Narrowing World Health Disparities and Longevity

A report from the International Longevity Centre Global Alliance dinner debate, Cape Town

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Our particular thanks go to Jill Adkins from Age Rights International, who made the notes from the debate for this report.

All opinions expressed in this report are the authors' own and should not be attributed to Pfizer. All attendees were given an opportunity to comment on the views and opinions attributed to them in the report, to ensure their comments were accurately represented.

It should be noted the key themes and recommendations at the end of the report are strictly those of the ILC-UK and should not be attributed to any of the delegates directly.

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Foreword

All major public health issues are the result of disparities of one kind or another. This may seem simplistic and indeed we must never under-estimate the size or complexity of the global challenge with regard to these health inequalities. Globalisation means that we are increasingly interconnected and yet this transnational communication has also served to highlight the profound inequity that exists across and within countries. We must constantly ask why is it that we are still looking at a difference in life expectancy of over 35 years between certain countries. Global problems call for global solutions and we have a responsibility not only as citizens of our own respective countries, but also as global citizens to look beyond our coastlines and work together. This was the spirit of the meeting that is recorded here. I believe that this report highlights the priority issues we should all help to take forward and will serve as a platform for future action.

While there may be no panacea or common solution the debate sought to explore the commonalities in social, economic, environmental and political variables which affect or determine health disparities for older people. The specific needs of older people are often ignored, especially when it comes to policy-making. It is clear that we need appropriate and targeted policy interventions. But equally important are the significant disparities that exist between healthcare systems in developing and developed countries; whether we're talking about health inequalities linked to poverty and social exclusion, the problems of securing sustainable access to health promotion and disease prevention, the differences in the awareness of the specific needs of ageing populations or the importance of addressing early life development conditions, one thing is very clear - delay in acting causes enormous suffering and ultimately costs lives.

It was a great honour to be involved with this important discussion and I should like to thank all the participants some of whom travelled great distance to take parts. One of the unique strengths of the ILC-Global Alliance is the ability to provide an international, interdisciplinary, life course perspective to the opportunities and challenges population ageing presents to modern society. By seizing these opportunities and facing these challenges we shape our future.

Dr. Jack Watters

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Introduction

The International Longevity Centre Global Alliance dinner debate on 'Narrowing World Health Disparities and Longevity' was held on the 25th October 2010 in Cape Town, South Africa, during the ILC Global Alliance annual meeting. The format of the evening included: welcome and introductions, a speech from the guest speaker, and then an open forum for debate on the issues.

The discussion provided a unique opportunity for a debate on an issue which is keenly felt on all sides of the world. One of the aims of the debate was to produce this report, summarising and highlighting the key issues which emerged from the discussion. From this, the ILC-UK has formulated some recommendations on how to narrow the inequalities of circumstance and opportunities that affect the health of older people, which could be applicable in many parts of the world.

The International Longevity Centre Global Alliance

The ILC-UK is part of the International Longevity Centre Global Alliance. We have 12 partners across the globe in Argentina, the Czech Republic, the Dominican Republic, France, India, Israel, Japan, the Netherlands, Singapore, South Africa, the United Kingdon and the United States of America.

The alliance is a multinational research and educational consortium, united in a common purpose to understand and address the consequences of population ageing and advancing longevity. Our unique alliance undertakes joint studies and symposia as well as country-specific activities to engage and inform a wide variety of stakeholders from across the globe.

The over-arching aim of the alliance is to provide an interdisciplinary, intergenerational and life course perspective to promote and highlight the opportunities and challenges population ageing presents to modern society.

The political and policy context of the debate

Global ageing and longevity

Worldwide demography has been changing rapidly for a number of decades, and will continue to dramatically alter the makeup of the world population into the future. The United Nations' World Population Prospects report (United Nations, 2007a) predicts that the world population will increase by 2.5 billion by 2050, when it will reach 9.2 billion. Within this increase, over half is accounted for in the rise of the population aged over 60. This ageing will take place in all countries, with the potential for the older population (aged over 60) to nearly double in more developed regions (from 245 million in 2005 to 406 million in 2050). More moderate ageing will be seen in the 50 least developed countries. However, the perception that ageing is an issue which only affects post-transitional economies is a fallacy: in developing countries as a whole, the percentage of the population aged over 60 was 8% in 2006 but will rise to 20% by 2050 (United Nations, 2007a). Though it should be noted the current level and pace of population ageing varies widely both within and by geographic regions, increasing longevity is a phenomenon which will be felt worldwide.

Longevity varies widely around the world, with life expectancies of over 80 in Japan and Sweden (Commission on Social Determinants of Health, 2008), to 45 years in Lesotho and Zambia, and falling as low as 44 in Afghanistan and Zimbabwe (World Bank Data, 2008). Estimated length of life can also differ hugely within countries. For example, a recent study showed that people who live in the North of England are 20% more likely to die prematurely (before 75) than those who live in the South (Hacking et al, 2011). These differences are often extreme: there exist up to 20-year gaps in life expectancy between rich and poor counties within the United States (Murray et al, 1996). The health gaps demonstrated by longevity differences represent the huge inequalities experienced between different people globally.

Longevity is a vital measure of health disparities as it can be compared simply both within and between countries and regions. Health indicators of the population are also important as "a measure of whether a population is benefiting as a result of a set of social arrangements" (Marmot, 2005).

Health disparities

Favourable health status and optimal healthcare across the life course contribute to longevity through increases in life expectancy and reductions in mortality. Conversely, compromised health status and inadequate healthcare across the life course affect longevity negatively. Across the life course health status is shaped by genetic, behavioural, environmental and systemic factors – and the positive and negative effects of healthcare disparities on health are cumulative in later life. Systemic factors refer to barriers to healthcare, which include availability, accessibility and affordability of health care.

Health disparities exist in individuals' ability to access adequate or quality healthcare in order to maintain favourable health status, and to overcome contributors to, or reduce risk factors for poor health – across the life course and in later life. Disparities as a result of systemic factors disadvantage, or discriminate against certain social groups, which raises issues of equity through fair access to adequate or optimal healthcare.

Disparities exist between the healthcare systems operated in developed countries and those in developing countries, broadly, as well as in health systems within countries. In developing countries healthcare priorities are combating communicable diseases and building healthcare infrastructure, rather than treating non-communicable (chronic) diseases. As countries' economies develop they will experience the 'epidemiological transition': a shift from the biggest health problems being communicable (infectious) diseases towards the chronic non-infectious diseases (Omran, 2005, first published 1971) more commonly experienced by developed countries with older populations.

In developed countries there is more of a focus on non-communicable diseases, although this varies between nations. In general, patients in developed countries benefit from advances in medical technology, and innovative management and prevention of chronic disease, while such advances are largely not available nor a priority in developing countries (despite a growing tidal wave of chronic disease as a result largely of urbanisation). However, despite the medical improvements available in the care of older patients in developed nations, discrimination and neglect still prevent universal good health for older people in these countries.

In developing countries healthcare priorities are focused largely on youth and development oriented health priorities on maternal and child health, reproductive health, the provision of safe water and sanitation, malnutrition and infectious diseases such as malaria, HIV/AIDS and tuberculosis. The healthcare needs of older persons – specifically, chronic illness, impairment, disability and long-term care – tend to be deprioritised, and these individuals are marginalised: thus, they tend to be discriminated against in public healthcare systems. In developing countries, very few individuals have health insurance cover, and are unable to afford private healthcare, the majority must therefore rely on public healthcare. Equity issues pertain to older patients' access to adequate or quality healthcare in terms of affordability and other barriers. Older people may also be discriminated against with regard to health education and rehabilitation.

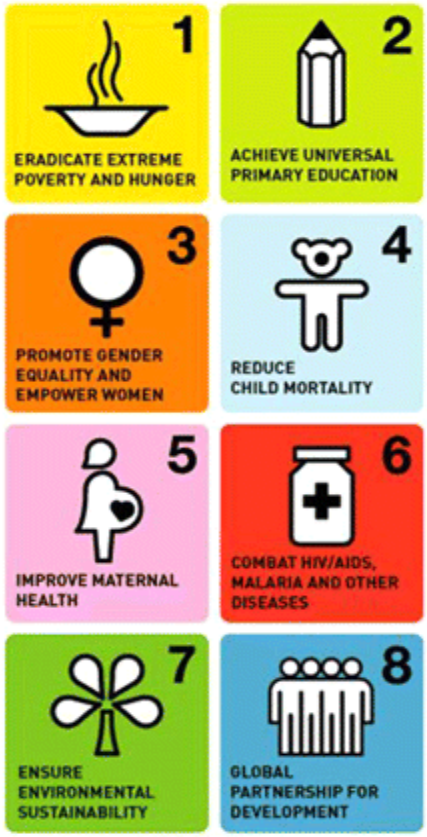
While mortality on the whole is decreasing, one area where the number of deaths is rising is in regions worst affected by HIV/AIDS (United Nations, 2007a). As use of anti-retroviral therapy becomes more widespread, survival periods of HIV positive patients are extended. The successes of this treatment are good news, but as the population ages and survival rates continue to improve, we will be begin to see an increasing number of older people with severely impaired immune systems over the long-term, presenting a new dynamic in healthcare.

Current international health and equality targets

Some attempts are being made to combat the levels of health disparities worldwide. These have been issued by international organisations such as the United Nations and the World Health Organisation.

The Millennium Development Goals

In 2000, world leaders gathered to formulate the United Nations Millennium Declaration, covering a range of topics around health and development and with aims to combat global inequalities by 2015. The targets set by this summit are now known as the Millennium Development Goals (See infographic). However, while some goals are focused on health, and will affect longevity as health indicators targeted by the goals improve, none of them specifically target issues facing older people worldwide.



Millennium Development Goals Infographic, Lawn, 2010

Commission on Social Determinants of Health

The World Health Organisation established the Commission on Social Determinants of Health to support countries and global health partners to address the social factors leading to ill health and inequities. It aimed to alert society to the social determinants of health that are known to be among the worst causes of poor health and inequalities between and within countries and to shed light on the systematic and structural causes of poor health.

The Commission's three main recommendations were:

1. Improve daily living conditions: the circumstances where people are born, grow, live and age, create social protection policy supportive of all, create conditions for a flourishing older life.
2. Tackle the inequitable distribution of power, money and resources: focusing on the structures of government and the public sector as well as discrimination against certain groups.
3. Measure and understand the problem and assess the impact of action: acknowledging the issue of health inequities, expanding the knowledge base, developing a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.

(Commission on Social Determinants of Health, 2008)

The recommendations include a multi-level approach, with action taken on local, national and international platforms.

A critical element of the Commission's report with regard to poor health in older people is the issue of resource allocation. While resources may be provided on a national level, there are social determinants that control how these resources are distributed. For example, the report found ageism and isolation could both play a role in limiting an older person's access to healthcare and medical resources: they may not be prioritised by family members, carers or medical professionals controlling allocation, or they may be unable to access facilities through lack of mobility, or assistance. In these cases, a policy approach of providing more health care resources to respond to sick older people is not sufficient to solve the structural problems causing these issues. The Commission's work highlights the importance of a coordinated response to health disparities, taking into account non-medical factors. In understanding the bigger picture it is possible to make more focused and successful attempts to combat disparities in health.

The Madrid Plan of Action on Ageing

In 2002, representatives from 159 countries at the Second World Assembly on Ageing made steps towards preventing poor health for older people with the introduction of the Madrid International Plan of Action on Ageing (Zelenev, 2008). The plan built on the foundations made by the Vienna Plan from 1982, which aimed to address the social economic and political ramifications of the increasing proportions of older people in the population. The Madrid plan acknowledges the rising median age and increase of ageing populations due to rises in life expectancy and the fall in fertility rates. The plan calls for changes in 'attitudes, practices and policies' at all levels. Ageing is to be acknowledged as a social achievement and a positive progression for humankind. Societies should reflect these changes, and the aims laid down by the Madrid plan are for a 'society for all ages'.

The Madrid Plan of Action on Ageing focuses on three key policy areas:

1. **Older persons and development**, covering: active participation in society and development, working and the ageing population, rural development, the labour force, migration and urbanisation, access to knowledge, education and training, intergenerational solidarity, eradication of poverty, income security, social protection and poverty protection, emergency situations
2. **Advancing health and well-being into old age**, covering: health promotion and well-being throughout life, universal and equal access to healthcare services, older persons and HIV/AIDS, training of care providers and health professionals, mental health needs of older persons, disabilities
3. **Ensuring, enabling and supportive environments**, covering: housing and the living environment, care and support for caregivers, neglect, abuse and violence, images of ageing

(Zelenev, 2008)

The Plan states that while major disparities exist in healthcare provision for older persons in developed countries and developing or emerging countries, the situations and healthcare systems are hardly comparable, and the imposition of solutions from Western countries may be inappropriate. Developing countries are plagued by scarcity and multiple competing priorities for government expenditure, and must develop indigenous responses to gaps in their health services. The Madrid Plan aims to combat the issue of vast differences between member countries by encouraging the empowerment of older people and for their opinions to be considered at all stages of implementation of the aims of the plan (United Nations, 2007b).

Progress so far on the Madrid Plan

While progress has been made on some of the aims of the Madrid Plan, there remains a significant distance left to travel. In 2007, at the five year mark from the introduction of the plan, a review suggested that improvements should be made on:

- the effective direction of the limited resources available for projects relating to the Madrid Plan;
- ensuring that policy was translated into practical actions on programmes with fruitful results;
- co-operation between nations and internationally.

(United Nations, 2008)

There are additional reviews of progress planned for 2012, as ten years will have passed since the Madrid Assembly.

Summary of the 'Narrowing World Health Disparities and Longevity' debate

The following questions with a policy brief were sent to all attendees of the dinner debate prior to the event to help stimulate thoughts and frame the discussion.

Questions for consideration:

1. Is it possible or indeed is there any value in considering health disparities between the developed and the developing world, including emerging countries or even within these two worlds, given the profound differences in health care delivery needs and the diversity of interventions required?
2. Are there any commonalities in social, economic, environmental or political variables which affect or determine health disparities for older people at the global level? For example the status of many older women in society or the reluctance of older men to seek out health care?
3. To what extent can old age compound the preexisting inequalities an individual may have been exposed to through their life?
4. What are the social determinants that lead one group to suffer greater health inequalities than the other, for example the gradient to which different groups are unequal in health in the US is greater than many other OECD countries? To what extent do the equality strands in terms of disability, ethnicity, religion, sexuality, gender, play a role in this respect?
5. What sort of public health measures are needed to address such burgeoning health disparities, particularly for older people? How do we balance the need to improve basic health knowledge and medical technology at the same time as working with existing knowledge and technology, but allocating resources more efficiently?

Summary of the debate

Baroness Sally Greengross – ILC-UK

Baroness Sally Greengross, in her position as chair, opened with a welcome on behalf of the ILC Global Alliance and ILC-UK to everyone who was attending the meeting. She thanked Pfizer, represented by Mr. Jack Watters, for sponsoring the event as well as supporting other work conducted by the ILC-UK on dementia. She also thanked Dr. Monica Ferreira and Ms. Sebastiana Kalula for organising the event, and Ms. Jill Adkins who made notes of the discussion. She also welcomed Dr. Marc Combrinck and Dr. George Petros.

Baroness Greengross opened the discussion by commenting that health disparities affect life expectancy and quality of life, and exist in both developed and developing regions. In developing countries more emphasis is placed on the needs of the younger population

and there is a systemic bias against researching older people and relatively scant knowledge on ageing. She noted however that this is not solely an issue in developing countries: for example, in the UK there is a 14 year difference in life expectancy in various areas of the country due to both socioeconomic and health inequalities. She then invited the speaker, Dr. Debbie Bradshaw, to open the debate.

Dr. Debbie Bradshaw noted that health status is affected by a number of factors that compound over a lifetime: genetics, behaviour, environment and health systems. While acknowledging the differences in health that exist within societies she focused on the disparities between countries.

She illustrated the difference between health systems by comparing her recent trip to Canada with a recent WHO meeting in South Africa. She described the living conditions in Toronto where there is a strong focus on neighborhoods, supported by government funding. She felt that Toronto provided a secure and safe environment for its inhabitants across the generations, as well as quality hospitals and primary healthcare services, all of which enhance the ability of any person with a disability, for example, to achieve his or her potential. She mentioned the work of the Canadian Health Institute (the Institute gathers information on health and creates independent measurements and standards) in examining issues like waiting times and the mechanisms for managing operations: for example, bringing forward older people with hip operation requirements in waiting lists for their benefit.

The WHO meeting in Cape Town involved the planning of building better health information systems for Western and Southern African countries. She noted that Mozambique has a life expectancy of 51 years and three quarters of its population lives in poverty (defined as less than one US dollar per day). In South Africa, 25 per cent of the population lives below that poverty level.

Dr. Bradshaw commented that profound disparities of wealth impact access to health care and the setting in which people live. The number of doctors in comparison to the size of the general population is a crude but revealing indicator of a population's access to health care. She stated that, on average, lower income countries have four doctors per 10,000 people and higher income countries have 28 doctors per 10,000. Mozambique has one half of a doctor per 10,000; South Africa has 8 doctors per 10,000; while the United States has 27 doctors per 10,000. These disparities affect individuals' ability to access quality healthcare and manage and reduce risk factors leading to chronic diseases. She said that in general, healthcare clients in developed countries benefit from the advances in medical technology and innovative management of chronic diseases, but these advances are largely unavailable to the poor. Middle and low-income countries have the challenge of not only the lowest resources but also the largest burdens of disease. The poor often experience multiple burdens of disease such as communicable disease, health issues associated with childbirth or early age, and a lack of basic services such as access to sanitation and clean water. Consequentially, these wealth disparities have a magnification effect on the differences in the provision of healthcare.

Dr. Bradshaw posed the following questions to be debated by the group:

- Do we fundamentally need to change the basic inequalities in the world, or are there things that can be done in these contexts to ameliorate these situations?
- What global public health initiatives are needed to address the burgeoning health disparities for older persons?
- Having set out minimum standards in the Madrid Plan for countries to aim for, what progress has been made, and how could the plan be further used to address this topic?

Baroness Sally Greengross added another question:

- Considering the agreements made for the Millennium Development Goals and the Madrid plan, what do we think is the best strategy for encouraging intergovernmental bodies to take ageing and demographic change seriously?

Dr. Lia Diachman pointed out that there are differences within the global 'South' and that developing countries are heterogeneous: Argentina is very different to other countries in Latin America, and to those of southern Africa and Asia. She stated that we should not assume that poverty is the main reason for health inequalities and when some say it is a social problem is it therefore considered to be without a solution. She questioned if health disparities are not also the result of a misuse of economic and human resources. She emphasised that after ten years the goals of the Madrid Plan have not been achieved in developing or developed countries.

Ms. Francoise Forette stated that this debate is actually tackling two different issues. In developing countries, poverty is the most important factor in health disparities as well as having a large role to play in epidemics. She noted, however, that the more developed countries also have disparities, using France as an example where there is a seven-year difference in life expectancy between white collar and blue collar workers. Francoise noted that most studies show that poverty and working conditions are factors in health disparities but that education and lifestyle are equally significant. She emphasised that promotion and prevention are essential to reducing health inequalities and must start early in life. Ms. Forette also commented that health education and promotion of healthy lifestyles must be sponsored by employers, in the work place and during work time in order to be effective. She closed by stating that the North needs to provide a greater monetary contribution to the South.

Ms. Marieke van der Waal remarked that war has a devastating impact on life expectancy. Both Afghanistan and Zimbabwe (which she described as basically being in a state of civil war) have average life expectancies of 44 years. Further, she noted the impact of lower socioeconomic status on life expectancy: for example, in the Netherlands, at age 65 those from lower socioeconomic backgrounds have a life expectancy of three and a half years less than those from high socioeconomic backgrounds. These life expectancies are based on income and level of education, so

where you start in life will predict your prospects for later life. She stated that the Netherlands is focusing on the disparities debate and how to address it. Access to health care and health literacy are essential. She commented on the country's ban on smoking in public places, and the importance of prevention schemes for smoking. She suggested that both education programmes and new laws like a ban on smoking are sometimes needed to bolster health care issues.

Prof. Sara Carmel stated that there are many reasons for health disparities. Among them, factors which impact health inequalities in all countries, such as ageism, sexism and discrimination based on other grounds. Health inequities are particularly compounded for persons who experience multiple forms of discrimination, for example, the discrimination faced by an older woman will be related to her age and her gender. She remarked that discrimination is created by society (social norms and values), not by genetics or physical environment, and therefore, under society's control. Prof. Carmel noted that if social discrimination will be eradicated, significant improvements will be noticed in health inequalities worldwide.

Baroness Sally Greengross commented that discrimination issues such as these are often found in the funding of research for dementia.

Mr. Jack Watters stated concern over the use of the terms 'developing' and 'developed', and pointed out that there are aspects of a country like the United States which could be described as 'developing'. He suggested that countries could more accurately be described in terms of their economies, such as emerging, mature, declining or stagnating. The differences between these economies have their roots in a lack of innovation, be it in education, healthcare development or other factors. There is therefore an inherent judgement about defining economies thus. All public health problems have their starting point in some disparity. He noted that disparities can be based on a variety of factors including gender or ethnicity as well as sexuality. It is not an accident that the first Millennium Development Goal is to ensure primary education for all. Based on his work around Africa, he remarked that education is the silver bullet for addressing HIV and AIDS, and especially the education of girls and women. He felt that corruption is a major problem in virtually all countries and that it impacts health care delivery. Until corruption is addressed debates like this will never disappear.

Dr. George Petros stated that organs of society especially Non-Governmental Organisations (NGOs) could play an important role by holding government accountable on the international agreements they signed to meet older persons' needs. However, there is a lack of community involvement in issues affecting older persons. NGOs should also play a monitoring role to assess and ensure that government actions reflect and address community/older persons' needs.

Baroness Sally Greengross asked a question of the attendees:

- Do changes in attitudes and behaviours follow changes in laws- could community pressure also initiate changes or is early legislation necessary and attitudinal change will follow some time afterwards?

Ms. Francoise Forette felt that there are limits to legislation, noting that while the passive effects of smoking have decreased since the public smoking ban in France, on a global level, smoking has increased in recent years.

Dr. David Matchar stated that health disparities are a reflection of underlying economic and social issues, unrelated to healthcare organisation and education provision. He indicated that while issues such as sanitation and nutrition are important, many of the factors which impact health disparities are not about the health system. There are some issues such as reduction of hypertension that could be easily solved. He wondered to what extent the health system should be held responsible for health disparities if a society ignores aspects unrelated to the health system.

Mr. Jayant Umranikar stated that legislation is a short cut for societies which are not capable of reforming themselves through social movement. As pressures are brought upon the government it will change the law, but if there is no social support, efforts to effect change will fail. Within some families, there is a priority basis for education for boys over girls, not due to sexism, but due to long term security concerns of the parents; a boy may stay with his family and care for his parents in later life, but a girl would get married and leave the family home. Regarding the earlier suggestion that health promotion and prevention should be encouraged in workplaces, he commented that this applies only to the organised sector and fails to address the many people who work in the unorganised sector, which makes up a significant number of workers in developing countries. He remarked that disparities are a natural result of the different abilities of people, and reiterated that only through social movement will there be change because many of the other factors influencing health inequities (such as corruption) will always exist. Social movement has more power to reform than government, and official political structures should not be relied on to change society. He also mentioned that disparities within societies could be seen as a representation of the differences between people.

Mr. Shinichi Ogami suggested that both laws and social movements are needed. He felt that the more developed countries should bear a greater responsibility in addressing global health disparities. He noted that Japan initiated a project which sends experienced people overseas to volunteer in less developed countries, and that half of those volunteers are over age 60. He commented that older people themselves can be participants in resolving health disparities.

Baroness Sally Greengross agreed that regarding older persons as a resource to improve society is important. She then focused the discussion on what priorities and special projects should exist for today's underprivileged older persons, as opposed to a health focus on children and young people.

Dr. Lia Diachman emphasised the importance of raising awareness within society and within communities through use of the media, prior to new legislation. She felt this was more important that enacting laws which may or may not be followed. She also noted that older people must believe in their rights.

Mr. Martin Boekholdt stated that the discussion of some problems was too general and that we should think in terms of 'levels of development'; firstly for clean water/sanitation, then primary health care, and finally more sophisticated care for older persons. He noted that at all of these levels, there are problems relating to lifestyle, education and human rights. In order to address these levels regional plans should be made, moving away from general terms of 'good' and 'bad'.

Ms. Masako Osako reflected on what Robert Butler (Chair of the Global Alliance 2000-2010) would make of the discussion. She had recently read his book, 'Longevity Revolution', and focused on the differences between it and his book 'Why Survive?'. In the newer book (Longevity Revolution) he focused on individuals' rights and responsibilities, and that individuals and society have responsibilities to receive education and be educated.

Mr. Jack Watters stated that it is never too late for education and awareness. He related his recent experience launching a speaking book for healthcare community workers near Johannesburg to educate people on safe medicinal practice (for example, not sharing prescriptions). He noted the importance of innovation, the training of community workers and taking an intergenerational approach on the issues of older persons as factors in a strategy to address inequalities in health as mentioned by Dr. Bradshaw in reference to intergenerational communities in Toronto. He agreed that introducing the idea of younger people's responsibility for the older members of society should be introduced to a greater extent.

Ms. Mary Ann Tsao stated that the issue of health disparities will require a variety of approaches, and emphasised the need to empower older persons and communities to take ownership. Older persons' groups and NGOs are powerful mechanisms, and people need to be educated, empowered and motivated to change their behaviour (i.e. health seeking behaviour). She commented that governments do not respond to calls to emphasise primary health care and that it is better to put the responsibility on communities and older persons themselves. She mentioned the poor quality of the built environment in Singapore, and in both rural and urban locations, and how difficult it can make life for older people. This in turn leads to complications with health as people cannot easily access healthcare. Services need to be brought to community levels where there needs to be more trained community health care workers.

Baroness Sally Greengross remarked on the concept of lifetime neighbourhoods and on the need to reduce the isolation of older persons. She noted that many environments simply are not friendly to older persons, and a lifetime approach to the built environment could be extremely helpful. She also proposed that including ageing in biology classes at

school might be a useful tool for increasing awareness of the issues facing older people, and there was general agreement on this.

Ms. Noreen Siba stressed the need for an intergenerational approach and commented that older persons need to connect with the younger generation in order for the empowerment discussion to take place. Discussions on healthy ageing need to begin at a younger age, as well as discussion on other issues which affect older persons such as lack of respect. There needs to be investment in younger people and an encouragement for joint projects with young and old people. She suggested that the West has a lot to learn from the respectful relationships with older people in Eastern countries. Pfizer is also sponsoring a project with ILC-UK to bring together older and younger people to improve intergenerational relations.

Dr. Debbie Bradshaw emphasised this point that intergenerational cooperation should be a top priority in combatting health inequities.

Ms. Sebastiana Kalula agreed that society needs the contributions of all generations, and that this should start with young children. She further emphasised the role of work in producing a sense of worth in people and that those who do not work tend not to take responsibility for themselves, in line with others not respecting them. The lack of self-respect includes a valuation of their health care.

Dr. Lia Diachman also agreed on the importance of intergenerational support, and commented on the two-way relationship between younger and middle aged people and older people. Intergenerational solidarity already exists and it should be enhanced. She also spoke of the importance of accessibility as a barrier to health care, and communication as being part of this. Universally the radio is the most common source of contact for older people, and that this relationship with the radio should be used to raise awareness of older persons' rights and services.

Baroness Sally Greengross remarked on Ms. Sebastiana Kalula's comments about people being identified with their work and with what they 'were' as opposed to who they are, now. She described retirement as a 'drop from grace' and suggested that it would be beneficial to prevent a negative view of people who do not work any more, and restore the dignity of retired people.

Ms. Marieke van der Waal made the point that this would be difficult because what you did in your working life continues to affect your later life, for example, you can afford a private nursing home if you were able to save enough money. She emphasised that the health care system needs to be accessible. She advocated a return to the basics of a health care system: water, hygiene, reliable medications and health literacy. She mentioned the widespread flu vaccination programme for over 65s to prevent high mortality amongst the elderly in the flu season. Also, she noted that people often think that fast food is the most affordable food, and that this is a health literacy issue.

In reference to how people retain value in their lives after retirement **Ms. Masako Osako** spoke of the academic Durkheim who argued that people are social beings and need to

be integrated into society (and that working is one of those forms of integration). She stated that people must develop other social roles, such as volunteering. It might be a difficult transition to make from someone who spent their working life accumulating money but it could be of benefit. Some general discussion followed on the importance of various roles and preparing for older age.

Mr. Marc Combrinck reiterated Dr. David Matchar's earlier remarks on many health issues being unrelated to or larger than the health care system itself. Health in South Africa acts as a barometer for the rest of the country. He questioned whether health care providers are apportioned too much responsibility in discussions on health disparities.

Dr Monica Ferreira noted that the majority of older persons in South Africa receive a means-tested, non-contributory state old age pension. Beneficiaries of a social pension are accorded access moreover to certain government services, including free health care at public health care facilities. A problem in the country's three-tier public health system, however, is that entry is at a primary level and older patients are not routinely referred to higher levels of care, if needed, which is discriminatory. Nonetheless, once they reach a tertiary level, they are given first world standards of care.

Key themes and recommendations

This section will provide an overview of some of the key themes that emerged from the debate, priority areas in dealing with health disparities and recommendations for action at the local, national and international level.

Key Themes

1. **The need to recognise the conceptual limitations of reductive classifications.**

Caution has to be exercised to avoid treating older people as a homogenous group and acute awareness must also apply to the representation of the developing and developed world and assuming westernised model of analysis when looking at health inequalities. Indeed, the dichotomous terms of "developing" and "developed" falls far short from the complex reality of the global picture, and in many respects almost all countries are still "developing" in terms of their policy interventions and responses to older people.

2. **Recognition that health is mediated by a range of experiences.**

We need to define health as a product of many factors: biological, psychological, social, political, cultural and economic. Disparity in access and health outcomes in developed and developing countries, is closely associated with the wider disadvantages individuals experience in society, in terms of human capital, location, economic and social resources and should be viewed within this context.

Thus the interplay of a wide range of biological, economic, sociological, political factors and membership of equality groups or strands in terms of gender, disability, race/ethnicity, religion or belief and sexuality for example, should also be considered. It is the 'intersectionality' between the strands which merit further understanding and investigation in order to improve heath and indeed life outcomes for older people.

We also need to consider the power relations which affect healthcare decision-making within an economy, and the influence these political decisions will have on varying groups' resource access.

3. **Acknowledgement that older people warrant separate and specific attention with regard to health care interventions and policy-making.**

As we age, women and men share the same fundamental needs related to the employment of human rights such as food, shelter, access to health services, dignity, independence and freedom from abuse, however, as we age we are also subject to additional discrimination, disadvantage and inequalities.

4. **Engendering healthy behaviour and lifestyles.**

There are significant subtleties in the relationship between the state and the individual across the world. Some improvements in health are brought about by pressure from active communities, with laws being created to reflect the views of these collectives in society. Other changes will need sanctions (be they positive or negative) to reinforce, for example, a healthy choice or behaviour, and an attitudinal change in individuals may

follow. A good example of this (provided by Ms. van der Waal) is the decrease in smoking seen after the introduction of public smoking bans in the Netherlands. These influences can be exerted through the media, or legislation.

5. **Empowering older persons (and all persons) to take responsibility for their health and control of their lives.**

Investment needs to go into empowering older people and populations in general to have control over their health and care. This could take the form of both ensuring higher levels of knowledge and understanding in individuals as well as encouraging communities to take action on issues which are important to them.

6. **Awareness, education and training for health and care professionals.**

In addition to ensuring a greater level of knowledge for the public with regards to their own health, there needs to be additional training for medical students and doctors to be able to identify and assess vulnerable older people, and make better decisions about their care. More could also be done to improve the understanding of families in situations where care responsibilies have been transferred to them from an ageing individual, so that they are better able to make informed decisions.

7. **The need for an intergenerational approach towards supporting healthy lifestyles and healthy ageing.**

We need to address pre-existing health inequalities between generations, prioritising, not discriminating against, older people in healthcare. The value of the older generation needs to be incorporated into the design and delivery of healthcare and medicine for this group, with a focus on healthy ageing and recognition of the potential of many healthy years of life to follow.

Accessible information and education for all ages is a crucial element for the aims of the Madrid Plan to be met. Risk factors for the chronic diseases most commonly affecting older individuals are determined across the life course, so knowledge of how they can be prevented should be communicated to younger generations to prevent further disease incidence. In order to achieve sustainable health for future generations, we need to tackle the short-sighted focus on exclusive treatment of symptoms and invest more in preventive medicine.

8. **An intergenerational strategy to encourage positive images of and attitudes towards older persons.**

It is acknowledged that older people within some communities can be subject to discrimination, disadvantage and isolation, as a result of their ageing status. There needs to be greater acknowledgement of the past contribution of older people and at the same time recognition of the continued involvement they can offer their communities, for example in the form of volunteering. There is a need to change the underlying assumptions about the value of older persons and increase understanding of the ageing process, perhaps through including education about the biology of ageing in compulsory

education (as suggested by Baroness Greengross). Prioritising intergenerational cooperation needs to be given greater importance.

9. **The need for a grassroots, bottom-up approach focusing on community initiatives, including improved accessibility of health care services, which involves the largest possible numbers of persons.**

Consultations with older people on policy issues should be ongoing. Community solidarity and mobilisation to improve their social environments should be supported by decision makers and governments. It is important to acknowledge that schemes and initiatives will need to be responsive and appropriate to different situations, with specific focus for a country's particular issues and requirements. Use of indigenous and existing projects, technologies (such as the radio, as suggested by Dr. Diachman) and ideas will allow for additional funds to be focused where they are most needed, and for energies to be centred on what is achievable in a particular scenario.

Recommendations

These recommendations were formed from the debate and are intended to stimulate discussion, inform further consideration on these issues and focus on narrowing the inequalities of circumstance and opportunities that affect the health of older people at the local, national and international level.

Empowerment and inclusion of older people at all levels.

In line with the recommendations made by the Madrid Plan, consultation with older people should occur throughout the processes of policymaking and delivery. Decision-makers should make individual assessments on the best way to target and include older people in policy choices, including using existing technologies and schemes to facilitate this process efficiently. Older people should be fully informed of their rights and the full implications of decisions regarding their health and social care. Medical and care professionals should be made more aware of the needs of older people and how to communicate effectively with them. Training and education should be provided to all health and social care professionals to combat ageism and discrimination in healthcare.

Intergenerational community involvement.

Communities should be encouraged to take action on issues important to them and governments and legislation should be responsive to the decisions called for by communities. Intergenerational cooperation should continue and expand in order to educate all generations, particularly younger people about ageing and the issues faced by older people.

Taking a life course approach.

As we understand more about the long-term causes of many chronic diseases it is important to communicate preventive measures to younger generations in order to ensure healthier future populations. We should encourage younger people to understand the processes of ageing and have a greater relationship with older people.

Continued support for the goals set by the United Nations and the World Health Organisation.

We need to continue to support the outcomes of the Madrid Plan of Action on Ageing, the Commission on Social Determinants of Health and the Millennium Development Goals and aim to achieve the set goals as soon as possible, not as objectives to be achieved in the long term.

Increasing the evidence base for ageing and longevity.

The extent to which some countries have begun to generate and use critical evidence for an effective health response has been suboptimal. This is particularly prominent in low and middle income countries, partly because the demographic transitions have been relatively recent. More research is needed, particularly in the ageing arena in this regard.

References

Commission on Social Determinants of Health (2008) *Closing the gap in a generation: health equity through action on the social determinants of health*. World Health Organisation.

Hacking, J., Muller, S. and Buchan, I. (2011) Trends in mortality from 1965 to 2008 across the English north-south divide: comparative observational study. *British Medical Journal*, Vol. 342, c: 7794

Lawn, J. (2010) Are the Millennium Development Goals on target? *British Medical Journal.* Vol. 341, c: 1136 http://www.bmj.com/content/341/bmj.c5045.full

Marmot, M. (2005) Social determinants of health inequalities. *The Lancet*, Vol. 365, pp. 1099-1104, March 19th 2005

Murray, CJL., Michaud, CM., McKenna, MT., Marks, JS. (1998) *US patterns of mortality by county and race: 1965-1994*. Harvard Center for Population and Development Studies, Cambridge.

Omran, A.R. (2005 first published 1971) The epidemiological transition: A theory of the epidemiology of population change. *The Millbank Quarterly*, vol. 83, issue 4, pp. 731-757. Reprinted from *The Millbank Memorial Fund Quarterly,* vol. 49, no. 4 part 1 pp. 509-538

United Nations (2007a*) World Population Prospects: the 2006 revision*. United Nations Department of Economic and Social Affairs: Population Division, New York.

United Nations (2007b) *Progress in the Implementation of the Madrid International Plan of Action on Ageing*. United National Programme on Ageing, Department of Economic and Social Affairs, New York.

United Nations (2008) *Report of the Secretary-General: First Review and Appraisal of the Madrid Plan of Action on Ageing: Preliminary Assessment.* Commission for Social Development, 46th Session. United Nations Economic and Social Council, New York.

World Bank Data (2008) Life expectancy at birth, total (years) http://data.worldbank.org/indicator/SP.DYN.LE00.IN?display=default

Zelenev, S. (2008) The Madrid Plan: A comprehensive agenda for an ageing world. *In:* United Nations Department of Economic and Social Affairs (2008) *Regional Dimensions of the Ageing Situation.* United Nations, New York.

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