Summary of

Focusing on Opportunities: Active Ageing

Keynote Speech for Panel Discussion
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Irene Hoskins

Introduction

The presentation will begin with the question of what is Active Ageing and how is it defined by various organizations such as OECD, EU, WHO as well as by various bodies within the US.

In the US, the term Active Ageing is most commonly associated with policies and programs to ensure that people, as they age, remain physically active and in good health. Various initiatives and a National Blueprint on Active Ageing bear witness to the long-term health benefits of remaining physically active into advanced ages.

The OECD defines Active Ageing more broadly in economic terms as referring to *the capacity of people as they grow older, to lead productive lives in society and in the economy. This means that people can make flexible choices in the way they spend time over life – learning, working, and partaking in leisure activities and giving care (OECD, 2000).*

The European Union approach is, on the other hand, more comprehensively laid out in the communication from the Commission *Towards a Europe for All Ages* (1999):

Active Ageing is a coherent strategy to make ageing well possible in ageing societies. Active ageing is about adjusting our life practices to the fact that we live longer and are more resourceful and in better health than ever before, and about seizing the opportunities offered by these improvements. In practice it means adopting healthy lifestyles, working longer, retiring later and being active after retirement. Promoting active ageing is about promoting opportunities for better lives, not about reducing rights. Adequate income provision is part of the agenda.

Finally, there is an even broader emphasis on the entire life course and broad policy goals provided by the WHO definition of Active Ageing:

Active ageing is the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age.

By shifting the emphasis to the entire life course and the broad social determinants of health as well as the focus on achieving the optimal quality of life at older ages, the WHO definition refers to the importance of continued participation in social, economic, cultural, spiritual and civic affairs and not just the ability to remain physically active or to participate in the labour force. Both the WHO and the EU definitions take a rights-based approach. The life course perspective makes it clear that older people are not a homogenous group and that individual diversity in all aspects tends to increase with age. The life course perspective provided by WHO focuses attention on the important roles of population-wide health promotion and prevention policies. In

other words, policies implemented at the earlier stages of the life course can make an important difference in preventing disability and more costly curative interventions later in life. The policy focus is on three desirable goals: health, participation and security.

How do the broad policy objectives for Active Ageing policies relate more specifically to two relevant commitments of the Regional Implementation Strategy (RIS), Commitment 4 and Commitment 7?

Both commitments encompass vast policy arenas. Within the time-limited framework of these remarks it is only possible to touch upon a few areas. I will therefore make a few remarks on the principal objectives that I believe need to be met in order to fulfill these commitments.

I. Commitment 4 contains four broad policy objectives:

1) Preserve and strengthen the basic objectives of social protection, namely, to prevent poverty and provide adequate benefit levels for all.
The most fundamental question in this regard is whether countries will be able to enact changes in their pension and social protection systems now so that the future solvency and ability to pay adequate benefits to future generations will be guaranteed. Among the steps to be taken by countries to prepare for the aging of their populations would be the following:

- **Raise the retirement age:** Increasingly, citizens of the ECE region have become accustomed to withdrawing permanently from the labour force by age 60 or even younger. Most workers -- men and women -- in the Region are no longer attached to the labour market before they reach age 65, which is widely considered as the legal pensionable age. The large numbers of workers exiting the labour force before the legal pensionable age has been driven by a number of factors: generous unemployment benefits, easier access to disability pension benefits, lowering the early retirement age in the old-age pension system for older workers and the long-term unemployed and the readiness on the part of employers to encourage early retirements as a way to restructuring their workforces. Citizens of the ECE region thus became within the span of the last 4-5 decades accustomed to withdrawing permanently from the labour force at increasingly younger ages. More recently, however, the trend toward early retirement has been gradually going in the opposite direction as countries tighten eligibility requirements for early retirement. Does this also imply an improved health status for older workers or, alternatively, has there been an adjustment to the needs of older workers in the workplace? Or, as some have speculated, does the trend toward continued connection to the labour market reflect a growing insecurity on the part of older workers with regard to the adequacy of their future retirement income?

  End age discrimination. Many experts would claim that age discrimination is by far the greatest obstacle for older workers interested in remaining in the labour force. Why are older workers far less likely to benefit from either employer-provided training or to participate in active labour market programs? What are the true costs to employers of encouraging early retirements while recruiting younger less experienced workers?

2) Adapt existing social protection systems to demographic changes and changes in family structures

Among the recommendations that may be considered in this regard:

> **Raise the statutory retirement age.** Will it be possible to send the signal throughout the Region that, in line with gains in life expectancy, it should be expected that citizens will have to work longer in the future? A few countries, such as Sweden, have already abolished the concept of a fixed retirement age in favor of a more flexible approach according to which future retirement ages will be fixed in relationship to future gains in life expectancy.

3) Establish or develop a regulatory framework for occupational and private pension provision

> While recommendations for the implementation of this commitment are best left to the pension specialists at ILO, the World Bank and other expert bodies, a more general remark should be made with regard to changes in Central and Eastern Europe where State pensions formerly provided almost the total retirement income. A major part of the restructuring of the economies of these countries has been to build the financial institutions and the markets to encourage the development of private pension plans. Building an adequate retirement income through individual savings efforts takes however many years of effort. Will public pensions be adequate for those generations of workers who have not had the opportunity to build adequate retirement savings accounts? Will State regulations and supervision of the banking and insurance sector provide adequate protection against mismanagement and market failures which may occur in spite of the responsible behavior of individual savers?

4) Pay special attention to the social protection of women throughout their life course

> What will be the impact of the above-mentioned changes to the social protection system on women? Changes in the retirement age or particularly on the level of the guaranteed minimum old-age benefit have in general a much more direct impact on women than on men. The reasons relate to the different work patterns of women, who continue to have more interrupted careers due to family caregiving responsibilities; to be paid less; to suffer from often subtle forms of discrimination in the workplace; and who by and large live longer than men. Poverty among older women persists even in the most generous welfare states of the Region, and the rates rise significantly among the very old and frail who are almost always female. How can countries of the ECE address this problem of persistent poverty among older women? What are the life course policies that could attenuate the occurrence of poverty among older women? Among them might be the following:

- Caregiving credits for pension calculations
- Minimum age-related “social” pensions

- Eliminating the twin jeopardy of age and sex discrimination, particularly in the work force.

II. Commitment 7

Commitment 7 recognizes that the high overall level of health of the population is vital for economic growth and for the general development of societies.

Commitment 7 contains the following broad policy objectives:

1) **Promote health and well being over the entire life course by mainstreaming health through intersectoral policies.** The life course approach recognizes that individual differences in health status tend to increase as people age**.** What are the factors that influence health? WHO points to a substantial body of evidence that suggests that, in addition to gender and cultural issues, the broad determinants of health include economic, social, physical, personal, behavioural factors as well as access to quality care over the entire life course. The evidence suggests that interventions and investments in health promotion activities, such as improving dietary habits and engaging in physical activity; raising awareness about the negative impact on health of tobacco use as well as the misuse of alcohol are effective for people of all ages**.**

   Among the recommendations might be the following:

   - Debunk the argumentation that investments in health promotion activities for older people may be too late and are not cost effective. Research conducted in Sweden and elsewhere demonstrated that health promotion and prevention programs targeting older people often led to improved quality of life and decreased health care consumption.

   - Renewed attention must be given to the physical environment and its impact on the health of older citizens, including access to affordable transportation, safe housing, clean water and safe air. In the UNECE Region as elsewhere, the majority of older persons live in cities. A recently published WHO guide on what makes a city more “age-friendly” draws attention to the needs of older persons living in cities with respect to social and civic participation, personal mobility and transportation, housing, community support and health services

2) **Ensure equal access to health and social services including long-term care for persons of all ages.** Chronic non-communicable diseases, many of which afflict older people, represent a huge challenge to the Region. Much of this challenge will need to be managed through the primary health care (PHC) system, a system which is for the most part still oriented towards care for acute, episodic conditions. Chronic conditions require extended and regular health care contacts instead of the find-it and fix-it model of acute care. The PHC system should also be better equipped to prevent and screen for chronic conditions.

Among the recommendations may be the following:

- PHC providers should become more familiar with geriatric care and how to diagnose and manage geriatric conditions (especially the giants of geriatrics, i.e. falls, incontinence, immobility and confusion in order to improve older persons lives).

- the enormous differences in health status in the Region (reflected in life expectancy, adult mortality rates and other health indicators) must be addressed by national bodies and international organizations.

- Long-term care (LTC) needs will increase throughout the Region. More needs to be known and shared within the Region in terms of successful models of LTC, how they are being financed and delivered.

3) **Ensure appropriate financing of health and social services for persons of all ages.**
In a recent publication, the European Commission has concluded that the ageing of the population has not on its own strongly influenced increases in health spending. Instead the driving forces behind increased health expenditures have been national policies relating to universal access, developments in health technology and rising demands from citizens for better quality care. The report therefore concludes that the demand for health care in an aging population depends ultimately on the health status of citizens, both younger and older, and not on age per se. Healthier older citizens will consume less health care than citizens with chronic diseases and disabilities. This therefore constitutes an overwhelming argument in favor of policies for health promotion and prevention.

4) **Enable people to make healthy choices.**
This policy objective very appropriately comes at the end of Commitment 7 and does not require much additional comment. The remarks made under health promotion equally apply here as well. Of specific interest is the use of the word “enable” instead of “promote” healthy choices. Enabling people to make healthy choices would also apply to the pricing and labeling of healthy food and creating environments that are conducive to healthy behaviors, such as bicycling, walking, and exercising.