



Health Inequalities in Old Age



Health inequalities exist in access to health care as well as health outcomes

Sustainable Development Goal 3, to ensure healthy lives and promote well-being for all at all ages, recognizes that health needs and considerations evolve throughout the life cycle. Although many older persons retain overall good health and functioning well into old age, the process of ageing entails an increasing risk of poor health.¹ Age is in fact estimated to be the most important determinant of health. Yet while older persons on average have greater health care needs than younger age groups, they also face distinct disadvantages in accessing appropriate, affordable and quality care.

Ageing involves biological changes, but also reflects the accumulated effects of one's exposure to external risks, such as poor diet, and can further be influenced by social changes, such as isolation and loss of loved ones.² Genetics are estimated to be responsible for about 25 per cent of differences in health and function in old age, with other determining factors including aspects of the natural and physical environment such as air pollution and accessibility, risky behaviors such as smoking and inactivity, and individual characteristics such as occupation and level of income or education.³ Moreover, these factors are often intertwined, such that individual characteristics among older persons may hold sway over other health determinants.

In other words, disparities in old age in health and other areas often reflect accumulated disadvantage, due to factors such as one's location, gender and socio-economic status, as well as to ageist attitudes and practices and to lacking or inadequate laws and policies—or their enforcement—that provide for equality and the rights to health and social security. In the context of rapid population ageing, age-related inequalities take on greater urgency. Between 2015 and 2030, the number of people aged 60 and over is expected to increase from 901 million to 1.4 billion.⁴

The newly-adopted Sustainable Development Goals⁵ give priority attention to promoting equality and inclusion. In addition to Goal 3 on good health and well-being “for all at all ages”, Goal 5 is to achieve gender equality and empower all women and girls, among whose targets is ending “all forms of discrimination against all women and girls everywhere.” As well, Goal 10 is to reduce inequality within and among countries. Among the targets laid out to achieve the goal are to “ensure equal opportunity and reduce inequalities of outcome,” including through measures to eliminate discrimination, and to “empower and promote the social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status.”

Source: United Nations General Assembly, *Resolution on transforming our world: the 2030 Agenda for Sustainable Development*, 21 October 2015 (A/RES/70/1).

¹ United Nations, *World Population Ageing 2015* (ST/ESA/SER.A/390).

² Ibid.

³ World Health Organization, *World Report on Ageing and Health* (Geneva, 2015).

⁴ United Nations, *World Population Ageing 2015* (ST/ESA/SER.A/390).

⁵ United Nations General Assembly, *Resolution on transforming our world: the 2030 Agenda for Sustainable Development*, 21 October 2015 (A/RES/70/1).





Older persons confront multiple barriers in accessing quality health care

Despite their increased health risks, a large number of older persons across countries lack access to adequate levels and quality of health care.⁶ A 2010 multi-country survey⁷ revealed that 63 per cent of respondents found it difficult to access health care when needed.⁸ Among the barriers that older persons confront is affordability. Older persons often work in low-paying jobs, live off of family support or assets, or receive limited income from pensions. Where health care is not provided universally and at no or very low cost, many older persons avoid preventive care and even treatment or pay medical fees at the expense of other basic needs. When health care is accessed, older persons, particularly in developing countries, often encounter health care professionals who have little knowledge of their distinct health issues and health care services that are not age-appropriate.⁹ Rural areas, where many older persons live, are especially prone to shortages of skilled health workers. Accessibility is another significant barrier to health care, particularly for those older persons with limited mobility and in rural areas with poor transportation infrastructure and where long distances must be travelled to reach health facilities.¹⁰

Age discrimination and age-related stigma additionally function as a barrier to health care, both deterring older persons from accessing health services and also resulting in reduced quality of care. Stigma is sometimes attached to health conditions most often experienced by older persons, in particular dementia, hindering early diagnosis, and has been estimated to be the dominant factor behind the large gap between prevalence estimates and diagnosis rates for Alzheimer's disease.¹¹ Preconceived notions and negative attitudes about older persons among health care workers sometimes result in care rationing, such that care is limited or withheld entirely because patients are deemed too old for treatment and not due to the expectation of poor treatment outcomes. This effect is illustrated by a 2009 poll of 200 doctors with membership in the British Geriatrics Society, which found that 72 per cent of respondents felt that older persons were less likely to be referred for surgery or chemotherapy, and that 66 per cent believed that symptoms were less likely to be investigated among older persons.¹² In addition, symptoms of depression among older persons are often overlooked due to the prevalent belief that such symptoms are a normal feature of the ageing process and to lack of knowledge on the part of medical professionals and caregivers.

Research and data on the health status and quality of life of older persons are inadequate and mainly found only in developed countries. Gaps in these areas are reflected in and perpetuated by common health indicators which exclude older ages, such as prevalence rates for HIV that are reported only for those between the ages of 15 and 49.¹³ Many drug and treatment trials also either exclude or include only few older persons; in the United States, although older persons constitute

⁶ United Nations General Assembly, *Report of the Secretary-General on follow-up to the Second World Assembly on Ageing*, 26 July 2012 (A/67/188).

⁷ The survey covered 1,265 people over age 60 from 32 countries across Africa, Asia, Europe and the Caribbean.

⁸ HelpAge International, *Insights on Ageing: A Survey Report* (London, 2011).

⁹ United Nations General Assembly, *Report of the Secretary-General on follow-up to the International Year of Older Persons: Second World Assembly on Ageing*, 24 July 2015 (A/70/185).

¹⁰ United Nations General Assembly, *Report of the Secretary-General on follow-up to the Second World Assembly on Ageing*, 26 July 2012 (A/67/188) and HelpAge International, "The right to health in old age: unavailable, inaccessible and unacceptable," August 2011. Available from <http://www.helpage.org/silo/files/the-right-to-health-in-old-age-unavailable-inaccessible-and-unacceptable.doc>.

¹¹ Alzheimer's Disease International, *World Alzheimer Report 2012: Overcoming the Stigma of Dementia* (London, Alzheimer's Disease International, 2012), in United Nations General Assembly, *Report of the Secretary-General on follow-up to the Second World Assembly on Ageing*, 19 July 2013 (A/68/167).

¹² See <http://news.bbc.co.uk/2/hi/health/7850881.stm>, cited in United Nations General Assembly, *Report of the Secretary-General on follow-up to the Second World Assembly on Ageing*, 26 July 2012 (A/67/188).

¹³ United Nations General Assembly, *Report of the Secretary-General on follow-up to the International Year of Older Persons: Second World Assembly on Ageing*, 24 July 2015 (A/70/185).



over 60 per cent of cancer patients, they are 25 per cent of participants in clinical treatment trials.¹⁴ The need for comprehensive and comparable data and research on health and well-being in old age has implications not only for the quality of care but also for monitoring and assessing health-related progress and trends.

In addition to disparities in health care between older persons and the rest of the population, disparities are also evident among older persons themselves, such as by gender, income level and racial or ethnic background. Although disadvantaged older persons tend to be more exposed to health risks and to experience more health problems, they often confront more challenges in accessing health-related services.¹⁵ A study of 12 European countries observed disparity by education level among people aged 50 and over in visits to medical specialists and dentists.¹⁶ In the UK, lower socio-economic groups of older persons are disadvantaged in terms of access to and utilization of several health services, including mammography screening, vaccinations, eye and dental exams, and heart surgery.¹⁷

Inequalities are also evident in health outcomes

“...healthy ageing is significantly influenced by social determinants of health, with people from socioeconomically disadvantaged groups experiencing markedly poorer health in older age and shorter life expectancy”

Source: World Health Organization, 69th World Health Assembly, *The Global strategy and action plan on ageing and health 2016-2020: towards a world in which everyone can live a long and health life*, Eighth plenary meeting, 28 May 2016 (A69/VR/8).

Life expectancy

Inequalities are similarly reflected in life expectancy and patterns of mortality and poor health throughout the life cycle and into old age. While life expectancy at birth continues to climb across regions, differences are significant according to countries' levels of socio-economic development and are also evident by gender and other factors—namely education.¹⁸ In 2010-2015, life expectancy was highest in Northern America, at 79.2 years, followed by Oceania, Europe, Latin America and the Caribbean, Asia and Africa, the latter region in which it stands at 59.5 years, well below the global average of 70.5 years. In all regions, women's life expectancy at birth is higher than men's. Life expectancy at age 60 has also improved in each region, though at varying paces. As life expectancy at birth rises, reflecting reduced mortality at all ages, improved survival in old age accounts for a greater part of longevity gains. Persons at age 60 can expect to live longest—an additional 23.7 and 23.5 years, respectively—in Oceania and Northern America, declining to an additional 16.7 years in Africa, with a global average of 20.2 years. Globally, women at age 60 can expect to live an additional 2.8 years on average than can men. Differences in survival by sex are greatest in Europe,

¹⁴ Phoebe Weaver Williams, “Age discrimination in the delivery of health care services to our elders”, *Marquette Elder's Advisor*, vol. 11, No. 1, Article 3 (Fall 2009), see Ref 125. Available from <http://scholarship.law.marquette.edu/cgi/viewcontent.cgi?article=1012&context=elders>.

¹⁵ World Health Organization, *World Report on Ageing and Health* (Geneva, 2015).

¹⁶ Marco Terraneo, “Inequities in health care utilization by people aged 50+: evidence from 12 European countries”, *Social Science & Medicine*, vol. 126 (February 2015), pp. 154–63, cited in World Health Organization, *World Report on Ageing and Health* (Geneva, 2015).

¹⁷ Equality and Human Rights Commission, *Age Concern and Help the Aged, Just Ageing? Fairness, Equality and the Life Course: Socio-Economic Inequalities in Older People's Access to and Use of Public Services* (2009). Available from <http://justageing.equalityhumanrights.com/socio-economic-inequalities-in-older-peoples-access-to-and-use-of-public-services/>.

¹⁸ United Nations, *World Population Ageing 2015* (ST/ESA/SER.A/390).

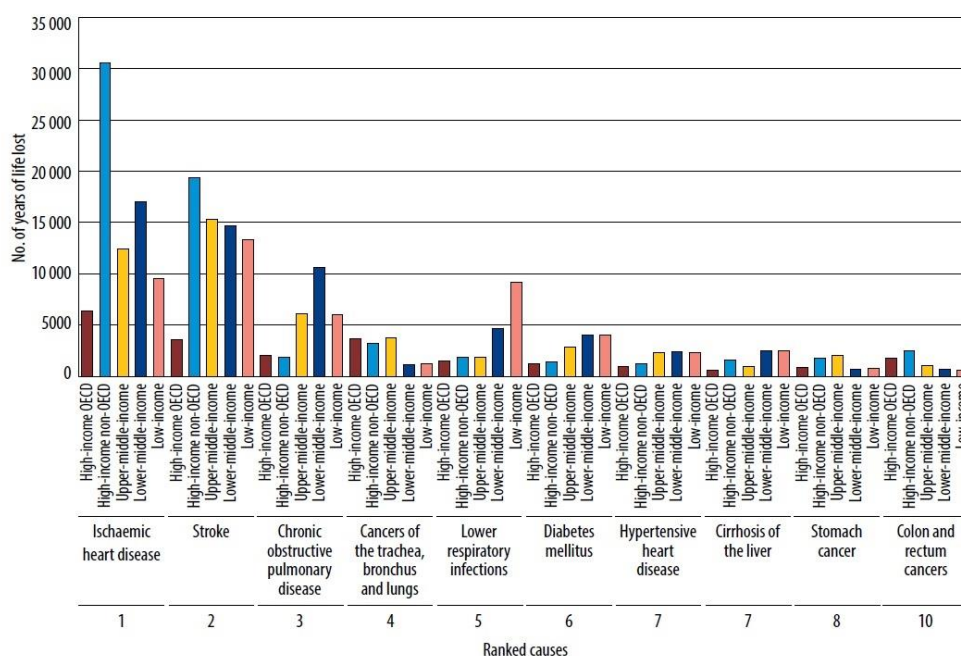
where women live an average of four years longer than men, and smallest in Africa, where women live an average of 1.5 years longer.

Education level has a strong influence on life expectancy. In OECD countries, persons who have attained the highest education level can expect to live an average of six year longer than persons with the lowest level. For men, in particular, the average gap is nearly eight years.¹⁹

Causes of death

Patterns of causes of death and poor health are closely connected to the level of development where one lives. Across countries and regions, mortality among older persons is primarily due to non-communicable diseases (NCDs).²⁰ In low- and middle-income countries, however, deaths from NCDs result at earlier ages than in high-income countries, and communicable diseases continue to cause a significant number of deaths at all ages. Globally, most of the diseases responsible for mortality among older persons, led by ischaemic heart disease, stroke and chronic obstructive pulmonary disease, have significantly greater impact in middle- and low-income countries than in high-income OECD countries (see Figure 1).²¹

Figure 1: Number of years of life lost to mortality (YLL) per 100 000 population for the top 10 causes of lost years, in populations aged 60 years and older, 2012



OECD: Organisation for Economic Co-operation and Development.

Source: Global health estimates 2013: deaths by cause, age, sex and regional grouping, 2000–2012. In: World Health Organization, Global health estimates [website]. Geneva: World Health Organization; 2015 (http://www.who.int/healthinfo/global_burden_disease/en, accessed 24 July 2015). In: World Health Organization, *World Report on Ageing and Health* (Geneva, 2015), p. 61.

¹⁹ Organization for Economic Cooperation and Development, *Health at a Glance 2015: OECD Indicators* (Paris, OECD Publishing, 2015).

²⁰ World Health Organization, *World Report on Ageing and Health* (Geneva, 2015).

²¹ The high impact of cardiovascular disease in high-income non-OECD countries is largely due to high rates in the Russian Federation.



Causes of disability

The greatest causes of disability in old age world-wide are estimated to be sensory impairments, such as hearing and vision loss, back and neck pain, chronic obstructive pulmonary disease, depressive disorders, falls, diabetes, dementia and osteoarthritis. Yet sensory impairments and chronic obstructive pulmonary diseases have a higher burden in low- and lower-middle-income countries, whereas basic interventions such as eyeglasses and medication in wealthier countries improve one's functioning. The higher burden from sensory impairments may also be due to greater cumulative exposure to noise and sun, among other factors, and that from chronic obstructive pulmonary diseases to greater cumulative exposure to air pollutants in the home and outdoors. At the same time, dementia has a higher burden in high-income countries, which is likely caused in part by their proportionately larger older populations and greater awareness of—and capacity to diagnose—types of dementia.²²

Other inequalities can be observed in older persons' health status. Among other factors, socio-economic status has been shown to have influence on the decline in cognitive functions with age.²³

Multimorbidity

The likelihood of simultaneously experiencing multiple chronic conditions—or multimorbidity—increases for everyone with age.²⁴ While there is limited evidence from low- and middle-income countries, multimorbidity is likely to be more common in these than in high-income countries. In addition, in the mostly high-income countries studied, it affects more than half of older people, yet has a higher prevalence among those with low socio-economic status.²⁵ Moreover, a study from Scotland found that multimorbidity presented itself earlier—by 10 to 15 years—among those living in the most deprived areas than those in the most wealthy.²⁶ Race or ethnicity is also associated with higher risk of multimorbidity; in the United States, Blacks had a higher—and Asians a lower—incidence than did Whites.²⁷

Conclusions and priority policy issues to be considered

Many older persons face distinct challenges in accessing quality healthcare services. Moreover, most disparities in old age health are not random, but are associated with disadvantage that has accumulated over the life course. Those persons in the poorest health are the least likely to have access to the interventions they need. That experiences of health among older persons differ so greatly underscores the message that poor health in old age is not an inevitability. Policies can influence some health determinants, such as access to care, risky behaviors and individuals' capacities such as health literacy, enabling persons to enter old age in a healthier state. Such types of policy responses, which should direct particular attention to people living in poverty and belonging to other disadvantaged groups, should be undertaken alongside broader efforts to better align health systems with the general needs and concerns of all older persons.

²² Ibid.

²³ Ibid.

²⁴ Ibid.

²⁵ Ibid., Chapter 3, see Refs 81, 82 and 85.

²⁶ Ibid., Chapter 3, see Ref 84.

²⁷ Jennifer L. St. Sauver and others, "Risk of developing multimorbidity across all ages in an historical cohort study: differences by sex and ethnicity", *BMJ Open*, vol. 5, No. e006413. Available from <http://bmjopen.bmj.com/content/5/2/e006413.full>. Cited in World Health Organization, *World Report on Ageing and Health* (Geneva, 2015).



In this regard, it is important to emphasize that increases in the proportion of older persons in the population are not strongly or clearly associated with increases in health care costs.²⁸ Even though older persons generally have greater need for health care than younger persons, as has been described above--many older persons who need care do not access it. Yet even where demand for care more closely aligns with the need for it, increasing age does not consistently correlate with increasing expenditure on health. Evidence from high-income countries reveals that such expenditure per person tends to peak and then decline markedly at around age 70, after which expenditures outside the traditional health system rise. The type of health care system has been shown to have an important effect on the relationship between age and health costs, which may relate to variations in, for instance, provider systems and cultural norms, especially prior to time of death. In fact, time to death may well be a more important determinant of health expenditure than age, as research in some countries points to a significant proportion of medical costs being incurred in the last year of life, and to such costs declining with increasing age. Given gains in life expectancy, the last year of life is increasingly experienced in advanced old age, when health expenditures tend to decline. In many cases, growth in health-care expenditure is more closely linked to other factors, including changes in clinical practice such as those relating to technological advancements, and expanding access to care to all segments of the population. Accordingly, population ageing does not likely pose a major economic burden, and should not deter Governments from directing investments towards improving the health and well-being of older persons and the promotion of good health across the life cycle.

To reduce health inequalities that adversely affect older persons and to promote their social inclusion, the following policy suggestions are proposed:

- Ensure the availability of affordable, quality and accessible social services, including health care and long-term care, to all older persons, and increase support to education and training in geriatrics and gerontology;
- Introduce or enhance legislation to promote equality and non-discrimination on the basis of age in the provision of health and health insurance services and in social protection policies and programming, and undertake measures to prevent multiple discrimination against older persons;
- Adopt a life-course approach to the promotion of good health and well-being, including through the design of health systems that promote healthy ageing;
- Improve the collection, analysis and use of health and other data disaggregated by age, as well as sex, race, ethnicity, disability and migrant status, and income, across the life course, including through upper age bands to age 100;
- Elicit the views of representatives of older persons' associations and older persons themselves, of diverse backgrounds, on their respective needs and concerns regarding policies that address health and well-being, and establish and implement follow-up mechanisms; and
- Enhance policy and programme coordination on issues affecting health across sectors, such as labour and the environment.

²⁸ See World Health Organization, *World Report on Ageing and Health* (Geneva, 2015), pp. 95-98.



For further detailed reading

- Equality and Human Rights Commission, Age Concern and Help the Aged. *Just Ageing? Fairness, Equality and the Life Course: Socio-Economic Inequalities in Older People's Access to and Use of Public Services*. 2009. Available from <http://justageing.equalityhumanrights.com/socio-economic-inequalities-in-older-peoples-access-to-and-use-of-public-services/>.
- United Nations. Political Declaration and Madrid International Plan of Action on Ageing. *Report of the Second World Assembly on Ageing, Madrid, 8-12 April 2002*. United Nations publication, Sales No. E.02.IV.4, chap. I, resolution 1, annex II.
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