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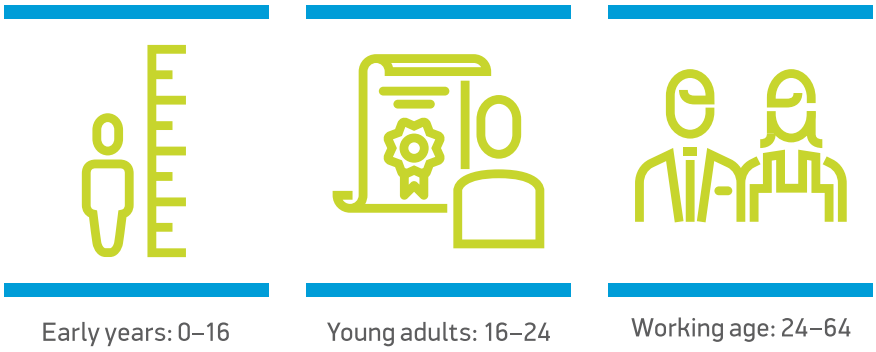

Reducing inequities in health across the life-course

Later life and healthy ageing

A publication of the European Health Equity Status Report initiative

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Ritu Sadana & Shixin (Cindy) Shen

ABSTRACT

Healthy ageing is the process of developing and maintaining functional ability that enables well-being in older age. Health inequities, which are systematic, unfair and avoidable differences in health status or in the distribution of health resources, accumulate over time and alter health trajectories across the life-course. Appropriate measurement and ongoing monitoring of health inequities and determinants can support policy actions that aim to reduce inequities among older people. Successful actions progressively raise or flatten the health gradient across the life-course. This paper discusses multiple determinants of health among older people: health services; personal and community capabilities; living conditions; employment and working conditions; and income and social protection. It outlines policy options and concrete examples of what can be done in health systems and across multiple sectors to reduce health inequities among older people, and potential indicators for measuring progress.

Keywords

HEALTH EQUITY
HEALTHY AGEING
SOCIAL DETERMINANTS OF HEALTH
PUBLIC POLICY
DELIVERY OF HEALTH CARE
INTERSECTORAL COLLABORATION

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Introduction

A life-course approach recognizes the importance of timing and circumstances in understanding causal links between exposures and outcomes across a person's life. Although a growing scientific literature exists, there is a need for a better, shared understanding of how people's health and well-being are shaped by multiple factors, and how resilience and risk accumulate across stages of life and generations *(1)*. The predominant focus on treating single diseases or planning for specific age groups within health systems, rather than addressing person-centred health throughout people's lives, remains an obstacle to operationalizing a comprehensive life-course approach *(2)*. Life-course literature tends to remain theoretical or discipline-based, instead of simultaneously informing policies and interventions on what can be done in practice.

Although this paper focuses on older people, it also aims to contribute to an integrated and comprehensive understanding of the determinants of health and health equity across the life-course that optimizes capabilities and reduces unfair and avoidable inequalities. This builds on issues and policies to address inequities in previous papers in the series. Specific considerations for older people include the following.

Social determinants of health

The paper uses the framework developed for the WHO Commission on Social Determinants of Health *(3)* to consider the determinants and pathways that lead to health equity, highlighting the importance of social position and processes that determine people's access to resources and opportunities. Rather than using one category to describe people's experiences, intersectionality illuminates the complex ways a person experiences discrimination simultaneously, across ageism, sexism, racism and other forms of institutionalized discrimination. Acknowledgement is also made to more recent analyses of the Commission's framework that refine it to describe and explain the health of older people and the experience of healthy ageing *(4–6)*. Recent work further extends this across the life-course *(7)* and reiterates the need to go beyond biomedical determinants of individual conditions or multiple morbidities older people experience *(8)*.

Older people's views on healthy ageing

Concepts and frameworks reflect older people's views on the ageing process and lead to policies and actions that empower older people. An increasing number of in-depth studies document older people's understanding of what they consider determinants of health, their perceptions of health needs over time and ways to build resilience (see recent studies by Menichetti & Graffigna *(9)* and Tkatch et al. *(10)*). As Bryant et al. documented *(11)*, health means "going and doing something meaningful". Reflecting on interviews, they identified four components of healthy ageing: something worthwhile to do; balance between abilities and challenges; appropriate external resources; and personal attitudinal characteristics.

Each study aims to highlight unique views and nuances, yet some common insights emerge that are highly relevant for policy guidance and how programmes are crafted in a specific context: what older people may need from their own resources, families, communities, support systems (including the way health services are organized) and their broader environment to maintain their health and well-being over time.

The *World report on ageing and health* defines healthy ageing as the "process of developing and maintaining the functional ability that enables well-being in older age" *(12)*. Functional ability is "all the health-related attributes that enable people to be and to do what they have reason to value". It reflects a person's intrinsic capacity (the composite of all their physical and mental capacities) and the interaction with their specific environment (the broader determinants of health that accumulate over the life-course and contribute to heterogeneity in strengths and vulnerabilities).

Healthy ageing is a continuous process and is not defined by chronological age. Although longevity is important, healthy ageing as a process should optimize a person's trajectory across the life-course, with a focus on reaching a high level of ability and capacity early and delaying declines as much as possible. It also means that people with declining trajectories have the right to treatment and other forms of care and social support, with dignity. Although beyond the scope of this chapter, understanding pathways and documenting trajectories should help illustrate and explain individual, group and overall inequalities, whether within or across countries. Enabling healthy ageing should therefore be inclusive of all older people, not only those who are disease- or disability-free, or above or below a clinical threshold, and, at the same time, recognize that older people's needs and values are highly diverse.

Measurement, intervention and monitoring of impact

The WHO Commission on Social Determinants of Health noted that a policy-maker would know that health inequities are getting better over time if there is documented evidence of a progressive "raising" and "flattening" of the health gradient *(13)*, meaning that the health of all social groups is improving toward a level closer to that of the most advantaged social group. This requires longitudinal studies to assess if inequalities are stagnant, worsening or improving across the life-course, addressing total inequality and inequities among social, economic and demographic groups.

Depending on the pattern of inequality and evidence on what can be done, policy or programme interventions may be targeted to specific people or groups, or may be universal in nature. Selective interventions may target those without opportunities or access to effective services, while proportionate universalism offers everyone the opportunity to be included, with scale and intensity proportional to the level of disadvantage or need.

Universal and targeted services exist in tandem in some cases, with the latter serving to ensure that more disadvantaged subpopulations do not fall through the cracks due to specific barriers they may face. Reducing health inequities also requires that baseline information be known prior to specific interventions, with follow-up monitoring and analysis of the degree to which interventions optimize healthy ageing and health equity. In Europe, markers of healthy ageing have been shown to differ by age, sex, country and household wealth, reflecting cross-sectional data from the longitudinal Survey of Health, Ageing and Retirement in Europe (SHARE) study in 20 countries.

Differences by age, sex, country and household income in domains of healthy ageing are illustrated in Fig. 1a–c. These are based on nationally representative data from 20 countries included in the most recent waves (2013–2016) of the SHARE survey, including more than 120 000 people aged 50 or older.

Fig. 1a shows that women in all age groups in all 20 European countries have higher cognitive capacity (measured by a 10-word recall test) than men, but Fig. 1b demonstrates that men in all age groups in all countries have higher physical capacity (measured by grip strength) than women. Fig. 1c identifies that levels of cognitive capacity in most countries increase by household wealth (quintiles), illustrating a social gradient. This analysis reflects cross-sectional data and can conflate cohort and age effects.

Similar social gradients nevertheless are found for physical capacity by household wealth. Differences in education levels did not correlate to differences in cognitive or physical capacity (not shown in Fig. 1a–c).

Fig. 1a. Cognitive capacity, by age and sex, 20 European countries, ages 50 and above, cross-sectional data (2013–2016)

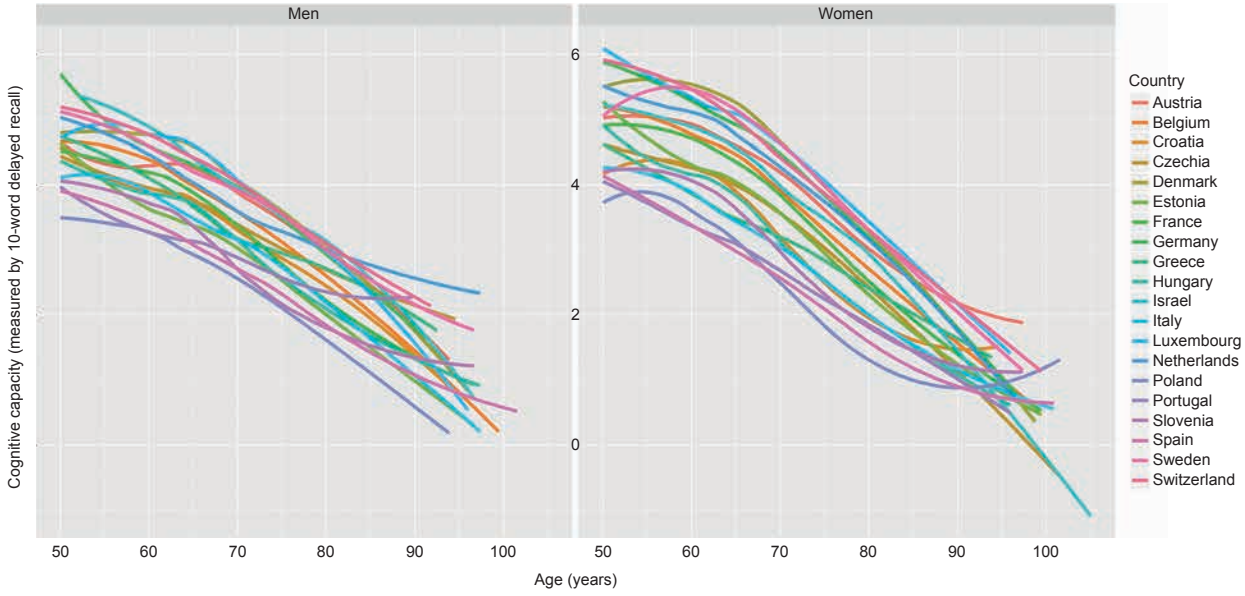


Fig. 1b. Physical capacity, by age and sex, 20 European countries, ages 50 and above, cross-sectional data (2013–2016)

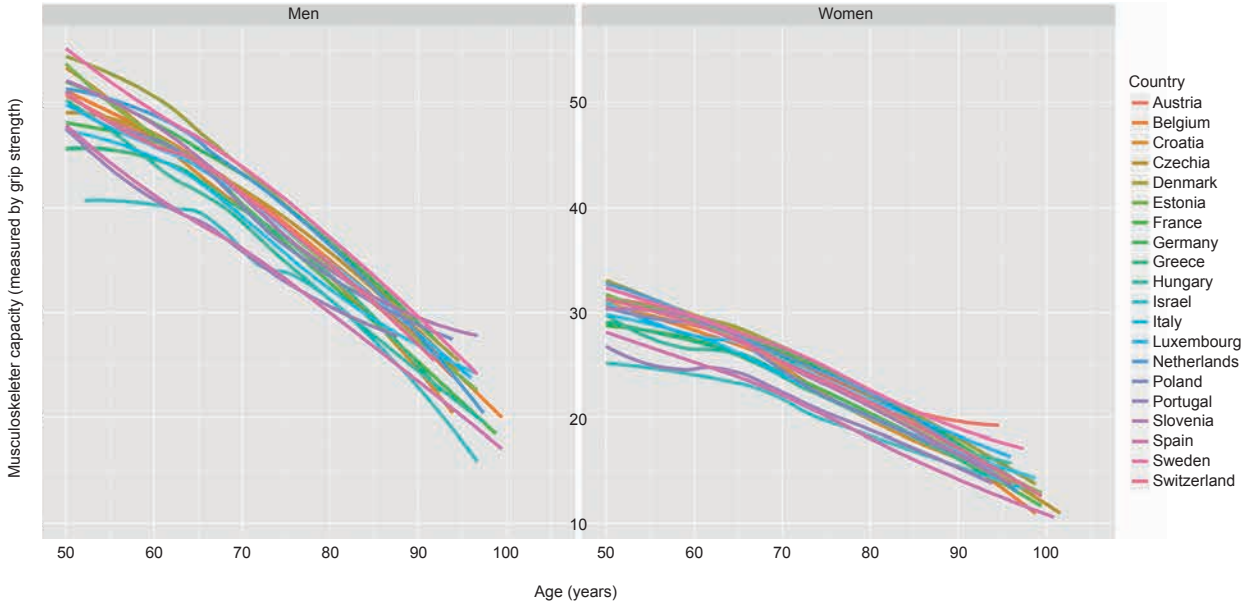
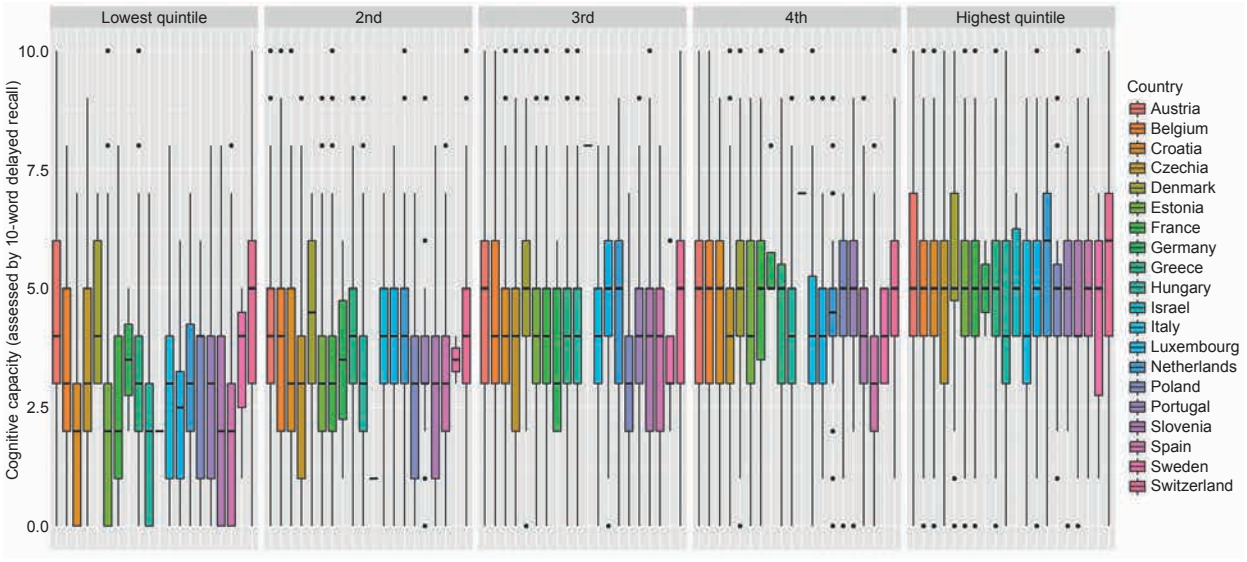


Fig. 1c. Cognitive capacity, by age and household wealth (quintiles), 20 European countries, ages 50 and above, cross-sectional data (2013–2016)



As agreed in the *Global strategy and action plan on ageing and health (14)*, WHO currently is testing an approach to measuring healthy ageing with a network of collaborators, including many in the European Region *(15)*, which involves advocating that all countries have cross-sectional and longitudinal surveys inclusive of older people, and preparing a global status report on healthy ageing for release by 2020.

Multiple determinants of health and health equity and complex pathways and relationships exist (see Kuh et al. *(1)*, Sadana et al. *(6)* and Bell & Marmot *(7)*). This paper focuses on a subset in line with the series themes across all life-stages. Notably, a European task group reviewing evidence on social determinants of health and older people agreed that the distribution of factors that lead to differences in the health of older people reflect the accumulated disadvantage, discrimination and experience of underlying inequities, such as in health, education, social cohesion, gender, and living and working conditions *(16)*. This paper therefore considers the following determinants: health services; personal and community capabilities; living conditions; employment and working conditions; and income and social protection.

Evidence on what can be done to address these determinants and impact on health inequities was gleaned from relevant grey literature and research studies. Addressing determinants requires collaboration between health and non-health sectors. Policy options and country examples of policy actions that aim to improve healthy ageing and health equity were identified from available literature, summarized in Table 1; however, the validity of each policy option was not reviewed.

An important limitation is that most literature focuses on western Europe or countries in the European Union, while the regional framework for health and well-being, Health 2020, covers the 53 Member States of the WHO European Region. Indicators from the Healthy Equity Status Report (HESR) that may be used to measure change within each policy area are provided in Table 2.

Table 1. Summary of policy options and country examples from the WHO European Region identified from literature

Determinant of health inequities	Policy options to enhance each determinant	Country examples
Health services	• Progressively realize universal health coverage with comprehensive and integrated services tailored to the needs of older people, and strengthen mechanisms of financial protection; comprehensive health services not only include treatment, rehabilitation and palliation, but also prevention and health promotion, including reduction of risk factors and disease screening, and addressing not only medical care, but also mental health care, oral health care, long-term care and other health services important for older people • Expand formal community-based long-term care, including end-of-life care, based on local needs; support carers and families through measures such as financial aid, training, respite support and provision of day centres, taking into consideration a gender perspective • Implement integrated care for older people using existing guidelines *(17)* and frameworks *(18)* with seamless transition among health care, long-term care, provision of assistive devices and social services depending on the need to support "ageing in place" • Overcome barriers to health care and long-term care access in rural and remote locations through policies and incentives for workforce development and retention, collaboration with the transportation sector, and exploration of mobile resources such as telecommunication • Improve accessibility by older people with mobility issues and reduced intrinsic capacity in health-care settings, including installation of wheelchair ramps, ample seating and training of health-care workers aimed at improving communication with people who are visually or hearing impaired • Introduce or enhance legislation to promote nondiscrimination on the basis of aspects including age and gender in the provision of health services; promote gender-responsive, person-centred health-care services and long-term care	**Telesupport at home (Maltepe municipality, Turkey)** In 2013, a free wireless device was provided to people over the age of 65 years through public–private partnership, which aimed to improve access to health information and services and reduce social isolation. Older people were connected on demand to a call centre that provided health advice on prevention and healthy living, someone to talk to and referral to emergency services, home care and health services *(19)*. **Community-based multidisciplinary teams for older people (Torbay, United Kingdom (England))** Starting in 2000, community-dwelling people aged 65 years and older with complex health needs have been provided with integrated care after discharge from hospital using pooled funding from the National Health Service and local authority. Multidisciplinary teams provide nursing, occupational therapy, physiotherapy and social work services to older people to support "ageing in place". Timely access to community long-term care improved while hospital admission and emergency department visits decreased at no additional cost *(20)*. **Gerodent (Belgium (Flanders))** Established in 2010, this multi-pronged oral health-care programme aimed to provide nursing home residents with equitable access to dental services. The programme included regular visits of a mobile dental team to deliver preventive and curative oral health care, introduction of oral aides and oral health coordinators, education and training of nursing home staff, and implementation of oral health-care guidelines. An evaluation study of residents of 21 nursing homes reported significantly lower prevalence of dental caries, which narrowed the gap between these residents and the western European average. Before the intervention, the prevalence of untreated tooth decay in permanent teeth among adults residing in the homes was 70.5%, compared to the western European average of 35.8%; after the intervention, prevalence dropped to 36.5%.

Table 1 contd

Determinant of health inequities	Policy options to enhance each determinant	Country examples
		The programme was also associated with reduced need for fillings among those with natural teeth and a decreased proportion of dentures that needed repair, rebasing or renewal *(21)*. **Social care provision in foster families (Russian Federation)** In many rural and remote areas of the Russian Federation, foster care families provide a place to live for older people, along with assisted living services such as meal preparation, laundry and medical support. The aim is to enable care-dependent older people who live alone to stay in a familial social environment for a longer period of time. Foster families receive training and monetary compensation after committing to caring for these older people and passing an interview and evaluations of their living conditions *(22)*.
Personal and community capabilities	• Involve older people, especially those belonging to groups experiencing inequities, in policy design, implementation and evaluation at all levels of government through direct participation, consultation or expansion of the role of civil society in governance arrangements • Connect older people to opportunities for social participation, including volunteering opportunities and group activities, without age discrimination and applying an equity lens by addressing barriers associated with costs, education, mobility, language and culture • Support intergenerational community programmes • Provide locations in the community where older people can meet and socialize, including senior centres, public parks and community centres; provide computer and online access at no or low cost, such as in community centres and libraries • Improve health literacy among older people by providing access to resources, using age-friendly formats in communication, considering equity factors (including language barriers) in provision of health information, and providing training in the use of information technology • Encourage public debate on healthy ageing and health equity, and develop accountability mechanisms such as the use of equity impact assessment and indicators	**Ripe Apples (Austria)** Implemented between 2002 and 2004 and funded in part by the Ministry of Education, Science and Culture and participating local governments, this community service programme created activities and support services for women, including established meeting places, and advocated for political and social changes *(23)*. **City for All Ages (Edinburgh, United Kingdom (Scotland))** A sustainable structure was provided to allow older people of different ethnicities to be actively involved in the planning, implementation and evaluation of this programme, which serves as a joint long-term plan for older people living in Edinburgh *(23)*. **Multigeneration Houses II (Germany)** In 2012, 450 multigeneration centres were funded nationwide by the Federal Ministry of Family Affairs, Senior Citizens, Women and Youth to bring together socially isolated older people with young families who need support. Each multigeneration house is unique and focuses on different activities: examples include homework support for school-aged children and "international kitchen chats" for people of various ethnicities *(24)*.

Table 1 contd

Determinant of health inequities	Policy options to enhance each determinant	Country examples
Living conditions	• Implement policies that support equitable access to quality and affordable housing for older people, strengthen legal security of tenure for all and protection of citizens from unlawful eviction, and support "Housing First" policies to address later-life homelessness • Promote sanitation, heating and fuel efficiency in housing, and support home repair, maintenance, assessment and modification through measures such as minimum housing standards and subsidies • Become an age-friendly community with support from guidelines *(19)* and tools *(25)*, and learn from age-friendly cities and communities *(26)*; measure age-friendliness of the community and apply an equity lens *(12)* • Promote equity-enhancing built environments, including land-use patterns and neighbourhood design that support physical activity for all, universal urban design, and affordable and accessible public and specialized community transport; improve equity through neighbourhood regeneration programmes • Improve food security for older people by introducing fiscal policies that improve the affordability of healthy and sustainable food choices, providing food subsidies and non-stigmatizing food banks, and promoting healthy food environments through appropriate urban planning • Strengthen measures to reduce emission of outdoor air pollution and reduce exposures to air pollution by vulnerable groups such as older people, especially those with pre-existing conditions and lower socioeconomic status, through education and communication	**Renovation subsidy for older people (Gyoer, Hungary)** Local government created a dedicated fund that allowed older people to apply for funding to renovate homes based on the WELHOPS guidelines, which aim to address direct home and housing needs in addition to the quality and safety of immediate surroundings *(14)*. **Softline buses (Stockholm, Sweden)** The bus service ran through residential areas with many older people and connected these locations to central points, such as pharmacies, food services and banks. Instead of stopping at prearranged points, buses stopped when people on the street waved their hands *(23)*.
Employment and work conditions	• Develop active labour-market policies to facilitate access to employment among older people, such as provision of tax incentives and benefits to encourage recruitment, and consider equity factors in policy-making, such as flexible statutory retirement and pensionable ages that consider occupation type and life expectancy of different groups	**Italy** In 2012, financial incentives were introduced with the aim of increasing employment of older workers in disadvantaged locations in the country. Specifically, wage and social contribution breaks were provided to employers of older people *(27)*.

Table 1 contd

Determinant of health inequities	Policy options to enhance each determinant	Country examples
	• Encourage employment at an older age by providing favourable working conditions through measures such as flexible working arrangements, and involve social partners such as trade unions, nongovernmental organizations and employer organizations • Establish a comprehensive strategy on discrimination in employment; legislate against discrimination by age, gender and other forms of discrimination in employment • Promote training, career counselling and employment programmes for older workers, with the equity-enhancing goal of ensuring people of all education backgrounds have access to inclusive labour markets • Provide occupational health and safety policies and programmes applicable to all workers, including older people and informal workers; identify the contribution of informal unpaid work to the economy by accounting for it in jurisdictional calculations	**Austria** In 2011, a national life-long learning strategy was created to establish a countrywide network of training and education services for older people in their communities. It aimed to help older workers maintain skills and access training and education while supporting work environments that promote learning *(27)*.
Income and social protection	• Combine contributory and non-contributory public pension schemes anchored in legislation, and implement minimum levels of benefits and indexation mechanisms to ensure adequate benefits and coverage • Extend contributory pension schemes to previously uncovered workers, including those who are informally employed, recognize paid and unpaid contributions as care providers, and reduce income-based barriers to join pension schemes • Provide universal public non-contributory pensions that would enable maintenance of living standards • Consider redistribution mechanisms in pension schemes to account for disparities in past earnings, including the application of higher replacement rates to those with lower work incomes • Provide survivor pensions with a minimum level and favourable indexation to reduce gender-related inequities; equalize the pensionable age of men and women • Establish policies and multilateral agreements to support portability and transferability of pensions • Provide accessible publicly financed health and social services, including health care, long-term care, housing, sanitation, food security and employment services	**Cyprus** The pension system in Cyprus has both contributory and non-contributory components. The latter, called the Social Pension Scheme, provides non-means-tested pensions to residents aged 65 years and older who did not participate in the labour market; 95% of beneficiaries are women. Pension reform introduced in 2009 provided a pension increase to households with income below the poverty line and at least one resident receiving pension from the Social Pension Fund or other pension schemes. Households with relatively lower income received a larger increase in pension. This pension reform reduced the poverty rate and income inequality, as demonstrated by the Gini coefficient among older people *(28)*.

Table 2. Potential indicators from the HESR to measure impact in each policy area

Health services	Personal and community capabilities	Living conditions	Employment and work conditions	Income and social protection
• Screening (cervical) • Percentage of people with hypertension treated • Percentage of people with diabetes treated • Avoidable admissions per 100 000 population • Out-of-pocket (OOP) expenses • Impoverishing OOPs • Catastrophic OOPs • Self-reported unmet needs for health care • People providing informal care or assistance at least once a week • Self-perceived quality in health care • Policies protecting rights of non-national migrants to health-care services in a country • Development of subnational health-care resource allocation formulae • Smoking • Alcohol consumption (regular and binge) • Obesity/overweight	• Freedom of choice and control over one's life • Equal treatment under the law and absence of discrimination • Perceived ability to influence politics • Adult literacy rate • Participation rate in formal and informal education and training • Participation in voluntary activities • Frequency of meeting socially with friends, relatives or colleagues • People who have someone to ask for help • Trust in others	• Inability to heat home adequately • Food insecurity • Fast food outlet density disaggregated by area deprivation • Percentage population with convenient access to public transport • Housing overcrowding • Share of households receiving housing allowance • Severe housing deprivation rate • Housing cost overburden rate • Public spending on housing and community amenities as percentage of gross domestic product (GDP) • Statutory rights protecting security of tenure/property rights • Death rate and disability-adjusted life-years (DALYs) lost due to unsafe sanitation • Percentage with inadequate supply of drinking water/ improved sanitation • Satisfaction with living environment	• Labour share of GDP (wages and social protection transfers) • Job strain • Accidents at work • Disability employment gap • Percentage caring for ill/ disabled relatives/friends several times a week • Labour-force participation rate • Average wages/earnings • Skills and discretion index • Proportion of workers working in excess of 40 hours per week • Redundancy pay at two years of tenure, in months • Unemployment rate • Public spending on labour market programmes (LMPs) as percentage of GDP/LMP participants per 100 wanting work • Subsumed, see above (LMP participants per 100 wanting work) • Earnings loss from moving to unemployment benefits as share of previous earnings	• Poverty rates • Indicator of income inequality (GINI) • Public spending on social transfers and services, excluding health • Pension net replacement rates (by sex and socioeconomic status) • Percentage of people above statutory pensionable age receiving a pension (by sex and socioeconomic status) • Fiscal sustainability • Sustainability of public services • Social justice and rights • Social protection expenditure • Coverage, benefit incidence and adequacy of social assistance programmes • Ratification of International Labour Organization social protection conventions by programme

Table 2 contd

Health services	Personal and community capabilities	Living conditions	Employment and work conditions	Income and social protection
		• Promoting independent living • Death rate and DALYs lost due to air pollution • Percentage reporting pollution/grime/other environmental problems • Victims in road-traffic accidents • Feeling safe/secure in neighbourhood • Access to green space	• Proportion of unemployed receiving unemployment benefits • Share of temporary employees • Statutory nominal gross monthly minimum wage relative to median monthly wage • Collective bargaining coverage rate (%) • Average number of labour inspectors per 10 000 employed people • Self-reported work-related health condition • Death rate and DALYs lost due to occupational exposure	

Health and health services

The traditional view is that for many people, health needs become more complex and chronic with increasing age. In 2015, 61% of the European Union population aged 65 years and over had at least one longstanding illness or health condition *(29)*. Five chronic noncommunicable diseases – cardiovascular disease, cancer, diabetes, chronic respiratory disease and mental disorder – were responsible for 77% of the disease burden and 86% of deaths in the WHO European Region *(30)*. Primary preventive measures that address lifestyle and other risk factors of noncommunicable diseases, such as smoking cessation, increased physical activity and reduced alcohol consumption, have positive health impacts at older ages; and secondary prevention, including cancer screening, are effective in preventing mortality *(30)*. However, preventive health services geared toward older people often are limited and uncoordinated *(31)*.

This chapter focuses on ways to implement a person-centred approach and increase access to health and social services. The extent to which broader multisectoral interventions create age-friendly environments and increase abilities and choices for older people will be addressed in subsequent chapters.

Later life is often accompanied by decreased intrinsic capacity *(12)*, a composite measure of all physical and mental capacities (see Fig. 1a and b for cross-sectional measures of physical and cognitive functioning by age and sex in 20 European countries). Globally, the largest contributors to reduced intrinsic capacity are hearing loss, vision problems and osteoarthritis, and in the European Region, dementia affects approximately 10 million people, a prevalence that is expected to double by 2030 *(32)*. Care dependence, representing severe decline in intrinsic capacity, is the inability to perform at least one of the activities of daily living – dressing, eating, bathing or showering, walking across a room, getting in and out of bed, or using the toilet *(12)*. Functional ability, or the ability to be and do what older people value, is determined by intrinsic capacity and interaction with broader social, economic and physical environments.

People who are care-dependent require health and social support often provided by long-term care systems, whether at home, in communities or, if needed, in residential settings. “Ageing in place”, or remaining living at home in the community with some level of independence, is preferred by older Europeans and is associated with several social, psychological and financial benefits. To support this desire, increased accessible and person-centred long-term care provided in homes, the community or day centres is needed *(33)*.

Most long-term care in Europe is provided by unpaid carers, especially women *(34)*. Although a majority of formal long-term care is provided in the community, large variations exist in its funding, delivery and organization *(35)*. Health services, long-term care and social services are often organized in a siloed way with limited coordination even in high-income countries, which results in additional costs to older people and to the system, and decreased satisfaction with care *(12,36)*.

Evidence

One of the largest barriers to older people accessing health services is out-of-pocket costs resulting from a lack of financial protection *(29)*. Financial burden due to health payments, demonstrated by catastrophic spending, impoverishment and the need to borrow money, is higher for households

with people aged 50 years and older in six countries, including the Russian Federation *(37)*. Wealth determines the use of health care in countries where health services are not provided universally, and many older people avoid preventive care and even treatment due to other competing basic needs *(38)*. Out-of-pocket payments for health care and long-term care are common among older people across Europe *(39)*. Older populations with higher socioeconomic conditions in several countries have higher use of medical, dental and specialist appointments *(40)*. Even in some of the wealthiest countries in Europe, older people living with chronic diseases are affected by catastrophic health expenditure *(41)*.

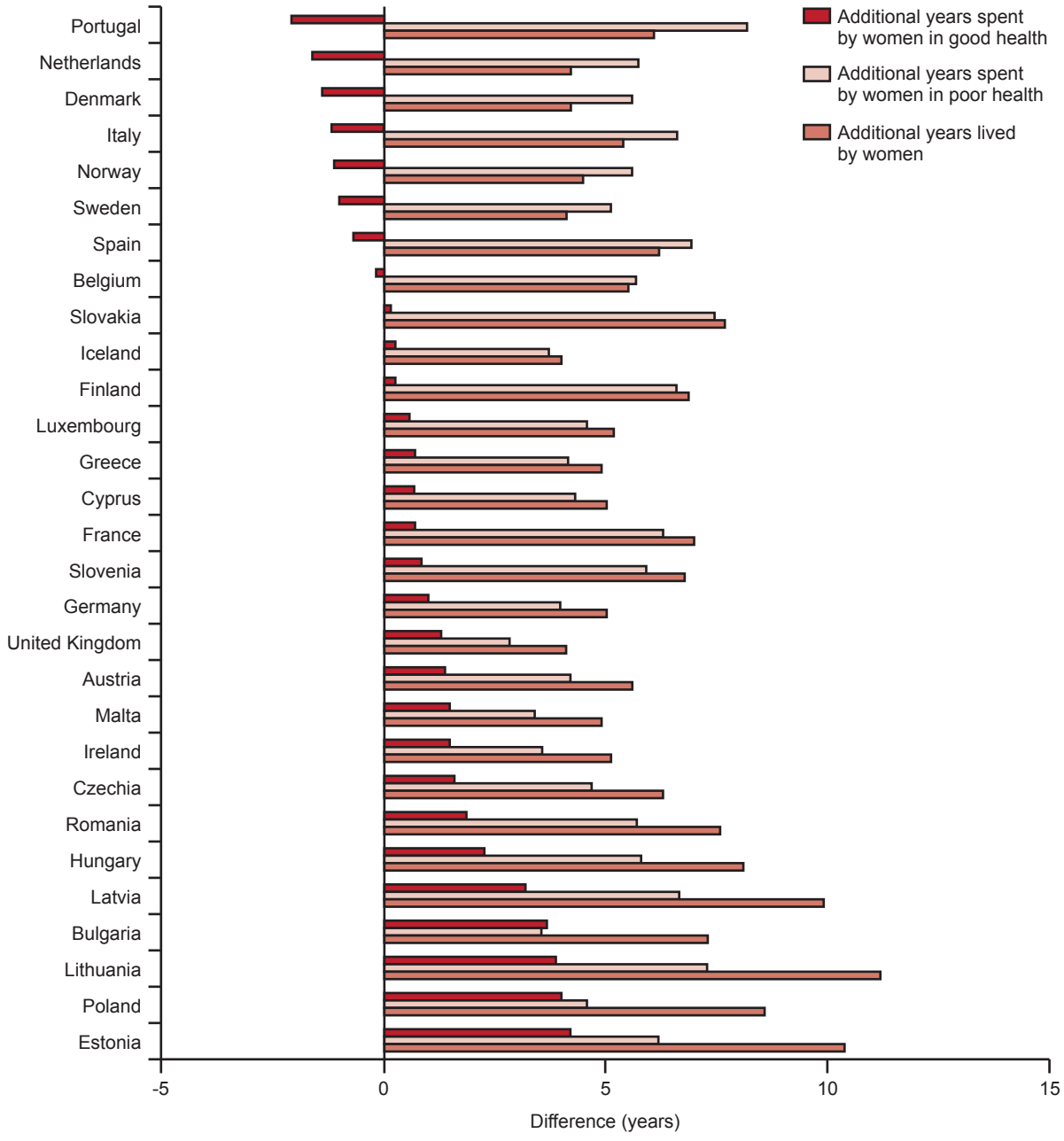
Access to long-term care is determined not only by need, but also by level of wealth. Although the literature remains inconclusive, pro-rich inequality has been reported for paid home-care services in Europe *(42)*. Unmet care needs among older people in six European countries were found to be especially high where public service use was low *(43)*. Greater state involvement in stewardship of long-term care has been correlated with improved equity in access to services. The benefit of public financing has also been shown in end-of-life care, a subset of long-term care. According to a study of 16 European countries and Israel in which public spending on long-term care was higher, outpatient end-of-life care was more commonly used and hospitalization was reduced *(44)*.

In addition to having lower access to health services and long-term care, poorer social groups are also more likely to have poorer health outcomes. Older people in Europe who are less wealthy and less educated are more likely to die and have poor health, functional limitations, and problems with hearing, vision and chewing *(45–47)*. Large disparities exist by socioeconomic status for diseases and risk factors of major causes of lower quality of life across the European Union *(45)*.

Older women are especially likely to have cost concerns related to accessing health services and long-term care. Women are more likely to be in poverty due to the accumulation of gender inequalities in the labour market across the life-course; the gender gap in material deprivation in Europe is largest among people over the age of 65 years *(48)*. At the same time, older women tend to have higher needs for health services; they live longer than men in every country in the European Region *(49)* and tend to spend more time not in good health *(50)* (Fig. 2). As they tend to outlive their spouses, older women may also not have as much support for care dependence and may require formal long-term care support. On the other hand, as mortality rates between 30 and 70 years of age are often higher among men, factors such as underutilization of health services and more prevalent risk-taking behaviours should be addressed among older men *(51)*.

Living in rural or remote locations may also be a barrier to accessing health services. Older people who live in these areas, especially those with limited mobility, may encounter difficulties with transportation, as health services are often located in cities *(36)*. Health workforces trained in working with older people are especially lacking in rural and remote areas. Other barriers are health organizations' lack of accommodation to compensate for the decline in physical capacity common among older people, which means they may have to wait in long queues and have limited or no access to toilets, and providers' inadequate communication of information to those with vision or hearing loss. Along with inattention to health literacy, ageist attitudes among health-care professionals may also deter access to services.

Fig. 2. Differences between women and men in healthy life years, years not in good health, and life expectancy at birth in select European countries in 2012



Source: Marmot et al. *(50)*. Reprinted from The Lancet, 15, 380, Michael Marmot, Jessica Allen, Ruth Bell, Ellen Bloomer, Peter Goldblatt, WHO European review of social determinants of health and the health divide, 1011–1129, © 2012, with permission from Elsevier.

Policies

To improve health services for older people, countries should:

- progressively realize universal health coverage, with comprehensive and integrated services tailored to the needs of older persons, and strengthen mechanisms of financial protection *(52)*: comprehensive health services not only include treatment, rehabilitation and palliation, but also

prevention and health promotion, including reduction of risk factors and disease screening, and addressing not only medical care, but also mental health care, oral health care, long-term care and other health services important for older people, including devices and aids that support functioning;

- expand formal community-based long-term care, including end-of-life care, based on local needs;
- support carers and families through measures such as financial aid, training, respite support and provision of day centres, taking into consideration a gender perspective (see chapters on: Health, and employment and working conditions; and Health, and income and social protection);
- implement integrated care for older people using existing guidelines *(17)* and frameworks *(18)* with seamless transitions among health care, long-term care, provision of assistive devices and social services, depending on the need to support "ageing in place";
- overcome barriers to health care and long-term care access in rural and remote locations through policies and incentives for workforce development and retention, collaboration with the transportation sector, and exploration of mobile resources such as telecommunication;
- improve accessibility by older people with mobility issues and reduced intrinsic capacity in health-care settings, including installation of wheelchair ramps and ample seating, and training health-care providers to improve communication with visually- or hearing-impaired people;
- introduce or enhance legislation to promote non-discrimination on the basis of aspects including age and gender in the provision of health services; and
- promote gender-responsive, person-centred health-care services and long-term care.

Member State commitments

Member States have committed to the following resolutions and initiatives:

- World Health Assembly resolution WHA69.11 on health in the 2030 Agenda for Sustainable Development *(53)*;
- Addis Ababa Action Agenda *(54)*;
- Sixty-fifth session of the United Nations General Assembly, health and foreign policy (resolution on universal health coverage) *(55)*;
- *Strategy and action plan for healthy ageing in Europe 2012–2020 (56)*;
- *Global strategy and action plan on ageing and health 2016–2020*, endorsed by World Health Assembly resolution 69.3 *(14)*;
- Rio Political Declaration on Social Determinants of Health *(57)*;
- Council conclusions on closing health gaps within the EU through concerted action to promote healthy lifestyle behaviours *(58)*;
- Adelaide Statement on Health in All Policies *(59)*;
- World Health Assembly resolution WHA 62.14 on reducing health inequities through action on the social determinants of health *(60)*; and
- Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions – solidarity in health: reducing health inequalities in the EU *(61)*.

Stakeholders and partners

Stakeholders and partners include:

- health-care organizations, community agencies, long-term care and home-care organizations;
- housing, local planning and transportation agencies (to support accessibility to health services and long-term care and secure “ageing in place”);
- different levels of government, including cities and communities (to improve provision and funding of health services, create healthy public policies that reduce risk factors such as smoking, alcohol consumption and unhealthy eating, and increase opportunities for healthy choices and lifestyles for people across the social and economic gradient);
- academic and research institutions (to support evaluation and research); and
- business and private–public partnerships (to encourage innovation, and product and built environment design that supports “ageing in place”).

Health, and personal and community capabilities

An understanding of the needs, concerns and voices of marginalized and otherwise vulnerable groups is needed to improve health equity. Also necessary is evidence on what works to build inclusive processes and tailored interventions that prevent unintentional worsening of inequities *(62)*. Development of community and personal capabilities enables engagement of people who experience inequities and allows for the formulation of more effective, appropriate and acceptable equity-enhancing public policies.

Evidence

Mechanisms to engage older people affected by inequities can empower them to contribute to public policies that influence their health, building community capabilities in the process *(62)*. Direct involvement of older people, especially older women, in policy-making is often not the norm, however, despite the higher likelihood of older people (up to the age of 75 years) engaging in community and civic activities such as voting, compared to younger people *(23,63)*. Coproduction across the social and economic gradient empowers people in the community of interest to identify problems and find solutions. Mediating agencies, such as civil society organizations and official senior councils, can engage older people by increasing authentic and effective participation *(19)*. As suggested by a survey of governments in 25 European countries, inclusive policy-making improved trust in government, compliance with decisions made and outcomes at less cost *(64)*.

Personal capabilities can be improved through social participation, which enhances self-esteem and motivation among older people and empowers them to do what is personally meaningful *(65,66)*. Social participation can occur through volunteering, involvement in community-based institutions and governance of public institutions (employment is discussed separately in the chapter on Health, and employment and working conditions). Approximately 9% of people aged 55 years and above in the European Union reported participating in volunteering activities at least once a week, with a range of 1% to 21% *(19)*.

Volunteering can also improve mental well-being, increase life satisfaction and perceived health, and reduce social isolation, which is a known risk factor for premature mortality and functional impairment *(23,67)*. As a result, volunteering and other social participation or culturally appropriate contributions may especially benefit the one in three Europeans aged 65 years and older (mostly women) who live alone *(27)*. Volunteering by older people also brings community benefits and allows for intergenerational dialogue and learning. Inequities nevertheless exist: people at 80 years and over and those with lower levels of education, for instance, are less able to volunteer *(68)*. Older people with reduced mobility or intrinsic capacity, and those who have language or cultural barriers, may also be less likely to participate. Not every older person may want to volunteer and personal choice should be respected.

In addition to social participation and civic engagement, other parts of the social environment that promote personal capabilities include social inclusion and non-discrimination *(67)*. Age-friendly communities aim to improve social connectivity *(69)*. Social networks have been linked to improved resilient coping, subjective well-being and life satisfaction among older Europeans *(70–72)*. Intergenerational programmes are particularly associated with reduced loneliness and improved self-reported health and self-esteem among older people, and with improved perception of older people among children *(73)*.

Personal capabilities can also be supported by health and social literacy *(62)*. Literacy can be defined as the possession of knowledge, skills, understanding and confidence to have control over one's life. Older people with lower levels of health literacy are less likely to advocate for their own health. According to a survey of eight European countries, 61% of people aged 76 years and older had limited health literacy, compared to 47% of the general population *(74)*. Such disparity is further exacerbated by challenges experienced by some older people with information technology, an increasingly prevalent conduit of health information *(75)*. In addition, those with low social status, low income and low levels of education have much higher proportions of limited, or critical, health literacy skills compared to the general population. Social mobilization can occur by addressing such inequities in health literacy and reducing disparities in self-care, health-related decision-making and access to health services *(74,76)*.

Policies

To improve personal and community capabilities, countries should:

- involve older people, especially those belonging to groups experiencing inequities, in policy design, implementation and evaluation at all levels of government through direct participation, consultation or expansion of the role of civil society in governance arrangements;
- connect older people to opportunities for social participation, including volunteering opportunities and group activities, without age discrimination and by applying an equity lens to address barriers associated with costs, education, mobility, language and culture;
- support intergenerational community programmes;
- provide locations in the community where older people can meet and socialize, including senior centres, public parks and community centres;
- provide computer and online access at no or low cost in, for example, community centres and libraries;
- improve health literacy among older people by providing access to resources, using age-friendly formats in communication, considering equity factors (including language barriers in provision of health information) and providing training in the use of information technology; and
- encourage public debate on healthy ageing and health equity, and develop accountability mechanisms such as the use of equity impact assessment and indicators.

Member State commitments

Member States have committed to the following resolutions and initiatives:

- Addis Ababa Action Agenda *(54)*;
- the European policy framework for health and well-being, Health 2020 *(77)*;
- Article 25 of the Charter of Fundamental Rights of the European Union *(78)*; and
- the political declaration and Madrid international plan of action on ageing *(79)*.

Stakeholders and partners

Stakeholders and partners include:

- civil society organizations
- health and community services
- education and culture services
- academic and research institutions.

Health and living conditions

Older people's health is affected by living conditions, including access to services and structures. An age-friendly environment includes affordable and quality housing, access to quality foods and other services (such as public transportation), and a physical environment that is safe and supports healthy and active living *(25,80)*. Universal design in home environments (where products and environments are usable by all people) enable "ageing in place" without the need for remodelling and, combined with control of housing-related health hazards such as temperature extremes, indoor air pollution, poor sanitation, and fire and trip hazards, are gaining traction *(81,82)*. The social environment includes household structure and meaningful interaction with other generations, which are discussed in the chapter on Health, and personal and community capabilities.

Evidence

In the European Union, 4.1 million homeless people have been reported annually, and later life homelessness has become increasingly common *(83,84)*. The lack of affordable and social housing is one contributor to the increase in primary homelessness (living on the street) and secondary homelessness (having no usual residence and frequently moving between accommodations) *(85)*. Limited tenure security can be another contributor; eviction has been shown to be an especially common reason for homelessness among older people in certain jurisdictions, especially older single people without family *(86)*.

Older people tend to experience longer periods of homelessness due to challenges with workforce reintegration and are more likely to have mental illnesses, chronic medical problems, cognitive impairment and functional decline *(87,88)*. Compared to the general population, homeless people are more likely to have unintentional injuries, with the disparity especially striking among older people *(89)*.

Homelessness disproportionally affects subpopulations, such as people who are poor but in work and migrants *(84)*. Significant gender-related inequities exist in home ownership, housing cost overburden and overcrowding among older people in many Member States of the European Union *(90)*. Overcrowded living can also be experienced by multigenerational families who live together *(91)*.

Even when older people have housing, they may not be able to afford adaptations required to support the quality of housing necessary for "ageing in place". Older people of lower socioeconomic status are more likely to live in low-quality housing *(92)*. Poor heating in the winter and inadequate cooling in the summer are experienced respectively by 12% and 17% of people age 65 years plus in the European Union and are associated with increased seasonal mortality and morbidity *(93,94)*. Basic sanitation, such as showering and connection to sewerage systems, are not as widely available in some European countries, especially in rural and remote areas *(93,95)*. Inappropriate home environments also increase the risk of falls and other injuries.

Nutrition is also a key determinant of healthy ageing *(96)*. Food insecurity in older age can be attributed to multiple factors, including limited financial resources, functional limitations and social isolation. Undernutrition results in health complications that cost European health and social care systems roughly €120 billion per year, while consumption of processed foods and obesity are becoming increasingly common among older people *(96,97)*.

Outdoor built environments, including land-use patterns, urban design and transportation systems, can support healthy ageing and active living *(98,99)*. Complete neighbourhoods provide proximity of services, improve the ease of access and promote physical activity through active transport. A walkable neighbourhood with appropriate pedestrian and cycling infrastructure can especially benefit people of lower socioeconomic status and those with reduced intrinsic capacities *(100)*.

Outdoor built environments also influence injuries among older people. In the European Region, 46 000 people over 70 years die as a result of falls each year, approximately 26% of which can be attributed to the environment; older people also have one of the highest road-traffic death rates in the Region *(101,102)*. Universal design, which includes the removal of trip hazards and use of street lighting, clear signage and audio signals at traffic lights, can be used to prevent injuries in outdoor settings and improve accessibility for older people with reduced intrinsic capacity *(19)*. Available, affordable and accessible public transportation is also important for ensuring physical and mental well-being and functional ability among older people, especially women and those with low incomes, declining intrinsic capacity or who live in rural settings *(56,103–105)*.

Older people tend to be more vulnerable to the health impacts of outdoor air pollution due to higher prevalence of pre-existing respiratory and cardiovascular conditions *(106,107)*. Although emission of outdoor air pollutants generally has improved in Europe, concentrations continue to exceed reference values in several cities *(106)*. Higher air pollution exposure has been linked to higher mortality and morbidity from cardiopulmonary causes and increased incidence of respiratory diseases in older people *(107)*. Exposure to ambient air pollution has also been associated with cognitive decline among older people *(108,109)*. People with limited education and other socially disadvantaged older people are particularly at risk of exposures *(106)*.

Policies

To improve living conditions of older people, countries should:

- implement policies that support equitable access to quality and affordable housing for older people, strengthen legal security of tenure for all and protection of citizens from unlawful eviction, and support “Housing First” policies to address later-life homelessness;
- promote sanitation, heating and fuel efficiency in housing, and support home repair, maintenance, assessment and modification through measures such as minimum housing standards and subsidies;
- promote age-friendly communities with support from guidelines *(110)* and tools *(25)* and learn from age-friendly cities and communities *(26)*.
- measure age-friendliness of communities and apply an equity lens *(82)*;
- promote equity-enhancing built environments, including land-use patterns and neighbourhood designs that support physical activity for all, universal urban design, and affordable and accessible public and specialized community transport;
- improve equity through neighbourhood regeneration programmes;
- improve food security for older people by introducing fiscal policies that improve the affordability of healthy and sustainable food choices, providing food subsidies and non-stigmatizing food banks, and promoting healthy food environments through appropriate urban planning; and

- strengthen measures to reduce emission of outdoor air pollution, and reduce exposures to air pollution by vulnerable groups such as older people, especially those with pre-existing conditions and lower socioeconomic status, through education and communication.

Member State commitments

Member States have committed to the following resolutions and initiatives:

- Copenhagen Consensus of Mayors: healthier and happier cities for all *(111)*
- Addis Ababa Action Agenda *(54)*
- Rome Declaration on Nutrition *(112)*
- United Nations Convention on the Rights of Persons with Disabilities *(113)*.

Stakeholders and partners

Stakeholders and partners include:

- housing and energy agencies
- local planning, transportation and infrastructure agencies
- environmental agencies
- food and agriculture agencies
- academic and research institutions
- business and public–private partnerships.

Health, and employment and working conditions

The proportion of older people who work has increased in Europe. The rate of employment among people aged 55–64 years in the European Union rose from 36% in 1997 to 49% in 2012 *(114)*, perhaps resulting from government policies that promoted high levels of labour-market participation to ensure sustainability of the pension system *(103)*. Longer life expectancy, reductions in physically demanding jobs and older people wanting to stay in the workforce made working at older ages possible *(115)*.

Although some older people work to stay active physically and socially and to contribute to society, many work out of necessity due to insufficient pensions and savings. This is especially common among those who were unemployed, underemployed or had low incomes earlier in adult life *(68)*. Slightly over half of people aged 65–69 years in the European Union who receive a pension continue to work to improve their financial situation *(27)*. The need to work at older ages is especially prevalent in lower-income countries and jurisdictions where public services have been reduced, resulting in higher out-of-pocket costs for social and health services.

The need for older people to work can be reduced by appropriate social protection and equitable pension systems (see the chapter on Health, and income and social protection); while older people who want to work should be given equitable and flexible employment opportunities and appropriate working conditions to enable healthy ageing. The latter is the focus of this chapter.

Evidence

Older age is one of the largest barriers to employment in Europe. The employment rate among people between 70 and 74 years is half that of people aged 65–69 *(116)*. Age discrimination, based on ageist stereotypes of older workers' limitations, has been reported in employee recruitment and retention *(12,115,117)*. According to a 2012 survey of 26 500 older people across Europe, 21% had either personally experienced or witnessed discrimination at work due to their age *(118)*. Although some older people are less employable in the digital economy due to unfamiliarity with changing technologies and can therefore benefit from training, age discrimination has been reported in retraining of workers *(117)*.

Among older workers, the employment rate is higher for men than women in all Member States of the European Union *(68)*. This disparity can be attributed to gender discrimination and entrenched traditional gender roles that support men as providers for families *(119)*. Gender-based discrimination continues to exist in hiring, compensation, promotion, dismissal and working conditions in all European countries *(116)*, but it has been shown that an equal proportion of men and women in the European Union, roughly 20%, expressed an interest in working until "as late as possible" *(120)*. Women also appear to face age discrimination earlier than men; the intersectionality between age and gender discrimination is challenging for women in the labour market *(115)*.

Older people who have higher levels of education are more likely to work than those with lower levels of education. Among Europeans between 65 and 80 years of age, those who received tertiary education were more likely to work than those with primary or lower-secondary education *(121)*. Although they were less likely to find work, Europeans with a low education level were more likely to work out of financial need than those with a tertiary education *(27)*.

Employment has a number of benefits that positively contribute to health and well-being, including financial security, personal development, social status, social connections and self-esteem *(122)*.

According to a survey of older people in 10 European countries, perceived poor health was strongly associated with a lack of employment *(123)*. Disparities in employment due to age, gender and education status therefore result from unequal opportunities and lead to inequities in health and well-being. Policies that increase employment opportunities for these groups support equitable healthy ageing by enabling older people to work as long as they wish *(115)*. Another benefit of an older workforce is increased economic productivity *(124)*.

Working conditions, which are related to tasks performed by workers, the physical, chemical, ergonomic, technological and psychosocial work environment, and the type of contractual relationship with employers, also influence health *(13,122)*. A survey in the Netherlands found that favourable conditions for older people that encourage them to continue working include working fewer hours or days per week, less demanding work, higher job satisfaction, and more support from employers or colleagues *(116)*. Those with lower socioeconomic status, however, are at higher risk of experiencing work stress and hazardous working conditions *(125)*.

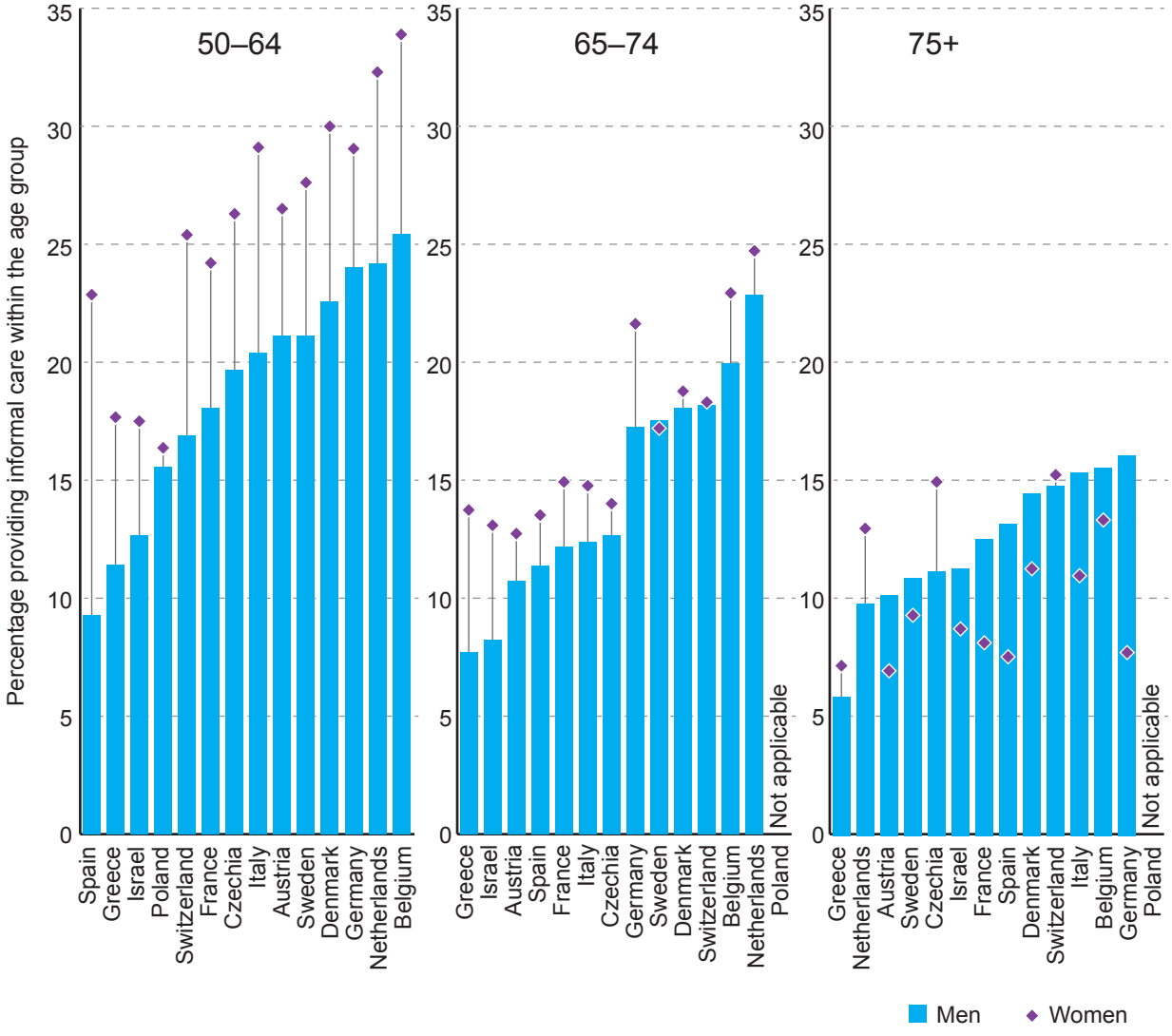
Working conditions are especially of concern for informal workers, such as carers *(122)*. Informal employment is usually not subject to statutory regulations that protect working conditions, occupational health or safety. Europe has over 100 million unpaid carers. Many (especially women) are 65 years and older; they provide care for spouses, parents, grandchildren and others *(23)*. A study of 14 European countries showed that approximately 25% of people aged 50–64 years provided mostly unpaid care, and that caregivers are more likely to be women until ages in the mid-70s *(126)* (Fig. 3). Informal carers, especially those who care for more care-dependent people, have high risks of becoming overburdened and isolated. They are also more likely to have mental health problems and to live in poverty due to the lack of paid employment *(127,128)*.

Policies

To improve employment and working conditions for older people, countries should:

- develop active labour-market policies to facilitate access to employment among older people, such as providing tax incentives and benefits to encourage recruitment and considering equity factors in policy-making, including flexible statutory retirements and pensionable ages that reflect the occupation type and life expectancy of different groups;
- encourage employment at an older age by providing favourable working conditions through measures such as flexible working arrangements, and involve social partners such as trade unions, nongovernmental organizations and employer organizations;
- establish a comprehensive strategy on discrimination in employment, and legislate against discrimination by age, gender and other forms of discrimination in employment;
- promote training, career counselling and employment programmes for older workers, with the equity-enhancing goal of ensuring people of all education backgrounds have access to inclusive labour markets;
- provide occupational health and safety policies and programmes applicable to all workers, including older people and informal workers; and
- identify the contribution of informal unpaid work to the economy by accounting for it in jurisdictional calculations.

Fig. 3. Share of women and men providing informal care by age group and country (as percentage of female and male population)



Source: Rodrigues et al. *(126)*. Reproduced with permission from Rodrigues, R., Huber, M. & Lamura, G. (Eds.) (2012). Facts and Figures on Healthy Ageing and Long-term Care. Vienna: European Centre for Social Welfare Policy and Research.

Member State commitments

Member States have committed to the following resolutions and initiatives:

- Addis Ababa Action Agenda *(54)*
- the Europe 2020 strategy *(129)*
- the political declaration and Madrid international plan of action on ageing *(79)*
- the employment equality framework directive (European Council directive 2000/78/EC) *(130)*
- the International Labour Organization older workers recommendation 1980 (No. 162) *(131)*.

Stakeholders and partners

Stakeholders and partners include:

- private and public sector employers
- labour and economic development agencies
- education and training agencies
- trade unions
- associations of older people
- academic and research institutions.

Health, and income and social protection

Social protection programmes support the functional abilities of older people by developing and maintaining intrinsic capacity through reduction of health risks or provision of services, and/or enabling them to perform daily tasks or, more generally, do and be what they value, irrespective of their level of intrinsic capacity *(12)*. Public pensions are the largest component of social protection; other social security measures include cash or in-kind transfers in health services (see Health and health services chapter), housing and living conditions (Health and living conditions), employment services (Health, and employment and working conditions) and education *(132,133)*. National social protection floors are social security guarantees for all people throughout the life-course that can reduce and prevent poverty, vulnerability and social exclusion *(134)*.

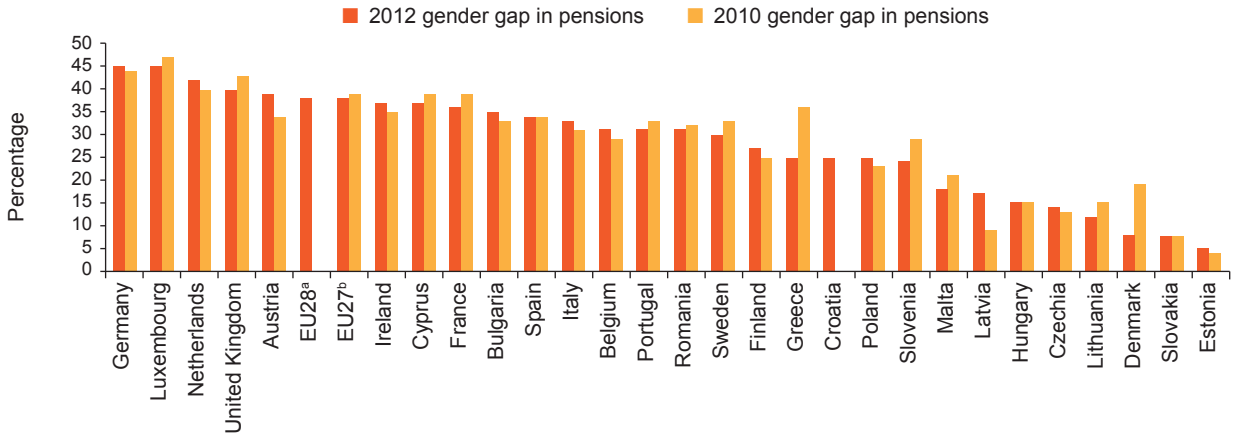
Evidence

Older people are poorer than the average population in many countries, especially in lower-income countries. The at-risk of poverty or social exclusion rate among older people across the European Union averages 18%, with a wide range between 9% and 46% *(132)*. Poverty is a major determinant of poor health in older age. Pensions are received by over 90% of the population above statutory pensionable age in most European countries, but pension benefits may be insufficient to enable people to lead healthy lives. In addition, many countries have begun to reduce the generosity of pension schemes and/or increase the statutory retirement age, citing concerns about financial sustainability *(97,135)*. Savings and intrafamily transfers provide other sources of income for older people, but they are often limited. Despite their importance in supporting older people financially, pensions are especially low for older women, low-income workers and informal workers.

Women tend to live longer than men, but older women often have lower pensions as they are less likely to have been involved in the formal labour market and more likely to have interruptions in employment, earlier retirement, and lower earnings and pension coverage due to gender roles and gender-based discrimination *(136)*. The pension gap between men and women in the European Union was 39% in 2010 and 38% in 2012 *(137)* (Fig. 4). In 2016, women aged 65 years and older had a more than 5% higher at-risk of poverty and social exclusion rate than older men *(138)*. Although older women are more likely to live in poverty than men, they tend to spend more years in poor health and therefore accumulate higher health-care and long-term care costs. Adequate pension benefits, including social or non-contributory pension schemes, and social security measures that include universal access to health services and long-term care, are crucial for reducing gender-based economic and health inequities at older ages.

The accumulation of socioeconomic inequality across the life-course negatively affects the health and well-being of poorer older people and widens the gap in health outcomes as wage inequalities continue to grow worldwide *(12,139)*. In Europe, low-income workers are also less likely to have adequate pensions from employment-related contributions at older ages *(28)*; workers with insufficient income levels in some countries may not even have access to contributory pensions. While a large proportion of people work in the informal economy, they often do not qualify for contributory pensions. Among total employment in the European Union, 14% are self-employment, 13% are in temporary positions and 19% are in part-time employment *(140,141)*. Women and migrants are especially overrepresented in the informal economy *(132)*.

Fig. 4. Gender gap in pensions, European Union Member States, 2010 and 2012



[a] EU28: European Union Member States as of 1 July 2013.
[b] EU27: European Union Member States before 30 June 2013.
Source: European Institute for Gender Equality *(137)*.

Europe receives roughly 14% of international migrants aged 65 years and older, with numbers increasing since 1990 *(142)*. Forcible displacements drastically increased the number of refugees to Europe in recent years *(143)*. Migrants generally spend shorter periods of time in employment in any particular jurisdiction, tend to have lower pensions and are more likely to live in poverty at older ages *(144)*.

Adequate pensions reduce inequalities in income and health. According to data from 17 European countries, a universal social pension scheme could substantially decrease the poverty rate, from 20% to 2.5% *(145)*. A cross-national analysis of 16 European countries showed that larger public pension entitlement was associated with a reduction in unmet need for medical services due to the cost of services among adults aged 65 and older, especially those with low income *(146)*.

Investing in social protection for older people is also likely to result in cost savings. In the United Kingdom, for example, older people's contributions through consumer spending, taxation and other economically valuable activities were estimated to be nearly £40 billion in 2010, more than expenses through pensions, welfare and health care combined *(147)*.

Policies

To improve income and social protection for older people, countries should:

- combine contributory and non-contributory public pension schemes anchored in legislation, and implement minimum levels of benefits and indexation mechanisms to ensure adequate benefits and coverage;
- extend contributory pension schemes to previously uncovered workers (including those who are informally employed), recognize paid and unpaid contributions as care providers, and reduce income-based barriers to joining pension schemes;
- provide universal public non-contributory pensions that would enable maintenance of living standards;
- consider redistribution mechanisms in pension schemes to account for disparities in past earnings, including the application of higher replacement rates to those with lower work incomes;

- provide survivor pensions with a minimum level and favourable indexation to reduce gender-related inequities;
- equalize the pensionable age of men and women;
- establish policies and multilateral agreements to support portability and transferability of pensions; and
- provide accessible publicly financed health and social services, including health-care, long-term care, housing, sanitation, food-security and employment services.

Member State commitments

Member States have committed to the following resolutions and initiatives:

- the High-level Political Forum on Sustainable Development *(148)*
- European Pillar of Social Rights *(149)*
- Addis Ababa Action Agenda *(54)*
- the International Labour Organization social protection floors recommendation, 2012 (No. 202) *(150)*
- European Social Charter *(151)*.

Stakeholders and partners

Stakeholders and partners include:

- social services
- health-care and long-term care services
- housing, labour, food and agriculture agencies
- associations of older people
- academic and research institutions.

Conclusion

Older people can be more vulnerable to the effects of social, economic and environmental determinants, which can have immediate impacts on their capacities and abilities, as well as diseases, conditions and overall mortality. These can also have affects across the life-course through increased risks or exacerbations of existing conditions in a person's overall context, and through the accumulation of strengths, resilience, deficits or vulnerabilities.

This paper outlines policy options and concrete examples (Table 1) of what can be done in health systems and across multiple sectors to address social determinants of health among older people, and potential indicators for measuring progress (Table 2). These relatively high-level policy options need to be appraised and adapted with local evidence and further context-specific information and evaluation to guide national and subnational interventions.

Many are coherent with the strategic objectives of the WHO *Global strategy and action plan on ageing and health 2016–2020 (14)* and the *European strategy and action plan for healthy ageing in Europe 2012–2020 (56)*, both adopted by all Member States of the WHO European Region. The former identified 10 mid-term actions towards implementation of strategic objectives addressing policy commitments, age-friendly environments, aligning health systems to the needs of older persons, ensuring a system of long-term care, and enhancing monitoring and research, with assessments of progress for Member States by each WHO region (including the European Region) conducted in 2018. The latter identified eight specific priority interventions: five led by the health sector (promoting physical activity, falls prevention, vaccination of older people and infectious disease prevention in health-care settings, public support for informal caregiving with a focus on home care, and geriatric and gerontological capacity-building among the health and social-care workforce) and three linked to the wider social context (prevention of social isolation and social exclusion, prevention of elder maltreatment, and quality of care strategies for older people, including dementia care and palliative care for long-term care patients.)

A life-course approach should be taken to promote healthy ageing and health equity, with policies and actions engaging multiple sectors (health and others) and a wide range of stakeholders, including older adults. Actions that dismantle discrimination, including ageist policies and norms, and which address a wide range of social, economic and environmental determinants of health, are needed. These should not only target the most vulnerable or poorest subgroups, but also aim to level-up socioeconomic conditions across different social, economic and demographic groups. Changing the conditions that make societies stratified, reducing the impact of social stratification and increasing overall equity will most likely uplift the trajectory of healthy ageing for all people, not just improve conditions for the best-off or the statistical average of older people.

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