Malnutrition within an ageing population: a call for action

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1. Introduction: A Call to Action

The prevalence of malnutrition is high across all community and care settings in Europe. Existing research suggests that 46% of all hospitalised patients are malnourished on admission. This figure rises to over 50% among older patients.

Yet awareness of malnutrition is low amongst policymakers and the general public. It is under-recognised and under-treated by health and social care professionals.

Certain groups are more at risk of malnutrition, including older people. The causes of malnutrition in older people are social, economic and clinical. Much of malnutrition is preventable. Effective and cost-effective interventions exist. These interventions are not only clinical. For example, social support networks can restore eating as a social activity for older people, and prevent the social isolation that can often lead to malnutrition.

Malnutrition is a critical issue for Europe. The European population is ageing. By 2050, one-third of Europeans will be over 60. Thus preventing malnutrition among older Europeans is of utmost urgency for all of society: for older generations of today as well as those of tomorrow.

Malnutrition is also a serious problem of public health. Its burden on health and well-being is significant. Effective interventions require private/public partnerships, involving not only health professionals but insurers, regulatory agencies and suppliers of nutritional products. The EU has a critical role to play in setting standards and protocols, enabling partnerships, facilitating exchange and raising awareness of this critical issue.

On September 14th 2005, stakeholders from across Europe gathered together in London to discuss malnutrition at the inaugural conference of the European Nutrition for Health Alliance (ENHA). Delegates at the conference were deliberately invited from across a broad spectrum of health, residential and community care. This reflects the fact that malnutrition can affect older people in any setting.

In his opening address, ENHA Co-Chair Professor Claude Pichard spoke to the three themes of the conference: the prevalence of malnutrition, the effectiveness of interventions and the cost and burden to society.

“The message could not be clearer: malnutrition is highly prevalent and leads to poor clinical outcomes. Solutions are available and effective nutritional support improves clinical outcomes and is cost-effective. The time to act is now.”

This report draws on discussions and recommendations from the conference. Its aim is to focus the attention of policymakers and all stakeholders on the need for action on malnutrition.

Specifically, we propose three calls-to-action to advance progress against malnutrition in older people:

1. Malnutrition is ‘alive and killing’. It must be recognised as a disease in its own right.

2. We can no longer afford to tolerate the high prevalence of malnutrition. Malnutrition is a serious social and economic issue with significant repercussions for individuals and society as a whole.

3. All stakeholders need to take ownership and action to address the problem. Malnutrition occurs across all settings. Targeted actions are needed to address the root causes of malnutrition and empower individuals to foster ‘well-nutrition’ for themselves.

“How will history judge the early 21st century? If things go on as they are, the verdict will be dismay and condemnation, that wealthy societies and established social protection systems could allow the tragedy of malnutrition to occur in such a large segment of the population. This is just not tolerable, and the European Nutrition for Health Alliance, with growing support, is determined to tackle this issue.”

Mel Read, former Member of the European Parliament
2. Background

What is malnutrition?

The World Health Organization defines malnutrition as "the cellular imbalance between the supply of nutrients and energy and the body’s demand for them to ensure growth, maintenance, and specific functions."

Put otherwise, **malnutrition may be seen as the antithesis to good nutrition or ‘well-nutrition’.**

What is good nutrition? It implies eating the appropriate nutrients (carbohydrates, protein, fat, fruits, vegetables and dairy products), in the right proportions, to be able to maintain normal tissue function, repair and renewal on a daily basis (European Nutrition for Health Alliance).

What is malnutrition? Malnutrition is any situation where the required nutrients are not available in the right proportions. It is possible to be obese and to present malnutrition. Generally however, individuals (especially older people) with malnutrition present low body weight.

Older people may be especially vulnerable to malnutrition. Why?

The prevalence of malnutrition rises with age. Many changes associated with the process of ageing may exacerbate malnutrition – although malnutrition is by no means an inevitable facet of ageing (Gariballa, 1998). Older patients may be at greater risk of not being able to recover from malnutrition (Pirlich et al: 2003).

Malnutrition may be secondary to certain conditions (*disease-related malnutrition*), such as cancer, arthritis, diabetes, or emphysema (Hickson et al: 2006). It is also a condition in its own right. Common risk factors for malnutrition are summarised below.

### Risk factors for malnutrition in older people

**Clinical factors:**
- Poor appetite
- Poor dentition
- Loss of taste and smell
- Disability and limited mobility
- Drug interactions
- Other disease states (cancer, diabetes, arthritis,...)

**Lifestyle and social factors:**
- Lack of knowledge about food, cooking and nutrition
- Isolation and loneliness
- Poverty
- Inability to shop or prepare food

**Psychological factors:**
- Confusion
- Depression
- Anxiety
- Bereavement
- Dementia

(Adapted from Hickson 2006)
It is important to recognise that it is not just clinical factors that predispose some older people to malnutrition. Living conditions and socioeconomic circumstances play an important role as well. Moreover, older people are not a homogeneous group, therefore these factors will present differently from one individual to another.

Screening tools are available but they are not universally used

Malnutrition is common, under-recognised and under-treated – thus it is a prime candidate for screening (Elia et al: 2005). Various screening tools to detect malnutrition have been developed: the Malnutrition Universal Screening Tool (MUST); Mini Nutritional Assessment and the Geriatric Nutritional Risk Index (GNRI) are the most common. Screening measures vary in their precision, cost and in the skill required to administer the procedure (Stratton et al.: 2005).

Several guidelines advocate the use of systematic nutritional screening; however, it is far from universally adopted (Elia et al: 2005). Systematic nutritional screening has, in some instances, been introduced in hospitals and care homes. However, screening in community settings remains sporadic at best.

Malnutrition remains a low priority for clinicians and policymakers

Malnutrition has not yet risen to the political agenda as a recognised problem of public health. More worrying still is the fact that is greatly under-recognised by clinicians and under-treated as a result. Physicians receive little specific training on nutrition. In a European survey of older people, one third of people over the age of 80 reported that they had never been weighed by their treating physician (SHARE, 2005).

Poor coordination between health and social care professionals, as well as between primary and secondary care physicians, means that information about a patient’s nutritional status gets lost in the chain of care. As a result, nobody has clear accountability for patients’ nutrition. Any problems are likely to be left undetected and untreated.

‘Political authorities are still not aware of the problem of malnutrition. It’s not on the political agenda, in any of the 25 countries of the EU nor in Brussels. Thousands of people are suffering or dying. It is urgent that policy makers and society in general make this major public health problem a top priority.’

Presentation: Baeyens, 2005

- Causes of malnutrition in older people are not only clinical: they are social and psychological as well.
- Malnutrition is under-recognised and under-treated – therefore screening is essential.
- Malnutrition remains a low priority in clinical care.
3. Prevalence of Malnutrition

Prevalence figures

Estimates of the prevalence of malnutrition vary by setting, subgroup and method of assessment. Prevalence rates may be affected by confounding factors such as disease status or setting. Definitions vary across studies, and sample sizes are often too small to allow for meaningful interpretation of data.

Nevertheless, what evidence is available is startling to those unfamiliar with the problem.

Professor Claude Pichard presented data suggesting that rates of malnutrition among hospitalised patients (of all ages) were 46%. Among older patients, the prevalence of malnutrition is significantly higher. It rises from 50% in persons over 60 to 77% amongst patients over the age of 80 (Kyle et al.: 2002; Wyszynski: 2003).

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Prevalence of malnutrition in nursing homes:
Stratton et al, 2003; King et al, 2004: 60-100%

High prevalence in hospitals and care homes

Most prevalence figures relate to malnutrition in hospitals or care homes. Yet malnutrition in these settings does not necessarily result from poor or insufficient food. It results mostly from logistic failures in getting appetising food to patients at the right time. Specific causes for concern are:

- Food delivered at inflexible and inconvenient times
- Insufficient time given to eat
- Lack of staff to help feed patients
- Patient difficulties in reaching food, using cutlery or opening food packaging
- Unpleasant sights, sounds and smells
- Limited provision for religious or cultural dietary meals.

(Adapted from Hickson, 2006)

Although food provision is often sufficient in hospitals and care homes, patients still may not have their estimated nutritional needs provided for.

(Dupertuis et al.: 2003)
Malnutrition in community settings

Malnutrition is not just a problem amongst in-patients and care home residents. The prevalence of malnutrition is also high among older people treated in the community.

Prevalence of malnutrition in community settings

- 26% of patients receiving district nursing care (Stratton et al, 2003)
- 15% of older adults living in the community (Hajjar et al, 2004)
- 37-40% of older adults living in the community (Ryan et al, 1992)
- 5-44% of home-bound older adults (Hajjar et al, 2004)

Conference paper: Wait: 2005

High prevalence but low awareness

A remarkable fact of the prevalence of malnutrition among older people is the low awareness of malnutrition among health and social care professionals.

For example, for older people living in the community, the local family doctor is the first port-of-call. Yet awareness among family doctors of the symptoms and the risks of malnutrition is often alarmingly low.

The conference heard from Dr Neil Bacon of a survey of UK family doctors about their awareness of malnutrition and use of nutritional support services. The survey found that:

- 88% of respondents were not aware of any nutritional screening tool designed to identify patients at risk of malnutrition
- Only 13% always referred a patient at risk of, or suffering from, malnutrition, to an NHS Dietician
- 40% never provided dietary advice to patients at risk of malnutrition prior to an elective admission to hospital.

(Nutricia Clinical Care/doctors.net.uk: 2005)

Delegates agreed that there is a clear need for greater education of GPs as to the problem of malnutrition. Governments, health authorities and GP professional associations all have a role to play in achieving this.

Dehydration: a key feature of malnutrition

Water is rarely offered or considered as part of nutritional care. It is a vital, but overlooked component of nutrition and wellbeing. The adverse effects of poor hydration include:

- Kidney damage
- Dizzy spells
- Falls
- Constipation
- Urinary tract infections
- Cognitive impairment
- Certain cancers
- Pressure sores
- Extended recovery from illness

Presentation: Ellins: 2005

Low awareness of malnutrition is not limited to professionals in primary care; it is endemic across secondary and residential care as well.
Conference Recommendations: AWARENESS

Malnutrition should be recognised as a primary disease in its own right

Malnutrition, currently, is not on anyone’s radar. It is not recognised as a significant problem of public health, nor as a preventable social phenomenon, nor as a significant health risk in ageing populations. To receive the attention it needs, malnutrition must be recognised as a primary disease which warrants proactive detection, dedicated health promotion, and comprehensive treatment guidelines. Building it within this framework would prevent it from being ‘forgotten’ as is currently the case. It would also stimulate professional awareness and scientific research.

Professional education and training

Improving professional education is key to the treatment of malnutrition. It is hugely important that health and social care professionals, and those working in residential care, become aware of the prevalence of malnutrition, and are educated about detection and prevention. Governments must make this a key priority. Health professionals need more training in dealing with malnutrition, and expert nutrition organisations need to have a greater role in evaluating and determining the training of health professionals. Professional bodies should influence curriculum development in nutrition training for health professionals.

Awareness building among the public

Many of the interventions for preventing and treating malnutrition can be undertaken by friends and relatives. Greater public awareness of the problem is vital to beating malnutrition. Governments need to implement major public awareness-building campaigns to enlist the public in preventing malnutrition among older people.

Benchmarking

Efforts must be made to benchmark good nutritional practice. Relevant health agencies need to coordinate efforts to collect prevalence data in a standardised way and measure practice to enable the comparison of the burden of malnutrition across different settings.
Detection and screening
As has been already described, malnutrition often goes undetected. Many older people never have their nutritional status properly evaluated when receiving health or social care.
A first response to the prevalence of malnutrition among the elderly is therefore to improve detection and screening. Delegates at the conference produced the following recommendations.

Conference Recommendations: DETECTION

**Adopt measurement tools for nutrition/oral intake/clinical signs of malnutrition**
The absence of a universally-preferred screening tool for malnutrition has frustrated attempts to develop policy solutions. Ideally, such a screening tool should be adopted across Europe, so as to enable cross-border comparison and learning.

**Universal mandatory malnutrition screening for older people must be adopted**
Screening should target older people where they are most vulnerable, in secondary care, residential care and in the community. Nutritional assessment should be incorporated into all geriatric assessment.

**Define and identify at risk groups**
Certain groups among older people are at particular risk of malnutrition. Research to identify these groups should be undertaken, and the results distributed among health and social care professionals.
4. Effectiveness of Interventions

Just as the causes of malnutrition may be clinical and social, the sphere of interventions to prevent and treat malnutrition must address its clinical and social manifestations. The individual must be central to any approach taken: care, health promotion and support must be user-centred and have the explicit aim of empowering individuals to foster their own ‘well-nutrition’ and prevent malnutrition from occurring in the first place.

Clinical interventions

Different interventions are available to treat and prevent malnutrition. Targeted clinical interventions are very effective.

The origin of the acronym “MEALS ON WHEELS”:

The acronym ‘Meals on Wheels’ is used internationally to denote the provision of meals to people in their homes. However, it also spells out many of the root causes or contributing factors to malnutrition. Addressing these various causes may provide effective and comprehensive treatment to malnutrition in older adults.

- Medication (e.g. digoxin, psychotropics, theophylline)
- Walking (dementia)
- Emotions (depression)
- Hyperthyroidism/hyperparathyroidism
- Anorexia/Alcoholism
- Enteric problems (malabsorption)
- Late Life paranoia
- Eating problems
- Low-salt low cholesterol diets
- Oral and dental disorders
- Shopping and food preparation problems
- No Money (poverty)

When treatments are effective, clinical results can be dramatic: rapid increase of body weight, positive changes in protein in blood analyses, fewer infections and substantial decrease in length of stay in hospital (Thierry Pepersack).

Interpretation of clinical study findings, however, can be complex. Differences in methodology, setting and clinical definitions of outcomes may make it difficult to interpret the literature and reach consensus as to which treatments should be widely used (Stratton et al, 2003). Arguably this lack of consensus has frustrated policy development. There is a great need for better data on the effectiveness as well as the cost-effectiveness of interventions across different care settings.

Below are some examples of the effectiveness of (par)enteral and immo-nutrition cited at the conference.

Selected examples of Intervention Benefits

- Conference speaker Professor Thierry Pepersack briefed delegates on the use of a comprehensive programme of nutritional intervention for hospital patients in Belgium which was associated with significantly decreased hospitalization.
- The use of nutritional supplements with older malnourished patients in the community resulted in reduced medical costs (hospital, nursing and other medical care) of 723 lower on average. Arnaud-Battandier et al.: 2004
- A systematic review of evidence on the use of immonutrition in hospital patients found that it was associated with lower infectious complications, and compared to immune-enhancing diets, a lower mortality rate. Heyland et al.: 2001
Another key point is that many of the most effective interventions are remarkably simple and inexpensive, and may not even require professional involvement. For example, improving nutrition for patients in hospital or care homes can be as simple as making sure that glasses of water are placed within their reach.

**Eating is a social activity**

An important risk factor for malnutrition is social isolation. Eating is a social activity. Friends and family can play an important role in preventing their relatives from becoming malnourished.

Friends and relatives can help to detect malnutrition, by identifying:

- weight loss
- signs of apathy or depression
- checking the fridge
- “tell me what you had to eat yesterday”

Presentation: Potocka: 2005

**Community support**

Older people’s organisations can also be critical in helping prevent malnutrition among older people.

Older people’s organisations can help by:

- Undertaking awareness campaigns with language that really talks to older people and their informal carers.
- Raising awareness of families and care professionals on the risk of malnutrition and providing them with recommendations and tips how to prevent problems from arising.
- Helping dependent older people keep their social network, preventing the social isolation and depression that can lead to malnutrition. Setting up special peer support measures, for example through daily visits by specially trained volunteers who know to whom to report problems, can be used to break this isolation.
- Training older people to shop, cook, and feed themselves.

Presentation: Potocka: 2005

**The role of the private sector**

In addition to older people’s organisations, friends, relatives and professionals, the food industry has a key role in tackling malnutrition by making healthy food more accessible and more adaptable to the needs of older people.

The food industry should take into consideration that, with age:

- the sense of taste, smell and sight may decrease
- decreased jaw strength and reduced production of saliva result in difficulty with chewing and swallowing
- immune response and function decreases, making food safety an increasingly important issue
- manual dexterity decreases, making packages difficult to open.

Food manufacturers should develop products incorporating:

- Packaging that is easy to open.
- Larger labels that are easy to read and understand with useful nutrient information.
- Smaller portions and better adapted packing.
- Clear instructions on the packaging as to how to preserve the food.

Presentation: Potocka: 2005
Conference Recommendations: INTERVENTIONS

Community settings:
Recognise the role of social care agencies in promoting good nutrition
It is not just in secondary care that good nutrition should be promoted for older people. It is often forgotten that a key setting for preventing malnutrition among older people is the community. Social care agencies can promote nutrition and prevent many of the problems of malnutrition that later require the involvement of health professionals.

Promote nutrition as a social activity
Eating is a social activity, and malnutrition is often associated with social isolation. Promoting the social aspect of eating is a cheap and highly effective way of preventing malnutrition among older people.

Promote self-assessment
Some of the simplest tests for detecting malnutrition can actually be self-administered. Educating older people in self-assessment would be a very useful step in tackling malnutrition.

Hospital and residential care:
Governance:
Create accountability at board level as a precondition for responsibility at the ward level.

Inspection and audit:
Residential and hospital care inspectors should be trained in nutrition, to enable the regular inspection of providers for standards of nutrition.

Health promotion and public health:
Make public health campaigns more effective
There is significant scope to improve the effectiveness of public health campaigns that promote good nutrition.

Identify patient preferences / promote service user involvement
Encouraging good nutrition is more effective when the preferences of individuals are incorporated. Strategies to fight malnutrition among older people must take into account ‘user views’ wherever possible.
5. Cost and burden to society

There is a definite business case for promoting better nutrition in institutions.

Presentation: Potocka: 2005

A business case for the prevention and treatment of malnutrition

One of the key messages from the September conference was the need to convey the 'business-case' for the prevention and treatment of malnutrition to all stakeholders.

The facts are clear:
- Malnutrition costs individuals, the health care system and society billions every year (Elia et al, 2005).
- The prevalence of malnutrition is striking.
- Much of malnutrition is preventable.
- Effective interventions exist that are simple and inexpensive to implement.

Thus targeted actions to prevent and treat malnutrition can only be cost-effective.

Malnutrition increases clinical vulnerability for older people

In addition to its core symptoms, malnutrition leads to:
- Higher vulnerability to illness and other conditions.
- Increased mortality for a number of diseases, most notably malignancies (Pirlich et al.: 2003).
- Altered pharmacokinetics of drugs (ie the process by which a drug is absorbed, distributed and metabolised by the body may be altered), leading to lower clinical effectiveness.
- Impaired thermoregulation.
- An increase in falls.
- Inactivity, especially in bed-ridden persons, which may lead to pressure sores and thromboembolism.

In the context of individuals receiving medical treatment in hospitals, malnutrition is associated with:
- Complication rates 2-3 times higher in malnourished surgical patients compared to their better nourished counterparts.
- Predisposition to infections.
- Impaired wound healing, resulting in prolonged recovery from illness, increased length of hospital stay and delayed return to normal activities.
- Reduced respiratory muscle strength, which may lead to long-term dependency on ventilators or breathing support.
- Pneumonia and pulmonary failure.

(Adapted from NICE: 2005)

Malnutrition has important social and psychological consequences

The burden of malnutrition does not only manifest itself in terms of clinical outcomes. Social and psychological consequences include:
- Depression, apathy and self-neglect.
- Lack of self-esteem and poor body image.
- Possible confusion with slow recovery.
- Low interest in food leading to decreased interest in social interactions.
- Mood behavior shifts and changes in attitude.

(Adapted from NICE: 2005)
A high cost for society

How does the burden of disease translate into financial costs? Principally, this cost takes the form of higher health and social care costs to society:

- Individuals suffering from malnutrition are more likely to visit their GP.
- The increased vulnerability of malnourished older people to various conditions, increases their need and use of social and health care.
- The impact of malnutrition in secondary care (higher rates of complications, impaired wound healing and extended recuperation periods in hospital) leads to higher healthcare costs.

Recent data suggest that malnutrition in the UK costs in excess of £7.3 billion each year, the bulk of which arises from the treatment of malnourished patients in hospital (£3.8 billion) and in long-term care facilities (£2.6 billion).

(Elia: BAPEN: 2005)

Who pays for nutritional solutions?

This question needs to be raised with policymakers, regulators, social security and third-party payers: who pays for malnutrition? Who pays for nutritional support?

The costs of malnutrition have repercussions for all settings of care, as well as for social services. Yet because interventions range from better nutrition in the home to clinical nutritional support in the hospital, coverage of these interventions is inconsistent. Ear-marked funding needs to be ensured within health and social care budgets to fund solutions to malnutrition, otherwise the burden of payment will fall indiscriminately on older people and their families.
Conference Recommendations: COST AND BURDEN TO SOCIETY

Community settings:
We must recognise the huge social cost of malnutrition. Malnutrition may lead to deteriorating quality of life, causing loss of independence and disability, as well as increased costs of care for older people. The financially impaired face a spiral of deterioration which can easily be avoided through effective interventions.
We need to advocate the provision of additional community-based services to prevent and treat malnutrition in older people.
Efforts are needed to present the economic opportunity for malnutrition interventions – awareness building – to all stakeholders providing services.

Hospital and residential care:
To make the case for change, the real costs of malnutrition need to be communicated to professionals and managers working in care settings. This may lead to greater accountability from a clinical and budgetary perspective.

Public health and health promotion:
Make good nutrition a viable and attractive option.
We have to ensure that nutritional options are accessible and affordable for all individuals, particularly people of lower income. It is important to make healthy options attractive compared to unhealthier options (as well as affordable).

Across all settings:
It is essential to communicate to policymakers and the wider public, the quantitative figures associated with the economic benefits of interventions for malnutrition.
Further research is needed to define the economic benefits of interventions on malnutrition. The use of pilot screening initiatives in given settings may help provide measures of effectiveness and economic impact.
All stakeholders need to take responsibility for reducing the burden of malnutrition: this will require coherent reimbursement and coverage policies as well as coordinated service provision.
6. Calls to Action:

Why isn’t the problem solved already?
• There is no single set of diagnostic tools.
• It’s not a compelling issue for professionals and policy makers.
• Financial underperformance is divided and hidden across several budgets.
• Causes and consequences interfere with each other.

This report of the inaugural conference of the European Nutrition for Health Alliance has identified numerous actions for stakeholders and policymakers.

In conclusion, we identify three key messages to take away from this conference.

1. Malnutrition is alive and killing.
It must be considered as a serious disease in its own right.

Implications:
• Malnutrition is a serious and prevalent public health problem: we need dedicated health promotion efforts.
• Screening tools exist: We need proactive detection and targeted screening programmes.
• Comprehensive treatment guidelines exist: they must be implemented.
• Preventing and treating malnutrition should be made part of the standard medical curriculum.

2. We can no longer afford to neglect the issue of malnutrition.
It must be recognised as a serious social and economic issue. Its high prevalence should not be tolerated.

Implications:
• Raised awareness and training of all health and social care professionals is vital: this applies to clinical and community settings.
• Raised awareness amongst older people themselves is essential: older people should be empowered to foster good eating and ‘well-nutrition’ within their homes.
• Malnutrition starts in the community: we need to develop community-level interventions and services to address the predisposing risk factors for malnutrition in communities.
• Prevention of malnutrition must be a key public health goal: this requires adequate resourcing and sustainability.
• Malnutrition cannot be dismissed as an inevitable consequence of old age: neglecting to address it is blatant age discrimination.

3. All stakeholders need to take ownership and action to address malnutrition.
Malnutrition occurs across all settings. Solutions require public-private partnerships that span across health and social care.

Implications:
• Management of malnutrition must be person-centred: coordination across all professionals and care settings is needed for comprehensive and lasting solutions to be implemented.
• There must be a coherent reimbursement policy for nutritional support across health and social care systems.
• Insurance companies and third-party payers must allow for comprehensive coverage of nutritional support.
7. Conclusions

Malnutrition is highly prevalent amongst older Europeans. It causes significant complications, compromises quality of life and leads to considerable costs for the health care system and society overall.

Yet most malnutrition is preventable and effective interventions exist to detect it and treat it.

That we have allowed malnutrition to prevail to such an extent is an embarrassment. Part of the problem is low awareness. Part of it is lack of ownership. The causes and consequences of malnutrition fall across multiple policy spheres. No single health professional is accountable for malnutrition. This prosaic aspect of malnutrition has stalled action on the problem at the clinical as well as the policy level.

What is needed is concerted action, partnership and coordination amongst different stakeholders. Together, we must ‘own’ the problem of malnutrition to drive changes across different policy realms. Urgent attention must be given to the issue and sufficient resources must be made available to enable lasting solutions to be implemented.

Malnutrition is as much a social as a clinical issue. To address it requires recognition of responsibility, accountability for change, raising awareness, and training.

Most importantly, we have a responsibility towards older people. We need to provide them with sufficient information and empower them to recognise their nutritional needs, take control of their food intake and promote their own ‘well-nutrition’.

To support and enable this empowerment, a cultural shift among many social and health care professionals and organisations is needed. We cannot allow malnutrition to be added to the long list of evidence of age discriminatory practices in our society. Malnutrition cannot be dismissed as an inevitable consequence of ageing (Wait, 2005b).

Too often forgotten: the older population

- “If you are old, you don’t count”
- “If you have grey hair, you are invisible”
- “When you get to my age, doctors think you are going to die soon anyway”
- “You get passed on like an unwanted parcel”

Presentation: Read: 2005

In conclusion, addressing malnutrition is urgently needed across Europe. Achieving ‘well-nutrition’ for all groups within society is achievable and within our realm – concerted action is needed to start addressing this now.
References


