Elderly lives - challenges in risk assessment

The first question we should ask is what do we mean by an elderly life? We all know that people are generally living longer, so at what age should we consider someone to fall into an older life category?

There is no single definition of when someone is considered 'elderly'. Some use chronological age:[1-3]

- 60+ years - used by the United Nations (UN) and in many international studies.
- 65+ years - most commonly used for retirement policies and healthcare systems
- 75+ years - sometimes referred to as 'old-old'
- 85+ years - the 'oldest-old'.
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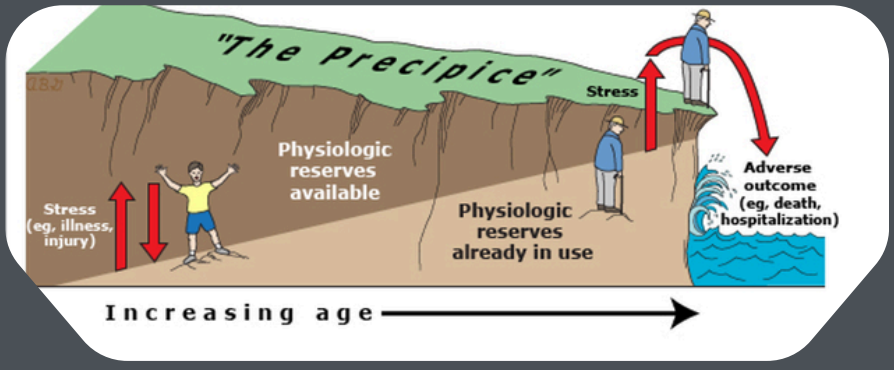
Other definitions utilise medical criteria to define geriatric patients:[4]

- aged 65+, OR any age with
  - multimorbidity
  - frailty
  - cognitive impairment
  - functional decline.

So, what does 'normal ageing' look like? Ageing is not considered to be a homogeneous process. It can occur at different rates depending on an individual's genetic make-up, their lifestyle choices and various environmental factors.[5]

So called 'successful ageing' involves maintaining a high level of physical, mental and social activity without regard for the normal ageing process. This includes maintaining regular physical activity, a nutritious and balanced diet, mental stimulation and strong social connections.[5]

The term 'Homeostenosis', first recognised in the 1940's suggests that with age, diminishing physical reserves are available to meet any challenges to the status quo - or homeostasis, leading to increased vulnerability to disease.[5]



This reduction in physical reserves lowers tolerance to stressors, with the older individual constantly needing to call on additional reserves to combat the normal process of ageing leading to a reduction in resilience.[5]

With ageing, individuals become more susceptible to multiple impairments, including hearing loss, eyesight problems such as cataracts, musculoskeletal pain from arthritis or other joint disorders, respiratory disorders, diabetes, mental health issues such as depression, with many suffering from multiple impairments simultaneously.[6]

Geriatric syndromes such as frailty and reduced physical strength can result in instability and falls, while urinary or renal problems can lead to incontinence.[6]

Problems such as deafness and sight loss can be significantly disabling and lead to social isolation, which can, in turn, result in depression or even cognitive decline.[6]

Therefore, the risk assessment of elderly lives can present several challenges, all of which may require careful consideration and even specialised underwriting.

There are two important areas of concern that are specific to elderly lives - frailty and cognitive decline.

Although there is no specific test for identifying frailty, it is commonly diagnosed when 3 or more of the following exist:[7]

- weight loss - >5% of body weight in the last year
- exhaustion
- weakness - as measured by a reduction in grip strength
- slow walking speed - more than 6-7 seconds to walk 15 feet
- decreased physical activity.

Frailty is linked to higher levels of hospitalisation, institutionalisation, more ED (Emergency Department) visits, and increased levels of disability as measured by ADLs (Activities of Daily Living).[8]

Mild cognitive impairment (MCI) is defined as an intermediate state which falls between normal cognition and dementia.[9]

MCI is regarded as a syndrome, where there is cognitive impairment which is greater than can be accounted for by normal ageing, but does not meet the criteria for dementia.[9]

Several criteria and subtypes of MCI have been proposed, and while there are differences, there can also be considerable overlap. In general, they consist of a measurable deficit in cognition in day-to-day functioning, in at least one domain, in the absence of dementia or other impairment.[9]

When diagnosing MCI, reasonable judgment is needed to distinguish between what is normal for an older person but is not indicative of dementia. This can vary between individuals; therefore, distinctions are reliant on clinical judgement rather than any specific form of testing.[9]

Many older individuals have multiple impairments which require extensive medication, or so-called 'Polypharmacy'. In the United Kingdom, the average number of medications per patient, per annum rose by more than 50% in the 10 years between 2001 and 2011.[10]

Arterial stiffness is likely to increase with age because of a reduction in elasticity, resulting in an increased risk of myocardial infarction and other vascular disorders such as stroke and renal disease.[11]

In conclusion, the reduction in physical reserves as we age causes a lower tolerance to stressors and challenges to homeostasis.

Underwriting considerations when assessing elderly lives:

✅ no evidence of cognitive impairment
- living independently with good functional status, able to manage financial affairs, medication and activities of daily living without help

✅ no serious long-term chronic conditions, e.g. hypertension or diabetes well controlled on treatment

✅ physically and socially active

⚠️ some evidence of cognitive decline
- needs help with activities of daily living, managing finances or medication

⚠️ frailty as evidenced by multiple falls, or polypharmacy:
- receiving 10 or more regular medicines
- receiving 4 - 9 medicines with associated co-morbidities

⚠️ physically inactive, perhaps with indications of poorlifestyle, including non-compliance with medication.

Remember, older lives have different 'norms', and to measure physical and mental well-being against what should be expected at their age.

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