Achieving Universal Health Coverage fit for an ageing world

2024 edition

HelpAge International

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Contents

Overview

Universal health coverage (UHC) is defined as everyone, everywhere having access to the health services they need, when and where they need them, without suffering financial hardship. Progress towards UHC is essential for promoting healthy ageing, delivering social and economic development, and building resilient and equitable societies that respond effectively in times of crisis.

Alongside action to address factors that shape our health and wellbeing across the life-course and tackle the root causes of poverty and inequality, the commitment of governments to achieve UHC within Sustainable Development Goal 3.8 aligns directly with their duty to fulfil all people's right to the highest attainable standard of physical and mental health.

By 2030, 1.4 billion people will be aged 60 or over. Yet the majority of health and care systems worldwide remain unprepared for population ageing and associated increases in rates of non-communicable diseases (NCDs) and disability. This is particularly true in low- and middle-income countries where over 70 per cent of older people live.

Today, millions of older people in these countries are unable to access the services they need or are pushed into poverty doing so. Meanwhile, critical opportunities for promoting healthy ageing across the life-course and reaping the associated benefits for people, systems and societies are being missed.

To deliver better outcomes for all, we must harness the opportunity UHC presents to reorient health and care systems to meet the needs and uphold the rights of older people and promote healthy ageing for all. The impact of COVID-19, climate crisis and wider threats to global health security make this an even more urgent priority.

To deliver this vision, governments, service providers and health actors at all levels must work together to:

Champion age and disability inclusive and gender responsive health and care systems that deliver equitable, integrated and person-centred services, founded upon strong primary health care approaches promoting healthy ageing for all.

This must include:

1. Addressing the barriers older people face to enjoying their right to health

This means addressing the barriers older people face to enjoying their right to health, including those related to the availability, accessibility, acceptability and quality of health-related goods, facilities and services, as well as ageism and age discrimination in their funding, design and delivery.

Ben Small/HelpAge International

2. Investing in the building blocks of a health system fit for purpose in an ageing world

This must include:

- **Services** Services must deliver integrated, person-centred and community-based care that holistically responds to older people's health and long-term care and support needs and preferences across the full continuum of care, including:
    - Health and wellbeing promotion
    - Prevention of disease and disability
    - Diagnosis and treatment
    - Specialist services
    - Rehabilitation
    - Palliative and end of life care
    - Long-term care and support

- **Workforce** A well-paid, well-trained and well-resourced, multidisciplinary workforce must be able to respond effectively and holistically to the diverse and more complex health and care needs of ageing populations.
- **Access to medicines, vaccines and assistive technologies** Essential goods and products lists must include the tools and technologies recommended for addressing the conditions most common in later life and for promoting older people's intrinsic capacity, functional ability and quality of life.
- **Information and data systems** Data on all components of people's right to health and long-term care and support must be available and disaggregated by sex, age, disability, location, and socio-economic status as a minimum to inform equity-based decision making. Information systems must support the delivery of person-centred and integrated care that promotes healthy ageing.
- **Financing** An equity-based approach must ensure those most at risk, including older people with the greatest health and care needs, are prioritised in progress towards increasing financial coverage for the full continuum of UHC services, with the ultimate goal of care being available free at the point of use for all. Governments must commit to increasing public financing for health and care. Health financing must better respond to the health and care needs of the population across the life-course and move away from vertical disease programming towards investment in health system strengthening, primary health care approaches, and the delivery of integrated and person-centred care.
- **Governance and leadership** Governments must commit to achieving UHC and healthy ageing through multisector and 'whole of government' approaches that prioritise health and wellbeing for all. The right to health and long-term care and support must be established in legislation with policy and action plans in place to ensure these rights are respected, protected and fulfilled.

3. Promoting a rights-based approach, ensuring the voices of all groups, including older people, are heard within system and service design, delivery, monitoring and evaluation

This must include systems and services promoting the PANEL principles at all levels, including:

- Participation
- Accountability and transparency
- Non-discrimination and equality
- Empowerment, and
- Legality for all at all levels.

HelpAge and network members are part of the solution and are supporting progress towards UHC fit for an ageing world from grassroots to global levels.

See how here.

Ganesh Bista, Ageing Nepal

Introduction

The World Health Organization (WHO) defines healthy ageing as the process of developing and maintaining the functional ability that enables wellbeing in older age.[1] An older person's functional ability is determined by their intrinsic capacities, the environments in which they live, and the interaction between the two. 'Intrinsic capacities' are a person's physical and mental abilities. The 'environment' refers to all the elements of a person's home and community, the relationships they have, and the wider social, political, cultural, economic, environmental and physical contexts in which they are born, grow, live, work and age.

The Sustainable Development Goals (SDGs) and the blueprint they outline for creating a better future for all are directly aligned with the ambitions of healthy ageing and the United Nations Decade of Healthy Ageing. They advocate for whole-of-government and whole-of-society action to promote strong and sustainable communities and societies. This includes SDG 3 focused on promoting health and wellbeing for all at all ages. A key target within SDG 3 is the achievement of universal health coverage (UHC) so that everyone, everywhere is able to access the quality health and care services they need without suffering financial hardship.

Progress towards UHC as part of Agenda 2030 is essential for promoting healthy ageing, delivering social and economic development, and building resilient and equitable societies that respond effectively in times of crisis.[2] **But to achieve its promise, models of UHC must be fit for an ageing world.** Today, more than 1 billion people globally are aged 60 years or older, with the majority (70 per cent) living in low- and middle-income countries.[3] The number is set to increase to 1.4 billion by 2030 and to 2.1 billion by 2050.[4] This increase is occurring at an unprecedented pace and will accelerate in coming decades, particularly in developing countries, while the fastest growing segment of the population is people aged 80 and over. Within the older population, women outnumber men at all ages.

While people in nearly all countries of the world are now living longer, ensuring that everyone, everywhere is able to enjoy dignity and wellbeing in later life is a challenge. The World Health Organization (WHO) estimates that at least 142 million older people worldwide today are unable to enjoy their basic rights including their right to enjoy an adequate standard of living and their right to food, clothing, suitable housing, and access to quality health and care services that meet their needs.[5]

The majority of health and care systems worldwide remain unprepared for population ageing and associated increases in rates of non-communicable diseases (NCDs) and disability. Many low- and middle-income countries are experiencing population ageing whilst facing a 'double burden' of infectious and non-communicable diseases (NCDs), with rapidly increasing numbers of older people who require health and long-term care and support services. Failure to adapt systems to changing demographic and epidemiological shifts is leaving millions of older people globally without access to the services and support they need. Meanwhile, critical opportunities for promoting healthy ageing across the life-course and reaping the associated benefits of preventing, reducing or delaying the onset of more acute care needs are being missed.

To deliver better outcomes for people, systems and societies, we must harness the opportunity UHC presents to reorient health and care systems to promote healthy ageing and to meet the needs of an ageing world. The impact of COVID-19, climate crisis and wider threats to global health security make achieving UHC and the resilient societies that it can support even more urgent.

This report explores the barriers that must be addressed and the key components necessary to deliver on this vision and achieve UHC fit for an ageing world.

Box 1: The three transitions – reorientating health and care systems to be fit for an ageing world[6]

The demographic transition

- The world is ageing rapidly. In 2030, 1.4 billion people will be aged 60 and over, making up 17 per cent of the global population. By 2050, 2.1 billion people will be aged 60 and over, making 22 per cent of the global population.[7]
- Today, the majority (more than 70 per cent) are living in low- and middle-income countries. By 2050, 80 per cent of older people will live in low- and middle-income countries.
- Women outlive men around the world by an average of 5.4 years, but spend a greater proportion of their lives in ill health or with a disability.[8]

The epidemiological transition

- The global pattern of disease is shifting towards non-communicable diseases (NCDs). Before COVID-19, NCDs already contribute to 80 per cent of all years lived with a disability globally and 74 per cent of all deaths.[9, 10]
- NCDs have a disproportionate impact on older people – in 2019, 85 per cent of all deaths from NCDs were among people aged 55 and over.[11]
- Many countries face a 'double burden' of disease due to high levels of infectious diseases and rising rates of NCDs.

The health and care system transition

- Health and care systems must adapt to changing patterns of disease and disability, to meeting the needs of ageing populations, and to promoting healthy ageing for all.
- The Sustainable Development Goals, the Decade of Healthy Ageing and the global drive towards UHC provide opportunities to catalyse action.

David Lomuria/HelpAge International

UHC and older people's right to health

The right to the enjoyment of the highest attainable standard of physical and mental health is a fundamental human right and is indispensable for the exercise of other human rights.[12] Health is defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The right to health goes beyond access to health services to embrace "a wide range of socioeconomic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment".[13]

A central component of the right to health is the right to the goods, facilities and services necessary to support a person's enjoyment of the highest attainable standard of health. These facilities, goods and services must be available, accessible, acceptable and of good quality and provided to all without discrimination. The right to health also explicitly includes the right of populations to participate in all health-related decision making.

The commitment of governments towards achieving UHC as part of Agenda 2030 aligns directly with their duty to respect, protect and fulfil people's right to health. Within the Political Declarations adopted by the UN General Assembly at the High-level Meetings on Universal Health Coverage in 2019 and 2023, Heads of States and governments committed to accelerating progress towards UHC, based on nationally determined sets of essential services, ensuring that the use of these services does not expose people to financial hardship. The Political Declarations on UHC, commit governments to pursue whole-of-society and equity-based approaches that seek to meet the needs of the furthest behind first. Primary health care is recognised as the cornerstone of a sustainable, people-centred, community-based and integrated health and care system and the foundation for achieving UHC.

The Political Declarations on UHC also included clear commitments to promoting healthy ageing. Specifically, they committed governments to *'Scale up efforts to develop, implement and evaluate policies and programmes that promote healthy and active ageing, maintain and improve quality of life of older persons and to identify and respond to the growing needs of the rapidly ageing population, especially the need for continuum of care, including promotive, preventive, curative, rehabilitative and palliative care as well as specialized care and the sustainable provision of long-term care, including home and community care services, and access to assistive technologies, taking note of the proclamation of the United Nations Decade of Healthy Ageing (2021-2030), reaffirming the importance of extending universal health coverage to all older persons'*.[14]

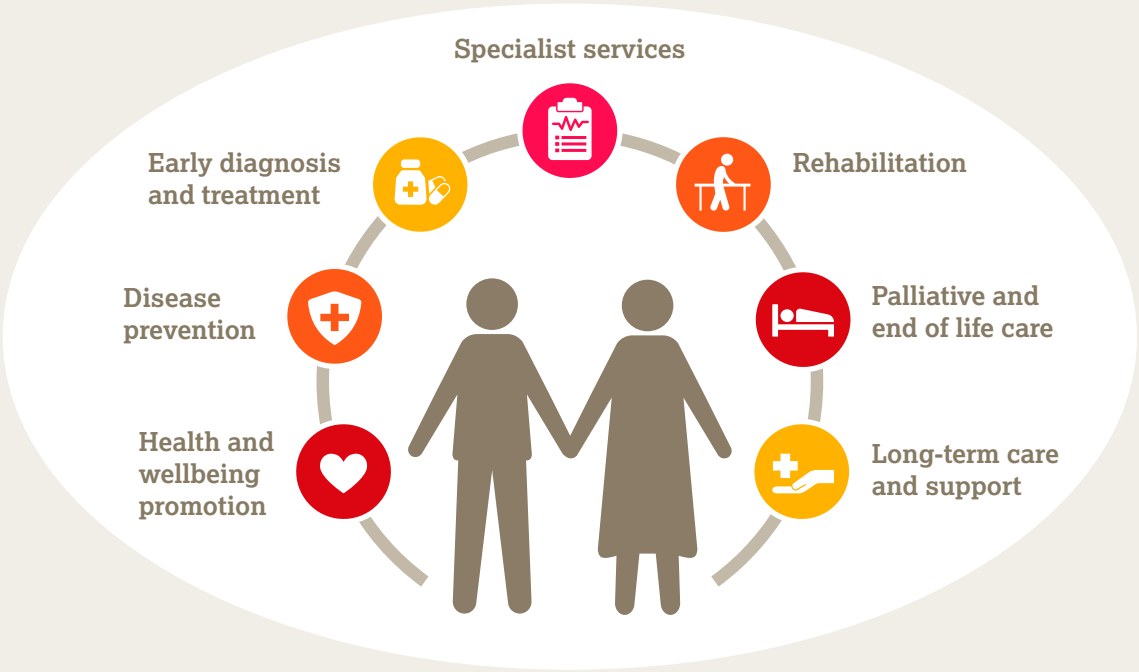
YAKKUM Emergency Unit/HelpAge International

To achieve these ambitions, a step change is needed in the design and delivery of health and services so that they fulfil the rights and meet the needs of older people and promote health and wellbeing across the life-course for all.

Box 2: UHC continuum of essential integrated services

The full continuum of essential, quality and integrated health and care services includes:

- **Health and wellbeing promotion** – focused on enabling people to increase control over and to improve their health and wellbeing
- **Disease prevention** – focused on reducing risk factors, preventing the occurrence of disease, arresting their progress over time, and reducing their impact on health and wellbeing once established
- **Early diagnosis and treatment** – focused on diagnosis, treatment and management of health conditions
- **Specialist services** – focused on diagnosis, treatment, prevention and management of specific, rare or complex health conditions
- **Rehabilitation** – focused on optimising functioning and reducing experience of disability in individuals with physical, mental, psycho-social or cognitive health conditions in interaction with their environment
- **Palliative and end of life care** – focused on improving the quality of life of people who are facing challenges associated with life-threatening illness and their families.
- **Long-term care and support** – focused on enabling people who experience significant declines in capacity and their caregivers to receive care and support that allows them to live a life consistent with their rights, fundamental freedoms and human dignity.



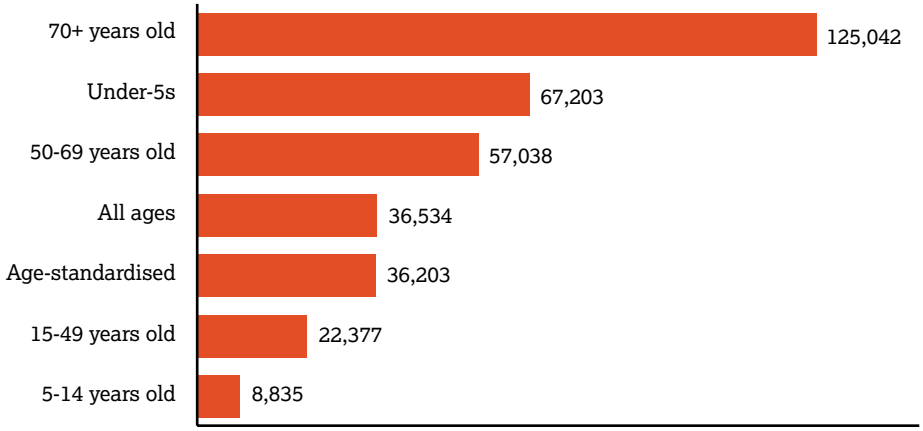
Barriers older people face in enjoying their right to health

Older people are among those with the greatest need for health and care services, yet often furthest behind in accessing them.

Older people are the age group that faces the greatest burden of disease.[15] Yet limited funding and attention is given to meeting their needs or to addressing the barriers they face to accessing care.

Burden of disease, by age group, World, 2021

Disability-Adjusted Life Year (DALYs) from all causes per 100,000 individuals, by age group.*



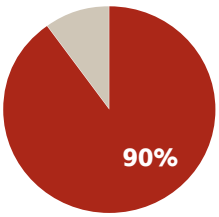
*DALYs measure the total burden of disease – both from years of life lost due to premature death and years lived with a disability. One DALY equals one lost year of healthy life'.

Source: Data source: IHME, Global Burden of Disease (2024)

Responses to the Decade of Healthy Ageing progress survey in 2023 from 134 countries reveal that:[16]

- Only 27 per cent of countries reported having adequate resources for delivering the person-centred and integrated care that older people need.
- Only 34 per cent reported having adequate resources available for action on long-term care and support.
- 64 per cent reported having capacity-building plans to strengthen the geriatric and gerontology workforce, though this was just 21 per cent in low-income countries.
- Just 37 per cent reported having cross-sectional, nationally representative data on older people and their health and care needs to inform decision making.

At global level, Development Assistance for Health (DAH), which is the funding provided by governments and private organisations in high-income countries to low- and middle-income countries, is also failing to keep pace with population ageing. Analysis of DAH by age from 2017 data shows found DAH targets younger more than older age groups relative to their disease burden, with 90 percent of DAH going to people younger than 60. Rather than responding to population ageing, this trend seems to be increasing, with analysis finding that diseases causing health burden at older ages were actually deprioritised between 1990 and 2013, despite the demographic and epidemiological changes that increased their importance.[17]



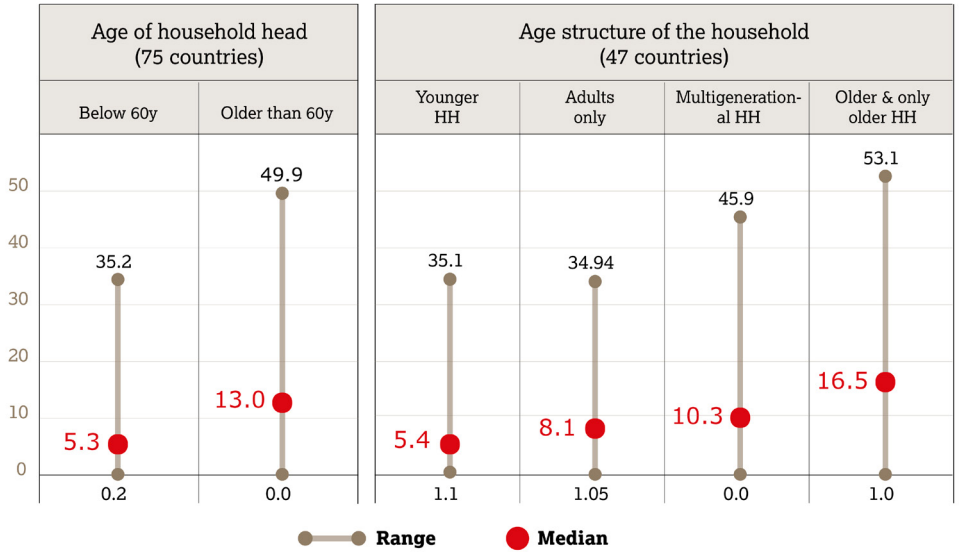
90 per cent of Development Assistance for Health (DAH) went to people younger than 60.

Meanwhile, funding for NCDs which are more common in later life, received just 2.3 per cent of DAH funding in 2023, despite being the leading cause of disease and disability globally.[18] More broadly, the focus of DAH on single - largely infectious - disease funding is also missing opportunities for investing in health system strengthening[19] and integrated primary health care approaches that would benefit people across the life course.[20]

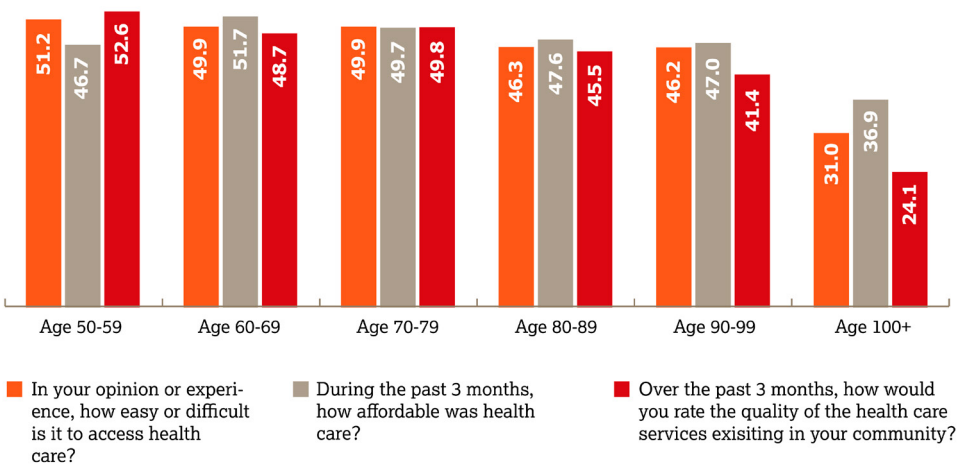
Failures to adapt health systems to population ageing contribute to older people being among those with the greatest need for health and care services but furthest behind in accessing them. Older people face multiple barriers to accessing the services they need including those related to the availability, accessibility, acceptability and quality of services, as well as ageism and age discrimination in their design, delivery, monitoring and evaluation.

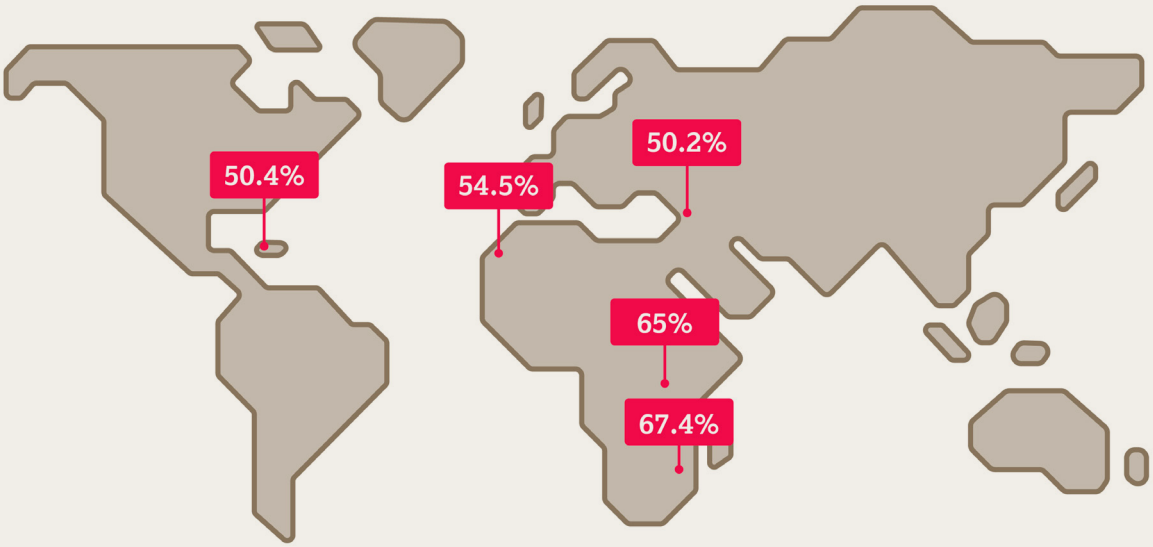
For example, of the more than 2 billion people each year facing financial hardship due to out-of-pocket spending on health, older households are most at risk of catastrophic health spending (meaning that more than 10 per cent of their household income was spent on health related costs), while intergenerational households including older people are most at risk of impoverishing health spending (health care spending which pushes households below the poverty line).[21]

Percentage of population experiencing catastrophic health expenditure



Older people's perceived access to health services, by age





Prevalence of unmet health need among older people exceeds 50 per cent in several countries – including Georgia, Haiti, Morocco, Rwanda and Zimbabwe.

Across 3000 older people surveyed by HelpAge and partners across nine countries in Africa, Asia and Latin America, on average, older people rated the access, affordability and quality of services as only 50 out of 100. These scores were lower for older groups, those with a lower level of education and for older people living in rural areas.[22]

The barriers older people face to accessing the health and care services they need contribute to more than 50 per cent of older people facing unmet need in several countries.[23] While unique, these estimates are likely underestimates, and do not begin to address issues of poor quality of care as a barrier or contributing to unmet need in those who are able to access care.[24]

In the section below, we explore in more detail the barriers that older people in LMICs face to enjoying their right to health.

Services fail to meet the health and care needs of older people or to promote healthy ageing across the life-course

The failure of governments to invest in primary health care means at least half of the world's population – 4.5 billion people – lack access to essential health services.[25] Even where services are available, they often focus on addressing a burden of disease dominated by acute, time-bound conditions. They do not respond effectively to older people's diverse health and social care needs (see box 4) or deliver integrated, person-centred and community-based care focused on promoting healthy ageing.

Failures to deliver integrated, person-centred and community-based health and care services deny older people their right to health and mean critical opportunities are being missed to prevent or delay the onset of more acute needs and support healthy ageing for people of all ages. McKinsey Health Institute have estimated that up-to 45 million years of better quality life, with multiple related economic benefits, could be gained by investing in healthy ageing across the life-course.[26] Meanwhile, the International Longevity Centre-UK has estimated that across G20 countries, preventable conditions cost economies $1.02 trillion USD in yearly productivity loss among those aged 50-64 alone. This is roughly equivalent to the estimated loss in global worker income for the first half of 2021 as a result of COVID-19.[27]

"The truth is current programmes or provisions of the government are unfit and incompatible or inappropriate for the needs of older persons."

Older person, Philippines

Box 3: Who is most at risk of being left behind?

Older people are not a homogenous group. Large inequalities exist both between and within countries in the extent to which all people are able to enjoy healthy ageing and their equal right to health. Although some of the diversity we see in older age reflects genetic inheritance or the choices made by people across their lives, much is influenced by factors beyond an individual's control.[28] The impact of unequal power relations, inequalities and discrimination experienced by people on the grounds of age, sex, gender, functional ability, socio-economic status, ethnicity, religion, legal status, sexual orientation or other grounds, intersect and accumulate across life-course, and can lead to compounded disadvantage in later life. These inequalities have a profound impact on people's health and wellbeing, and often result in those with the greatest needs for health and care services being least able to access them.

Which older people are most likely to be left behind depends on the context but is likely to include poorer older people, the oldest old, older women, older people with underlying health conditions, older people with a disability and/or care and support need, older people with lower levels of education, older people from minority ethnic or religious groups, older members of the LGBTQI+ community, migrants, refugees and internally displaced persons, and those living in remote, insecure, or fragile environments, contexts or settings. For more exploration of who is most at risk in being left behind in UHC, see HelpAge's report, *Older people's perceptions of health and wellbeing in rapidly ageing low- and middle-income countries.*

An equity-based approach to UHC demands that we consider the diversity of older people when designing policies, and programmes and engage them directly to identify who is most at risk of being left behind in different settings and how we can most effectively tailor UHC to meet their needs and fulfil their rights.

YAKKUM Emergency Unit/HelpAge International

"There are no support services available to older people in my community. Only family members are taken as or believed to provide assistance with daily activities. But this does not happen for all."

Older woman, Nepal

"There is no service for palliative care in the community, the health centre is at a distance of 10 km and the nurse performs care once a month."

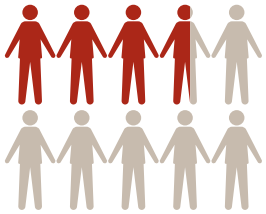
Older person, Bolivia

"[The health clinic] is too far for me to walk to. It takes a day to get there on foot and I don't have enough money to go by bus."

Older woman, Mozambique

"The infrastructure is not friendly at all. There are no proper toilets at the hospital and also no ramps for older and disabled people."

Older person, Kenya



Over a third of 3,658 older people said they faced difficulty in accessing health services.

Box 4: Older people's physical, mental, psycho-social and cognitive health and care needs

There is great diversity in how people age. Many older people maintain high levels of intrinsic capacity and functional ability well into later life. However, as people age, they are generally more likely to develop a health and care and support need.

Common conditions experienced in later life including hearing loss, cataracts and other eye disorders, back and neck pain and osteoarthritis, and leading non-communicable diseases (NCDs), including chronic obstructive pulmonary disease, hypertension, diabetes, cancers, depression, and dementia. As people age, they are also more likely to experience several conditions at the same time ('multi-' or 'co-' 'morbidity'). For example, just over half of people aged 60 years and over living in the community globally are estimated to live with two or more health conditions, 'multimorbidity', with rates for all adults higher among women (39.4 per cent) than males (32.8 per cent).[29, 30] These conditions are often a result of multiple underlying factors and include frailty, urinary incontinence, falls, delirium and pressure ulcers.[31] The presence of these conditions, coupled with ageing immune systems, means many older people are also at greater risk from infectious diseases.

The presence of a long-term condition or co-morbidity is closely associated with limitations in a person's intrinsic capacity and experience of a disability (see box 5). This may affect someone's ability to perform activities of daily living (ADL) and increase their likelihood of needing care and support.

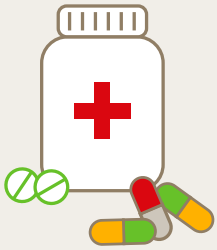
However, ageing is malleable. With the right interventions, delivered in the right place, at the right time, it is possible to prevent, delay or reverse the onset of more acute health and social care needs and ensure older people can maintain the functional ability that enables wellbeing in older age.[32]

Poor physical access

With a lack of primary health care delivered close to home, accessing services for many older people in low- and middle-income countries is impossible. In Sub-Saharan Africa, approximately 10 per cent of people aged 60 years and over across the region have an estimated travel time to the nearest hospital of 6 hours or longer and an estimated travel time of 2 hours to the nearest health facility of any type.[33] This was as high as 41 and 59 per cent of older people respectively in Sudan. For many older people with mobility issues, these facilities are simply out of reach. In one study in Thailand, researchers found that the likelihood of an older person not using a health care service increased by about 30 per cent with each additional kilometre they had to travel to the health care service.[34]

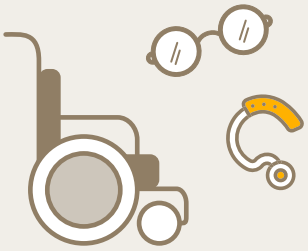
Many older people with disabilities find that, even if they can reach health services, they are not accessible. This might be due to lack of ramps, long queues, lack of suitable toilet facilities, or due to services not meeting the needs of different groups, including needs related to the provision of information and communication.

During COVID-19, rapid needs assessment carried out by HelpAge and partners in 12 low- and middle-income countries during 2020, found that over a third (37 per cent) of 3,658 older people surveyed faced difficulty in accessing health services.[35]



Only 54%

of 194 countries surveyed by WHO report general availability of 11 essential medicines for NCDs which are more common in later life.



Access to assistive technology for those who need it varies globally and is as

low as 3%

in some countries.

"Medicine prices have gone up and it is affecting our health as older people. Sometimes we get a dosage that is not enough because the money is not enough. Medicine is scarce and expensive in a way that we cannot afford to buy it, and we think we are going to die. We get sick and we no longer go to the hospital due to high transportation costs and now we cannot even afford to just buy at the pharmacy; the only thing left is for us to die."

Older woman, Malawi

Lack of access to medicines, vaccines, and assistive technologies to promote healthy ageing

Medicines, vaccines and assistive technologies are essential for supporting people's intrinsic capacity, functional ability and quality of life. Yet they are often unavailable to older people in low- and middle-income countries.

Despite the growing impact of NCDs in all settings, only 54 per cent of 194 countries surveyed by WHO in 2021 reported general availability of 11 essential NCD medicines,[36] with one in five countries (20 per cent) reporting only six or fewer were generally available. In a study conducted by HelpAge in Ethiopia, Mozambique, Tanzania and Zimbabwe, older people reported being unable to access medicine either because it was not available free of charge or, in many cases, not available at all.[37]

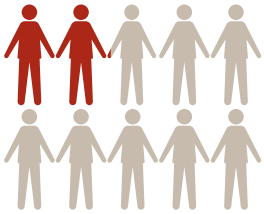
WHO estimates that 2.5 billion people – or 1 in 3 people – need one or more assistive products, such as wheelchairs, hearing aids, or apps that support communication and recognition, rising to two thirds (69 per cent) of older people,[38] but that nearly one billion people of all ages are denied access. This is particularly the case in low- and middle-income countries, where access can be as low as 3 per cent.

WHO also advises annual vaccination against influenza for people aged 65 and over and yet less than half of the countries around the world have a national immunisation programme targeted at older people.[39] In the most recent data, while per cent of countries have a vaccination policy for seasonal influenza, only 13 per cent have a policy for pneumococcal and 5 per cent for herpes zoster (shingles) vaccination.[40]

During COVID-19, despite older people being the age group most at risk of severe disease and death from the virus, millions of older people in low- and middle-income have faced barriers to accessing COVID-19 vaccines, tests and treatments.[41] As late as May 2022, less than 5 per cent of older people were vaccinated against COVID-19 in some countries, and were less likely to be vaccinated than younger age groups in some settings.[42]

Lack of accessible information and health education

Access to health-related information and education is a critical determinant of health and wellbeing and a key component of the right to health itself. But older people often lack accessible information and education about their health. This includes information and education on: health promotion and disease prevention; self-care and the effective management of long-term conditions; older people's health rights and entitlements; and how to access services and support.



21 per cent of 3,658 older people said they faced barriers in accessing COVID-19 information.

Where information is available, it is often not provided in a variety of languages, channels or formats to meet the communication needs of different groups, including offline, in easy-to-read versions, spoken word, picture format or braille. People who have disabilities that affect their hearing, speaking, reading, writing or understanding, and who communicate differently from people who do not experience these disabilities, commonly report communication barriers to accessing health information.[43]

Literacy levels, including levels of health literacy, are lower among older age groups than younger sections of the population.[44] The World Health Survey found that 1 in 10 older people did not know where to go to access healthcare when they needed it.[45] This is lower for certain groups of older people, including but not limited to older women, older people with disabilities and/or older people who have a lower level of educational attainment.

Rapid needs assessment carried out by HelpAge and partners in 12 low- and middle-income countries during 2020, found that one fifth (21 per cent) of 3,658 older people surveyed said they faced barriers in accessing COVID-19 information, despite being the age group most at risk.

"The mere thought of sickness terrifies me because we do not have any social safety net, healthcare coverage, or protection. Who would care for our fate?"

Older woman, Lebanon

"I spend most of my pension on the medication I need. I am lucky to have children who support me but others have to choose between buying food, having the gas or electricity at home or buying medicine."

Older woman, Kyrgyzstan

"I live with the disease since I do not have money to be treated."

Older woman, Kenya

Prohibitive cost

Poverty is one of the main threats to people's health, wellbeing and dignity worldwide and, in most countries, the risk of poverty increases with age.[46] In 2019, an estimated 2 billion people experienced financial hardship due to out of pocket spending on health, with older households most at risk of catastrophic health spending (meaning that more than 10 per cent of their household income was spent on health related costs), and intergenerational households including older people are most at risk of impoverishing health spending (health care spending pushing them below the poverty line).[47]

With limited access to health insurance and high out-of pocket costs for accessing services, medicines and assistive products, many older people tell us that they have no choice but to forgo seeking healthcare, or face impossible choices between health and other basic needs.

Workforce challenges

Alongside considerable general challenges facing the global health workforce, with WHO estimating a projected shortfall of 10 million health workers by 2030, mostly in low- and middle-income countries, older people often find that health and care workers lack the training to meet their needs and uphold their rights. Today, in many countries, the general training for the health and care workforce fails to include geriatrics or gerontology and, in some places, even a basic focus on the types of physical, mental, psycho-social and cognitive health issues faced in older age is missing.

Of the 130 countries that responded to the Decade of Health Ageing Progress survey in 2023, only 64 per cent reported having capacity-building plans to strengthen the geriatric and gerontology workforce, though this was just 21 per cent in low-income countries.[48]

"When you go to the hospital, they say, 'This one is too old, we are wasting medicine, it's better she dies.' And if a younger woman goes, they know that she still has more years to live."

Older woman, Kenya

"The employees of the health system or public servants are imposing; they do not have the attitude of listening to us to know what we want or need. They simply decide for us and give orders."

Older person, Columbia

"There are various levels of committees that are being initiated by government from grassroot to top-level but there are no older people representatives on them."

Civil society representative, India

"People who provide these services have a negative attitude towards older persons so we just avoid them."

Older woman, Uganda

A 2015 survey of medical schools in 11 African countries found that only 4 per cent had a geriatrics specialty, and nearly half offered no geriatrics training at all. This was attributed to a lack of staff expertise and funding, together with the absence of geriatrics in national curriculums.[49]

A key challenge for older people is also the failure to provide adequate pay, support and training to the mainly female underpaid, unpaid and volunteer caregivers who provide the vast majority of health and long-term care and support to older people in all countries. This situation is a key human rights challenge for older people who need care and support to meet their basic needs and for those providing care without adequate support – including older people who are caregivers themselves.

Ageism and discrimination

Older people often face ageism and age discrimination that violates their right to access health and care related goods, facilities and services on an equal basis with others. Where discrimination on the basis of age intersects with discrimination on the grounds of other characteristics the impact is compounded.

Structural failures in responding to older people's health and care needs and to ensure their inclusion in policy, services and data systems (see below), are often reinforced by more explicit ageism.[50]

Older people frequently report that the behaviour of health workers is a barrier to accessing the services they need.[51] They say their health issues are often dismissed as 'old age' or that they are treated like a burden. Ageism is particularly prevalent within some services. For example, within sexual and reproductive health (SRH) where the needs of older women and men are often neglected, and older people struggle to access appropriate advice or care (see box below). In several countries, this is contributing to a growing burden of sexually transmitted infections (STIs) and HIV and AIDS in older people.[52]

Limited quantitative data is available on older people's experience of ageism in accessing health services. However, in the U.S. about 20 per cent of people over 50 reported experiencing age-based discrimination in healthcare, according to U.S. National Health and Retirement data.[53] In a survey of ageing experts from across Europe, meanwhile, 80 per cent were worried about the standard of care they would receive in older age. Fifty-one per cent felt that older people were significantly less likely to receive adequate assessment and treatment compared with younger people.[54] During COVID-19, older people's right to health has been denied where age has been used as a basis for deciding who has access to scarce COVID-19 treatment, or when non-COVID-19 related health and care services which they rely on have been suspended, leaving them with unmet needs.[55, 56, 57, 58]

Failures to support older people's engagement, empowerment, independence and autonomy in their health and care

Older people are often not engaged and empowered effectively in the health and care they receive or given a voice in decision making processes. This denies them their right to participation and autonomy, and also leads to poorer individual and service level outcomes.

Older people often report that health and care professionals and family and friends exclude them from decision making about their health and care, or fail to support their engagement and empowerment in their health and wellbeing.[59] At the policy level, older people and those working with them are often excluded or not given the opportunity or support they need to meaningfully engage in the design, planning and delivery of health and care services.

On the one hand, this misses valuable opportunities to ensure older people have the right knowledge, skills and confidence to take action on their own health, which can help avoid or delay the onset of more acute care needs and help promote people's

quality of life. On the other hand, failing to engage and empower older people in decision making denies them their right to choice, participation, independence and autonomy.

Failing to support older people's meaningful participation in decision making also leads to poorer service design and outcomes. Such failures have been seen during the COVID-19 pandemic where older people and organisations working with them have been excluded from key decision making processes, despite them being the age group most at risk from the virus.[60]

Older people are not counted

For older people to be included they must also be counted. However, older people are often excluded from official statistics at local, national and global levels and data is not disaggregated to capture the diversity within older age groups.

Current measures of UHC, including the 'access' indicator (3.8.1) in the SDG indicator framework, do not include indicators such as physical access to health facilities, or staff skills, knowledge and attitudes – factors that are critical to understanding the barriers faced by older people. The indicator includes measures of a number of essential health services of relevance to older people's health needs, including for hypertension and diabetes. However, this indicator relies on age-limited data sources, including the WHO STEPS NCD Risk Factor Survey (STEPS), which usually only includes people up to the age of 69, and the Demographic and Health Surveys (DHS), which usually exclude women over the age of 49 and men over the age of 54. Similarly, despite NCDs having a disproportionate impact on people in older age, SDG 3.4 on NCDs focuses on the ageist target of reducing 'premature mortality' by one third by 2030, defined as death between the ages of 30 and 70. What gets measured gets done, and discriminatory age caps in data systems reinforce and perpetuate wider discrimination in policy and practice.

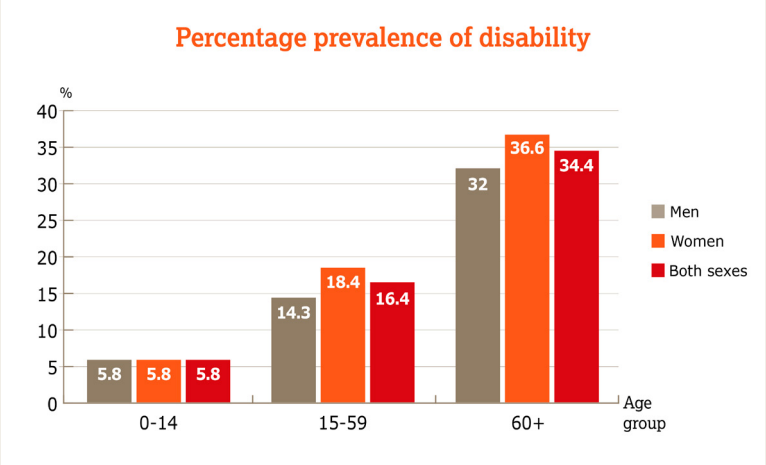
Even where data is collected on older age groups, it is rarely adequately disaggregated. Systems often fail to collect, analyse, report and use sufficiently disaggregated data for capturing the diversity of older people, understanding their health and care needs and preferences, access to services and outcomes to inform system and service design.

David Lomuria/HelpAge International

Box 5: Disability, ageing and the right to health

Experience of disability increases with age and, globally, around 34.4 per cent of older people experience a significant disability, with rates higher among women than men.[61] Leading causes of disability among older people include sensory impairments, back and neck pain, chronic obstructive pulmonary disease, depression, falls, diabetes, dementia and osteoarthritis.[62]

Disability prevalence is increasing due to ageing populations and an increase in the prevalence of NCDs, including diabetes, cardiovascular diseases, cancer, respiratory illnesses, and mental, psycho-social and cognitive health issues, including dementia. Globally, it is estimated NCDs contribute to 80 per cent of all years lived with disability.



Despite people with disabilities often, though not always, having greater health and care and support needs, people with disabilities face multiple barriers to enjoying their right to health and access to quality health and care services that meet their needs without suffering financial hardship. Physical, communication, attitudinal, social, structural and financial barriers experienced by people with disabilities of all ages mean they are three times more likely to be denied health care, four times more likely to be treated badly in the health care system, and 50 per cent more likely to suffer catastrophic health expenditure.[63] These barriers can be exacerbated due to intersecting discrimination and exclusion on the grounds of age, gender, poverty, ethnicity, as well as other characteristics.

Delivering disability inclusive UHC means understanding and responding to the rights and needs of persons with disabilities; recognising how disability intersects with other characteristics including but not limited to age and gender; and ensuring disability inclusion is mainstreamed into health systems and progress towards UHC to address barriers that persons with disabilities face to accessing goods, facilities and services and enjoying their right to health.[64]

In 2022, WHO launched the *Global report on health equity for persons with disabilities* and set out 40 actions that all governments must take to meet their obligations under international human rights law to address the health inequities faced by persons with disabilities of all ages.

Ben Small/HelpAge International

Box 6: Delivering gender-transformative UHC across the life-course

The Political Declaration on UHC committed governments to 'mainstream a gender perspective on a systems-wide basis when designing, implementing and monitoring health policies, taking into account the specific needs of all women and girls, with a view to achieving gender equality and the empowerment of women in health policies and health systems delivery'. To leave no one behind, UHC must respond to the needs and rights of women and girls across the life-course, including those of older women.

Women have a longer life expectancy than men and, partly as a result of this, are likely to spend a greater proportion of their lives in ill health or with a disability. As a result of inequalities in power relations, unequal distribution of care responsibilities, discrimination and exclusion on the grounds of gender across the life-course women are also more likely to face multi-dimensional poverty in older age.[65, 66] This has a profound effect on health and wellbeing and on women's access to health and care services.

Women aged 50 and over make up 27 per cent of all women globally, yet they are almost entirely left behind in health policy. Services and health programmes often fail to consider older women's specific needs, including but not limited to those related to menopause and post-menopause, higher rates of heart disease, risk of stroke and osteoporosis.[67] Older women are nearly always excluded from sexual and reproductive health programmes which focus on women of reproductive age. Yet 15 to 50 million women per year are injured or seriously disabled during childbirth, suffering from conditions such as severe anaemia, incontinence, damage to the reproductive organs or nervous system, chronic pain, and infertility. These conditions can worsen in later life, leading to greater dependence, lower quality of life, increased marginalisation and vulnerability, and overall reduced capacity.[68]

Ganesh Bista, Ageing Nepal

Older women also often struggle to access appropriate advice or care related to their sexual health, contributing to the growing burden of sexually transmitted infections (STIs) and HIV and AIDS in this group.[69] This is especially concerning in East and Southern Africa, where, despite progress, HIV continues to have a significant and complex impact on older people, both as people living and ageing with HIV/AIDS and as caregivers for orphaned and vulnerable children, or providing care for people with HIV/AIDS.[70]

Gender-based violence can occur across the life course and may be exacerbated in older age, with the intersection of ageism and sexism resulting in older women being subject to new and distinct forms of violence and abuse. Yet older women remain invisible in datasets on gender-based violence and are routinely excluded from policy and programmes to prevent and address violence against women and girls.[71]

At the same time as facing often more complex health and care needs across their lives, women of all ages – including older women – are the main providers of health and care globally, both formally and informally.[72] As many as 70 per cent of the global healthcare workforce is female.[73] Women and girls of all ages, including older women are also estimated to do at least two and a half times more unpaid household and care work than men, including care for older people.[74] The level of unpaid care women and girls provide has been further increased during the COVID-19 pandemic with people stuck at home and with key services and external support disrupted. This has had a profound impact on caregivers, including in terms of income and physical and mental health and wellbeing.

Women of all ages therefore stand to gain the most from the development of comprehensive, integrated and community-based approaches to UHC that meet the continuum of health and care needs of older people – including older women. This critically must include long-term care and support systems which have a transformative role to play in recognising, reducing, redistributing and rewarding the unpaid care work carried out by women and girls of all ages. A rights-based approach to UHC system and service design, delivery, monitoring and evaluation (see below) is also critical for ensuring the representation of women and girls of all ages in UHC.

For more information, see HelpAge's briefing *Achieving gender transformative Universal Health Coverage*

Achieving UHC fit for an ageing world

Progress towards Universal Health Coverage presents an opportunity to reorient health and care systems to meet the needs of an ageing world, uphold the rights of older people and reap the benefits of healthy ageing for individuals, systems and societies.

To achieve this vision, governments and UHC stakeholders at all levels must…

Champion age and disability inclusive and gender responsive health and care systems that deliver equitable, integrated and person-centred services, founded upon strong primary health care approaches promoting healthy ageing for all.

This must include:

1. Addressing the barriers older people face to enjoying their right to health

To achieve UHC fit for an ageing world and promote healthy ageing for all, UHC must address the barriers older people face to enjoying their right to health.

This necessitates health and care related goods, facilities and services being:

- **Available** – Older people must have access to health and care goods, facilities and services covering the full continuum of health promotion, prevention, treatment, specialist care, rehabilitation, palliative and end-of-life care, and long-term care and support
- **Accessible** – Older people must have:
    - physical access to health and care services, goods and facilities, incorporating a universal design based approach and providing reasonable accommodation for persons with disabilities[75] to ensure products, environments, programmes and services are usable by people of all ages and abilities.
    - access to affordable health and care services, goods and facilities.
    - access to health and care information in accessible and appropriate formats.
- **Acceptable** – Older people must have access to care that is appropriate and respectful of their culture and responsive to their diverse needs and preferences.
- **Good quality** – Older people must have access to health and care services, goods and facilities that are safe, effective (evidence-based), timely, equitable, integrated, efficient and person-centred, addressing older people's health and care needs holistically.
- **Equality and non-discrimination** – Governments must take effective and appropriate measures to:
    - prohibit and prevent discrimination against older people on the basis of age or any other status in the provision of health and care services
    - ensure older people have access to health-related goods, facilities and services on an equal basis with others
    - ensure health-related goods, facilities and services respond to older people's specific needs.

2. Investing in the building blocks of a health system fit for purpose in an ageing world

All health and care system building blocks must consider and respond to the rights and needs of older people:

Services

Services must deliver inclusive, integrated and person-centred care, founded upon strong primary health care approaches that holistically meet older people's health and long-term care and support needs and preferences.

Services must be delivered as close to home as possible and founded upon strong primary health care approaches that engage and empower people and communities, meeting the needs of the furthest behind first.

UHC service coverage must progress towards delivering the full continuum of essential health and long-term care and support services, including those related to communicable and non-communicable disease, and their mental, psycho-social and cognitive health and wellbeing Box 2: UHC continuum of essential integrated services

Services should focus on promoting people's intrinsic capacity, functional ability and quality of life. Care must be person-centred, integrated, well-coordinated and inclusive, responding to older people's needs and preferences in a holistic way and in line with a human rights-based approach (see below).

Box 7: Primary health care approach[76]

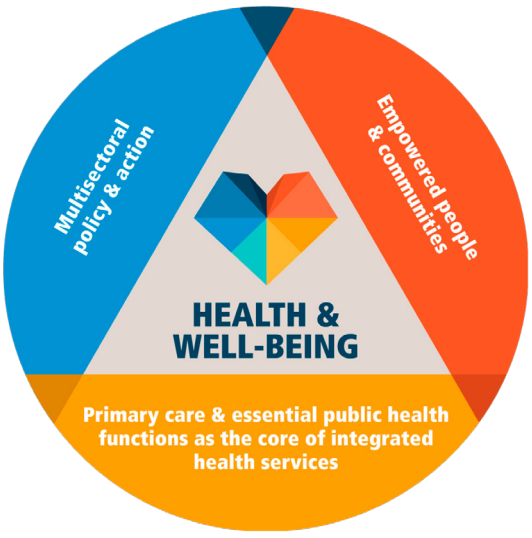
Primary Health Care (PHC) is the foundation for achieving Universal Health Coverage and the most effective approach for delivering comprehensive, accessible, integrated and person-centred services that promote people's intrinsic capacity, functional ability and quality of life at all ages.

It is estimated that 90 per cent of essential services can be delivered through primary health care,[54] while evidence suggests that PHC can produce a range of economic benefits by improving health outcomes, health system efficiency and health equity.

A primary health care approach includes three components:

- meeting people's health and care needs throughout their lives;
- addressing the broader determinants of health through multisectoral policy and action; and
- empowering individuals, families and communities to take charge of their own health.

Components of primary health care



Source: World Health Organization

Workforce

A well-paid, well-trained and well-resourced multidisciplinary health and long-term care and support workforce must be able to respond effectively to the diverse and more complex needs of ageing populations through the provision of high quality care across the full continuum of UHC services.

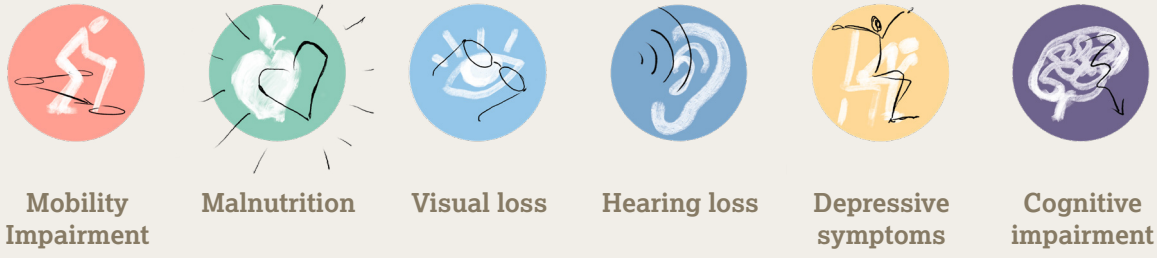
The workforce must be able and equipped to provide integrated and person-centred care that addresses people's physical, mental, psycho-social and cognitive health and long-term care and support needs holistically. They should be trained in age- and disability-inclusion and promote a human rights-based approach to service delivery, including by promoting autonomy, dignity and effectively engaging and empowering older people in their health and wellbeing.

The workforce must have the knowledge and skills to be able to deliver medicines, vaccines, and assistive technologies that support healthy ageing, including through harnessing digital technologies.

Policy must promote decent work and gender equality, ensuring all health and care professionals have the support they need to deliver good quality care. It must also address how unpaid care work, carried out mostly by women and girls of all ages, can effectively be recognised, reduced, redistributed and rewarded, ensuring those providing care are represented in decision making spaces and supported to deliver high quality care and support.

Box 8: Integrated Care for Older People (ICOPE)

WHO's Guidelines on Integrated Care for Older People (ICOPE) provide evidence-based recommendations for improving the health and wellbeing of older people and moving closer to the achievement of universal health coverage for all at all ages. ICOPE promotes a person-centred and coordinated model of care founded upon a primary health care approach and focused on optimising older people's functional ability. ICOPE involves holistic, person-centred assessment, including screening for losses in intrinsic capacity and understanding a person's life, values, priorities and social contexts. A personalised care plan is then developed to ensure seamless referral and coordinated services are delivered to enable an individual to achieve their self-identified goals. Interventions are delivered in the home and community by multidisciplinary teams that work together to optimise care. Interventions include managing declines in intrinsic capacity, providing care and support, promoting self-management, and provision of support to caregivers. Key domains of intrinsic capacity the interventions address include: mobility, nutrition, vision, hearing, cognitive capacity and psychological capacity.



Source: World Health Organization

Ben Small/HelpAge International

Access to medicines, vaccines and assistive technologies

UHC packages and essential medicines, vaccines and assistive products lists must include the tools and technologies recommended for addressing the conditions most common in later life and for promoting people's intrinsic capacity, functional ability and quality of life.

Medicines, vaccines and assistive technologies must be available and accessible to people of all ages to support healthy ageing, including those which address NCDs, age-related conditions and disability.

Health and care professionals must have the knowledge and training needed to appropriately prescribe and support the use of health and care related goods and be trained to effectively support people with multiple conditions, including managing polypharmacy in older age groups.

Information and data systems

Data systems must provide information on all components of people's right to health and long-term care and support disaggregated by age, sex, disability, location and socio-economic status, as a minimum.

Data systems and research must provide the information needed to understand and address older people's diverse physical, mental, psycho-social and cognitive health and care needs and their access to services to inform equity-based decisions about system and service design and planning. This must include strengthening civil registration and vital statistics (CVRS) and ensuring population health surveys, including the Demographic and Health Survey, remove age caps and gather data on older people.

Information systems must provide evidence on and support the delivery of high-quality, person-centred and integrated care across the full continuum of essential services in line with people's right to health. They should also aim to provide information on the extent to which people are engaged and empowered in their health and long-term care and support.

Measures of UHC and other global health monitoring frameworks must include older people by removing age-caps in indicators, including ageist concepts such as 'premature mortality', and by including indicators on older people's access to services, on the training of staff working with older people, distance to health centres, and on the affordability and availability of appropriate medicines and assistive products.[77]

Box 9: WHO's Priority Assistive Products List and Training in Assistive Products

The Priority Assistive Products List was the first step of WHO's GATE initiative towards improving global access to assistive products for everyone, everywhere. The list includes essential items for many older people and persons with disabilities to be able to live a healthy, productive and dignified life, including hearing aids, wheelchairs, communication aids, spectacles, artificial limbs, pill organizers, memory aids and other essential items.

WHO also recently launched open access online training resource to increase the assistive technology workforce. Training in Assistive Products (TAP) is targeted at the primary health care and community workforce, as well as those providing services to people who need assistive products within other sectors. TAP has been developed over a number of years and with a range of partners, including HelpAge and our network. It is currently available in Arabic, Chinese, English, French, Georgian, Kiswahili, Portuguese, Russian, Spanish and Ukrainian.

Box 10: Minimum Standards for Sex, Age and Disability Disaggregated Data

HelpAge has developed Minimum Standards for Sex, Age and Disability Disagregated Data Minimum. This sets out HelpAge International organisational standards regarding when, how and some of the reasons why Sex, Age and Disability disaggregated data should be collected. It also provides a step-by-step example of how to code and analyse this data.

Financing

Those most at risk, including older people with the greatest health and care needs, must be prioritised in progress towards increasing financial coverage for the full continuum of UHC services, with the ultimate goal of care being available free at the point of delivery for all.

Current funding levels are insufficient to achieve UHC by 2030. There is an urgent need for governments to invest more and invest better. They must commit to mobilising public resources for health and care through equitable and mandatory resources as part of prioritising health and care, and healthy ageing, within a sustainable macroeconomic framework, including committing to spend at least five percent of Gross Domestic Product (GDP) on health and moving progressively towards this target.[78] Governments must also work to improve efficiency and equity in the use of existing resources, increasing pooling mechanisms and reducing reliance on impoverishing out-of-pocket payments. Purchasing arrangements should drive quality of services and incentivise health promotion and disease prevention, including through prioritising primary and community-based services.

Vitaliy Konovalov/HelpAge International

Governments should progressively move towards financial coverage for the full range of essential services, medicines, vaccines and assistive technologies needed to promote people's intrinsic capacity, functional ability and quality of life at all ages, ideally with services being available free at the point of delivery. To ensure equity in progress towards this goal, focus must be given to extending services and financial coverage to meet the health and long-term care and support needs of those furthest behind first, including older people who experience the highest levels of needs and face the greatest risk of catastrophic and impoverishing health costs. Progress should be informed by data and analysis on equity in health and care service access and financing.

At global level, Development Assistance for Health must better respond to the health and care needs of populations across the life-course and move away from single disease programming towards greater investment in health system strengthening and the delivery of integrated primary health care approaches that promote healthy ageing for all.

Governance and leadership

There must be political commitment to achieving UHC and healthy ageing at the highest levels underpinned by legislation and a strong policy framework that protects and promotes the right of people of all ages to health and long-term care and support.

UHC must be driven through whole-of-government, whole-of-society and health-in-all policies approaches that promote health and wellbeing for all at all ages and address social determinants of health, including by adopting a One Health approach and promoting global health security.

There must be strong political leadership for achieving age- and disability-inclusive and gender-responsive UHC, founded upon a human rights-based approach to system and service design and delivery (see below).

The right to health and to long-term care and support should be incorporated into national law and accompanied by comprehensive and fully funded policy frameworks that support strong coordination and integration within and across the health and care system and with other sectors.

3. Promoting a rights-based approach, ensuring the voices of all groups, including older people, are heard within system and service design, delivery, monitoring and evaluation

Human rights principles must be upheld in all areas of service design, delivery, monitoring and evaluation. This includes:

Participation

Health and care systems are everybody's business and must engage individuals, communities, civil society and private sector. All groups of older people must be able to participate in system and service design, with support if necessary, to ensure that their voices are heard and that they have agency and influence in decision making processes at all levels.

Accountability and transparency

Those involved in provision, commissioning and policy-making for health and care must be accountable for all areas of system and service design, delivery, monitoring and evaluation. Effective and transparent feedback, complaints and redress mechanisms must be in place and accessible to all.

Non-discrimination and equality

All older people must be able to enjoy equitable access to services which meet their specific needs without discrimination of any kind. Older people have intersecting identities based on their age, gender, functional ability, ethnicity, religion and many other grounds. Each of these identities must be considered and respected, and the needs of different groups of older people must be responded to effectively in system design and in service delivery.

An equity-based approach to UHC means reaching the furthest behind first. This demands that we consider the diversity of older people when designing policies and programmes and engage them to identify who is most at risk of being left behind and how we can most effectively tailor UHC to meet their needs and fulfil their rights.

An equity-based approach to UHC means reaching the furthest behind first. This demands that we consider the diversity of older people when designing policies and programmes and engage them to identify who is most at risk of being left behind and how we can most effectively tailor UHC to meet their needs and fulfil their rights.

Empowerment

All older people must have the information and support they need to understand their rights in relation to health and care and how to claim these rights. Older people must be given a voice in decision making processes at all levels and be informed and empowered to exercise their rights in relation to the care they receive, including their right to choice, independence and autonomy. Where they exist, substitute decision making regimes must be abolished and systems and policies for supported decision making should be developed to ensure that all groups have appropriate information, training, advocacy and support, in line with their rights, needs and preferences.[79]

Legality

The right to health and the right to long-term care and support should be included in legislation. A human rights-based approach to policy and practice should be embedded into the work of all public authorities and all health and care providers. Legislation and regulation should be in place to ensure services are delivered in line with human rights law, with explicit prohibition of discrimination on the basis of age or any other grounds, and clear processes for taking effective action against any breaches of these rights. This includes but is not limited to UN Declaration of Human Rights; Covenant on Economic, Social and Cultural Rights; the Convention on the Rights of Persons with Disabilities (CRPD); and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). Governments should also support calls for a United Nations convention on the rights of older people to provide a comprehensive international framework to promote and safeguard the rights of us all as we age.

Ben Small/HelpAge International

How HelpAge and partners are driving progress on achieving UHC fit for an ageing world

HelpAge and its global network members in over 90 countries work together with health and care stakeholders at all levels to promote healthy ageing and older people's right to health in both development and humanitarian settings. We engage in broad based advocacy, conduct research, provide technical expertise, deliver projects and programmes, and work with older people and their communities from grassroots to global levels to effect change. We are a non-state actor in official relations with WHO and an active collaborator within all areas of the UN Decade of Healthy Ageing.

Below are some examples of how the HelpAge network is supporting progress on key components of achieving UHC fit for an ageing world at different levels.

Community-based approaches to promote healthy ageing and older people's right to health

Our community approaches promote older people's role in healthy ageing and their enjoyment of their right to health. We implement evidence-based interventions for promoting self-care and supporting older people's access to quality health and care services. We work with governments, UN agencies, researchers and other civil society actors to support the development of older people led community-based groups (CBGs) and older people's associations (OPAs). These groups become equal partners in the design, implementation, monitoring and evaluation of community healthy ageing approaches. This includes activity focused on addressing demand and supply side barriers to the enjoyment of their right to health, and supporting all groups of older people to access good quality health and care services that meet their needs.

HelpAge's VOICE framework reflects our community-based approach. It outlines the way we work across regions and countries to support older people's voices to be heard at all levels and for key PANEL principles (see above) to be promoted in all sectors – including within health and care systems and services.

One example of this work is the SANAII project that HelpAge delivered from 2018–2021 in partnerships with country offices and network members, including HelpAge Bangladesh, HelpAge Vietnam, HelpAge Cambodia and YAKKUM Emergency Unit (YEU) in Indonesia. Project activity focused on engaging older people and their communities in health promotion activity; supporting them to be informed and empowered to take action to demand their right to health at local, regional and national levels; and creating spaces for barriers to service access to be identified and solutions to be discussed collectively. It led to older people and communities taking action to amplify their voices and created opportunities for state-citizen interfaces allowing different groups of older people to raise their needs and rights with service deliverers. Overall, the project successfully contributed to older people's health and wellbeing through improving health promotion and health-seeking behaviour, and through strengthening supply-side health and care service responsiveness and accountability to older people.

Read more about our community-based approaches and our VOICE work here.

> *"Now we know many things about services, how to keep good health, about rapport building, [and how] to identify the problems of the community people and find ways to resolve the problems together."*
>
> Older man, Bangladesh

Duc Le/HelpAge International

Scaling up primary health care interventions for non-communicable disease

The Scaling up Non-Communicable Disease Interventions in Southeast Asia (SUNI-SEA Project) 2019–2023, was an action research project implemented in Vietnam, Myanmar, and Indonesia, through a consortium of partners, including research institutes based in Europe and in Vietnam, Myanmar and Indonesia. The aim of the project was to inform policy and strategy for evidence-based, effective, efficient, and feasible scale up of NCD interventions to reach more people. The project worked in close collaboration with and builds upon the work of government and other sectors.

Community NCD interventions were implemented by community-based organisations with the support of volunteers in Vietnam and Myanmar. Following skills building, the volunteers conducted community level screening for NCDs, planned and facilitated health promotion sessions, motivated people for peer support and self-care activities, referred people at risk of NCDs to the health facility and monitored, reported and evaluated their activities. In Vietnam, the project activities were implemented at primary health care facility level by government partners with support from the in-country research institutes. Activities include strengthening the quality of NCD care and treatment services through health centre management training, capacity building, update of service guidelines, development of user-friendly job aids, supportive supervision, and strengthening the linkages between the community and local health facilities. Digital technology was used to support stronger community-based NCD screening, management and data in Vietnam, and for self-screening and health promotion in Myanmar. In Vietnam, 295 health volunteers were trained in best practice screening and health promotion alongside 126 commune-health staff who strengthened their capacities around screening, diagnosis and treatment for NCD. In Myanmar, where the context was different, 30 health volunteers were trained and a self-screening mobile application tool was used to reach close to 2000 people, who are now able to regularly screen for diabetes, hypertension and cardiovascular disease, alongside common mental health conditions. In Indonesia 100 health cadres were trained.

Through its activity, the consortia demonstrated that; community interventions, led by older people, boosts self-care, and increases awareness about NCDs, underlining as well that adopting a community-based approach, integrated with strong primary

health care, is key to achieving UHC and improving health outcomes. To work well, community health services must be community-led, people-centred, and delivered through co-ownership. Furthermore, sustainable scaling up requires engaging local authorities and advocating for bottom-up funding to support implementation. Recognising gender dimensions and ensuring meaningful engagement of diverse populations, including those living with NCDs and mental health conditions, is essential for NCD responses. Finally, the project was able to demonstrate the effectiveness of community and PHC interventions. The investments in health promotion, prevention and early detection and treatment of NCDs pays off, as chronic diseases and complications are averted.

Read more here.

Promoting age-friendly health and care systems and services in Kenya and Mozambique

The Better Health for Older People in Africa Project (BHOPA) 2019–2022, was a comprehensive health system strengthening project implemented by HelpAge Kenya and HelpAge Mozambique in collaboration with network members. The project's objective was to make health systems more inclusive, responsive, and accountable to the needs of older people, particularly those with chronic diseases and disabilities. Activities focused on (i) strengthening and improving integration of formal and informal health systems and services in Kenya and Mozambique; (ii) national and regional level progress in the development, adoption and domestication of key policies influencing older people's health and inclusion in the health system; and (iii) robust evidence and lessons generation to support advocacy and health system strengthening.

"Before HelpAge came with this project, all the training we received as community health volunteers (CHVs) was not inclusive of older persons. We would mostly attend to women and children. But now, we are able to help older persons to access and get the services they need from hospitals. At the same time, we advocate for our health centres to have special places for attending to them."

Community health volunteer, Mozambique

The project strengthened integration and coordination between formal and informal health care systems through capacity building of the health workforce, both at health system level (clinical officers, nurses) and at community level (home-based care volunteers and community health workers), using WHO standard training materials for integrated care for older people (ICOPE). A total of 220 community health workers were trained on healthy ageing and supported to provide healthy ageing services, while 50 clinical officers and 220 nurses were trained on ICOPE.

At the community level, the project reached 29,000 older people with health and care information and services, including through referrals, while 1000 OPA members were trained on healthy ageing and 360 older citizen monitoring groups (OCMGs) received capacity building (see below). This activity successfully strengthened older people's leadership, participation and voice within health and care activity, and their

"We aired our opinion, worries, and the challenges that we encounter while we visit the health facilities, like the unavailability of medicines. You know, back in the days, even the health system would neglect older persons by telling them that they are suffering from old age, but after the implementation of the project, they can now access and get medical attention."

Older man, Kenya

Eva-Lotta Jansson/HelpAge International

skills for promoting healthy ageing, monitoring the access and quality of health and care services, and advocating for more inclusive and age-friendly systems. In Mozambique, the project contributed to improved access to free care in public hospitals for older people, covering consultation, treatment and medicines, by raising awareness of the policy of free medical services for older people in public hospitals among older people themselves and health workers. In Kenya, the work contributed to increased numbers of older people registering as members of National Health Insurance Fund (NHIF). Training of health and care staff and volunteers also led to more responsive services, outreach programmes, and referral processes. The project contributed to advancements at national policy level, particularly in Kenya where there was limited health and care policy for older people before the project. A draft national healthy ageing strategy is now in place and the development of national ICOPE guidelines will be rolled out in the coming year.

Strengthening data and accountability for age and disability inclusive, and gender responsive, services

Older citizen monitoring (OCM) involves older people at grassroots level monitoring the implementation of policies and services affecting their lives and using evidence they gather to advocate for change at local, national and international levels. Developed by HelpAge International and originally piloted with funding from the UK Department for International Development (DFID) in five countries in 2002, OCM has helped some of the most disadvantaged people hold government to account for the fulfilment of their human rights, enabling them to communicate directly with decision makers – sometimes for the first time in their lives. OCM aims to: (i) empower older people to claim their rights, (ii) help older people access existing services and schemes, and (iii) to use monitoring data for influencing policy, legislation and service delivery so they better respond to the needs of older people.

To date, over 3,000 older people's associations in 27 countries have engaged in OCM. Data has been collected and used for advocacy on a range of issues, including access to health and services and social protection, the inclusion of older people in local planning and budgeting, and in humanitarian responses. In Tanzania local advocacy has led to funding being allocated for NCD drugs, geriatric health units, identity cards used to access free health services, consulting rooms dedicated to older people in clinics, and access to counselling. In Bolivia, network member Fundación Horizontes worked with the National Older People's Association of Bolivia (ANAMBO) and used OCM to increase registration of older people to the health insurance, Older People's Health Insurance Scheme (SSPAM) which entitles Bolivians over 60 years of age, and with no other insurance, to receive free healthcare. In Pakistan, OCM has been used to support local OPAs and support organisations to collect sex-, age-, and disability- disaggregated data, make referrals and advocate for better access to assistance for those most at risk within emergency responses. An external evaluation of the programme highlighted the efficiency of the OPAs in responding quickly and cost-effectively, and their strong capacity for advocacy and identification of those who are most at risk of being left behind.

Read more about HelpAge's OCM work here.

Improving access to assistive technology

Between 2023-4, HelpAge and Age International worked with partners YAKKUM in Indonesia and HelpAge Tanzania on a project on improving access to assistive technology for older people and persons with disabilities. The project was funded by ATScale, the Global Partnership for Assistive Technology, United Nations Office for Project Services (UNOPS) and the United States Agency for International Development (USAID), and was part of a 12 country programme to strengthen assistive technology systems.

In Indonesia, where it's estimated over 40 per cent of people over 60 live with a disability, YAKKUM has worked with the government and other stakeholders to create a roadmap in Central Java Province for improving access to assistive

technology. This has included work to raise awareness and share best practice on AT delivery, identify communities in need, and make referrals to appropriate services. As part of the one-year project, over 500 people were registered and assessed for items like hearing aids and prosthetics, with 261 accessing AT. YAKKUM has also set up a working group – a government-endorsed legal entity – to provide leadership on improving access to AT services in Purworejo district and to design and implement an integrated service model for AT. At national level, an AT working group created in 2018 which was dormant has be restarted as a result of project activities.

In Tanzania, our partner HelpAge Tanzania has worked with partners, including the government and WHO, to establish a multi-sector working group to provide leadership and coordination on AT. They have provided support to conduct a national AT capacity assessment, in line with WHO guidance, and worked with a wide range of stakeholders, including older people and persons with disabilities, to develop a national strategy to improve systems, policies and budgeting for assistive technology. This activity has built on their previous work with WHO and HelpAge developing and piloting WHO's Training in Assistive Products which included training over 60 healthcare staff in Tanzania in identifying and meeting the needs of people who would benefit from assistive products.

Delivering home-based care and support in Vietnam

Intergenerational Self-Help Clubs (ISHCs) are a ground-breaking model, pioneered by HelpAge International in Vietnam working with local partners, including the Vietnam Association of the Elderly, the Vietnam Women's Union, and the Centre for Ageing Support and Community Development (CASCD). Having launched the model in 2006, Vietnam now has over 3,000 ISHCs nationwide with a total membership of over around 160,000 people. Roughly 70 percent of the members are older people, and many are among the more at risk groups.

The ISHC takes a comprehensive and inclusive approach that promotes healthy ageing through multi-sectoral interventions. This includes promoting physical and mental health and psychosocial wellbeing, as well as delivering home based care (HBC) and support. The HBC services are offered through trained homecare volunteers, each of whom works with 10 individuals to design joint care plans based on their needs, preferences and goals, which are then delivered through regular visits. Today, ISHCs are the largest care providers in the country with more than 16,000 caregivers providing regular and ongoing care to 10,000 plus clients. The work of the volunteers can include everything from providing a friendly ear, helping with housework, and taking the individual out for a walk, to helping with personal hygiene, monitoring blood pressure, and supporting with referrals.

In 2020 the work of the HelpAge team in Vietnam was awarded for its work in developing ISHCs by Asia Health and Wellbeing Initiative with the Healthy Ageing Grand Prize for Asian Innovation.

Read more here.

Improving the health and protection of at risk populations in Venezuela

HelpAge network member, Convité, is an NGO based in Venezuela focused on promoting human rights and social justice for groups most at risk, including vulnerable women, young people and older people. Between 2020-202, Convité, with the support of HelpAge, carried out a project focused on supporting older people and people with disabilities most at risk from COVID-19. The ECHO-funded project delivered interventions in five municipalities focused on improving health and protection interventions for at risk older people and people with disabilities, and strengthening the responses of local authorities, humanitarian actors and UN cluster system.

The project provided assistance to 1,216 older people, 73 per cent of whom were women and 61 per cent people with disabilities. Interventions included Psychosocial Support (PSS) through volunteers, home-based care provision and individual protection assistance (IPA). IPA included provision of medicines; provision of assistive products including, walking canes and frames, crutches, wheelchairs, urine flasks, toilet chairs, incontinence kits, pill organizers, glasses and pressure relief mattresses; provision of hygiene kits; delivery of hot meals; and referrals. An endline survey found 95 per cent of 455 sampled beneficiaries reported an improved feeling of safety and dignity, 97 per cent improved independence and/or ability to carry out daily tasks, 47 per cent general emotional wellbeing, 94 per cent reported feeling safer, and 96 per cent indicated that their lives were more dignified.

In addition, the project included strategic advocacy and coordination with humanitarian actors, including the UN cluster system, NGOs, local authorities and service providers. A key success was the establishment of an Age and Disability Technical Working Group within the Protection cluster led by UNHCR, to ensure the inclusion of the needs and rights of older people and people with disabilities within the humanitarian response.

Supporting access and uptake of COVID-19 vaccination in Tanzania

In September 2021, only 1.6 per cent of older people in Tanzania had been vaccinated against COVID-19, as a result of misinformation, ageism, limited exposure to reliable news in mainstream media and service access barriers. Working alongside UNICEF, HelpAge Tanzania embarked on a holistic programme to promote vaccine access and uptake. HelpAge staff spoke with older people, leaders and communities; they worked with volunteers and government health workers to spread the message; distributed clear, accurate information through their network of home-based care providers and Active Ageing Clubs; and held community intergenerational dialogues to share information and address questions and concerns. When they then organised eight mobile vaccination clinics in the most remote areas, almost 7,000 older people in the project area received their vaccination, while demand in other age groups increased by 88 per cent.

Read more about our work on COVID-19 vaccine equity here.

Research to support global and national evidence-based advocacy and policy on UHC

Ahead of the high-level meeting (HLM) on UHC in 2019, our *Global AgeWatch Insights* report presented data and analysis on the progress being made in realising the right to health of older people around the world, outlining how health systems and universal health coverage must adapt as the global disease burden shifts towards NCDs. The report was launched in Columbia, Myanmar, Pakistan, Serbia, Tanzania, Vietnam and the United States, engaging with key government and global health stakeholders at all levels.

The Global AgeWatch Insights report was accompanied by the findings from HelpAge's health outcome tool, *Older people's perceptions of health and wellbeing in rapidly ageing low- and middle-income countries.* This report presented data from over 3,000 older women and men, collected between 2015 and 2018 in nine low-and middle-income countries across Africa, Asia and Latin America. The report highlights how particular groups of older people are being left behind, including the oldest old, those in rural areas, those with the lowest levels of education, and those least able to meet their basic needs. It provides a basis for recommendations to governments and service providers on how to meet the needs and fulfil the rights of the most at risk or marginalised older women and men.

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