Longevity increased in most countries during the first half of the 20th century mainly as a result of reduced infant mortality from infections and other preventable causes. However, since the 1950s the average lifespan has again increased, mainly because older people with chronic illnesses such as cancer, heart disease, and stroke are living longer. Data showing that the proportion of older people with depression and other mental illnesses will grow disproportionately faster than the overall older population are less well known. One reason for this is a higher risk of these mental illnesses in people born in the post-second world war baby boom than in those born before the war. The changing demographics have been described as a “silver tsunami,” pointing to the high healthcare costs of the ageing population. A more constructive socioscientific approach would be to develop means of keeping older adults healthy.

The linked randomised controlled trial by Von Korff and colleagues (doi:10.1136/bmj.d6612) assessed an important model for promoting healthy ageing in people with multiple chronic illnesses. The authors sought to improve hyperglycaemia, hypertension, hyperlipidaemia, and depression by integrating a treat to target programme for diabetes and risk factors for coronary heart disease with collaborative care for depression. The intervention, called TEAMcare, combined self management support, monitoring of disease control, and pharmacotherapy for each of these illnesses. The outcome was a significant improvement in social role disability (Sheehan disability scale) and overall quality of life. It has previously been shown that prevention and treatment of late life depression can enhance quality of life and be cost effective. What is unique about Von Korff and colleagues’ study is that the integrated care simultaneously targeted physical and mental illnesses.

Comorbidity is a rule rather than an exception in old age. Comorbidity exerts a synergistic effect such that the combined disabling effect of different diseases is greater than the summed effect of each of them. Meeting the healthcare needs of the older population should be tackled at four levels—basic, clinical, educational, and societal.

From a basic science perspective, research should continue to help us better understand and modify common biological processes that underlie ageing related disorders, such as oxidative stress, inflammation, and immune regulation. Interventions and lifestyle changes—such as eating a Mediterranean diet—that target these mechanisms may have a widespread effect on physical and cognitive ageing.

In terms of clinical research, integrated care approaches to promote successful ageing similar to TEAMcare should be expanded to patient groups that were excluded from the current study, such as non-English speakers, those in long term care, and people with serious mental illnesses. A question arises, however, about what is meant by successful ageing. Traditional objective definitions have emphasised the absence of physical and cognitive disabilities. Yet, exceptional longevity is often associated with frailty. Recent data suggest that for most older people subjective quality of life is more important than objective measures, and successful ageing is primarily predicted by psychosocial protective factors such as resilience, optimism, and social support. A longitudinal survey has shown that psychosocial interventions may have a more lasting effect on successful ageing than physical health approaches.

Therefore, randomised controlled trials should not just focus on pharmacotherapy but also on behavioral and psychosocial treatments. Positive changes in personal behaviour may be more beneficial than drugs in reducing pathological effects of chronic stress on neural, cardiovascular, autonomic, immune, and metabolic systems.

Another way of dealing with physical and mental health comorbidity may be through use of interventions that simultaneously increase physical activity, cognitive stimulation, and positive affect, thereby affecting all three components of the thinking-moving-feeling triad implicated in poor health related quality of life. An example of such an approach is the use of “exergames”—entertaining video exercise games. If such approaches were specifically adapted to the needs of older people, they could conceivably affect obesity, diabetes, heart disease, and depression simultaneously.

With regard to education and training, the current number of geriatricians and geriatric psychiatrists is too small for the numbers of older patients who need care, and the demand will far exceed the supply in the coming decades. Therefore, these specialists’ role will increasingly become that of consultants to primary care doctors. Existing curriculums in medical schools and nursing schools as well as residency training programmes...
must be modified so that future primary care clinicians and specialists are better trained in the specific needs of the ageing patient population.

The most important change needed though is that of society’s attitude towards ageing. Older people should not be considered as a burden but as an invaluable resource to younger generations. It is only by reducing the stigma against ageing that we can turn the much feared spectre of a silver tsunami into a golden boom, with successfully ageing adults contributing their knowledge, experience, and wisdom to their own as well as the society’s wellbeing.

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