nettement le niveau de santé des groupes défavorisés.


BUT EUROPÉEN 5 DE LA SANTÉ 21 – VIEILLIR EN BONNE SANTÉ*

D’ici 2020, les personnes âgées de plus de 65 ans devraient avoir la possibilité de jouir de tout leur potentiel de santé et de jouer un rôle actif dans la société.


Mots clés

- AGING
- HEALTH SERVICES ACCESSIBILITY
- HEALTH SERVICES FOR THE AGED
- HEALTH POLICY – TRENDS
- LOCAL GOVERNMENT
- EUROPE
Sechste Jahrestagung des Verbunds Regionen für Gesundheit
Kattowitz (Polen), 2.–3. Oktober 1998

Die Konferenzteilnehmer befaßten sich eingehend mit den Herausforderungen, die sich durch das Altern der Bevölkerung in Europa ergeben, erörterten innovative Maßnahmen zur Förderung und Unterstützung eines gesunden Altwerdens und befaßten sich mit der Frage, wie die Regionen das höhere Lebensalter lebenswerter machen können. In Referaten ging es um die komplizierten Sachzusammenhänge, denen sich die Politiker in ganz Europa in einer Zeit erheblicher politischer Veränderungen gegenübersehen, und um die Frage, was Arbeitgeber, der Gesundheitssektor und der gemeinnützige Sektor tun können, um das Bewußtsein für die Schwierigkeiten älterer Menschen zu schärfen und die Talente und den Enthusiasmus älterer Menschen in der Gesellschaft breiter zu nutzen. Ausgehend von den Referaten und persönlichen Erfahrungen arbeitete man in Arbeitsgruppen an einem Aktionsprogramm, das dazu dienen soll, makro-ökonomische und kulturelle Veränderungen zu fördern, die Gemeinschaften zu stärken, die Bereitstellung von bedürfnisorientierten Diensten zu stützen und den einzelnen Menschen zu helfen, ihre Spannkraft zu entwickeln und zu erhalten.

Weitere Produkte:
Neben dieser Zusammenfassung liegt ein Tagungsbericht auf englisch vor.

**Gesundheit21 Europäisches Ziel 2 – Gesundheitliche Chancengleichheit**

Bis zum Jahr 2020 sollte das Gesundheitsgefälle zwischen sozioökonomischen Gruppen innerhalb der Länder durch eine wesentliche Verbesserung der Gesundheit von benachteiligten Gruppen in allen Mitgliedstaaten um mindestens ein Viertel verringert werden.


**Gesundheit21 Europäisches Ziel 5 – Altern in Gesundheit**

Bis zum Jahr 2020 sollte Menschen im Alter von über 65 Jahren die Möglichkeit geboten werden, ihr Gesundheitspotential voll auszuschöpfen und eine aktive Rolle in der Gesellschaft zu spielen.


**Schlüsselwörter**

- AGING
- HEALTH SERVICES ACCESSIBILITY
- HEALTH SERVICES FOR THE AGED
- HEALTH POLICY – trends
- LOCAL GOVERNMENT
- EUROPE
Шестая ежегодная конференция сети “регионов здоровья”
Катовице, Польша, 2–3 октября 1998 г.

На конференции были рассмотрены проблемы и трудности, с которыми сталкивается стареющее население Европейского континента; новаторские усилия, направленные на пропаганду и поддержку сохранения здоровья в старости (“здорового старения”); а также пути и способы внесения дополнительного вклада в обеспечение более полнокровной жизни в пожилом и преклонном возрасте. Были заслушаны ряд выступлений и проведены презентации, свидетельствующие о всех тех сложностях и трудностях, с которыми сталкиваются лица, разрабатывающие и определяющие политику в странах Европы, в период далеко идущих политических изменений, а также о том, чего могут достичь предприниматели, сектор здравоохранения и добровольный сектор, повышенная осознание всех тех трудностей, с которыми сталкиваются пожилые и престарелые люди, и используя таланты и энтузиазм лиц старшего возраста на благо общества в самом широком смысле. Основываясь на данных выступлений и презентаций и опираясь на свой собственный опыт, рабочие группы разработали программу действий, направленную на содействие макроэкономическим и культурным переменам, укреплению общин, содействуя обеспечению четкости, отзывчивости и быстрого реагирования при оказании медико-санитарных услуг и способствуя сохранению и повышению жизнеспособности и жизнерадостности представителей старшего поколения.

Дополнительные материалы

Помимо настоящего резюме, имеется отчет о данном совещании на англ. яз.

ЗДОРОВЬЕ-21: ЕВРОПЕЙСКАЯ ЗАДАЧА 2 — РАВЕНСТВО В ВОПРОСАХ ОХРАНЫ ЗДОРОВЬЯ*

К 2020 г. разрыв в уровне здоровья между социально-экономическими группами внутри стран должен быть сокращен по крайней мере на одну четверть во всех государствах-членах за счет значительного улучшения уровня здоровья групп населения, не получающих достаточного обслуживания.

*Принято на сорок восьмой сессии Европейского регионального комитета, Копенгаген, сентябрь 1998 г.

ЗДОРОВЬЕ-21: ЕВРОПЕЙСКАЯ ЗАДАЧА 5 — СОХРАНЕНИЕ ЗДОРОВЬЯ В ПОЖИЛОМ ВОЗРАСТЕ*

К 2020 г. люди в возрасте старше 65 лет должны иметь возможность полностью реализовать имеющийся у них потенциал в отношении собственного здоровья и выполнять активную социальную роль в обществе.

*Принято на сорок восьмой сессии Европейского регионального комитета, Копенгаген, сентябрь 1998 г.