Plenary 5: Nutrition and Ageing

Nutrition for older people
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People are living longer. Australia now has the second longest life expectancy (at birth) in the world: about 71 years for males and 74 for females. At 60 years our average health-adjusted life expectancy (HALE) is another 16.9 in men and 19.5 in women (mortality is longer). Around 20% of Australians are now over 65 years old. Many occupations are no longer obliged to retire people at a fixed date and a number continue working past 65. “70 is the new 60!” So we have to adjust the cut offs for “older” people and “elderly”.

Nutrition research in older people is handicapped by (i) great heterogeneity of the people’s health and conditions, (ii) special problems with access, (iii) confounding by medications, (iv) the varied, often indirect criteria used for nutritional status.

Nutrition science’s concerns with this age group can seem to be looking in two opposite directions. “Don’t eat too much, so you’ll stay healthy for longer” (and there’s the calorie restriction hypothesis) OR “We’ll help you get more to eat to keep you healthy for longer”. Which direction depends partly on interpretation of the limited research. It depends more on the stage an individual is at: third age or fourth. Chronological timing of aging is more variable than the timing of growth in teenagers.

For the third age there is much good advice in the NHMRC’s ‘Dietary Guidelines for Older Australians’ (1999) (1). Among the messages to be found in it:- “Anyone refusing to give a sprightly 66 year old dietary advice to prevent cardiovascular disease could be accused of age discrimination” (p 85). ‘We know that salt sensitivity (of blood pressure) increases with age’ (p 110). ‘Keep active to maintain muscle strength and a healthy body weight’ (p 29). ‘Older people may become infected with food borne pathogens at low doses that might not produce a reaction in (younger) people’ (p 48). As people age ….. a lowered energy output leads to a lowered energy intake: we eat less food. ‘Because of this older people need foods that are rich in nutrients – nutrient-dense foods – if they are to maintain their intake of essential nutrients’ (p xx i).

The National Nutrition Survey (1995) confirmed lower energy intakes over age 65 y. As to requirements of essential nutrients, the NH&MRC (2005) sets RDIs higher for protein, calcium, riboflavin and (especially) vitamin D for the 70+ year line (than for younger adults).

In the fourth age old people are no longer healthy and under – or malnutrition is likely to be associated. SENECA Study participants who lost 5 kg body weight had a significantly shorter survival. Undernutrition in old people has many, often combined causes. Broadly these are (a) serious disease or advanced aging, and (b) socio-economic and management problems. The first group are for medical care, AUSPEN and high tech nutrition support. The latter group are the main challenge for this society: older people who are not eating what they need because they are socially isolated, have chronic disabilities, were nutritionally depleted by major illness in hospital, are housebound or don’t eat enough in nursing homes.

Different agencies and professionals are theoretically in a position to help nourish and re-nourish people in some of these situations. Nutritionists/dietitians are likely to be advisers rather than at the front line. For most jobs there’s a manual telling the best way to do the job. In nursing homes this has been lacking for nutrition. Bartl and Bunney asked 100 people for practical ways of looking after nutrition and food in nursing homes. This is embodied in their manual (2), which a book reviewer considers “ideal for aged care staff who want a single source of information in plain English, which will assist them, or prompt them, to address all the food and nutrition related standards and guidelines for aged care”.

Housebound elderly are scattered, isolated, out of sight and more difficult for nutritional advice to access. This was discussed – with no major answers – at a conference at Sydney University last year. We heard stories about individuals with food insecurity, about the adverse effects of bad teeth, early Alzheimer’s, depression, social isolation and other disadvantages. In Lipski’s experience at least 30% of independent community living elderly are undernourished, most unrecognised. Meals on Wheels cost more than they used to. Community nurses and care services help some people. An increasing number of commercial companies will deliver meals for those who can pay. It is estimated there will be a large increase of frail older Australians living in the community and not enough people to care for them - ? us. This important exception to the obesity epidemic deserves much more of our attention.

References