

DELIVERABLE D2.4

Analyses and recommendations to ensure equal participation and autonomy of older people

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1. Description of the deliverable

This deliverable summarises AGE's policy papers and positions issued to ensure equal participation and autonomy of older people. While other deliverables look at equality and intersectionality, this one is more concerned with socio-economic policies, such as pensions, long-term care, social inclusion, employment, life-long learning housing or health. All our advocacy and policy work is based on the valuable input of our Task Forces, therefore this deliverable also reports on the outcomes of some of the discussions and work mentioned in D2.5. This deliverable also covers the reporting of Task T2.5.

The main processes that we fed into in 2024 are:

1. Age Manifesto Explainer #2: participation and active ageing
2. Age Manifesto Explainer #3: Autonomy and well-being
3. Work-life integration policy paper
4. Priorities for national implementation of the EU Care Strategy
5. Contribution to 2024 Pension Adequacy Report
6. Joint letter on EU Care Strategy in the next Commission
7. Joint work on suicidality
8. Joint letter on Mental Health
9. Joint Statement on medicine information leaflet
10. Position on the EU Pensioner's Card initiative

2. Key outcomes

2.1 Age Manifesto Explainer #2: participation and active ageing

In the framework of the AGE Platform campaign for the European Parliament elections, we have developed three manifesto explainers around the three main calls of our AGE Manifesto: *promoting age equality, encouraging participation and active ageing, and guaranteeing autonomy and well-being*. In these policy documents, we have explored these calls in detail with a view to providing future EU officials with recommendations for change.

The first manifesto explainer is reported in deliverable D2.1.

This second manifesto explainer focuses on *promoting participation and active ageing* and looks at what AGE means by participation and active ageing, why it is important to promote the participation of older people and proposes recommendations for achieving this at EU level.

a) Consultation method

We have drafted this explainer based on previous calls for the participation of older people and for the right to participate at all ages. Members of the Task Force Employment and Participation were consulted during a Task Force meeting (see D2.5) and were invited to send additional inputs in the weeks leading up to the validation and publication of the paper.

b) Content of the paper

This second manifesto explainer focuses on participation as a right that should be enjoyed at all ages. We stress the importance of recognising the term 'active ageing' as an aspect of 'desired ageing'. In other words, participation must be a matter of choice at all age, but it cannot be possible without recognising the autonomy of each person throughout their life and supporting them in their different roles and expectations as they age.

The explainer calls for a vision of older people's participation that goes beyond mere economic participation or consumption and includes them more fully in politics, culture, justice, employment, education and learning. Ageism and age discrimination often prevent older people from participating fully in society, limiting recognition of the many benefits of older people's participation for society.

The explainer proposes concrete measures to promote the participation of older people. In particular, it recommends the adoption of a European strategy for age equality and calls for policies that take into account the specific needs and challenges of older people in all their diversity, including older women, older migrants and older people with disabilities.

c) Outcomes

The paper is accessible on AGE's blog for the European Parliament elections and on AGE's website. It was also sent to several MEPs and MEPs-candidates, as well as to the various European Commission departments concerned, including the cabinet of Vice-President Šuica and the DG JUST unit responsible for non-discrimination and age.

2.2 Age Manifesto Explainer #3: Autonomy and well-being

In the framework of the AGE Platform campaign for the European Parliament elections, we have developed three manifesto explainers around the three main calls of our AGE Manifesto: *promoting age equality, encouraging participation and active ageing, and guaranteeing autonomy and well-being*. In these policy documents, we have explored these calls in detail with a view to providing future EU officials with recommendations for change.

The first manifesto explainer is reported in deliverable D2.1., the second is outlined above.

This third manifesto explainer focuses on guaranteeing autonomy and well-being, emphasizing the importance of equal rights at all ages. The text highlights the challenges faced by older people, particularly in terms of employment, retirement, combating violence and abuse, and access to health and care services.

a) Consultation method

The Manifesto was presented and debated with the TFs Adequate Income and Social Inclusion, Employment and Participation, as well as Dignified and Healthy Ageing.

b) Content of the paper

It summarises the outcomes of many processes led by these Task Forces in the past, namely the work on the EU Care Strategy and its measures for implementation, the European Semester, the energy and inflation crisis 2022, our work on healthy ageing and the AGE Barometer 2023. The aim is to have a summary of AGE's positions and contributions in these areas in view of the incoming new European Commission and MEPs. It looks at:

- Older workers
- Adequate pensions
- Fight against violence
- Care services

In each domain, it argues why an EU Age Equality Strategy can help in addressing the challenges to dignified ageing that arise in these domains.

c) Outcomes

The Manifesto explainer was circulated via AGE's campaign blog and website, and via email to all Commissioner's cabinets, Commission services, MEPs from the interest group on solidarity between generations and supporters of our EP campaign and key partners in the campaign. It proved an instrumental starting point for people who might be interested to work on one area mentioned by the Manifesto Explainer, without seeing this in the context of ageing.

2.3 Work-life integration policy paper

This document is a policy report published in September 2024, which makes the case for better work-life integration, focusing specifically on the crucial and often underestimated role of informal family carers. It has been drawn up to bring together our recommendations and update our position on work-life balance,

which we now call work-life integration. This paper has also been written to influence the European Economic and Social Committee opinion adopted in October 2024 titled '*Ensuring a needs-based work-life balance for all: How adequate flexible working conditions can support intergenerational solidarity and the empowerment of women*'.

a) Consultation method

Members of the Task Force Employment and Participation and the Task Force on Dignified and Healthy Ageing were invited to join a subgroup responsible for drafting the document. The subgroup met in August 2024 (see D2.5) to discuss the recommendations and finalize the draft paper. Additional meetings with the subgroup members are planned to discuss the spreading of our recommendations at European and national levels.

b) Content of the paper

This paper highlights the complexity and diversity of these carers' situations, particularly the situation of women who are the majority of carers, and highlights the negative consequences for their health, careers and finances. The report criticises the lack of adequate support, in particular the shortcomings of the European Directive on work-life balance, and puts forward concrete recommendations for improving carers' leave, providing financial and structural support, and adopting an inclusive and intersectional approach to better meet the needs of all carers. The main objective is to improve the European legal and political framework to recognise the economic and social value of carers' work, thereby promoting a fairer and more equitable society.

c) Outcomes

The paper has been sent to the rapporteur of the European Economic and Social Committee opinion '*Ensuring a needs-based work-life balance for all: How adequate flexible working conditions can support intergenerational solidarity and the empowerment of women*'. Several of our recommendations were found in the opinion. These recommendations were also presented during the European experts meeting organised by COFACE on Work-Life Balance Strategies in Family policy.

2.4 Priorities for national implementation of the EU Care Strategy

As part of the Council recommendation on access to affordable, quality long-term care of January 2022, Member States have committed to come up with national implementing measures by June 2024. In view of shaping these national reports,

AGE has delivered a policy paper outlining the main prioirities for reform in long-term care systems, in line with the priorities of the Recommendation, for all Member States in which AGE members are active in this policy area.

a) Consultation method

The priorisation paper was prepared based on a questionnaire provided to AGE members in the Task Force on Dignified and Healthy Ageing. They have been discussed amply in the two first TF meetings of 2024, before the release of the paper.

b) Content of the paper

On top of the national assessments and priorisation, the paper includes an EU-level summary and recommendations for the implementation of the EU Care Strategy with regard to long-term care. In terms of Member States, it covers Belgium, Cyprus, Czechia, France, Germany, Italy, Malta, the Netherlands, Norway and Poland. The paper also calls on the newly elected European institutions to maintain high ambition for the reform of long-term care systems in the European Semester, the implementation of the European Pillar of Social Rights and the next EU social agenda in general.

c) Outcomes

The paper has been circulated with all national long-term care coordinators of the Member States concerned and the main actors in the European Commission and the Parliament. It was warmly received and stirred discussion with a small number of long-term care coordinators with our members.

The paper has been published on AGE's website and was the subject of a our newsletter CoverAGE.

2.5 Contribution to 2024 Pension Adequacy Report

AGE had already the opportunity in 2023 to comment on the draft structure of the 2024 Pension Adequacy Report. In addition, AGE was the only civil society organisation next to Social Partners to be consulted with a draft version of the report and to provide its input in form of a two-pager.

a) Consultation method

Given the short deadline and the confidentiality requirement from the side of the European commission, no formal consultation was organised, but the documents

were shared in AGE's TF on Adequate Income and Social Inclusion for comments. The final contribution was also endorsed by the TF in a written procedure.

During the physical TF meeting of 26 June 2024, TF members discussed AGE's main messages for the conference taking place the next day, when the Pension Adequacy Report was launched by the Commission.

b) Content of the paper

AGE's main highlight to the Pension Adequacy Report was the call to halt the increase of old-age poverty, which has been ongoing since 2015 approximately, with varying degrees in different member states. AGE argues that it is impossible to attain the EPSR Action Plan target to reduce poverty and social exclusion overall if a sizable reduction of poverty among the growing share of older persons is not addressed.

c) Outcomes

The paper was included in the European Commission's official communication around the launch of the Pension Adequacy Report, alongside the contribution of ETUC. AGE has also published it on its website and the newsletter CoverAGE, and shared the contribution with all relevant actors in the pensions landscape.

2.6 Joint letter on EU Care Strategy in the next Commission (with ESIP)

In view of the next institutional cycle, AGE participated in the drafting and signature of a joint letter to the Council of Ministers calling for integrating social and health ambitions in the next Strategic Agenda

a) Consultation method

Given the letter is an initiative of EU-level networks, there has not been a particular consultation with AGE members, but AGE's signature builds on our positioning developed with our members in the AGE Manifesto and Manifesto Explainers

b) Content of the paper

The letter calls for sustained ambition on the social and health agenda in the next institutional cycle, particularly after the La Hulpe Summit Declaration.

c) Outcomes

The central repository for the letter is with the European Social Insurance Platform, but AGE promoted it via its social media and mentioned it with members in various occasions. ESIP has sent the letter to the Council of ministers via the Social attachés of the Permanent Representations in Brussels.

2.7 Joint work on suicidality (GAMIAN)

On World Suicide Prevention Day, AGE and GAMIAN-Europe have put a spotlight on suicidality among older persons. In general, suicidality rates are declining, but for older persons this is not the case – in combination with the growth of the number of older persons, this might mean in the near future that suicides of older persons may be rising.

a) Consultation method

The policy paper is the fruit of three online workshops delivered with GAMIAN-Europe and its network, and with AGE members from the task Force on Dignified and Healthy Ageing. This was complemented with an online survey designed to reach experts of experiences. AGE and GAMIAN coordinated the drafting and messaging of the final report at Secretariat-level

b) Content of the paper

The outcome paper is a small research report exploring the phenomenon of suicidality among older adults, providing a summary of the lived experience of older adults directly or indirectly affected by suicidality and outlines recommendations for policy.

c) Outcomes

AGE and GAMIAN-Europe both spread the resulting report among our main stakeholders in the Commission and the Parliament. AGE published the paper on its website and mentioned it in social media (and here), as well as an article and a Special Briefing in the CoverAGE newsletter.

The discussion and the paper provided a good introduction for our members and staff to further work on mental health issues, and the interest is translated into including mental health of older people in the 2025 work programme of the TF on Dignified and Healthy Ageing.

2.8 Joint letter on Mental Health (with MHE)

Mental health figured prominently in the new Commission's hearings and mission letters, and AGE fully supports stepping up the EU's focus on mental health after the COVID-19 and inflation crises, and building on the Comprehensive approach on mental health developed during the last legislature. As our members also support reinforced attention to mental health of older people, AGE was happy to work with Mental Health Europe and a coalition of other partners on a statement for World Mental Health Day

a) Consultation method

Given the statement is a joint statement of EU networks, there was little consultation of AGE members on this issue, but the Task Force on Dignified and Healthy Ageing was informed about AGE signing the paper.

b) Content of the paper

The paper calls for a Strategy on Mental Health, including access of vulnerable and/or excluded populations to mental health services. It calls on fighting mental health stigma, pay attention to mental health in the digital transition, calls for a legislative initiative on mental health at work, a community-based approach to mental health, deinstitutionalisation and funding research and innovation in line with a psychosocial model of mental health.

For AGE, it is particularly important that all population groups, including older persons, have access to mental health services, and that these services also reach people in situations of instutionalisation, such as in long-term care settings. Addressing psycho-social risks at work is in the interest of an ageing workforce, with mental health issues being a major reason for dropping out of the labour market early.

c) Outcomes

The statement has been deposited at Mental Health Europe, who also circulated it among policymakers. AGE relayed the statement on its own social media.

2.9 Joint Statement on medicine information leaflet – JW

a) Consultation method

As part of the work around the pharmaceutical package – COM(203)192 - ,AGE decided to focus its effort on the article 63 of the proposed directive, namely the General principles on the package leaflet. Indeed, the planned digitalisation of this

documentation which provides key information to patient is a critical issue for AGE members: older people constitutes the larger part of medicines' consumers. This issue was discussed with AGE members within the Task Force on Age-Friendly Environments.

To make our voice stronger, we decided to work with other stakeholders, notably healthcare professionals (doctors, pharmacists and nurses), social insurers, hospitals and consumers. CPME, representing the GP, took the lead to coordinate a joint statement.

b) Content of the paper

This joint statement highlights that the removal of paper package leaflets for accessing medicine information and the shift to Electronic Product Information (ePI) will create a digital divide. This will impose a level of digitalisation without considering those who do not want to use a smartphone/tablet, or cannot, due to age, geographical location, disability, health, income, religion or social situation.

c) Outcomes

The statement has been deposited at CPME, who also circulated it among policymakers and relevant stakeholders. AGE relayed the statement on its Website and own social media.

2.10 Position on the EU Pensioner Card Initiative

Contacted in December by MEP Gordan Bosanac after a discussion within the PETI committee on establishing an EU Pensioner Card, AGE consulted members about the initiative and points of attention if this demand is followed up by an initiative.

a) Consultation method

AGE members were consulted by email with questions about the existence of national pensioner's or senior citizens' cards and the benefits attached to such a card. Further questions were evolving around the criteria for receiving a card, the services that should be covered by such a card in the context of intra-EU mobility, and the risks of stigmatisation or intergenerational conflict that could arise from such a discussion.

b) Content of the paper

The scoping paper explores the responses to the questions outlined above. It shows broad support for such an initiatives, but also puts several points to the

attention to avoid the creation of new perceived discrimination based on age or other criteria. Furthermore, it warns against focussing too much policy attention on such a proposal if it serves to reduce attention to other, more structural issues, such as ageism, old-age poverty or lack of adequate, dignified care services.

c) Outcomes

The policy paper was shared mainly with Mr Bosanac and has not been formally published at the time of writing. However, depending on the publicity and attention put to the discussion, it might be further developed and published as an own publication at a later point in time.

3. Prints of relevant profs

1. Age Manifesto Explainer #2: participation and active ageing
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AGE Manifesto Pillar #2

Foster participation and active ageing

2024 European Parliament Elections

AGE Platform Europe

22 April 2024
www.age-platform.eu

Ahead of the upcoming European Parliament elections in June 2024, AGE Platform Europe calls in its Manifesto for a Europe for all ages. At the heart of the Manifesto are three major appeals to future Members of the European Parliament:

- Promote age equality
- Foster participation and active ageing
- Ensure autonomy and well being

By means of three Manifesto pillars, we explore these calls in details and provide future EU officials with recommendations for changes that we believe are essential for a European Union that address adequately population ageing and works towards a society for all ages.

Access to the AGE Manifesto blog

Endorse the AGE Manifesto

About AGE Platform Europe

AGE Platform Europe is the largest European network of non-profit organizations of and for older people. We elevate older people's voice, bringing their experience and aspirations to the table to celebrate ageing and fight for equality at all ages.

We call on the next European Parliament to foster participation and active ageing

What do we mean by participation and active ageing?

Older persons should have the same right and opportunities to participate in society as anyone else. This should cover politics, culture, justice, employment, education and learning, in the same way as for other age groups. Although this statement seems obvious, the prevalence and impact of age discrimination and ageism in our society, leading to isolation, exclusion and marginalisation, prevent older people from fully participating and being full members of society.

Participation is a right and must be guaranteed throughout life. The European Union's current approach to the participation of older people focuses on a vision of active ageing limited to economic participation or consumerism, and some aspects of social policies. To avoid the harmful and depreciatory effects of social constructions of old age, we need to move towards a vision of older people as individuals with rights that guarantee equality at all ages, throughout life, and for the diversity of experiences of ageing. It is about recognising the autonomy of individuals throughout their life and ensuring that, at all ages, they are supported in their different roles and expectations as they grow older. By treating older people as rights-holders, they can be empowered to improve their own lives, express their views, contribute to decision-making processes, be heard by policy makers, and continue to be active in the labour market rather than being treated as passive recipients of support.

Lastly, **equal participation of all age groups and in all their diversity** means recognising the challenges and assets associated with old age, as is the case for all stages of life. It also requires a good understanding of the challenges faced by older people in all their diversity, through an intersectional approach. Older women, older migrants, older LGTQI people, and older people with disabilities, to name but a few, face specific challenges that hinder their enjoyment of their right to participate. Recognising these challenges is essential to support in the best possible way and ensure older people's right to participate equally and meaningfully.

The right to participate must be the results of choice and measured according to the will of each individual. We suggest that the term "active ageing" is understood as one aspect of what Moulaert and Biggs call "desired ageing", a flexible approach that respects the autonomy of older people so that they can live their lives as they wish.

Why is fostering participation in old age important?

The participation of older people in society is diverse and plays an essential role. Because of ageism, it is often underestimated in society. Indeed, as soon as an individual is no longer present on the labour market, he or she is considered non-productive and therefore useless to society. On the contrary, whether an older person participates in the labour market or not, they bring a significant contribution to various aspects of the society.

Older people bring a wealth of experience accumulated over the years. Their knowledge and perspectives are invaluable for passing it on to younger generations. **They play a crucial role in cultural and memorial transmission**, and their involvement in cultural and artistic activities enriches society's heritage and helps to maintain links between generations. Their active involvement strengthens the social fabric and enriches community life. For older people themselves, their involvement and participation undeniably **contribute to healthier ageing, fostering better mental health and self-esteem**.

Older people are often pillars of their communities, providing valuable support and assistance to neighbours, friends and family. Volunteering is an important area of engagement for many older people, offering not only a valuable contribution to society but also a sense of purpose and social connection. In particular, it helps to strengthen the social fabric and create lasting intergenerational links. Volunteering are not limited to activities around ageing but contribute to areas of society, for which, older persons often form the pillars of contributing to logistics, management and long-lasting engagement. **The economic value of their voluntary participation in society is not negligible**, and can form the backbone of the functioning of large NGOs as well as small local clubs. The care sector, for example, is particularly dependent on older volunteers: volunteers visit older people who are isolated or unable to leave their place of care, and help to organise activities for other older people. In addition, 80% of care work itself is provided by informal carers, often older relatives and most of the times women. This has a cost on their income, ability to engage in paid work, health, risk of poverty and isolation. Without the work of informal carers or the voluntary work of older people, the economies of the Member States would be greatly impacted. However, to date, it is not sufficiently valued or supported by public policies.

As demonstrated by their high turnout at elections, **older people are enthusiastic about participating in decision-making and public life**. Despite their desire to contribute to building an inclusive world for all ages, their activism is often not recognised nor supported by public policy. Older people, particularly those living with long-term care needs or with disabilities, face physical or geographical barriers to participating in elections. Their consultation on relevant policy issues is often based on personal contacts and the activism of older people's organisations, without being anchored in structured dialogue or legislative procedures. This means that many voices are not heard, particularly in

Member States where public support for organisations representing older people is insufficient.

What do we need on EU level to achieve it?

Tackling the problems that hinder older people's participation in society means first and foremost recognising and supporting their full potential in all aspects of society and life. When older people are consulted, it is generally in relation to old age, such as for pensions. However, older people care about their communities, about the future for coming generations, and not just about their own interest. **Older people must have a say on all issues**. It must also be part of a longer-term process and not a one-off exercise. Often, participation only takes place at the early stages of the policy cycle, through consultations on the European Commission's 'Have your say' portal for instance. However, **meaningful participation involves stakeholders at all stages of the policy cycle**. This includes research, data collection, priority setting, policy formulation, budgeting, implementation, review and evaluation. In this respect, we call on the future European Parliament and the European Commission to work towards **the adoption of the European Strategy for Age Equality** by involving older people and their representatives in all aspect of life and at all stages of the policy cycle.

In the Strategy, participation of older people in public and political life should be fostered and **addressed as a human right**. It should also **provide guidance to Member States on how to make their policy-making processes inclusive** of older people and in line with human rights standards, through institutionalised participatory processes and the allocation of adequate resources. **In particular, this should be the case where Member States are implementing EU policies:** in the European Semester, the governance of EU funds, the EU Care Strategy etc. Finally, it should ensure that older people have a means of holding their government to account, while the recommendations of the mechanisms developed in this respect will feed into policy development and reform processes.

Tackling the problems that hinder older people's participation in society also means adapting policies to different individual circumstances and contexts. In particular, **it means ensuring that older people have full, affordable and equitable access to essential services.** The opportunities and challenges associated with exercising these rights differ, for example, between rural and urban areas. Access to places of participation, transportation to get there, essential goods such as health and care services, food, housing and banking services or access to the internet, is limited in rural areas. To guarantee the right to participation, it is essential to implement provisions to overcome these, by, for instance, maintaining alternative options to digital services, set up "service points" with access to internet, public services and essential private services in public places and develop mobile units to provide information and offer space for discussion and participation in public life in sparsely populated areas. As part of a comprehensive EU anti-poverty strategy, the EU should actively **fight against**

the non-take-up of public services and benefits by people who have the right to access these, such as by automatic enrolment or active outreach services.

These provisions are also **beneficial to older people who face intersectional challenges**. Older people with disabilities, particularly those living in institutions or requiring long-term care and support, face barriers to participation that mobile or outreach units could help overcome. Similarly, older people with low incomes who cannot afford digital technologies could participate more easily thanks to "service points".

In addition to the intersectional approach, the European Commission and the Members of the European Parliament must address the issue of participation in old age from **a lifelong, person-centred perspective**. The European Commission's Directorate-general on Employment, Social Affairs and Inclusion responsible for EU policy on employment, social affairs, skills and labour mobility has a major role to play in supporting people and encourage transition between learning, working, family care, periods of unemployment, and retirement at different ages. In particular, it is important to have the opportunity at all ages to acquire and update the skills needed to participate in public and political life. Learning in old age is currently very limited and **opportunities for education and training beyond retirement age need to be multiplied**. In particular, the Council's recommendation on **individual learning accounts** adopted in 2021 needs to be implemented in Member States by encouraging them to ensure the accessibility of such accounts beyond "adults of working age". It is important for **digital education** for instance as the lack of digital skills is a major obstacle faced by older people, creating new inequalities in terms of participation, as many of them have not yet had the opportunity to acquire basic skills or keep them up to date. **Particular attention should also be paid to older women's access to education**. Throughout their lives, women face additional obstacles to learning than men. When they are older, they might have not had the opportunity to acquire the skills they need to participate, and/or face additional barriers related to both their age and their gender that limit their access to training and therefore to participate.

At the European level, **a service dedicated to older people within the European Commission** ensured by the Directorate General Justice and Consumers, and **the re-establishment of the Intergroup on Ageing and Solidarity between Generations** would ensure that both the Commission and the Members of the European Parliament are committed to defending the rights of older people and that older people and their representatives are regularly consulted and involved throughout the decision-making and implementation process of public policies that affect them. In addition, the participation of older people will benefit from exchanges and dialogue with younger generations. The intergroup would be the ideal place to **maintain a dialogue between the generations and promote intergenerational solidarity,** including exchange of cultural, professional, technological knowledge and skills between younger and older people.

It could also give rise to more ambitious measures on dialogue between generations or participation of older persons, similar to the European Disability Parliament or the European Youth Event.

Contact

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AGE Manifesto Pillar #3

Ensure autonomy and well being

2024 European Parliament Elections

AGE Platform Europe

04 June 2024
www.age-platform.eu

Ahead of the upcoming European Parliament elections in June 2024, AGE Platform Europe calls in its Manifesto for a Europe for all ages. At the heart of the Manifesto are three major appeals to future Members of the European Parliament:

- Promote age equality
- Foster participation and active ageing
- Ensure autonomy and well being

By means of three Manifesto Pillars, we explore these calls in details and provide future EU officials with recommendations for changes that we believe are essential for a European Union that address adequately population ageing and works towards a society for all ages.

Access to the AGE Manifesto blog

Endorse the AGE Manifesto

Previous Manifesto Pillars:

- #1 Age Equality
- #2 Foster participation and active ageing

About AGE Platform Europe

AGE Platform Europe is the largest European network of non-profit organizations of and for older people. We elevate older people's voice, bringing their experience and aspirations to the table to celebrate ageing and fight for equality at all ages.

We call on the next European Parliament to ensure autonomy and well-being

What do we mean by autonomy and well-being?

Older persons have the same rights and opportunities to autonomy and well-being as anyone else. Everyone has the right to work, to enjoy financial security, to have access to health and long-term care and to live in an environment that supports and empowers them. All people should be protected from violence, harassment, neglect and abuse. This is no different for older persons, however their rights are not upheld on an equal basis with others. There are also policies that have some negative impact on us in younger age and continue bearing important consequences as we age. Policies should support us all along our lifespan and enable us to reach older age in full enjoyment of our rights.

Autonomy is the right to have control over one's life, to make one's own decisions and to have those decisions respected in an informed and uncoerced manner. It means to be empowered and supported to take decisions without undue influence.

Well-being means what is intrinsically valuable to someone. This involves – among others - the ability to guarantee ones' housing, food, energy, but also one's highest attainable standard of health and independence; as well as meaningful relationships, the inclusion in the community, the ability to pursue one's aspirations, to learn and evolve, to have access to culture, to contribute to society. Well-being has many different dimensions: physical, mental, social, cultural, economic, emotional, the perception of social justice.

Why is fostering autonomy and well-being in old age important?

Achieving autonomy and wellbeing is challenging for many older persons:

- **Older workers** may not be able to continue working and evolving in their jobs because of ageist glass ceilings, lack of access to training, new technologies raising a clear risk of exclusion, occupational, safety and health strategies that do not take a life-course approach and do not include older workers, because of age discrimination in hiring practices or the communication of employment opportunities in channels that are only used by particular age groups. Intersectional issues also affect older workers, such as older women, older workers with disabilities etc.

Employment rates of people between 55 and 64 have been 64% in 2023, compared to 75% for the entire 20-65 population. For 55-64-old women, the figure was 58%. Long-term unemployment is much more prevalent among older workers than among other age groups. Besides the sense of fulfilment that can come from employment, inability to enter the labour market has also important outcomes in terms of upholding one's income and living standards. Not working might be penalised in retirement systems as an incentive increase career duration, meaning that older people who cannot find a job lose out more than other age groups of unemployed. For those who would be able and willing to continue working past retirement age, this can become very difficult as there are still instances where employment contracts are terminated by default, inadequate or minimal social protection, and important services such as access to life-long learning may no longer be available past statutory retirement age. Between age 55 and 64, poverty and social exclusion rates are higher than for other age groups (23% vs. 22% for all age groups, 24% for women 55-64).
Events and experiences in the earlier career – unemployment, inability to access diplomas, care-related career breaks, experiences of discrimination or exclusion, health issues – have an impact on the chances to stay on the labour market in the later career. This makes it necessary to account for diversity in the older workforce when promoting employment at older age, rather than seeing them as a homogenous group.
AGE has recently mapped initiatives that empower workers to lead sustainable and quality working lives in its latest AGE Barometer.

- **Pensioners depend on pension systems for their income**, which should guarantee life free from the risk of poverty and social exclusion, compensate fairly for contributions to society during working life, be predictable and sustain an adequate standard of living until the end of life. Pension systems should also provide for solidarity mechanisms for periods in our lives when we are unable to work, because of sickness, care to children, persons with disabilities or other needs for support, unemployment etc. And pension systems should respond to sudden shocks, such as the 2021-22 inflation surge. This should not only be guaranteed for current pensioners, but also for the generations of pensioners-to-come.
  However, since 2014 old-age poverty (65 years and more) is increasing slowly and reached 20% in 2022. It is even higher for women aged 75 and up, affecting one in four women. Some Member States have minimum guaranteed incomes applied also to pensions, but the level at which these are set do not reflect the poverty threshold or costs of living to live in dignity. During the inflation surge of 2021-22, all governments adopted measures to support the purchasing power of citizens, but these were very often geared towards workers rather than pensioners and other categories of the population. In some countries, inflation has significantly reduced the purchasing power of pensions, despite pensioners have mobilized to ask for additional and extraordinary indexation. Furthermore, pension indexation rules have changed in many countries to take more account of

price developments (inflation) than wage developments. In some cases the Government's objective was to limit the burdens on the State budget, so the change in the rules led to reduced indexation for medium and high pensions. That also means that over the medium, term, pensioners have a relatively smaller increase than workers, leading to growing inequality
While there are EU-level exchanges about how pension systems compensate for periods of care responsibilities there is no European framework on this. The gender pension gap is currently at 27%, exceeding the gender pay gap by 10 percentage points and pension care credits could contribute to lower this.
Labour migration within the EU and the complexity of Member States' diverging rules regarding pension eligibility, tax treatment of statutory and supplementary pensions make it complex for mobile pensioners to access similar entitlements as non-mobile ones.

- The European Union has made important advances in the **fight against violence** against women, by the ratification of the Istanbul Convention and the Directive against gender-based violence. Similarly, the revision of the Directive on Victim's Rights is expected to improve the protection and support which all victims of crime can access, including older persons. Ageist violence is a reality: at the beginning of the COVID-19 pandemic, we have witnessed a wave of hate crime and hate speech against older persons as responsible for the severe restrictions of free movement, cultural and social life during the lock-downs.
  However, **elder abuse is still a largely unknown and under-researched phenomenon**. It can take the form of physical, emotional, psychological, sexual or financial abuse, or neglect, such as through the denial of care or the inadequacy of resources for care and many other forms. Violence can be perpetrated by strangers and by intimate family members or carers. Information on violence against older persons is rather scarce and depending on the study, prevalence rates vary between 0.8% and 29%, with a significantly higher prevalence rate for older women. WHO estimates that these numbers are probably largely underestimated and underreported. Gender and declining health can be key risk factors for violence and abuse.

- **Care services are widely unavailable** and have yet to take a shift in approach towards fully supporting autonomy. The needs for quality care services are increasing due to longevity. At the same time, it is estimated that 80% of care is provided by unpaid informal carers – most of the time, these are family members. Carers are often women who need to take time from their working lives to provide care and support for their close ones. Sense of overburdening, loss of income and social connections and reduced health are frequent among informal carers. **Informal care should remain a choice** and not an obligation due to the absence of appropriate services. This requires resolute social investment.
  Older persons in need of care and support, are not sufficiently supported by **accessible, quality formal care services**. While a majority of persons in need of care would like to receive **care at home**, only one in three have access to home care and almost half have unmet needs for help. The costs

of care would put 60% of older people at risk of poverty in 11 EU countries, even after receiving public support – making financial reasons the most prevalent reason to not access home care. In residential care, most facilities put their institutional needs above the rights, needs and wishes of their residents. With **severely limited human resources**, it is difficult to provide better quality and expanding service offers.

Older persons with cognitive diseases or impairments may be unable to **access supported decision-making services.** They may be deprived of their legal capacity and face informal barriers in making decisions about their lives.

The **EU Care Strategy** has developed and upheld important quality principles and ambitions for Member States, by placing respect at the centre of care provision, encouraging the development of community-based and home care, support for informal carers and to recruit more, better trained, staff into this sector of strategic importance for upholding our dignity in old age. However, it depends on Member States to take up this process and trigger changes towards care systems that promote autonomy and well-being. AGE has developed a vision for change in care services, supported regional authorities to find ways to implement a rights-based vision of care and developed quality principles that should be implemented. Recently, AGE has mapped the needs in Member States that require the most urgent attention for reform.

These policies require public funding, be it from social contributions or from taxes. As debt levels have risen substantially during the pandemic and the inflation surge, when the EU debt rules were eased, their reactivation from 2025 will put a severe burden reducing funding. Some Member States have taken reserves out of national social insurance schemes to fund other needs, leading to an additional pressure in pension and long-term care systems.

What do we need on EU level to achieve it?

AGE advocates for the adoption of an EU Age Equality strategy. The AGE Manifesto 2024 spells out the policies and areas that such a strategy should put in place and coordinate. Several items/issues have already been addressed in our Manifesto Pillars on Age Equality and on Participation and Active Ageing. Here, we develop our main demands in in relation to autonomy and well-being.

AGE, together with a variety of stakeholders, has called for ambitious social and health policies in the next legislature. This must involve investment into quality social services that enable autonomy and well-being.

Policies should **empower older workers for sustainable and quality working lives**, by removing barriers such as mandatory retirement ages, tackling age discrimination in the labour market, and adapting the workplace for all ages. We need to change the narrative on ageing at work and recognise the full potential and experience of older workers – not just in debates about financial sustainability of pension systems but highlighting their genuine value and rights.

Employers should implement age equality strategies at work by using specific tools to maintain, recruit and support older workers – some have already done so, and the European Union can play a key role in exchanging information about these practices and making them more widespread. Also, the European Social Partners Agreement on Active Ageing and an Intergenerational Approach provides an important framework that should be pursued and developed. At the same time, public authorities could support this by developing outplacement services for older workers leaving a job to reduce the risk of long-term unemployment or inactivity. Much has been said and done in developing life-long learning in the current legislature – such as individual learning accounts – but this must be more targeted towards older workers to prevent premature labour market drop-out. Developing European legislation on equal treatment, in particular in the area of access to goods and services. AGE has reviewed and proposed ways to improve the implementation of the Employment Directive can also help in lowering the barriers for older persons to remain in employment and equally participate in and benefit from society. Beyond ensuring the right to work, these policies will also help to reduce labour shortages linked to the thee big evolutions of our labour market: demographic, green and digital.

We should develop systems that promote well-being at work to ensure that all people age in a condition that allows them to work for as long as they desire. This includes also addressing mental health issues at work, alongside the existing framework on physical occupational health and safety and finding possibilities to fight against ageism and discrimination at the workplace. This also implies better policies to reconcile work and private life throughout the lifespan, for example by promoting equal care work through adequate remuneration for care leaves, mandatory co-parenting leave or parental leave, or support to informal carers.

Digitalisation is often seen as a way to reduce workload and make jobs more sustainable – all the more since the development of generative artificial intelligence. However, older workers might be negatively impacted if the rollout of technologies is not accompanied by training and skills policies. This will not happen by itself, there needs to be more effort to make technology and digital skills more inclusive, accessible and available.

Securing the adequacy of pensions and old-age minimum income schemes, means to set initial pensions at an adequate level and to address their erosion over time. This is by and large a national competence, but European fiscal rules are putting pressure on Member States to reduce their public deficits; for instance in the 2010s, pension systems were the main sources for reduced spending. The European institutions are doing important work with the tri-annual Pension Adequacy Reports, and they hold up the mirror of rising old-age poverty despite high employment rates. The EU should take this into account. The **Council recommendation on adequate minimum income** provides a benchmark for adequacy, also for minimum pensions: pensions should protect from poverty and social exclusion. AGE continues to advocate for a more binding framework, such as a **Framework Directive on adequate minimum income**, but the action under the Council recommendation should also lead to notable increases in minimum benefits and pension indexation mechanisms that uphold fairness and adequacy as pensioners age. To support pension adequacy for women, credits to account for periods out of the labour market for care should be integrated in all pensions

systems, and this should be part of a **Council recommendation on gender equality throughout the lifespan**. A similar approach could be taken for occupational (employer-sponsored) pensions: collective pension instruments should provide continued accrual of pensions during maternity, parental or carers' leave.

There are a number of issues regarding **transferability of pension rights and migration of workers within the EU**. Despite the ground-breaking directive on the coordination of social security systems, inconsistencies continue to apply: pensions can be taxed by two Member States, persons might have to pay for long-term care in the Member State they live in without reimbursement from the health or care insurance of the Member State that they depend on for their social protection. Depending on the degree of health care funding from two member states (via a specific premium or via taxation),a pensioner receiving pensions and reimbursement for health expenses from another member state than their state of residence may be double taxed. Others might no longer be able to work in their Member State of residence because of mandatory retirement, while they do not qualify yet for unabated pension payment from the Member State where they contributed for a significant part of their career. These should be topics for a **review of the EU rules on cooperation in social security** which take account of longevity and increased mobility of EU citizens.

We should protect older people against all forms of abuse and violence. First of all, this means understanding the phenomenon by intensifying research on the prevalence, risk factors and effective interventions against elder abuse and gathering data, disaggregated by age and disability. In addition, the recently revised Victims' Rights Directive should be applied in a manner that supports older victims of abuse and addresses some of their main risk factors. For example, it should be **possible to report abuse within long-term care settings to an independent support organisation without being penalised for it**. Prevention and information about abuse and neglect should be included into the **training of all health and care professionals**, including in continuous education. Quality standards must be effective and subject to independent inspection regardless of the type of care: residential or home-based, public or private. However, abuse and neglect happen also within families. There should be proactive outreach campaigns of support services to persons at risk, such as persons living alone, older women, persons with disabilities or cognitive impairments, older migrants and so forth. **Public authorities should fund multi-agency collaboration for the prevention and resolution of elder abuse**. The EU can support this by making elder abuse more visible on **World Elder Abuse Awareness Day – 15 June** annually, by fostering exchanges of practices, encouraging the use of EU funds for the prevention of elder abuse and provision of assistance to victims, and by making the **prevention of abuse an enabling condition for the acquisition of EU funds**, in particular in the fields of health and care.

To ensure **autonomy, independence, participation, and inclusion of older people in long-term care**, we need to improve the quality of long-term care. The EU Care Strategy and the Council Recommendation on Long-Term Care are very important developments in this regard, and the Commission and Council should continue to remind and encourage member states to live up to their commitments. These include presenting plans for the implementation of the Strategy and to

follow up on them. We have described the main priorities for reform for many Member States in our recent publication. **The Commission must continue to actively steer this process** and to encourage the use of EU funds for the development of high-quality care services. Care policy involves many different stakeholders: public authorities from national and local levels, national insurance schemes, service providers and workers' organisations, older persons, persons with disabilities, families, informal or unpaid carers, personal household service providers, migrant workers' organisations, and so forth. To create a constructive dialogue and uphold the ambition, **AGE and other partners have called for a European Care Platform**, which would bring all these stakeholders together regularly to support and uphold a rights-based shift and roll-out of quality care services.

The most important challenge identified by our members is **staff shortages**. There is already a **large-scale skills initiative** created by the care sector at EU level. The new institutions should actively support this initiative. In parallel, social dialogue on working conditions should be further amplified in order to build the attractiveness of the sector as a career path. Care professionals should be adequately trained throughout their careers and they should be better supported to combat burnout in their professions.

Informal and unpaid carers need better support. AGE already called for a **Council recommendation on social protection and services for informal carers** in 2019. The Council recommendation on long-term care includes a call for better support services, but little has been done to secure income support, improve reconciliation of work and care, to provide training and to support the health of informal carers. This does not do justice to the importance of their unpaid contribution, so we reiterate this call.

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Work-life integration

Policy Paper

AGE Platform Europe

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Informal care is a multifaceted landscape, shaped by the diversity of those who provide it, the unique situations they face, and the varying needs they encounter. It represents a tremendous economic value, informal carers playing a crucial role in ensuring the well-being of those most in need while supporting indirectly the broader healthcare system. **As demographic trends and policy shifts increasingly favour home care for older adults, the number of workers who also serve as informal carers is expected to rise significantly.** Adequate and flexible working conditions, along with quality care services, are essential not only to support but also to empower informal caregivers.

By valuing informal care, promoting gender equality, and ensuring access to flexible working arrangements tailored to individual needs, the implementation of the EU Care strategy and the strengthening of the Work-Life Balance Directive (Directive (EU) 2019/1158) can be transformative. These measures have the potential to create a more inclusive and equitable labour market. However, for these efforts to be truly effective, European legislation must better recognize and support the essential role of informal carers, and Member States must fully adopt and strengthen these provisions to maximize their impact.

Diverse situations and needs: embracing the complexity of informal care

Depending on their specific caregiving situation, **informal carers face diverse challenges**. Some are required to provide round-the-clock care, often living with the dependent person, while others, may only be able to visit a few times a week or after work. The needs of informal carers can vary significantly, with those providing emergency or short-term care facing different challenges than those involved in long-term caregiving, which can last for years. Addressing these varied needs requires tailored solutions within the broader framework of European and national policies. To date, the Work-Life Balance Directive defines a carer as a worker who provides personal care or support to a relative or a person who lives in the same household as the worker and who needs significant care or support for a serious medical reason. While providing a legal status to informal carers, this definition remains rather succinct and does not consider them in their diversity.

To fully address the diverse situations and needs of informal carers, we must move beyond the traditional binary view that separates work and personal life, often seen as opposing forces. Instead of using the term ‘work-life balance’**, AGE Platform Europe and its members advocate for adopting the concept of 'work-life integration,'** a term originally defined by the Haas School of Business at the University of California[1]. This approach

[1] Work-Life Integration - Human Resources - Berkeley Haas

emphasizes the interconnectedness of personal and professional domains, recognizing that they are not mutually exclusive but rather intertwined aspects of our lives.

Unlike the notion of work-life balance, which can imply an unrealistic separation of time and responsibilities between work and personal life, work-life integration offers a more realistic and holistic perspective. It acknowledges that our careers encompass all roles we play in life, blending our professional responsibilities with our personal identities. This shift in understanding better reflects the lived experiences of informal carers, allowing for a more comprehensive approach to supporting their needs.

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*"In the concept of **integration** lies the logic of holding together the components of a whole, consistent with the values and desires of the individual and his or her relatives. The traditional image of the binary opposition between work and life is replaced by a holistic vision in which synergies are created between all the areas that define 'life': work, home/family, community, personal well-being and health'.*

Cristina Cortesi, Italy, CUROPOLI Ente del Terzo

Empowering older women in the labour market

According to the World Health Organisation, on average **70% of unpaid informal carers are women**[2]. Despite the growing participation of women in the labour market, they continue to take on a disproportionate share of family responsibilities and unpaid care. This phenomenon is deeply rooted in social structures and perpetuates gender inequalities. Reduced working hours or withdrawal from the labour market because of family responsibilities have immediate and long-term consequences for women's incomes and the distribution of family responsibilities, exacerbating the gender employment and the gender pension gap[3].

In this context, older women can find themselves in a particularly vulnerable position. In addition to the cumulated gender discrimination, they are confronted with throughout their lives, they face a range of additional discrimination based on age. The intersectionality of sexism and ageism also creates an additional category of discrimination which has a significant impact on older women in the labour market. Other factors may also come into

[2] Caregiving impacts on informal carers' health and well-being – a gender perspective – Eurocarers
[3] The gender pension gap was seen at 26% in the EU in 2022 - The 2024 pension adequacy report - Publications Office of the EU (europa.eu)

play, such as social class, origin and sexual orientation, creating unique experiences of marginalisation that weigh even more heavily when work-life integration issues come into play.

For women aged between 50 and 64, the gender imbalance is more pronounced than for any other age group[4]. As a result of these new family responsibilities and the fact that they are not too far away from the statutory retirement age, many older women are reducing their working hours by opting for part-time work or early retirement, which reduces their income, slows down or prevents them from considering career progression and reduces their pension. The Work-Life Balance Directive aims to enable greater participation of women in the labour market alongside caring duties, and to reduce these responsibilities by encouraging more men to take over. However, the directive is unable to fully achieve its objectives, as demonstrated by an increase in unpaid care work and a rise of existing inequalities in unpaid care during the COVID-19 pandemic, highlighting the need to reassess and reshape the existing legal framework[5].

Unvalued caregiving impacts both caregivers and the society

Today, 80% of care in Europe is provided by informal carers[6]. Due to the high number of women in this role and cultural perceptions, caring is often seen as a 'feminine' responsibility, ignoring and sometimes even devaluing men who are informal carers and confining women to this role. **It is important to promote and effect cultural change in the way we perceive caring and to raise the status of this role, regardless of the gender identity of the carer.**

Informal carers receive little or no recognition, even though the value of informal care is estimated at 2.4% of EU GDP[7] and that informal carers struggle between their jobs and their caring duties. As things stand, many informal carers have no choice as to whether or not they provide care, or to what extent. In addition, **many carers experience negative effects** on their health, social inclusion, financial stability, educational opportunities and employment prospects due to a lack of adequate support. Of these, **the 45-65 age group is the most likely to provide care or informal help at least once a week**[8], most of them to support ageing parents. These people are still active in the labour market, or might wish to be, but

[4] In 2023, the employment rate of women aged 50 to 64 is 58.1%, compared with 70.1% for men: Employment rates by sex, age and citizenship (%) [lfsa_ergan__custom_12748933]
[5] Reshaping the Work–Life Balance Directive with Covid-19 lessons in mind-2022.pdf (etui.org)
[6] EU Election 2024 Manifesto – Caring for informal carers: you have a crucial role to play ! – Eurocarers
[7] EU Election 2024 Manifesto – Caring for informal carers: you have a crucial role to play ! – Eurocarers
[8] Statistics | Eurostat (europa.eu)

these responsibilities, combined with ageism in the labour market[9], can make it difficult to maintain stable employment.

The Work-Life Balance Directive, which aims to support informal carers, is a first step towards a better support, but its material provisions are clearly inadequate and hamper the effectiveness of improving the integration of work and private life. Firstly, the duration of carers' leave, which is five days per year per worker, hardly seems sufficient to provide care - at best, it provides for a few days to coordinate formal care services in the event of an immediate or urgent need for care. Secondly, while the directive introduces the right to adequate compensation for parental and paternity leave, no such provisions exist for carers' leave. **It is essential and urgent that informal care is better considered, valued and supported in Europe**. The EU Care strategy goes in the right direction by explicitly recognising the societal and economic value of informal care and the fact that carers should benefit from appropriate services enabling them to reconcile their professional and private lives, such as flexible working hours and access to respite care services. This EU Care Strategy must now be transposed into national legislation, with appropriate monitoring and evaluation procedures at EU and Member State level, and with the involvement of the organisations concerned on the field.

Informal carers and intergenerational solidarity: at work and in society

Flexible working arrangements help employees of all ages, whether as parents or as informal carers, to achieve a better work-life integration, thereby improving well-being and reducing stress**.** This can foster a more harmonious and supportive workplace where employees feel supported and valued, whatever their age. Indeed, flexible working conditions that take into account the needs of informal carers can lead to greater job satisfaction and retention of employees in all age groups. The flexibility and adaptability benefit all employees by creating a supportive environment that can respond quickly to changing circumstances, such as family emergencies or health problems.

Supporting workers who are also informal carers by offering them flexibility in their time and place of work promotes lifelong learning and professional development, enabling employees of all ages to gain new skills and experience that will also benefit the business. As well as supporting informal carers in balancing work and caring duties, adequate working conditions and support enable older workers to consider working beyond retirement age if they so wish. **This can also support people who have reached the legal pension aged in their decision to stay in the labour market for longer, to reconcile pension and part-time**

[9] End age discrimination in employment - AGE Platform Europe (age-platform.eu)

work or to return to work after a break. Collaboration between the generations benefits from this, especially as the diversity of ages in the company allows for a better exchange of knowledge between employees, a retention of experience and innovation. Employers can also set up mentoring programmes. These exchanges and this diversity of ages in the workplace help to fight stereotypes and age discrimination.

Finally, outside the workplace, flexible working arrangements can allow older relatives to modulate their working hours and locations to help young parents, while conversely, younger workers can support their parents in their caring roles. This intergenerational solidarity means that at any age, parents and carers, can be supported in their job search, retraining, apprenticeship and progress in the labour market.

> *"Intergenerational solidarity is a two-way street: young people often rely on parental support when job hunting, and when parents lose their jobs, it can force their children to abandon studies and take any available job. The employment status of older workers directly impacts the younger generation. Supporting older workers, especially in caregiving roles, also supports young people's employment, fostering positive intergenerational solidarity."* – an AGE Platform Europe Member

Some Member States are implementing policies and/or legislation aimed at attracting carers from abroad, like EU initiatives designed to bring in talent from outside the EU, in order to address the increasing demand for care services in these countries. Many people with a care background are responding to this demand for better working conditions and better pay. Although this dynamic responds to immediate needs, it can lead to long-term problems for the countries of origin and destination. These policies contribute to a major brain drain in the countries of origin, the loss of potential informal carers who are essential to the smooth running of the economy and **the loss of intergenerational exchanges**, and therefore the transmission of knowledge, within families. By recruiting from abroad, host countries may also be tempted to reduce investment in support, education and training in care, work-home integration and loosing par of intergenerational exchanges within their own population. To remedy this, **it is essential to start harmonising legislation and policies at European level to value the work of informal carers in all Member States.**

RECOMMENDATIONS

A critical reassessment of European work-life integration standards, and particularly the Work-Life Balance Directive, is needed to ensure that they meet the needs of modern workers. To this end, AGE Platform Europe recommends enhancing the position of informal carer, both at work and in society, by:

1) Strengthening carer's leave

According to a study carried out in January 2023 by Reed Smith for the Social Platform[10], **the Work-Life Balance Directive is not implemented equally in all Member States**. Belgium, for example, does not respect the minimum 5-day leave for carers. Some countries, such as France and Greece, have added conditions based on the carer-recipient relationship or the length of employment. The directive also gives carers the right to request flexible working hours and arrangements. However, Member States vary in their implementation, with some, such as Cyprus and Sweden, requiring a period of professional qualification for requests for flexible working European monitoring of the implementation of the directive in the Member States must be the number one priority.

The directive should also be revised and strengthened to guarantee a higher common minimum number of days off, without conditions of qualification or length of employment, and with appropriate monitoring and evaluation procedures both at EU and Member State levels. Smaller companies or those with limited resources should be supported by governments to enable them to guarantee these minimum provisions to employees. Informal carers represent a significant economic save which is likely to increase in the years to come given the policies favouring staying at home as long as possible. To maintain this fragile balance, governments must also guarantee support and assistance to the most vulnerable businesses and their employees.

Finally, the directive currently gives employers the discretionary power to grant flexible working arrangements and leave, without there being any formal legal right for workers. Carers can ask to work flexibly, but employers are not obliged to accede to their request. There is an urgent need to define the criteria under which an absence is justified and must be accepted by the employer in European standards. Based on these criteria, **employers should then justify their refusals on a common basis in all Member States**, protecting both their interests and those of carers. At the same time, and beyond European or national

[10] 2019 EU Work-Life Balance directive - Overview of national transposition measures. (s. d.). Reed Smith - Prepared at the request of Social Platform.

legislation, collective agreements should also play an important role by involving the social partners and negotiating as closely as possible to local needs, the specific features of the sector and the constraints of employees.

2) Providing financial and structural support

To date, European standards do not guarantee **financial support for carers**. The EU Care strategy aims to fill this gap through Council recommendations, which urge Member States to take voluntary action.

> *"In Portugal, if you need home care for your relatives, there is no place available anymore, and you don't have the choice, especially if you can't afford it in the private sector. The only option is to become an informal carer."* Teresa Martins, Portugal, APRe! - Associação de Aposentados Pensionistas e Reformados

In many regions, either home care or residential care are unavailable or not affordable: for example, home care might have to be paid from a persons' own pocket, while residential care, which might not be adequate to a persons' situation, might be fully reimbursed. The Council's recommendation on long-term care[11] emphasizes the need to **strengthen the affordability and availability of home and community-based care**. The funds not spent by the State and/or local institutions on building and managing residential facilities for dependent older people should be redirected to support informal care, by providing financial support for informal caregivers and developing the care services sector for instance.

Reinforcing community support is also essential and could involve creating support networks with more proactive public services that maintain regular contact with older people as a preventive measure, rather than responding only in emergencies. Regular communication between care professionals and caregivers must be established to better coordinate the care provided. In Portugal, for instance, several initiatives have been developed since the COVID-19 pandemic, such as neighbourhood policy programs[12] that support and maintain regular contact with isolated older individuals.

Caregivers could be compensated in various ways, such as through paid support services like respite care, counselling, psychological support, training, and peer exchange programs. Caregiving time could also be factored into the calculation of their pensions. **Upgrading the**

[11] EUR-Lex - 32022H1215(01) - EN - EUR-Lex (europa.eu)
[12] https://www.gnr.pt/ProgEsp_idososSeguranca.aspx

status of caregivers through appropriate remuneration would not only support current informal caregivers—most of whom are women—but also help achieve the objectives of the Work-Life Balance Directive by encouraging more men to become involved.

Finally, **new technologies are an asset to consider improving the integration of work and private life**. During the COVID-19 pandemic, teleworking was adopted by many companies and remains an option for many workers. Teleworking can help carers by reducing commuting times, for example. However, it is essential to supervise and regulate teleworking so that it does not lead to an overload of work for informal carers or reinforce gender inequalities. Furthermore, teleworking is only possible for a few professions and cannot be generalised as an ideal option for all jobs. Nevertheless, new technologies have the potential to be explored to improve working conditions and facilitate the integration of carers' professional and private lives in a wider range of professions.

3) Adopting an inclusive and intersectional approach

Adopting an inclusive and intersectional approach to supporting informal carers is essential to recognise the diverse realities of carers and to create a more equitable environment in which all workers can reconcile their work and caring responsibilities.

The intersection of age with discriminations based on gender, social class, ethnicity, disability, or sexual orientation significantly exacerbates the challenges older individuals face in accessing support for their role as informal carers. **The definition of a 'carer' in European legislation also needs to be broadened to better reflect diverse family structures**, including stepfamilies and LGBTI families, which may not be recognised in the same way in all Member States. By adopting an inclusive and intersectional framework, future reforms can ensure that all carers - regardless of their employment status, age or family composition - receive the necessary protection and support.

Extending protections to retired people and all type of jobs, including platform workers and the self-employed, many of whom are older or retired workers, would also ensure that all carers have the same rights and support, regardless of their situation. Although some Member States have social security schemes for the self-employed, these vary considerably. Other EU laws, such as Directive 2010/41/EU on equal treatment between men and women working as self-employed persons[13], indirectly support work-life integration, but do not offer equivalent measures.

Financial inequalities between informal carers have a profound impact on their ability to access care services and support. These financial inequalities can lead to significant

[13] Directive - 2010/41 - EN - EUR-Lex (europa.eu)

disparities in the quality and availability of care provided to those in need. Carers with greater financial resources can afford better quality care options, while those with fewer resources can rely on less comprehensive state-funded services that are often overstretched and underfunded. This disparity affects not only the carer, but also directly the health and well-being of the person being cared for.

To meet these challenges, **it is essential to adopt a person-centred approach** to supporting informal carers that would advocate greater flexibility in access to services, allowing carers to choose the types of support that best meet their needs, whether that be financial assistance, respite care or advice. It would also involve better integration of services to ensure that carers can easily navigate and access the full range of support available without unnecessary barriers.

You can stop ageism!

Please read our one-pager on communicating on older persons in a non-stereotypical way.

About AGE Platform Europe

AGE Platform Europe is the largest European network of non-profit organizations of and for older people. We elevate older people's voice, bringing their experience and aspirations to the table to celebrate ageing and fight for equality at all ages.

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AGE member survey on the EU Care Strategy

National priorities to implement the Council recommendation on long-term care

With contributions from Belgium, Cyprus, Czechia, France, Germany, Italy, Malta, the Netherlands, Norway and Poland

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May 2024
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Executive Summary

The EU Council Recommendation on access to affordable, quality long-term care is an important milestone for the European Union, as it includes a person-centred and rights-based approach to long-term care based on quality principles such as 'respect'. Against the backdrop of increasing longevity and the likely increase of long-term care needs, and the renewed pressure to reduce public deficits and budgets, it is important for the EU and Member States to reaffirm the ambition to which they committed in the Recommendation. The Council recommendation requires Member States to publish the national implementation measures that they intend to take to transpose the principles to which they committed.

AGE has collected views from its members on national level to define which pieces of the long-term care system in their country need the most urgent attention. Looking at the different contributions, AGE puts forward the following recommendations to implement the ambition included in the EU Care Strategy:

- Social and health ambitions should be part of the next Council Strategic Agenda for 2024-2029.
- It is time for a European Care Platform as part of the European Pillar of Social Rights Action Plan.
- Member States must show political will for establishing rights-based long-term care systems.
- Member States must pursue dialogue with civil society representing persons in need of care, persons with disabilities and their families.
- Workforce shortages seem the most common barrier to the success of the Council recommendation.
- Member States must develop sustainable funding mechanisms for long-term care services.
- To achieve autonomy and independence, all kinds of health and long-term care policies need to be developed to ensure an available spectrum of care that suits all needs: health promotion, prevention, curative generalist and specialist care, home and community-based care, support to informal carers, palliative and end-of-life care, housing adaptation and accessibility of environments, mental and physical health care.
- Long-term care must meet the reality of free movement within the EU.

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Introduction

We all want to age in good health and maintaining our independence. Yet, older age is often associated with the idea of increasing frailty, reduced independence, disability and/or sickness and moving into residential care. This mental model however does not fit the reality: residential care is far from being the standard model, as 80% of care is estimated to be provided by informal carers, often female relatives who reduce their own opportunities for employment, income, social inclusion to provide care to their loved ones. Also, developing a care need is not a fatality: many people do age without major health issues, and there is a range of conditions and disabilities that have only a progressive onset, against which preventive, curative or rehabilitative treatments are effective. With the advancement of the rights of persons with disabilities, not the least the UN Convention on the Rights of Persons with Disabilities, alternative forms of care such as home care, community-based care, personal assistance, and the development of adaptable and accessible housing and environments, including technical assistance become more available and known.

Overall, we are observing a shift from paternalistic models that 'care for' 'dependent' persons to models that empower persons in need for care to maintain their independence – aiming at the enjoyment of the same rights and opportunities as other persons.

The EU Care Strategy of September 2022, and the Council recommendation on access to affordable, quality long-term care of December 2022, include these considerations by encouraging Member States to develop person-centred approaches to long-term care. This new framework resonates well with AGE's vision of care: that it empowers us throughout our lives. These principles also find themselves in the WHO Framework for countries to achieve an integrated continuum of care, developed as part of the UN Decade on Healthy Ageing.

The Council recommendation therefore holds the potential for reform of our long-term care systems, depending on the starting point of each Member State and/or region.

However, it is vital for the success of the EU Care Strategy, and in a wider sense for the harnessing the potential of longevity in Europe, to sustain the momentum of the Council recommendation on national, regional and local level. While the European Commission is organising helpful mutual learning exercises, advice on reforms funded by the Recovery and Resilience Programme, the Technical Support Instrument, the European Social Fund Plus and other funds, the actual uptake of the Strategy lies with the national level. Therefore, AGE has surveyed its members to bring in their local and national experiences, setting the priorities that should be addressed most urgently to implement the Council Recommendation.

AGE hopes to positively contribute to the drafting and refinement of national plans of implementing measures of Member States, to be released in June 2024, with the present contribution.

AGE recommendations: using the EU Care Strategy and Council recommendation as a lever for change

The national contribution outlined below highlight common aspects that should be taken into account for the entire European Union. Also, in our exchanges on the EU Care Strategy we realise how important it is that the European institutions continue to promote its implementation.

To keep the momentum of the EU Care Strategy, AGE has co-signed two important common appeals towards the Member States as a whole:

Social and Health ambitions should be part of the next Strategic Agenda 2024-2029

Facilitated by the European Social Insurance Platform, AGE Platform Europe has co-signed a statement to the European Council to ensure that health and social ambitions are part of the next five-year Strategic Agenda which the Council will adopt in view of the upcoming legislature. This was issued relative to the concern that leaked version of the leaders' discussions did not include social policies as an important priority.

The reform of the Economic Governance Framework on public spending and public debt allows for some more flexibility for Member States on public spending, including when implementing European priorities such as the European Pillar of Social Rights. However, the return to the fiscal software governing the austerity policies of the 2010s, connected with the high public debt levels made necessary by the effective and coordinated European response to COVID-19 and high inflation in the wake of Russia's aggression against Ukraine, does not bode well for the importance of social policies. Increasing longevity and the already unsustainable shortages of quality services as well as care workforce command durable investment into care services, but also into social benefits and services which support health promotion and prevention, make environments accessible to persons with disabilities, provide rehabilitation and reintegration and support people in their independence and autonomy. Therefore, the next Strategic Agenda should be unequivocal that social investment is necessary to turn longevity into a success story for the EU.

Time for a European Care Platform as part of the European Pillar of Social Rights Action Plan

Ahead of the La Hulpe summit on the European Pillar of Social Rights (EPSR), AGE co-signed a declaration of a number of European NGOs calling for a European Care Platform as part of the EPSR Action Plan. The La Hulpe conference reconfirmed the institutions' commitment to the Pillar of Social Rights in the next legislature, but the Declaration suffers from important weaknesses: on one hand, Austria and Sweden have not supported the Declaration. On the other hand, long-term care does not enjoy a very prominent part in the declaration, despite being subject of Principle 18 of the European Pillar of Social Rights. The Declaration does not even name the EU Care

Strategy or the Council Recommendation, nor does it remind Member States of their commitment to implement the Recommendation. Care is mainly seen from a lens of 'increasing needs' and labour market integration of persons with responsibility for people in need of care, not as an own right in the spirit of the EPSR.

The EU Care Strategy and the fruitful exchange between the Member States, the Commission and relevant civil society organisations should be pursued and made permanent by the creation of a European Care Platform.

Political will for change as the basis for establishing the long-term care sector.

Across Europe, long-term care systems suffer from fragmentation of competences between authorities and a lack of political attention to the needs of the sector. For instance, very often responsibilities for long-term care are divided between the ministry of health, the ministry for social affairs, the national social protection institution, regional and local governance levels. The division of competencies might not be the same whether care is provided in residential settings or at home. This leads also to a lack of clarity for persons in need of care and their families, differences in the accessibility of residential and home care and between urban and rural territories.

Where care services exist, they may still follow a functioning where persons in need of care have to conform to the services' logic, rather than benefitting from services adapted to their needs and wishes.

To change this situation, political steering and attention is needed. Some examples such as the reflection process initiated on regional level in the Biscay province, or the Brussels region show that it is possible to change the mentalities, and this does not necessarily mean to massively increase spending on long-term care.

AGE welcomes the nomination of national care coordinators and the enthusiasm in changing long-term care for the better during the mutual learning exercises. It is important that long-term care coordinators are empowered with a mandate and effective tools to trigger change in a country's long-term care system. Where a care coordination is formed instead of a single coordinator, it is important that the responsibilities are clearly defined around a common vision.

Necessary dialogue with civil society organisations representative of persons in need of care and persons with disabilities

Our members in general formulate difficulties to contact the national long-term care coordinators and engage a discussion on the implementation of the Council recommendation. AGE reminds that the recommendation contains the requirement to consult with all relevant stakeholders, namely social partners, civil society and the social economy. However, requests for meetings or to be associated with the elaboration of national implementation measures have been frequently not responded to. AGE welcomes the association by the European Commission of relevant

stakeholders in the EU-level mutual learning workshops, however. Regarding the elaboration of an indicator framework by the SPC Indicators subgroup, we point however to the fact that there is no information about the indicators under discussion and the state of the work.

Workforce shortages put the success of the Council recommendation at risk.

Throughout the Member States, it seems that mainly the lack of qualified workforce is hindering the expansion of quality long-term care services. This holds true for most professions related to long-term care, but is particularly the case for some specific professions, such as geriatricians or medical professionals with a geriatric specialisation.

By and large, it is acknowledged that workforce shortages are due to a lack of attractiveness of the sector for new professionals. A large share of the current workforce is approaching retirement age and not enough younger people decide to embrace care as a career. In addition, working conditions are leading to a significant staff turnover, many care professionals leaving the sector to pursue other careers. It seems vital that care professions must be made more attractive by improving working conditions, increasing available time for human interaction, attractive salaries and career pathways. Therefore, Member States should strengthen sectoral social dialogue to improve these items. It can be argued that better pay and working conditions might also introduce a better gender balance in the composition of the care workforce.

The fact that long-term care is relying a lot on informal care a as a default choice (by the absence of affordable, quality formal services) and often untrained live-in care workers further shows that public policies do not see it as a serious career, despite the potential for job growth and economic value for the sector.

Develop sustainable funding and social protection for long-term care.

Even if changing care services towards a person-centred, rights-based approach might not need additional funding, the inaccessibility of care services shows that there needs to be investment into the expansion of quality services. The 2024 Pension Adequacy Report confirms that care needs remain an important financial risk and that the inability to fund out-of pocket costs for long-term care remain one of the main reasons not to access care.

There are positive examples of levying funds for long-term care, such as the progressive introduction of a social protection-based long-term care insurance in Slovenia. Against the backdrop of return to the EU's fiscal framework, the European Commission and Member States should ensure that enough fiscal space is left to allow for better availability, deinstitutionalisation and person-centredness of care to realise. As Member States have more flexibility in public spending when implementing EU funds and the European Semester's Country-Specific Recommendations, it must be ensured that more Member States received targeted recommendations on long-term

care. The European Commission has already started to lay the groundwork for this regarding four member States in the 2023 European Semester, these efforts should be continued.

To achieve autonomy and independence, all kinds of health and long-term care policies need to be developed.

All kinds of health and long-term care policies need to be expanded in most Member States to ensure an available spectrum of care that suits all needs: health promotion, prevention, curative generalist and specialist care, home and community-based care, support to informal carers, palliative and end-of-life care, housing adaptation and accessibility of environments, mental and physical health care.

In many Member States, reliance on informal care by absence or inaccessibility of formal services is the most common care 'policy' developed. Informal care, however, is not sufficiently supported as many informal carers – mainly women – need to reduce their availability for employment to provide care without compensation in terms of income support, accrual of pension rights or otherwise. Supporting informal carers would mean to allow for better financial support, more time and supporting services than the minimum standards of the EU's Work-Life Balance Directive. Supporting services, such as day care, respite care, peer exchange, training and counselling are vital given informal carer's risk of poverty and social exclusion, physical or mental health issues. Such support also contributes to harmonious relationships between informal carer and the person in need of care. In general, informal care should be a choice and not a necessity deriving from the inaccessibility of other quality services.

Where care is provided by live-in carers or other types of domestic workers, a proper employment status for these workers is often lacking. However, to provide quality care, these workers need adequate training, be part of a system that allows for life-long learning, exchange and some degree of oversight, protection from abuse and harassment and a system allowing them to take leave and respect sustainable working times, i.e. a system allowing for temporary or permanent replacement.

Beyond informal care, the care sector is still marked by a prevalence of residential care. Often, residential care is chosen above home care for reasons of availability or affordability (e.g. when residential care is funded by health insurance while home care is more funded by out-of pocket payments). Yet, most persons would prefer staying at home and maintaining their independence. Large institutions carry the risks of placing the institutional logic above individual needs and aspirations of the persons in need of care. Therefore, the development of home care and community-based care is important to expand the continuum of available options to persons in need of care.

The focus of the Council recommendation on long-term care services does not preclude an emphasis on prevention. The best care service is the one that is not needed. However, little seems to be done in terms of strengthening health prevention

in general and in particular of people with needs of care or with conditions that are likely to lead to the development of a care need.

It is also reported by AGE members that there is little availability of palliative care in the Member States. In many cases, palliative care is restricted to the end of life, rather than alleviating suffering over the longer and medium term of chronic and potentially degenerating conditions. Offsetting the onset of a care need through prevention, rehabilitation and other interventions would however be the best way to uphold the right to independence. In a similar way, strengthening the accessibility of public, private and online environments to persons with disability upholds people's autonomy while they face a potentially disabling health condition. Long-term care interventions should therefore also be available to adapt peoples' homes to keep them accessible in light of their changing needs.

Long-term care must meet the realities of freedom of movement.

The EU is built on the fundamental principle of freedom of movement. It is often highlighted that this means that potential long-term care workers and informal carers from Eastern or Southern Member States leave to work in Northern or Western Member States. However, beyond this reality, there also is the effect that many persons retire and may require care services in another Member State than the one responsible for their pension payments or health insurance. There is a risk that different philosophies of national systems might put these people at risk of not accessing the support they need: for example, if a person is insured in a Member State that relies on long-term care services provided in-kind for free or low co-payments and they reside in a Member State relying on an insurance model that provides cash benefits for care. The reform of the Directive on the Coordination of Social Security starts clarifying the competencies, but not all Member States have long-term care an established branch of social security. In the next long-term care report, it would be worthwhile to look at potential gaps derived from labour mobility in the access to care.

In the longer run, it might also be worthwhile to develop a long-term care reinsurance system, based on the model of the pandemic-era SURE reinsurance scheme for short-term unemployment. Such a reinsurance scheme would allow for solidarity between Member States who are net recipients of internal migration and those who have a net migratory deficit.

Long term care: National urgencies and priorities for reform

In the following sections, we summarise the contributions received from our members on the specific priorities included in the Council recommendation on long-term care that should be implemented in their national context. National long-term care coordinators are encouraged to contact the organisations having contributed to this section directly or contact AGE to have the contact of AGE members in their Member State. AGE reiterates that the consultation process on national implementing measures seems to not have been sufficiently accessible to national civil society.

Belgium (Flanders)

Comments provided by Vlaamse Ouderenraad

Main priorities for reform: development of formal care services, staff shortages, privatisation of care, affordability

Affordability

The government should urgently address the very high cost of a stay in a residential care centre and the rapid increase in that price (an increase of 10 percent in one year). The average daily price in 2022 is 64 euros, plus the cost of specific services, such as hairdresser, pedicure, laundry service, etc. These costs may vary depending on the resident's needs. The result is that the majority of residents cannot pay the cost with their pension. That is why an increase in the healthcare budget is necessary, as it has not been indexed in the last ten years. The monthly price is 2,039 € in public institutions, 2,111 € in non-profit institutions and 2,274 € in commercial institutions. As a comparison, the average employee pension in 2022 was 1,255.45 €. So, the cost of a residential care centre is double the monthly average pension.

There is a tendency to encourage older people to stay at home, even if they are requiring care, in their own community and as little as possible in residential care centres. The government expects that the family and the neighbours will help the older people when they need care. This seems good in theory, but in practice many older people appear to have no network that can help them. Moreover, they can rely less on informal care from their own children because they first these have to work longer (up to the age of 67) and often both partners are working.

The encouragement to have older persons stay at home is motivated by the desire from the government to make savings and reflects a strong neoliberal view in which the government is increasingly withdrawing and leaving care to private commercial institutions, which of course have a for-profit motive. The result of this policy is a strong sense of loneliness, with many people not receiving quality care because they cannot afford it.

Adequacy/Quality

There is a major shortage of professional healthcare providers.

There is generally still too little attention paid to the application of human rights, not even in healthcare training.

In Flanders, a research project is currently underway to investigate the quality of residential care centres from the perspective of the residents. the intention is to make recommendations for policy on the basis of these results. Currently, government control is still too focused on efficiency and economics and not enough on quality as experienced by the residents.

Workforce/professionalisation

There are major staff shortages in both home care and residential care. The healthcare profession appears to have become less attractive to young people. That is why attempts are made to attract foreign carers (from Eastern European countries, from India, from Africa). The problem with this is first and foremost a language problem. The foreign professionals usually do not speak Dutch or speak Dutch with difficulty, which makes communication with people in need of care very difficult. That seems to lead to friction and lower quality than people expect. Moreover, many of those foreign healthcare providers have a completely different work ethic than we expect here (for example, only the agreed hours and no extra availability). They often lack a human rights perspective. Moreover, the legal minimum standard for healthcare personnel is too low to provide the required quality.

Facilities

A serious problem is the privatization of healthcare. We have three types of residential care centres in Belgium: the public ones that are financed by public authorities (26% of all healthcare institutions), the strictly private ones that are managed by commercial organizations (32%) and which are therefore aimed at making a profit and thirdly the private institutions (non-profit institutions) (40%) that are not aimed at making a profit and are managed by charitable organizations such as religious organizations.

The problem is that private commercial institutions, aimed at making a profit and benefiting their shareholders, make a profit by using fewer staff and by curtailing the quality of care. In many of these types of institutions there is also an outflow of staff because the work pressure is very heavy. More and more of those institutions are in the news because of abuse and bad treatment. Much stricter government control over quality and humane care is needed. Moreover, the accounting of commercial institutions often appears to be not transparent.

Cyprus

Comments provided by PA.SY.DY

Main priorities for reform: availability and affordability of palliative care, fragmentation between public authorities and care providers

Affordability:

Social protection for long-term care in Cyprus is adequate, since the government provides financial support, preventing poverty. Financial support is provided to persons that choose to live (i) in community care centres (ii) in private long term care facilities or (iii) stay at home. Financial support is provided for people at pension age and as long as is needed (end of life). Support covers the additional cost for long-term care. In home care, this cost covers a domestic live-in carer. This is particularly the preferred option in rural areas.

The issue of affordability of palliative care derives from the fact that palliative care is only publicly supported for the short-term in hospitals. Private palliative care units exist but are prohibitively expensive.

Comprehensiveness:

The system of palliative care is not existent. In the hospital there is some short-term medical treatment, but this works with not with assistance at home.

In cases of severe care need, such as advanced dementia, you need to go to a private clinic which is very expensive. There is no public care for persons with dementia.

Quality and adequacy:

Support is provided relative to the needs and wishes of the person. Quality criteria apply to municipal and private long-term care centres, there are however no criteria for live-in carers, and no training requirements.

Professionalisation:

Remuneration of care professionals seems not to be an issue, but there is a need for better training and professionalisation.

A change in the law has made it easy for public authorities to transfer the institutions under their management to private commercial companies. They do this to pass on the costs of their own residential care centres. The effect is usually a reduction in the quality of care and, importantly, a serious price increase for residents. The difference between public and private commercial institutions in the monthly cost for a resident is on average 200 euros, while the services provided are less.

Governance

Responsibility for long-term care is fragmented between public authorities (ministry of health, ministry of the interior), agencies (state health services organisation, health insurance organisation) and providers (social welfare services, private care providers, non-governmental organisations, patient associations). A better coordination seems important to achieve a more effective long-term care system.

Czechia

Comments provided by Zivot 90

Main priorities for reform: development of alternatives to residential care, integration, support for informal carers

Availability:

The concept of long-term care in the Czech Republic is still predominantly associated with (and carried out by) medical institutions, i.e. hospitals, subsequent post-hospitalization institutions and residential care homes, sometimes with special regimes for dementia, etc. Therefore, it has an institutionalised ethos. The reality is that individuals, who underwent medical treatment and need further care, remain in an institutional setting for much longer than necessary, with few chances to make other choices. The perception is that the traditional model of institutional care provision forms the basis of long-term care at present. Outreach services, where they are available, are often not adequately staffed, and are unevenly available in terms of geographical distribution.

Zivot 90 calls for a shift towards home care, where an individual would be able to choose a mix of services if and when he or she needs them. Home care should be developed as a viable option, and be fully supported both financially as well as with a respite service for informal carers. We also call for coordination between sectors + greater emphasis on prevention as well as active participation of those in need.

Integration

There is inadequate cooperation between the medical and social sectors, though at present, new legislation was put on the table this year to interconnect the services between the two, and by 2027, it is expected that there will be a new type of profession that covers socio-medical service. No case management is in place (or it is completely inadequate) and there is not sufficient trained staff.

Informal carers

At the moment home care is carried out exclusively by informal carers and/or family (with an estimated 1 million of carers in a population of 10 million!), and supporting provisions are not easily accessible. The key problem is the lack of proper information,

and lack of coordination. There is a financial benefit that can be drawn by a caring family member, but this is limited to 90 days.

Information

Zivot 90 has introduced electronic and telephone service with which an individual can access help 24 hours per day. This has proven very successful, yet it is a service fully provided by an NGO and should be supported by the government.

France

Comments provided by: Confédération française des retraités, Anciens de BP France

Priorities for reform: workforce, quality in residential and home care

Availability:

In France, doctors, nurses and all other social and medical professionals are dramatically missing. As a consequence, people often do not receive care as soon and as long as they need with the expected level of quality, i.e. with the provision of what is needed to respect people in need, sometimes even their basic needs. Beyond trained human resources, sometimes equipment and consideration are lacking as well.

A good practice should be highlighted, the 'medicobus' that exists in some départements. This is a mobile medical clinic which allows medical teams to visit people in need of care who suffer from chronic diseases following a fixed calendar and itinerary.

Coordination is difficult because of the lack of professionals and because of the complexity of the French health system.

Palliative care is inexistent in more than 20 French "départements" (roughly 1/5 of France) and most often is insufficient in the other "départements".

Affordability

Care is less and less affordable because manly medicines are no longer or less and less refunded by the health insurance, because more and more professionals ask for extra financial contribution, because often necessary care can only be available far away from the patient home.

Adequacy

It seems that home and community-based care have developed during the past years despite the difficult working conditions for the professionals. Older people in need of care prefer living at home than moving to a dedicated institution. But here is a financial barrier. If you need only a little help, it is cheaper to stay at home than moving to an

institution, but if you need much help, it becomes too expensive and also difficult to manage by the family, especially is the family lives far away.

Technology and digital solutions in the provision of care services are not developed. Human presence and care are more important for the older persons and their family, but maybe digitalisation could help to increase coordination of professionals and the link between professional and informal carers and doctors.

Quality:

There is a policy for people to stay at home, but there is no control about the quality of care. There is the question of the prevalence of abuse, no one knows if the job is done well there. It is much better for the people to stay at home than to go into an institution, but there are not enough people caring.

We need not only nurses, but also training for managers. The quality of the nursing home can dramatically change between one home and another.

A director a nursing home must be a person who has the charisma necessary for this home to have a soul, for the well-being of the resident to be at the centre of the organisation and functioning of the teams, who listens to staff members and families with a view to continuous improvement and personalized adaptation to the needs of each of the residents and not just an administrative manager. However, in France, more and more managers are appointed in charge of several establishments and not managers who meet the above criteria, while the lack of staff, or even training of this staff, is sometimes glaringly absent.

EU Quality principles

- **Respect**: Most carers respect the older people they care for, but their job is difficult, they must work in a limited span of time, because sometimes they need a long time to drive from one place to another, their patient's home is not always very easy and organized for such care, and therefore the patient may feel disrespected. Administrative processes are desperately complicated and here again, patients may feel disrespected. Also, given the shortage in care opportunities and forms of care, older people's freedom and rights are not always respected.
  There is little control if any of the professionalism and ethics of carers, whether they are professionals or family carers.

- **Prevention:** Not much is done to develop prevention. Free preventive check-ups are available only until people get 75. In some regions, when an older person would need physical re-education after a vascular cerebral accident for instance, there are no longer physiotherapists available in the hospital, it is very difficult to get appointments with such a specialist down-town, and they do not visit people at home any longer because they have no time to go there. As a

consequence, these people develop a much stronger need for support. However, a positive development regarding prevention is the increasing number of walking and gymnastic clubs in the communities, as well as other kinds of physical or intellectual activities.

- **Person-centredness**: This is more or less respected thanks to the humanity and sense of ethics of the professionals.

- **Comprehensiveness and continuity**: Given the lack of means, this is far from being assured, even though professionals do their best.

- **Focus on outcomes**: There is little cultural support for evaluating in order to improve. The focus is mainly directed on saving short-term costs without taking into consideration the fact that prevention and early palliative care would at the end reduce costs. As an example, institution managers now often manage 2 or 3 homes, being in charge of administrative and financial objectives with no more time to devote to the residents and their family and even to the professionals as human beings and not only as numbers and status.

- **Transparency:** It is sometimes challenging to find the right person with the right information. But efforts have been made lately to provide central contact points for administrative information and help, in most place, even in very little towns.

Workforce:

This should be the first priority. In 2023, a host of meetings concluded that there was a financial argument to put this priority high up the agenda. We need to increase the quality of work in the sector. Professionals receive very low salaries and indecent reimbursements for their moving/travelling costs. They start work very early in the morning and end their work very late at evening. Care must be ensured 7 days a week. They have little opportunities to get continuous learning and are not efficiently trained for palliative care. Their work can be physically very hard despite improvements in medical equipment technology. Many have problems with their back.

There are more and more foreign people recruited as carers. This can create a problem when these carers do not speak French easily, having in mind the fact that older people often have difficulties to hear and most of them like and need to exchange with their visitors.

Informal carers

For a long time, no real attention had been paid to informal carers. Nowadays the situation is slightly improving. Some facilities are possible at work in a few firms, and

carers have the possibility to organize their work according to their family duties, colleagues can transfer part of their free time (RTT) to a family carer in their firm, time spent as informal carers can be taken into account for pension credits.
It is possible for older people in need of care to access institutions during the day, which makes it possible for informal carers to keep their job.
Some associations organize training for informal carers.
We must underline the fact that most informal carers do a wonderful job and really care for their relative, often in difficult conditions and to the detriment of their own life, their career, their physical and psychological health and their family life. However, we must also be aware that problems may exist within families: abuse, harassment, neglect, sometimes because the situation has become too difficult, sometimes because of a lack of empathy and respect.

Governance

The present French government's key objective is to have the Parliament vote the authorization of "active help to die", which clearly means to authorize both euthanasia and assisted suicide, although a law does exist (Loi Claeys Léonetti – February 2016), which allows for deep sedation until death in case of strong suffering of the patient. There is a risk that such a law is cynically adopted to save costs, to compensate for the lack of medical and social professionals and for the lack of places into hospitals and institutions dedicated to people in need of care. The promotion of assisted suicide has been a heavy discussion for years, but reduced to the choice between dying with terrible suffering or dying when we want without suffering. However, palliative care has not been part of this discussion although it has been proven than less people with a will to undergo euthanasia to a large extent do not maintain that wish when they have effective access to quality palliative care. Long-term care and palliative care in general have not been an important issue for the government despite very ambitious and very sensible plans, which largely remain wishful thinking since the necessary means are not allocated.

Germany

Comments provided by BAGSO

Main priorities for reform: compensation for informal carers, shifting the responsibility for ensuring care and choices in the care type to the municipalities

Adequacy and social protection:

Good care must be adequately and permanently financed. A need for nursing care and assuming the responsibility for providing it as an informal carer must not lead to dependence on social assistance or poverty.

A sustainable limitation on co-payments must be implemented urgently, e.g. by the way of turning the reimbursement system around: there would be a need for an upper

limit of co-payments and responsibility of the care insurance for the remaining (variable) costs. Co-payments could also be reduced by having investment costs covered in full by the federal states and the costs for medical treatment in in-patient nursing facilities by the health insurance companies.

Care has developed into a lucrative market in which profitability aspects play an increasingly important role. However, the quality of care and contributions to long-term care insurance must not be dominated by the expectations of return on investment of service providers and investors; at the very least, there is a need to define limits for profit-making.

Care service offer and care needs:

BAGSO calls for the mandatory introduction of a case and care management system coordinated by the municipalities. This should include regular and needs-based preventive home visits to older people in order to determine the need for support, directly and precisely *in situ* and to develop individual assistance plans based on this. These serve as the basis for individual benefit arrangements with the involvement of professional service providers, family support and civil society services. The counselling centres should be tasked with reporting to the municipality any additional needs that cannot be covered by the existing services.

Employment and working conditions:

The roles of the actors in the health and care sector must be designed in such a way that they better meet the needs of people in need for care and their relatives and conserve the human resources that are generally in decline. To this end, the roles of medical and social care must be changed, and their interaction optimised. Since social and health care are equally responsible for quality of life, health care must no longer take precedence or sovereignty over social/long-term care. The appropriate structures for training and professional development must be created in long-term care, while the work and remuneration conditions in the care sector must ultimately be designed in such a way that people can be employed in the long term in his field too.

Informal carers:

BAGSO calls for the introduction of a wage replacement for informal carers up to three years. The Independent Advisory Board on Work-Care Reconciliation set up by the Federal Government presented a detailed concept for this in 2022, which must now be implemented. Moreover, any disadvantages suffered in career or pension must be compensated.

Governance:

In view of BAGSO, it is necessary to assign the responsibility for the management and design of long-term care services to municipalities, and to provide them with sufficient

funding. With its call for new structures for care under municipal responsibility, BAGSO takes up a central point of the Federal Government's Seventh Report on Older People (2016), which has shown what role municipalities can and must play in shaping life in old age. To ensure equal care structures that take account of local structural characteristics (e.g. large cities, rural areas), municipalities must be obliged to collect data on population and care needs on a regular and territorial basis and, based on this, develop a needs planning for all areas that have influence on the lives of older people. This can be embedded in an overall concept for ageing policy.

For more details:
https://www.bagso.de/publikationen/positionspapier/positionspapier-sorge-und-pflege/

Italy

Contribution submitted by Older Women's Network Europe (Italy)

Priorities for reform: non-regulated privatisation, financing of the reform carried by law 33, need for specialist skills

In 2023 Italy issued Law 33[1] on Delegation to government on policies in favour of older people, both self-sufficient (on development of healthy ageing policies) and in need of care. In some respects, it resembles the EU Care Strategy. Lately (19/03/2024) a regulatory Legislative Decree came into force[2]

Adequacy and social protection:

Law 33 states that the sustainability of long-term care will be assured by the "Universal Performance" (max 850 euros per month) in the form of a financial allowance, or equivalent services identified upon the care needs of the patient. Under Legislative Decree no 29, the measure will be experimental for the coming two years. The Universal Performance enhances the previous "Accompanying allowance" only for very few people (annual income not above 6.000,00 euros)

Care service offer and care needs:

Art 4 of the Law 33 defines the Essential Levels of Health Care for people in need of care and a more simple and efficient assessment of needs and access to services at

[1] Full text on Gazzetta Ufficiale

[2] See the complete text on Gazzetta Ufficiale

home or in hospitals. The adoption of a monitoring phase regarding the way in which the ELHC are performed is also mentioned. The Legislative Decree, however, only postpones the adoption of a monitoring framework to a future decree.

In some regions, a financial choice seems to have been made to rather develop residential care than home care, following a budget review.

Quality

There is not sufficient control for private care facilities, quality is lower.

Employment and working conditions:

Art 5-point b3 refers to the identification of Region's professional requirements in the field of psycho-social health.

Non-regulated privatisation is a big issue for us all, professionals evade the public and go private and charge higher prices, creating labour shortages for public and not-for profit providers.

Art. 5 points b1 and b2 of the Law 33 refer to training and training standards. In the implementation of Law 33/2023, Legislative Decree no. 29/2024 establishes that National, Regional and Local authorities have the responsibility in defining the training paths to which the Regions CAN attain to develop nationally homogeneous training standards for professionals assisting older people in need of care, and in order to obtain the 'family assistant' qualification. There is however no mention of continuous training and regularization of undeclared work.

The geriatric specialisation has been abolished in Italy some years ago, because it was considered not necessary anymore. Older people with specific needs (cardiovascular, etc.) go into the generalist department in hospitals, but the numbers show that there is a big share of older persons in generalist services. It might be better to re-develop geriatric specialisation to provide adequate care for them.

Informal carers:

Art. 5-point c2 states that informal caregivers will be awarded with certifications for competences and skills acquired in the caring process. The Legislative Decree no. 29 recognize the value of informal caregivers and involve them in the definition of the caring process. Non-economic support is also mentioned.

Governance:

Under Law 33, the governance was accorded to a new institution, namely the National Caring System for People in Need of Care (an intergovernmental pool of experts, regional and local authorities with the active participation of civil society). In spite of

this provision, under Legislative Decree the Ministry of Labour and social Affair will be in charge of the governance the coordination, organization and governance.

Law 33 has been drafted with the essential contribution of *Patto Per la Non Autosufficienza*. However, the Legislative Decree has been approved by the government regardless of the many amendments requested by the Parliament and the civil society, leaving civil society organisations disillusioned[3].

Malta

Comments provided by National Association of Pensioners

Main priority for reform: attractiveness of the long-term care sector for employment, develop the sector in view of increased demand

Adequacy

It bears pointing out that like most other EU countries, Malta has an ageing population and therefore the demand for long-term care, whether in the community or in elderly homes, will continue to increase in time. Malta also has one of the lowest, if not the lowest in fact, fertility rates which according to latest EUROSTAT data, in 2022, stood at only1.08 and this will likely add to the problem in the long run.

Workforce

There is a need for attracting more Maltese youth to take up work in the long-term care sector. The present situation is that the country is becoming increasingly reliant on the importation of foreign workers, mainly from outside Europe, to compensate for the lack of Maltese workers employed in this sector. Such work has become unattractive and not much sought-after by Maltese youth.

The reasons are various, not least the relatively low pay and strenuous physical demands which care work with elderly people often necessitates. As is to be expected, when it comes to foreign workers, this situation is not fraught with difficulties, particularly insofar as the language barrier is concerned, and also the overall quality of long-term care service provided. It is pertinent to note that the Minister responsible for this sector in Malta has recently indicated that these workers will be required to have a basic knowledge of the Maltese language to work in long-term care provision.

In these circumstances, it is important that measures are introduced to encourage younger workers to move into the care work sector, as otherwise, the problem will become even greater and more foreign workers will have to be imported from abroad.

[3] Decreto Anziani: (dis)illusioni e possibili ripartenze per la non autosufficienza • Secondo Welfare

Netherlands

Comments provided by Oudere Vrouwen Netwerk Nederlands

Priorities for reform: Staff shortages, privatization, burden of administration, adequate housing

Availability

On paper, all forms of care are available, but in fact there is a shortage of services for people in need of care living at home. Another issue are people who are stuck in hospital because of the long waiting s in residential care.

Availability of services is fragmented, especially regarding home care, after the effect of liberalization of the care sector and public procurements procedures.

Quality principles

- Respect: the guidelines and regulations seem to guarantee 'respect', but the means allocated disprove this
- Prevention: after years of neglect for this topic, there is more awareness and attention to developing prevention, such as public awareness campaigns.
- Comprehensiveness and continuity: the stakeholders involved in care could work better together.
- Focus on outcomes: Carers have to spend too much time on administration and documentation.
- Facilities: residential care homes were closed, which forces people to stay home. However, there is not sufficient accessible and/or adaptable housing for older persons in need for care, so many are locked into inadequate housing.

Workforce and skills

- The liberalisation of the market led to the reduction of staff (not enough new was trained). Many people were trained in care institutions to build their career, but the number of institutions were reduced, they did not stay on.
- Salaries are less attractive than for other professions.
- There is a need for more in-service training.

Informal carers:

In many situations, the fact that there are informal carers mean the reduction of time formal carers.

Governance

There is a multiplicity of care need assessments that bring a lot of red tape. There are over 10.000 signatures for a petition to Parliament by formal carers, who spend more than 10 hours per week in administration of care. Informal carers face the same challenge.

Privatisation is an issue. Private equity companies are buying practices of doctors, dentists etc. and develop private care, where working hours are cut down and quality is reduced. Some doctors have only teleconsultations, which are less accessible to older persons and persons with disabilities.

Norway

Comments provided by the Norwegian Pensioners' Association

Priorities for reform: Staff shortages, development of home care and residential facilities

Availability of services:

A new reform in Norway has been launched about 'stay safe at home'. There is political will or wish for older persons to stay at home and need for a reform. Staff and housing are two main pillars of this reform. This year is the first that this reform is launched, we are expecting that the national assembly finishes the discussions next year.

Patients' organisations and carers' organisations ask for more residential facilities, because there is a lack of trust into home-based care. There is a feeling of safety connected to the fact of having staff available 24/7.

Workforce

Even as one of the richest countries, we face staff shortages, because of the massive needs related to ageing. The issue is not money but to find available health carers. This year, there was a dramatic decline in enrolment for nursing studies. In some rural areas, only 1/3 of the available student places are lacking students. As a rich country, we could import carers, but the official stance is that we shouldn't. But many people do come from Philippines and Eastern Europe to work as carers in Norway.

Governance

There are very few private nursing homes, and those which are private are mainly non-profit. Those who tried did not succeed because they did not deliver good quality.

Poland

Comments provided by Alzheimer Polska

Priorities for reform: staff shortages, quality of care, accessibility across the territory and of all forms of care

Affordability:

Long-term care provision relies heavily on informal (family) caregivers, mostly women. Most older adults have insufficient financial resources to self-finance their long-term care, especially for the costs of some residential LTC services for which they have to pay out of their pocket. Other services are co-financed at fixed rates that vary depending on the income (as they are means-tested).

One of the priorities for the government should be unification of the costs of LTC services, so that people in need of such care could afford them. Older people in need of LTC perceive the differences in the costs of staying in a residential nursing home (financed by local government vs. financed by the National Health Fund) as discrimination. They see no reason why they cannot be charged the same amount for LTC, regardless of the type of nursing facility.

Today, the cost of stay in a public welfare nursing home (DPS) is first charged to the beneficiary and their close family, and only when the person concerned is unable to pay does the local government step in. As for granting a place in the residential welfare nursing home, often the income threshold allowing the right to stay in such a nursing home is too low, and therefore becomes a barrier to even apply for such care. Co-financing of the care in such a nursing home by the family is highly challenging to them, which means informal, family carers have to carry on providing care on their own, often without public support.

On the other hand, residential LTC services offered by a healthcare nursing home are financed by the National Health Fund, with the beneficiary paying “an accommodation” fee amounting to 70 percent of their monthly income, which is much less than in a welfare nursing home. Therefore, the waiting time for a place in such a rehabilitation institution is much longer, and much more difficult to obtain.

Funding LTC is not necessarily the biggest challenge for the government, especially that underfunding is a problem, well known to current authorities.

Availability

Too often the services do not cover the potential users’ actual needs, as the services are either not available at all, or if they do exist, they do not address particular or changing needs as a person’s disease or disability develops. Access to care is limited by a long waiting time to get a care needs assessment, as well as by income threshold,

which entitles to certain services. If one's income is higher, care services cannot be granted, and one has to rely on private care services.

Care services are organized by both public and private sectors. As the private sector is mushrooming and the cost of stay in a private nursing home is similar to the cost in a welfare nursing home, waiting time is much shorter. There are a few very good, but very expensive private nursing homes which people with average income cannot afford. However, most private nursing homes offer lower quality care and untrained staff.

There are still significant regional differences in the provision of long-term residential care, day-care, as well as the number of well-trained staff. There is an issue with access to long-term care outside of bigger cities. Setting up more day care centres, offering respite care and granting hospice care in rural areas is needed. Access to palliative care is restricted to a set list of diseases, which excludes some conditions such as dementia and disregards actual needs.

The gaps are sometimes filled in through NGOs' support and initiatives who often lack financial resources to continue their care work. NGOs who offer care services should be recognized and helped by offering continuous government support.

There is a need to develop home care services, which are often cheaper and more welcome by persons in need of care, instead of living in an institution, as well as day care centres tailored to particular needs and wishes of the users. These should offer therapeutic and meaningful activities, diminishing social isolation, and in this way be a form of respite to informal carers and enabling them to continue working.

The biggest challenge in the access to facilities is our current law. People with long-term care needs should be able to decide and express their wishes. This is impossible today; it is the family who decides on their behalf, or the court. Incapacitation procedures are still in force in Poland but should be replaced by supported decision making.

Quality/Adequacy of care services

Quality often suffers because of poor recognition of older peoples' needs, and differs a lot in long-term care facilities, depending on the staff attitudes to the persons they care for, their training, the number of staff employed, and their working conditions.

Despite appropriate government regulations on those matters, often they are not followed for financial or other reasons, mostly attitude and inadequate training of the staff, as well as staff shortages.

Therefore, there are still cases of abuse of respect and dignity, improper staff attitude towards older people, cases of improper, discriminatory language used by the staff,

and neglect of their needs and human rights, often because of lack of understanding the needs or limitations of people who cannot express their will or are not even asked to express their wishes. Thus, the concept of person-centredness seems still one of the biggest challenges in the training programmes of people who are employed in LTC. However, the shortages in work staff form a serious challenge, which the government should deal with in planning the development of quality in long-term care facilities and in deinstitutionalization of care.

Workforce:

Staff shortages in LTC provision seems to be the primary issue to tackle in Poland. There is a decrease in the number of care workers, while at the same time there is an increase of the need to get quality care services at home or close to home, in the community. There are various reasons for the shortages: low wages, and thus lack of motivation, attractiveness, status, and recognition. Becoming a care worker, and especially to support the elderly people, is considered not an attractive job. The challenge is to motivate young people to take up such a job and see it as a career.

Government has recently promised a substantial pay rise for nurses employed as care workers, which is a positive signal, as the differences in payments between social/welfare and medical care facilities were discouraging nurses and other care staff from entering social care.

There is unequal access to geriatric care, as there are only 560 geriatricians, and some Polish regions have none. Experts believe there should be some 3,000 to adequately cater for the population, but few doctors want to choose this specialisation.

Poland needs also more well-trained staff in palliative and hospice care.

Informal carers

The family has traditionally been the main provider of LTC. Currently, there are mostly (80% and predominantly women) family members, like spouses or adult children of the person in need of care who carry the burden and responsibility for caring. Their needs are often ignored or not sufficiently understood and recognized. They should be helped with regular breaks, holidays, respite care, flexible working hours, if they combine care with work. They also expect information on available services, on how to get access to them, on their rights. Training should be granted to them on regular basis, including psychological education to avoid burnt-out. They constitute a large group of unpaid care workers which should be entitled to special benefits, as they pay financial, social and physical price for caring.

Governance

One of the biggest challenges for the governance of long-term care is collecting data on the health and care needs of older persons to be able to plan the development of care services. Another challenge is integration between the health and social sectors of care, both in terms of service provision and financing.

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Fighting old-age poverty: the missing piece of the Social Pillar

AGE commends the Commission and the Social Protection Committee for drawing up a detailed and important report that sheds the light on the living situation of 95 million people over 64 in Europe. It is particularly commendable that the report looks at the two major crises that unfolded since the data of the last report by comparing pension adjustment mechanisms.

We see this report as a call to action. After a decade of pension reforms aimed at securing financial viability of Member States' pension systems by reducing benefits, indexation mechanisms and increasing retirement ages, we now need to address the deterioration of pension adequacy.

Old-age poverty and social exclusion increased by two percentage points and **almost four million people since 2015** – in a context where the EU has committed to reduce poverty and social exclusion by 15 million between 2020 and 2030. Even more shocking, increased poverty stems mainly from worsening poverty rates among older women, one in four of which are at risk of poverty after age 75. **The fact that old-age poverty affects more than one in three persons in 7 Member States is equally unacceptable**. Increasing gender gaps, falling relative income rates and replacement rates also point to the fact that **pensions cannot be further targeted to save public spending**. On the contrary, the poverty reduction target of the **European Pillar of Social Rights Action Plan cannot be achieved without halting and reversing the expansion of old-age poverty**. Further reforms in favour of adequacy are needed.

Regarding retirement ages, while AGE advocates for **policies that empower workers to stay healthy and included in the labour market** until retirement age and **allow workers who want to continue working to do so**, the Pension Adequacy Report confirms why it is so difficult to change retirement age: there are **large inequalities between low-educated and higher-educated in retirement duration**. Changes in statutory retirement age must take into account these inequities and different situations. The projected increase to very high ages in some member states may be socially unsustainable against this background.

The recent experience of consumer price growth has shown the **importance of pension adaptation mechanisms** that are following price and wage developments, are performed regularly and automatically, based on law or statute. They safeguard the dignity and participation of older people in society and **also function as an automatic stabilizer to the economy**, as pensioners typically have lower incomes

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and spend a larger portion of income growth for local goods and services. The fact that many Member States had to introduce additional indexation or other income support measures during 2022/23 shows that **indexation systems still need to be improved**. There were also inequities linked to the fact that support measures other than pension indexation did not reach pensioners living outside the member state who pays their pension.

Care needs are an important factor increasing the risk of poverty, with out of pocket **costs of care representing 50-80% of income for moderate or severe needs.** This is highly alarming, particularly for women and influences people's decision not to access care although they need it.

The **persistence of survivor's pensions** is an important factor that hinders a further aggravation of the old-age gender pension and gender poverty gaps.

As a response to the Pension Adequacy Report, AGE calls for:

- **Ending old-age poverty**: Further pension reforms in favour of adequacy to achieve the European Pillar of Social Rights poverty reduction target and Sustainable Development Goal 1 by 2030
- A **Framework Directive on Adequate Minimum Income**, despite the adoption of a Council recommendation on the same matter in 2022. Such a Directive should cover as well minimum pensions. Member States must make consistent and tangible advancements in setting adequate levels of minimum pensions and for their adaptation over time. AGE calls on the SPC to work on an intermediary assessment of minimum income schemes before the 2030 implementation report required in the Directive. The Commission should use actively the European Semester to remind Member States of their commitment
- An **EU recommendation on pension credits** for time spent outside the labour market for reasons of childcare, informal care, sickness or unemployment to redress the growing gender inequality in old-age pensions
- **Accessible health that does not lead to poverty:** An ambitious implementation of the Council recommendation on access to affordable, quality long-term care and stronger work to move towards universal health coverage.
- **Coverage must be ensured for all types of work** and the recommendation on access to social protection should be strengthened. Platform workers, other types of new forms of work and self-employed must be subject to mandatory enrolment in pension schemes.
- **Statistics must evolve with the population**: the group of 85+ has grown by 25% over 10 years and continues to do so. It is no longer acceptable to assess data on

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pensions only based on two age groups (65-74 and 75+) while this phase potentially stretches over five decades.

- Similarly, the next Pension Adequacy Report should **take into account the mobility of pensioners**. 4.5 million persons receive a pension from outside their state of residence, many of which combine pensions from different member states, which can lead to inadequacies in terms of risk of poverty, adequacy of out of pocket payments for care, or pension taxation relative to the population of their member state of residence.

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To: President of the European Council, Heads of State, Ministries of the Health, Social and Employment affairs of EU Member States
CC: Permanent Representations attachés on social and health issues

Concerns: The upcoming EU Strategic Agenda 2024-2029

Brussels, 11/03/2024

Integrating Social and Health ambitions into the next EU Strategic Agenda 2024-2029

As signatories to this letter representing social and health stakeholders in the EU, we urge the Council of the European Union and Member States to ensure that the EU Strategic Agenda 2024–2029 keeps social and health ambitions high, as a prerequisite to achieving a "*strong, dynamic, competitive and cohesive Europe*".

The COVID 19 pandemic rightly highlighted the vital importance of having robust and resilient health and social protection systems. The concurrent challenges of population ageing, climate change, cost-of-living increases, accessibility and affordability of healthcare can only be overcome by giving health and social priorities the attention they deserve. Only then will the EU be able to build a European Union fit for the future, with resilient and sustainable social security and health care systems that serve economic prosperity.

"*Building a climate-neutral, green, fair and social Europe*" was a central pillar for EU action in the previous EU Strategic Agenda (2019–2024). As rightly highlighted by the Council in its Porto declaration, the European Pillars of Social Rights (EPSR) is "*a fundamental element of the recovery*" and is "*at the core of a highly competitive social market economy*". Addressing social inequalities and affordability of evidence-based healthcare are crucial for promoting cohesion and economic stability. A strong European economy goes hand-in-hand with a social and healthy Europe that works for all.

During the Spanish Presidency, the Council of the EU committed itself to *"continue its efforts to build a more cohesive, innovation-driven, and interconnected Single Market, preserving (...) its social dimension and its openness*", as stated in the Granada declaration. The ambitious agenda of the Belgian presidency foresees the perspective of the interinstitutional declaration of La Hulpe, intended to serve as a blueprint for future EU social policy work. The momentum generated by these two presidencies shall provide a strong health and social emphasis for the EU term to come.

We believe the social and health dimensions are of utmost importance and should be given the necessary attention at EU level, and so do the EU citizens according to the most recent European Parliament barometer. Therefore, we call for including these priorities in the Strategic Agenda 2024-2029 and on future decision-makers to provide adequate responses for a truly citizen-centred, solidarity-based social Europe.

Sincerely yours,

Signatory organisations

ACHSE - Allianz Chronischer Seltener Erkrankungen

AGE-Platform

AIEP - European Association of Paritarian Institutions

AIM - International association of mutual benefit societies

CESI - European Confederation of Independent Trade Unions

COFACE – COFACE Families Europe

ČAVO - Rare Disease Czech Republic

DSV-Europa - Deutsche Sozialversicherung Europavertretung

EAPN - European Anti-Poverty Network

EFFE – Homecare - European Federation for Family Employment & Home Care

EFSI - European Federation for Services to Individuals

EFN - European Federation of Nurses

EPF - European Patients Forum

EPHA - European Public Health Alliance

ESIP - European Social Insurance Platform

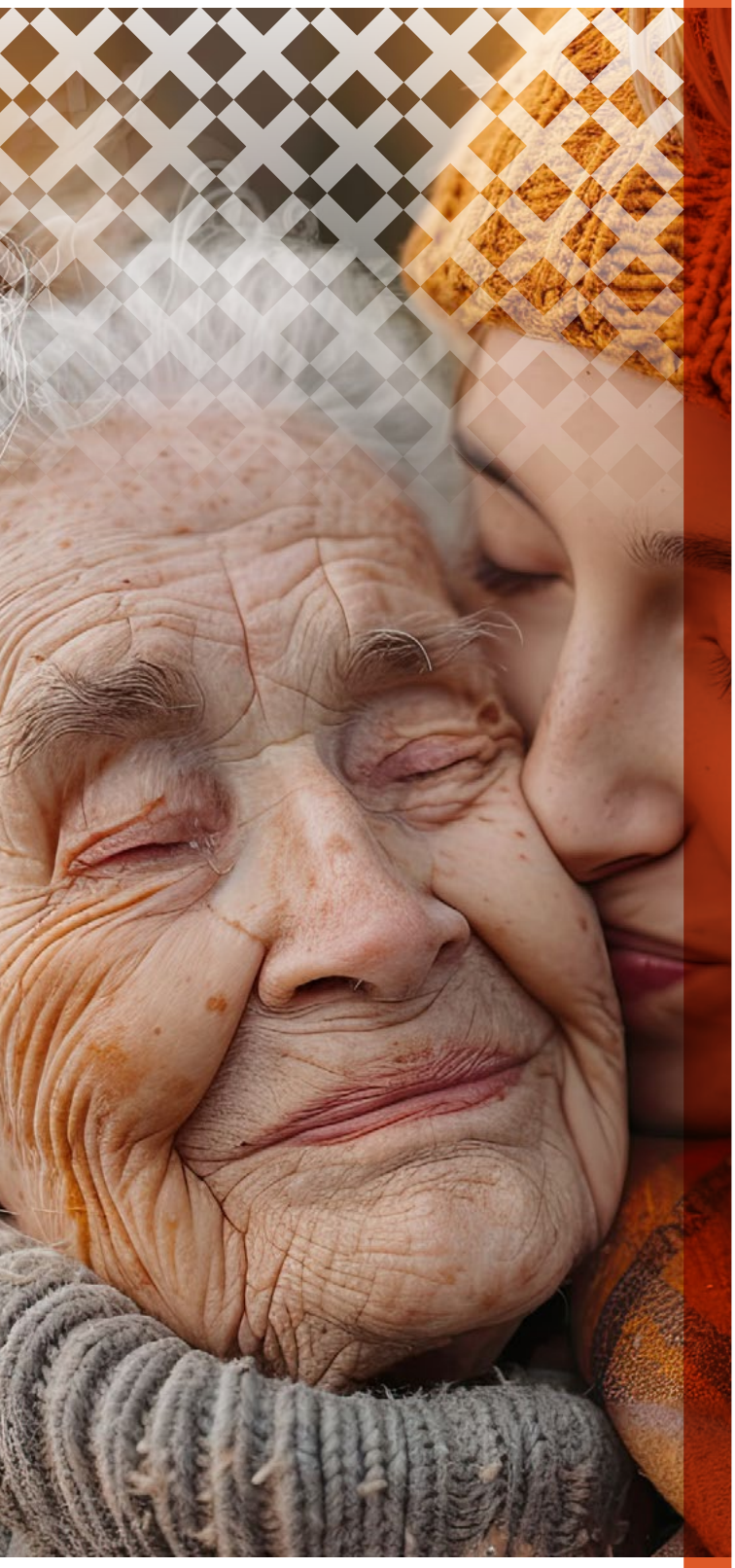
Eurocarers

Feantsa - European Federation of National Organisations Working with the Homeless

HCFA - Hellenic Cystic Fibrosis Association

REIF - Représentation européenne des institutions françaises de sécurité sociale

RONARD - Romanian National Alliance for Rare Diseases



ADDRESSING SUICIDE AMONG OLDER PEOPLE IN EUROPE:

A call for targeted interventions and policy reforms

GAMIAN-EUROPE

AGE PLATFORM Europe

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EXECUTIVE SUMMARY



Executive Summary

This position paper addresses the urgent and overlooked issue of suicidality among older adults in the European Union (EU), and calls for immediate and targeted policy interventions to address this, specifically – enhanced mental health policies and services to tackle the unique challenges faced by older adults, including mental health issues, loneliness, and difficult socioeconomic circumstances.

Despite a general decline in suicide rates across the EU over the past decade, older adults remain disproportionately affected. In 2021, there were **51,962** deaths by suicide among adults aged 70 and above, accounting for **0.99%** of all deaths in this age group. With the population of older adults projected to increase significantly by 2060, the absolute number of suicides may rise, even if overall rates continue to decline.

Suicide rates among older adults in the EU show significant variation, influenced by diverse socioeconomic and welfare policies across Member States. The EU average for older adults in 2021 was 19.8 per 100,000, which is substantially higher than the EU population average of 12.5 per 100,000 for all ages. In every EU country, suicide rates for older adults are higher than the nationwide average for all ages, underscoring the disproportionate impact on this age group.

Several factors contribute to the increased risk of suicide among older adults, including:

Mental Health and Psychosocial Issues: Around 6% of older adults in the EU are diagnosed with depression or severe anxiety, both strongly linked to suicidality. Social isolation and loneliness are major risk factors, while social inclusion acts as a protective measure.

Physical Health and Chronic Illness: Chronic conditions, disabilities, and cognitive decline, such as dementia, often lead to pain, functional impairment, and feelings of hopelessness, heightening suicide risk.

Socioeconomic Factors: Financial difficulties post-retirement and the loss of social status and routine contribute to stress and mental health challenges. Economic stability plays a crucial role, with disparities across EU countries.

Stigma and Discrimination: Ageism and mental health stigma exacerbate feelings of hopelessness and lower self-esteem, limiting access to essential services and contributing to the underreporting of suicides.

Focus groups conducted with older adults, mental health professionals, and family members highlighted several key issues related to suicidality among older adults:

Social Isolation and Loneliness:

Reduced social networks and increased isolation, often due to the death of peers or reduced mobility, are highlighted as significant challenges. Technological barriers further exacerbate feelings of isolation among older adults who struggle with digital literacy, for example, leaving them unable to adminster their own finances without support.

Cultural Attitudes:

Changing family dynamics, including reduced intergenerational support and increased reliance on formal care, contribute to feelings of dependence and loss of autonomy among older adults. Ageism and negative stereotypes further marginalise this group, impacting their mental health and access to services.

Financial Stability & Socio-Economic Challenges:

Economic insecurity, insufficient pensions, and the high cost of healthcare are major stressors for older adults, leading to increased mental health challenges and a higher risk of suicide. Addressing this financial instability, particularly in Eastern Europe, through better pension schemes and social safety nets is crucial to reducing poverty-related mental health decline in older adults.

Community Involvement & Affinitive Relationships:

Engagement in volunteer work, community groups, and intergenerational initiatives provides a sense of purpose and fulfilment for older adults, helping to mitigate feelings of loneliness and hopelessness. This coupled with Close relationships with family, caregivers, and community members are vital in reducing loneliness and suicidal ideation, providing emotional support and security for older adults.

Integrated Care Models & Gatekeeper Training:

Integrated care models promote collaboration between healthcare providers, community organisations, and mental health professionals, offering holistic support for older adults' physical, mental, and social needs. Also,"Gatekeeper" services equip community members, such as neighbours and volunteers, to recognise distress in older adults and refer them to appropriate services. This grassroots support is key to early intervention and crisis prevention.



Given the complexity of the issue, this paper proposes several policy recommendations at both the regional, national and EU levels:

Integration of mental health services in primary care:

Integrating mental health services into primary care is essential for reducing suicide rates among older adults, through appropriate mental health screening assessments and treatment. This approach ensures that mental health is addressed alongside physical health, reducing stigma and improving healthcare efficiency.

Establish and monitor national suicide prevention strategies:

Every EU Member State should develop and adequately fund a comprehensive national suicide prevention strategy, involving diverse stakeholders and adopting WHO guidelines. Monitoring and evaluation are crucial to ensure these strategies' effectiveness.

Increase availability of community-based resources:

Expanding community-based resources, including social clubs, peer-support networks, and age-friendly initiatives, is vital for reducing social isolation and supporting mental health in older adults. These resources should be accessible in both urban and rural areas.

Enhance training for healthcare providers:

EU-wide training programmes should be implemented to equip healthcare providers with the skills needed to address the mental health needs of older adults. This includes training in cultural competence, recognising elder abuse, and intervening effectively in cases of depression and suicidal ideation.

Standardise data collection and monitoring:

Establishing a standardised system for collecting and monitoring data on mental health and suicidality among older adults is essential for informing policy and targeted interventions. This system should be centralised and accessible to policymakers, researchers, and healthcare providers across the EU.

By implementing the recommendations outlined in this paper, the EU can take significant steps towards reducing suicide rates among older adults and improving their overall quality of life. The time to act is now, and every moment counts in the fight against suicidality in our ageing population.

INTRODUCTION



Introduction

Despite a general decline in suicide rates across the EU, with deaths by suicide decreasing by almost 14% over the past decade, older people remain disproportionately affected.



in 2021
51,962
deaths due to intentional self-harm for **adults aged 70+**

accounting for
0.99%
of all deaths

11.64
deaths per
100,000
people

In 2021, there were **51,962** deaths due to intentional self-harm in the EU for adults aged 70+, accounting for **0.99%** of all deaths, or an average of **11.64** deaths per **100,000** people[1] . Demographic trends heighten the concern. The population of individuals aged 65 and above in the European Union is projected to increase by **74.4%** by 2060, and the group aged 80 and above is expected to grow even more, by around **163%**[2]. This ageing population trend suggests that the absolute number of suicides among older people may increase, even as overall rates decline.

Suicide rates among older people vary significantly across Europe and are influenced by various socioeconomic and welfare policies.

For example, in Europe, suicide accounts for **1.4%** of all deaths across all ages, with the highest rates observed however, among those aged over 70, followed by the 45-59 age group[3]. This variability underlines the complexity of the issue and the need for targeted interventions.

For each suicide, at least 6-10 people, relatives and close familyare directly affected and in some cases can go up to 80 who are more prone to also die by suicide or to face mental health problems/complicated bereavement[4] are directly affected and in some cases can go up to 80 who are more prone to also die by suicide or to face mental health problems/ complicated bereavement.

[1]**Results from IHME Global Disease burden for 2021**
https://vizhub.healthdata.org/gbd-results/

[2]**Suicide among Older People in Different European Welfare Regimes -**
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9222638/#:~:text=The%20number%20of%20people%20aged,2

[3]**Suicide Prevention in the European Region -**
https://pubmed.ncbi.nlm.nih.gov/32208758/#:~:text=Although%20the%20majority%20of%20the,59%20years.%20Europe%20accounts%20%E2%80%A6

[4]Rockett, I. R. H., et al. (2010). "Suicide misclassification in an international context: A systematic review of the literature." Injury Prevention, 16(5), 344-349.

Suicide is often underreported due to several factors, including the stigma associated with mental health issues, variations in how deaths are classified, and differences in the quality of reporting across countries and regions. In some cases, it is estimated that between 10-30% of suicides in general are not reported.

World Suicide Prevention Day, observed annually on September 10th, is an essential global platform to raise awareness about suicide and promote preventative measures. Established by the International Association for Suicide Prevention (IASP) in conjunction with the World Health Organization (WHO), the day aims to foster worldwide commitment and action to prevent suicide. It emphasises the importance of addressing mental health issues, reducing stigma, and promoting supportive environments for those at risk.

Aim

This paper advocates for better mental health policies and services for older people in Europe. By addressing the current situation, the paper will provide a comprehensive analysis of the challenges faced by older people regarding suicidality. It will highlight the unique factors contributing to poor mental health and an increased rate of suicidality, such as mental health issues, loneliness, and socioeconomic challenges.

Drawing from successful initiatives across Europe and beyond, the paper will offer targeted policy reforms and interventions that can be adopted at the national level. These recommendations will focus on improving healthcare services, increasing funding for mental health programmes, and enacting policy changes to create a more supportive environment for older people. Additionally, it will add primary research perspectives from a focus group held with mental health professionals, representatives of older people and older people with lived experience regarding suicide along with a supplementary survey giving firsthand experience.

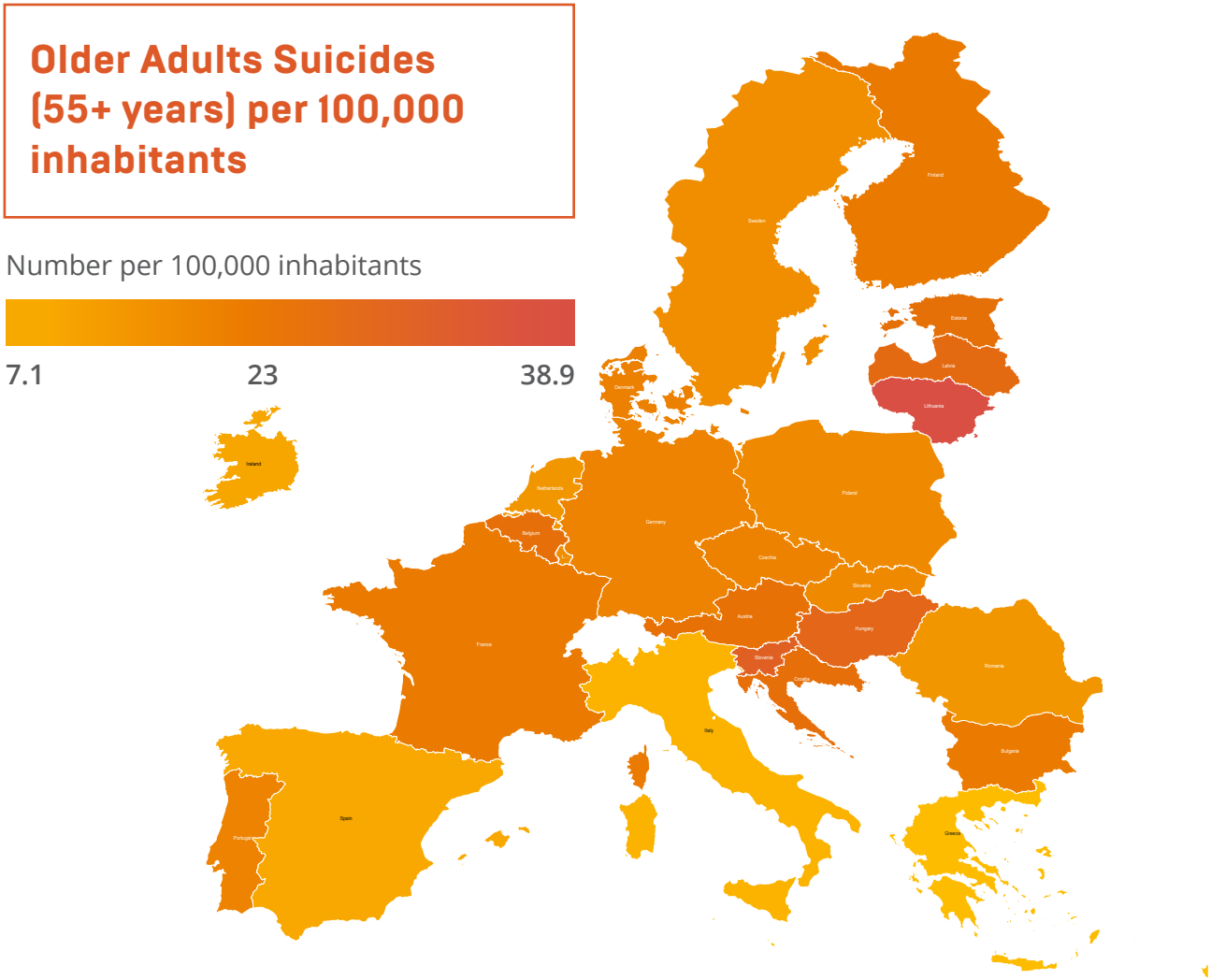
Ultimately, the goal is to influence policymakers and stakeholders at local, national, and European Union (EU) levels to highlight the current challenges and consequently implement changes that will significantly reduce the risk of suicide among older people and enhance their overall mental well-being.



Older people's suicide Rates and Trends

Recent data on suicidality at the EU level is scarce and often difficult to come by potentially due to the different metrics and variability in data collection methods that each Member State uses. This is coupled with chronic underreporting often due to the sensitivity of the topic and the vast amounts of stigma surrounding it.

Older Adults Suicides (55+ years) per 100,000 inhabitants



The latest available EU-wide data[5], from 2021, shows that the EU countries with the highest prevalence of death by suicide in older people[6], are Lithuania, Slovenia and Hungary with rates of **38.9**, **31.4** and **28** per **100,000** inhabitants[7] respectively. At the other end of the spectrum, the countries with the lowest levels of older people's suicide are Malta, Cyprus and Greece with **7.1**, **7.2** and **7.8** people dying by suicide per **100,000** inhabitants. While there is a fairly large disparity between all 27 Member States, The EU average for older people in 2021 was **19.8** reporting a much higher-than-average rate of suicide (compared to the total EU population average) which was **12.5**. Moreover, at the country level, in every EU country, these levels of older people's suicide are higher than the nationwide average for all ages indicating that

[5]From the Institute for Health Metrics and Evaluation's Global Burden of Disease

[6]Where older people are defined at 55 years and above

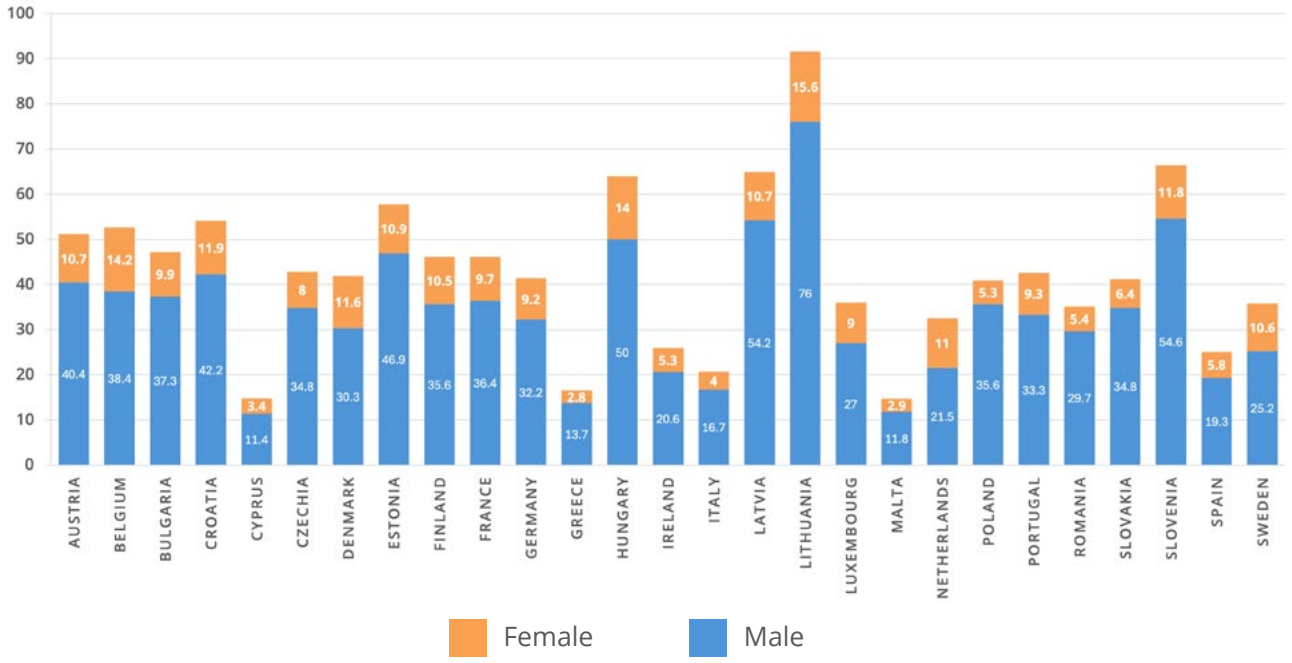
[7]100,000 per inhabitants used for country-comparison purposes as well as for clarity and consistency with standard public health measures.

older people are disproportionately affected compared to the rest of society.

Much like the prevalence of many other mental health conditions and overall suicide rates, suicide deaths of older people are a gendered issue with males showing higher rates across all 27 EU countries.

Only four countries, Sweden, Belgium, the Netherlands and Denmark, have levels of men dying by suicide less than 3x those of women[8]. The two countries with the highest levels of male older people dying by suicide mirror those countries with the overall highest levels of suicide, Lithuania (**76** per **100,000**) and Slovenia (**55** per **100,000**).

Male / Female ratio (Number per 100,000 inhabitants (55+) (2021)



There are reasons to feel more positive when looking back across the last decade (data from 2010). Except for Greece which witnessed an increase in suicide rates among older people[9], the rest of the EU 27 saw medium to large decreases in suicide rates in older people with 23 Member States experiencing a decrease in double digits and 8 of those with a more than **20%** decrease in deaths by suicide.

This appears to follow the general trend of national-level declines across all ages in suicide throughout the EU. It must be noted, however, that the declines for older people were less significant in all but five EU countries compared to the overall country rates[11]. The lower levels of declining rates over the last decade again point to the fact that compared to the rest of society, older people face a higher risk of death by suicide across the EU.

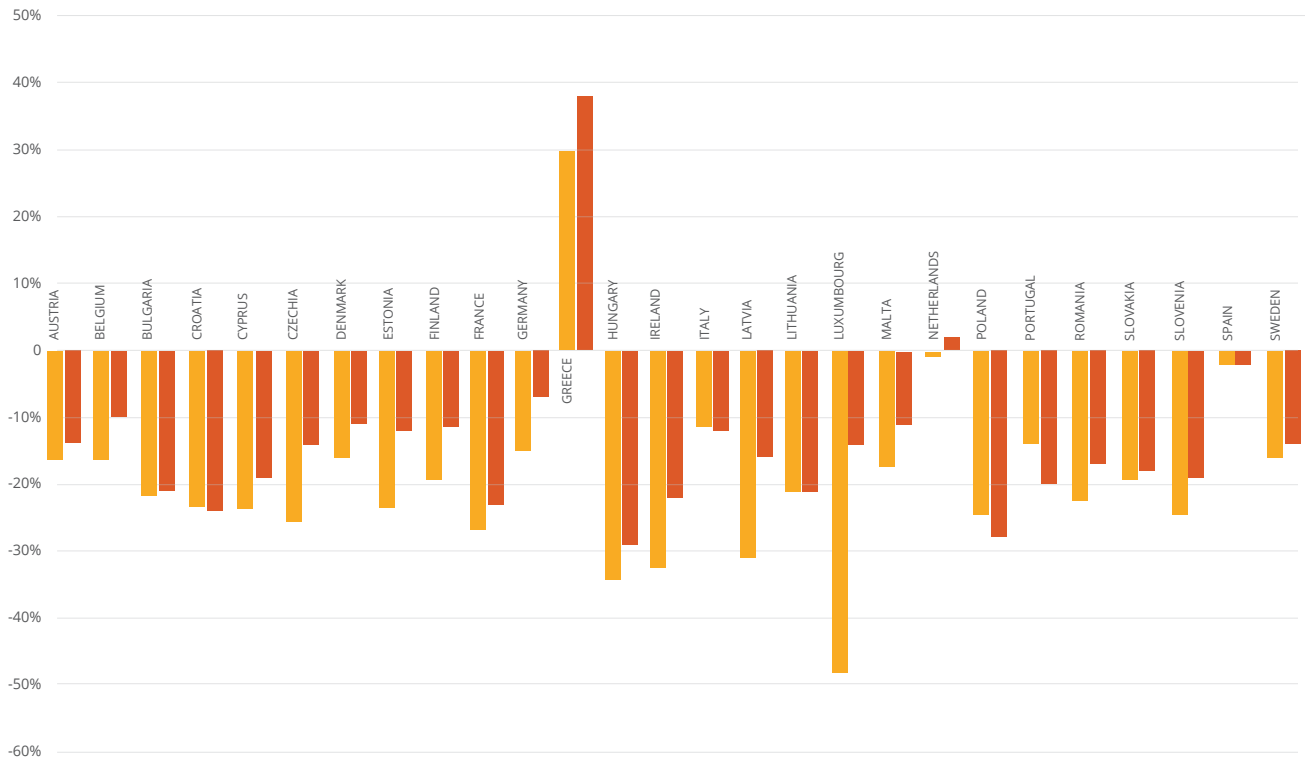
[8]Belgium =2.7x, Denmark =2.6x, Sweden =2.4x, Netherlands =2x

[9]Greece saw a 38% increase in suicide rates mainly due to increased male rates between 2010-2021

[10]Hungary and Poland saw the largest decreases with 29 and 28 percent respectively

[11]See annex/appendix 1 for a detailed table of comparable rates between older people and the national average

Total percentage of suicides between 2010 and 2021



All ages | 55+ years



While it is an undeniable success that the rates of suicides among older people have decreased, more work needs to be done due to the higher rates of suicides within the older population.

Factors Influencing Suicide Rates

Suicidality[12], in general, is influenced by a myriad of factors. There are individual factors such as mental health issues[13], substance abuse and trauma as well as relational, and community which can include family dynamics, social isolation, and lack of community support.

Other important contributors are societal, cultlural and socioeconomic factors such as economic instability, social inequality, media influence and public health policies. All of these can also be underpinned by other psychosocial factors such as stigma and taboos that can detrimentally influence the mental health and rates of suicidality in people.

With older people, there is a unique set of challenges that have an enhanced influence on this demographic.



Mental Health Conditions and Psychosocial Factors

Mental health issues affect all different segments of society across the EU and also the globe. In 2023, a Eurobarometer survey showed that 46% of EU citizens reported having emotional or psychosocial problems in the past year[14]. The same survey showed that 35% of older people have experienced a psychosocial issue. When it comes to diagnoses for depression and severe anxiety, around 6% of older people across Europe have both or one of these conditions which have a known link to suicidality[15] [16] [17].

Social isolation and **loneliness** in older people have been identified as a major contributor to suicidality.

Conversely, increased social inclusion appears to be a protective factor and has large effects on the prevention of suicide[18].

[12]Where suicidality is defined as past suicidal thoughts, intentions and attempts.

[13]These mental health issues may be brought on by things such as: berievement, informal care burden, physical health issues or disability leading to a mental difficulty to cope among other things.

[14]EU Mental heatlth related statistics

[15]Defined as having anxiety disorders

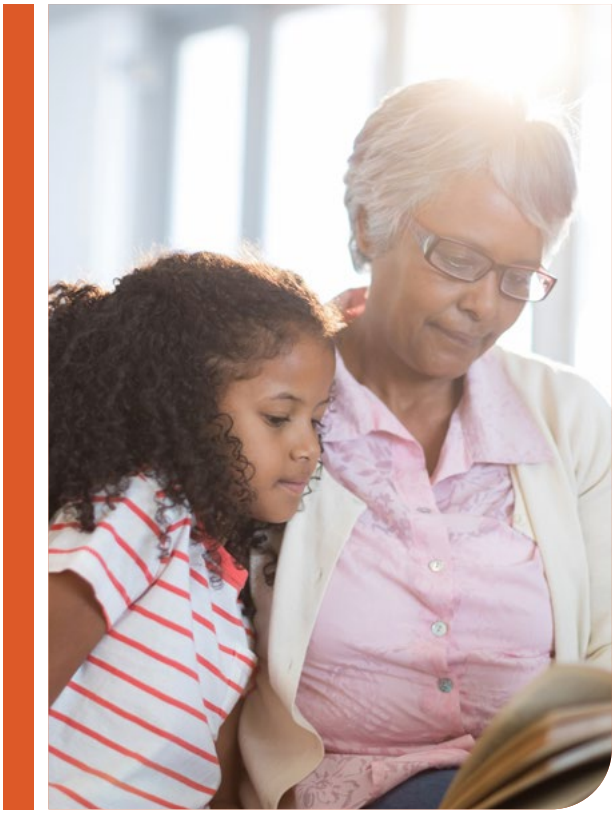
[16]https://ourworldindata.org/grapher/anxiety-disorders-prevalence-by-age

[17]https://ourworldindata.org/grapher/depressive-disorders-prevalence-by-age

[18]Cambride study 1

Physical health and Chronic Illness

The presence of chronic illnesses and physical health problems, such as pain and disability, is seen to deteriorate mental health in the form of feelings of hopelessness and despair which in turn can lead to an increasing risk of suicidality. These problems coupled with cognitive decline and conditions such as dementia have also been seen to play a role. More specifically, older adults are more likely to live with chronic conditions such as cancer or chronic obstructive pulmonary disease (COPD) which have been proven to increase the risk of suicide due to disruption of daily activity and functional impairment[19]. The way chronic disease and/or disability are supported by medical and social care can have an important impact on how these are perceived by an individual.



Socioeconomic factors

For older adults, financial difficulties and reduced economic status or changing social status after retirement can add to stress and mental health challenges.

Adjusting to retirement and losing a structured daily routine paired with social inclusion and recognition in the professional world can impact mental well-being.

These factors of course vary between different European countries due to their complex and diverse nature. However, it appears that increased suicide rates in older adults are linked to economic factors such as the ability to dedicate money to personal matters, buy basic goods and social deprivation.

These factors coupled with social factors such as self-perceived health and social inequality are also correlated to increased suicide in older adults[20].

[19] Cambridge study 2

[20] https://www.cambridge.org/core/journals/international-psychogeriatrics/article/eurold-preliminary-results-of-the-ecological-study-on-suicide-and-its-associated-socioeconomic-variables-in-people-over-85-in-europe/9B792573EF7B-3CFE4BB4EAE03A25B4CF

Stigma and Discrimination

Stigma towards ageing on one side, mental health problems on the other, and a combination of both stigmas may contribute to differences in suicide rates in a country. We hypothesise possible mechanisms explaining this link, including stigma as a stressor and social isolation as a consequence of stigma. Stigma towards older adults often takes the form of ageism which is known to have detrimental effects on mental and physical health.

Ageism is seen as a risk factor for suicide as it can promote the belief that depression is a normal part of ageing and weaken protective factors such as self-esteem, self-efficacy and hopefulness[21]. Overall, both stigma and discrimination towards older people have been shown to increase mental health conditions such as depression and also have physical outcomes such as shorter life expectancies[22] .



[21] https://www.nami.org/anxiety-disorders/ageism-mental-health-and-suicide-risk-in-older-men/

[22] https://news.yale.edu/2020/01/15/harmful-effects-ageism-older-persons-health-found-45-countries

The role of welfare policies and healthcare systems.

Welfare policies and healthcare systems in individual countries or regions play a crucial role in addressing suicidality in older people.

Social policies

Social policies offer vital support when it comes to suicidality in older people by mitigating economic insecurity and promoting mental well-being. In general, they should address the previously discussed variables, such as socioeconomic factors, to help reduce the risk of suicide among older adults. Social policies that provide robust safety nets in the form of adequate pensions, health and social care benefits and services have been proven to significantly lower the risk of suicide. Good examples of this are found within Northern and Western Europe countries, such as Sweden, Norway and the Netherlands[23], with more generous social policies, that tend to have lower rates of suicide compared to countries with less comprehensive welfare provisions.

> Other social policies that should be used to target suicidality in older people are those that focus on social support and inclusion as well as specific mental health policies.

Economic security provided by these helps reduce stress and financial anxiety, which are important factors in preventing suicide, particularly for those with insufficient income[24].

These can come as community centres offering social activities and community involvement via age-friendly initiatives that help increase a sense of belonging and reduce feelings of loneliness and hopelessness[24]. The World Health Organisation's framework for age-friendly cities and communities can give important guidance in this respect.[25]

Mental health support, including access to counselling, psychologists and psychiatric care, is an essential component of welfare policies looking to target suicide rates in older adults. Community-based interventions including peer support groups, helplines and mental health promotion activities tailored to older people's needs are known to provide significant help, particularly in rural or under-resourced areas where access to healthcare services may be limited[26]. Finally, policies that promote integrated care models to include mental health as a component of primary care by inserting mental health services into regular health check-ups are important in providing a holistic form of care which is crucial in mitigating suicidality for the older population[27].

[23] https://www.mdpi.com/1660-4601/19/12/7003

[24] https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-021-10592-4

[25] An age-friendly city or community is health promoting and designed for diversity, inclusion, and cohesion, including across all ages and capacities.' https://www.who.int/activities/creating-age-friendly-cities-and-communities

[26] https://www.oecd-ilibrary.org/sites/82129230-en/1/3/2/1/10/index.html?itemId=/content/publication/82129230-en&_csp_=e7f5d56a7f4dd03271a59acda6e2be1b&itemIGO=oecd&itemContentType=book

[27] https://www.who.int/publications/i/item/9789241550109

Healthcare systems

Healthcare systems are pivotal for mental health and suicidality challenges across all populations. For older people, the quality, accessibility and coordination of healthcare services are crucial in mitigating the risk factors associated with suicide in this population. Access to comprehensive geriatric care is important for aiding in the early detection and management of mental health issues such as anxiety and depression. As mentioned in welfare policies, integrated care models are key with their regular assessments and coordinated care which has been demonstrated to reduce hospital admissions and improve mental health outcomes in older adults[28].

Another important aspect of the healthcare system and its role in mitigating suicide in older adults is the availability of tailored geriatric-specific mental health services. Ensuring the availability of these is paramount along with tackling access barriers such as stigma and insurance limitations is vital to facilitate easy access to mental health professionals[29]. This needs to be coupled with continuity of care as there is a real risk of increased suicidality due to poor follow-up care or discontinuity in their treatment. Once again coordination between primary care providers, mental health professionals, and social services is essential to ensure ongoing support and monitoring.

Finally, an important part of the reduction in older people's suicide rates rests in the healthcare systems' training and education of staff.

Initiatives that underscore the necessity of targeted education and training programmes to equip healthcare providers with the skills and knowledge needed to effectively support older adults at risk of suicide are imperative. These may include training for nurses and other healthcare professionals in suicide risk assessment, especially focusing on older adults who may present with less obvious symptoms of mental distress[30]. Another important factor when it comes to education is making sure that there are specific frameworks to focus on suicidality among the older population. These frameworks are used to develop training curricula, evaluate existing training programmes, and ensure that healthcare providers are well-equipped to identify and manage specific suicide risks in older adults.

It is important to acknowledge that many of the chronic physical health conditions and disabilities that become more frequent, or more developed, in older age may impact mental health. The way physical health and long-term care services are provided can integrate this aspect by also screening for mental health challenges, including a mental health dimension into care plans and referring individuals with physical health challenges to specialised mental health care services. In particular, access to palliative care can be facilitated early in the care pathway of a person with a chronic disease to alleviate pain and help support the mental or emotional challenges associated with a certain condition[31].

[28]https://academic.oup.com/ageing/article/51/12/afac287/6931745

[29]https://www.ncoa.org/article/suicide-and-older-adults-what-you-should-know

[30]https://link.springer.com/referenceworkentry/10.1007/978-3-030-42003-1_24

[31]See the InAdvance Project results, notabily its policy recommendations (https://www.inadvanceproject.eu/_files/ugd/86b89d_d94210a18f4642cdb5a4c5088d137a65.pdf) and Guidelines for the implementation of evidence-based palliative care interventions (https://www.inadvanceproject.eu/_files/ugd/86b89d_0bdaa4d9ee2b40c98f3d6e2fa7c44dea.pdf)

FINDINGS FROM FOCUS GROUPS AND SURVEYS



Focus group results

To ensure that the academic research aligned with the lived experience perspective, a group of older people with experts with lived experience related to suicide, professionals (e.g. psychologists, older people advocates, counsellors) and family members were interviewed. They emphasised the following important factors that need to be considered when it comes to the prevention of suicide in older adults[32].

General challenges for older people

Suicidality remains deeply interconnected to mental health issues and older adults are not the exception. A typical scenario would include an individual experiencing in late life multiple chronic and physical health problems and seeing their mental health deteriorate. This is further compounded by financial issues, particularly for women over 75 years, shrinking social networks (due to the death of friends), reduced social activities, lack of mobility (e.g. not being able to continue driving, physical immobility), and a general lack of care and support. On top of this, older people feel an acute awareness of time passing, which contributes to anxiety and a sense of urgency.

The key points concerning the general challenges are:

- **Health Issues**

  Older adults often face chronic health conditions that can exacerbate mental health problems.

- **Multi-morbidity**

  The presence of multiple health issues complicates treatment and increases mental health vulnerability.

- **Polypharmacy**

  The use of multiple medications can lead to adverse interactions and worsen mental health conditions.

- **Grief and Loss**

  Loss of peers, friends, and family members can lead to profound grief and a shrinking social world.

- **Mortality Awareness**

  Increased awareness of one's mortality can lead to existential anxiety and depression.

- **Elder Abuse**

  Psychological and Emotional: Older adults are vulnerable to elder abuse. Elder abuse is not always physical; it can also be psychological. Older people may experience control over their decisions, social lives, and personal freedoms. Many older people are hesitant to report or confront abuse due to fear of conflict with family members or social stigma. They may prioritise preserving relationships over their well-being.

- **The Complexity of Caregiver Relationships:**

  Caregiver relationships can be complex, with some caregivers genuinely believing they are doing the right thing, even when their actions are restrictive or controlling. An example may be a daughter who believes she is caring for her immobile mother, restricts her independence by not allowing her to cook or have friends over, which isolates the mother further.

[32] 59 survey respondents and 10 focus group participants

Social Connections and Isolation

Reduced social networks and isolation are major issues for older people. With age, people's social circles tend to become much smaller. These experiences become a stark reality for many older people, knowing that they, too, will pass away which can also precipitate a fear of dying. While digital telehealth solutions are often heralded as cost-effective interventions, particularly for rural areas or communities with limited accessibility to services, older adults who may not have digital literacy are often left behind with the rapid advancement of such technologies, and these technologies might enforce a sense of lack of social interactions and remoteness. This digital divide is felt both in terms of communication and social connections as well as access to innovative mental health services such as telepsychiatry, telepsychology and the like.

The key points regarding social isolation and loneliness are:

- **Isolation:** Older adults often experience isolation due to the death of peers, relocation of family, and decreased mobility. Social isolation may or may not translate into feelings of loneliness, based on the individual's feelings associated with it.
- **Shrinking Social Networks:** As friends and family members pass away or move, older adults may struggle to form new connections.
- **Technological Barriers:** Digital divide issues can exacerbate feelings of isolation as some older adults may struggle with new technologies or feel that face-to-face interaction is increasingly substituted by digital means of communication.
- **Community Involvement** - Engagement in community groups or activities can help mitigate feelings of loneliness.
- **Volunteer Work** - Encouraging older adults to volunteer can help maintain social connections and provide a sense of purpose.



Cultural Attitudes

Cultural attitudes can affect mental health and suicidality in a myriad of ways. Intergenerational support from younger relatives, such as children, has changed with the introduction of residential care homes. This can be for reasons such as geographical mobility, work, childcare, lack of space, or inability to meet their health and other needs. It may also be due to the change in the cultural expectations themselves within different communities. In many cultures, older generations may also be hesitant to share emotional or mental health struggles, which exacerbates isolation and deterioration of mental health.

The key points concerning the cultural attitudes are:

- **Changing Family Dynamics:** Traditional family structures that support long-term care are changing, leading to, in some cases reliance on formal care, often in the form of residential care, but increasingly also home and community-based care. It must be mentioned, however, that 80% of long-term care is still provided by informal carers[34].
- **Ageism:** Older adults often face negative stereotypes and discrimination based on their age, leading to marginalisation and reduced access to essential services, which can significantly affect their mental health and overall quality of life.
- **Independence vs. Dependence:** Older adults may struggle with feelings of dependence and loss of autonomy.
- **Cultural Expectations:** Different cultures have varying expectations for long-term care for older persons, which can impact mental health and well-being.

Financial stability

Financial poverty is experienced by many older people throughout Europe. This is especially the case in Eastern European countries (the Baltics, Romania and Bulgaria), where at-risk poverty rates and inequality among older people are high. How financial constraints affect an older person depends on their previous life circumstances and whether they have developed resilience against financial distress or not. If suddenly their pension income is lower than what they expected, or if increasing costs for health and energy are not met by increases in old-age income, it can be difficult to manage their finances, potentially leading to unexpected debts.

The key points concerning financial stability are:

- **Economic Insecurity:** Financial instability and poverty among older adults can lead to increased stress and mental health issues.
- **Cost of Care:** The high cost of health and long-term care can be a significant burden.
- **Pension and Benefits:** Insufficient pensions and social benefits contribute to financial stress.
- **Financial Management:** Older adults may face challenges in managing their finances, especially if cognitive decline is present.
- **Elder Abuse - Financial:** This is where they may be coerced or feel obligated to prioritise their family's financial needs over their own, leading to significant hardship even when they are cognitively intact. There are also cases of inheritance pressure where family members may anticipate inheritance and may psychologically manipulate or restrict older people to gain control of their assets.

[33] https://eurocarers.org/about-carers/

Preventing Suicidal Thoughts and Actions

Some older adults face added complications of physical pain that come with the various conditions that can be associated with ageing. For those who may have had suicidal ideation earlier in life, this can be exacerbated by everyday discomforts in the form of chronic conditions.

Polypharmacy and medication are therefore important areas for suicide prevention as suicides may be carried out through medication poisoning. This is facilitated due to the potential easier access to medication or cognitive deterioration leading to accidental overdoses. Polypharmacy may also have impacts on cognition or mental health (depression, anxiety) as a side effect.

The key points concerning suicide prevention are:

- **Risk Factors**

  Where possible, reduce the exposure of older adults to specific risk factors, like ageism and social isolation. Strengthening preventive health throughout the life-span can prevent some chronic diseases and mental health conditions from developing; correctly accompanying these conditions can help to make people more resilient to them

- **Stigma:**

  Reducing the stigma around mental health and suicide is essential to encourage open conversations, early intervention, and seeking help, which can prevent the escalation of suicidal thoughts and behaviours.

- **Access to Means**

  Monitoring and managing access to medication, avoiding overprescription and reducing access to other means of suicide is crucial.

- **Reducing overmedication**

  exploring the interaction between medication used in cases of multi-morbidity and its impact on cognition and mental health can help in avoiding side effects by choosing other drugs or adapting their dosage

- **Mental Health Support**

  Providing access to mental health services, including counselling and psychiatric care, can help.

- **Early Intervention**

  Having conversations about mental health and advanced directives early can prevent crises.

- **Providing early access to palliative care**

  Palliative care can help mitigate pain and other factors that can challenge one's mental health

- **Community and Family Support**

  Strengthening social support networks through community and family involvement is key to empowering them to detect and intervene to prevent suicide

- **Spiritual and Religious Support**

  For some, involvement in spiritual or religious communities can provide comfort and reduce suicidal ideation.

Retirement age, planning, living and continued employment

Retirement planning is critical. Much of this will depend on people's individual choices of where to live, and in what type of house (e.g. a supervised apartment, bungalow, etc.), and financial ability will determine what an older person can afford. Work in and of itself can also be beneficial for older people's mental health as it continues to give them a purpose and goal in life. Work also helps prevent financial difficulties and maintains social networks. One participant felt it was important for older people to have the opportunity to work for as long as they wanted to.

The key points concerning retirement age, planning living and employment are:

- **Retirement Living Choices:** Discussions around the financial ability to downsize and find suitable living arrangements that foster community and accessibility.
- **Pre-retirement Planning:** Importance of considering location, community, and individual preferences in pre-retirement planning to avoid isolation and maintain quality of life.
- **Work and Mental Health** - Continuing to work longer can be beneficial for mental health, particularly for jobs requiring cognitive engagement.
- **Choice to Work** - Emphasized the importance of allowing people to work as long as they want to maintain purpose and mental well-being, but not to oblige them to stay in jobs that do not support their mental and physical help.

Volunteering and community involvement

Voluntary work provides an important opportunity for meaningful engagement. it can increase social interactions/participation and networks, keep older people engaged, and prevent loneliness and isolation.

Volunteering by older adults is also a key contribution to community development and in some cases can be an economic boost.

Several community interventions are becoming more popular as a way to connect vulnerable people to various social or community activities.

The key points concerning voluntary work and community involvement are:

- **Volunteer Work** - Older people engaging in voluntary work find a sense of purpose and fulfilment while contributing strongly to their community.
- **Universities of the Third Age** - Popular in Poland, these institutions offer free educational and social activities for older adults, encouraging social participation.
- **Neighbour Support Initiatives** - Local government-organised neighbour support programs help foster community connections and provide assistance in urban and rural areas.
- **Intergenerational initiatives** - these are very popular among older persons and may reduce social segregation based on age as well as reduce ageism.
- **Social Prescribing** - General practitioners (or Link Workers) recommend community activities for older people, including walking groups and Men's Sheds, to support mental and physical health.
- **Community Groups** - Importance of community groups and voluntary sectors in providing support and engagement opportunities for older adults.
- **Neighbourly Support** - Programmes that encourage neighbours to help each other and form connections, especially in big cities where isolation is common.

Survey Results

We conducted a survey to incorporate lived experiences in understanding the mental health challenges faced by older adults.

The survey gathered 59 responses from 12 EU countries, including 21 experts with lived experience, alongside professionals and relatives. The key findings outline the major issues and potential interventions for improving support for older adults.Many of the findings echoed the themes discussed in the focus groups, particularly around social isolation, financial instability, and cultural challenges, reaffirming their critical role in suicide prevention efforts among older adults. The new key points have been summarised below.

- **Gatekeeper Training:**

  Gatekeeper services, which involve equipping community members, such as neighbours and volunteers, with the skills to identify signs of distress in older adults and refer them to appropriate services, were strongly emphasised. This grassroots-level support is seen as a vital early intervention tool to prevent crises before they escalate, ensuring that older adults receive timely help within their communities.

- **Integrated Care Models:**

  integrated care models that foster seamless collaboration between healthcare providers, community organisations, and mental health professionals. These models aim to provide holistic support addressing the physical, mental, and social needs of older adults, creating a comprehensive framework for care that promotes well-being across all aspects of life.

- **Affinitive Relationships:**

  Close, supportive relationships, whether with family, caregivers, or trusted community members, are crucial in buffering older adults against loneliness and suicidal ideation. Fostering these relationships can provide emotional support and a sense of security, helping to combat isolation and its associated mental health challenges.

- **Socio-Economic Challenges:**

  Addressing financial instability, particularly in Eastern Europe, is essential for improving older adults' mental health outcomes. There is a need for policy-level changes to address financial inequality, including advocating for better pension schemes and social safety nets. Ensuring financial stability can help reduce the mental health decline often associated with poverty and economic insecurity.

Regional Highlights:

- **France** emphasized the need for better access to mental health services, social engagement, and programs that foster social contacts

- **Italy** focused on integrated care models and highlighted the need for holistic approaches that address both mental and socio-economic challenges.

- **Germany** raised concerns around ageism, social isolation, and the stigma surrounding mental health issues in older adults, with strong calls for community-based programs and psycho-social services.

In conclusion, the survey highlighted the importance of community-driven solutions, better access to mental health services, and integrated care models to ensure a comprehensive support system for older adults.

POLICY RECOMMENDATIONS



Policy Recommendations at the Regional/National Level

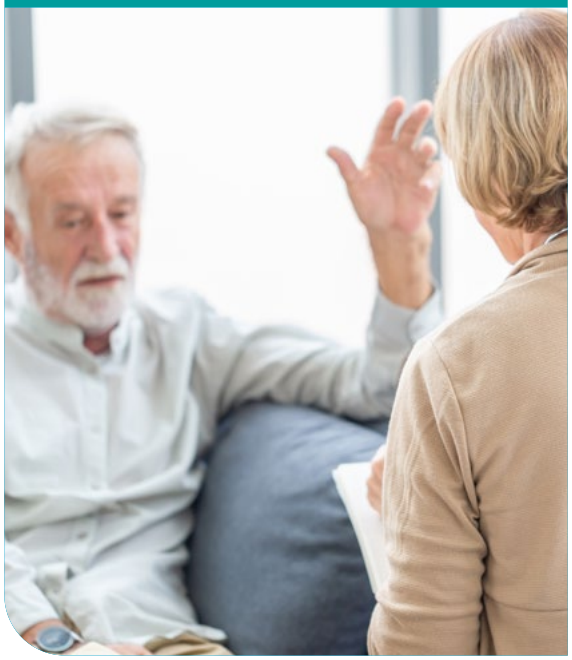
Due to the varied nature of policy, healthcare systems and resources within different EU countries, it is always challenging to have policy recommendations that apply to all. However, we believe the following recommendations are critical and apply to most if not all countries to prevent suicide among older people:

1 Integration of mental health services in primary care

The integration of mental health services in primary care is a key tool that has robust scientific evidence showing its effectiveness in reducing suicidal ideation and preventing suicidal behaviour. While upfront costs in training and education, some infrastructure adaptation and potential workforce expansion need to be factored in, these should be seen as initial "investments" for long-term benefits such as improved health outcomes leading to fewer complications and worsening conditions. Overall this will reduce hospitalisations and more expensive specialist care. Along with increased accessibility of mental health services, due to merging both physical and mental health checks simultaneously, this integrational approach is known to reduce the stigma associated with seeking mental health care.

The integrated approach for older adults is also essential to manage comorbid conditions. It ensures that treatments are complementary rather than conflicting. This can make everything more efficient verifying that there are no duplicate testing and that all providers are informed about the patient's overall health status.

Overall, the integration of mental health services in primary care not only enhances the overall efficiency and effectiveness of healthcare delivery but also promotes a holistic approach to patient wellbeing, ensuring better long-term health outcomes and reduced stigma around mental health issues.



2 Establish and monitor a national suicide prevention strategy

While in some EU states a national suicide prevention strategy does exist, many do not. Furthermore, those that have them in place often lack adequate funding and/or monitoring. It is therefore recommended that a prompt development of comprehensive national suicide prevention strategies, led by governments, is recommended. These strategies should involve diverse stakeholders, including healthcare providers, community organisations, and civil society, to ensure a wide-reaching and inclusive approach.

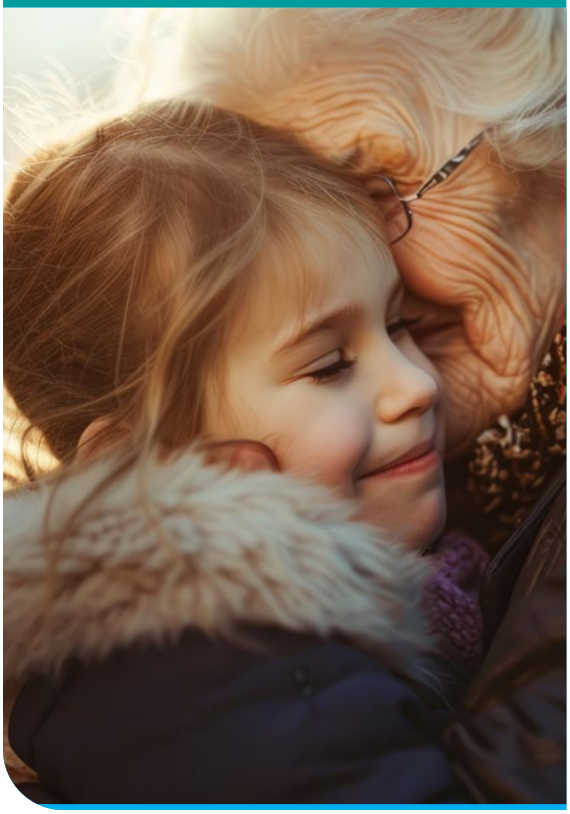
Key Actions (as recommended by the WHO[34])

- **Resource Commitment:** The allocation of necessary resources to research, community interventions, public awareness campaigns, and support services for individuals and families affected by suicide is recommended.
- **Decriminalisation of Suicide:** Legislative reforms to decriminalise suicide are supported to reduce stigma and improve prevention efforts, thereby creating a safer environment for individuals to seek mental health support.
- **Adopt WHO Guidelines:** The adoption of WHO guidelines and frameworks from resources such as "National suicide prevention strategies" and "Public Health Action for the prevention of suicide" is advised to guide the development and implementation of strategies.
- **Global Collaboration:** The promotion of the exchange of experiences and best practices through international platforms like the WHO MiNDbank is recommended to enhance the effectiveness of suicide prevention strategies globally.

In the absence of a national strategy, support for local suicide prevention activities, including supporting survivor groups, raising awareness, and advocating for vulnerable populations, is encouraged.

By adopting these recommendations, it is aimed to strengthen suicide prevention efforts, reduce suicide rates, and improve mental health outcomes across communities.

The implementation of a national strategy is recognised as a critical step in our commitment to enhancing public health and safety.



[34] https://www.who.int/activities/advocating-for-national-suicide-prevention-strategies

3 Increasing availability of community-based resources

Resources earmarked and mobilised for the creation of clubs, circles and centres for older people throughout different parts of the country and not solely in the larger cities. These initiatives should also be coupled with already established programmes such as the Universities of the Third Age[36] offering free educational and social activities for older adults, encouraging active participation. In addition to this, peer-support training programmes should be established so that peer-support programmes and networks can be set up where older adults can be connected with those going through similar experiences. Training community workers and gatekeepers such as meal delivery providers, in Applied Suicide Intervention Skills Training (ASIST)[37], or an equivalent, can help them recognise and respond to signs of mental distress and suicidality in older adults they interact with regularly. Since families are often the primary caregivers for older adults, social services should offer support, training, and resources to help them address mental health challenges. This could include counseling, respite care, and educational materials on managing mental health conditions. Initiatives to provide peer exchange and support can help reduce the sense of social isolation that many informal carers experience. Meetcaregivers[38] provide good examples of such initiatives.

It's important to raise awareness about less obvious forms of abuse, like psychological and emotional abuse, which often go unnoticed.

Media campaigns with sensitive storytelling on mainstream TV can help the public recognize these issues. Public campaigns on domestic abuse or harassment should also extend to the abuse of older people, educating both potential abusers and the public on what constitutes abuse.

Finally, it is important that "postvention measures"[39] are in place. Essential measures include immediate bereavement counseling, crisis intervention teams, and sensitive memorial services. Collaborating with the media for responsible reporting, offering educational programs to reduce stigma, and forming support groups are crucial. Additionally, ongoing follow-up care and targeted training for professionals can further support the community.

Implementing these initiatives will significantly enhance the support system for older adults, ensuring their mental health needs are adequately addressed and promoting a community-based approach to suicide prevention.

[34] https://www.who.int/activities/advocating-for-national-suicide-prevention-strategies

[35] https://www.u3a.org.uk/

[36] https://prevent-suicide.org.uk/training/asist/

[37] https://meetcaregivers.com/online-family-caregiver-training-programs/

[38] interventions conducted after a suicide, largely taking the form of support for the bereaved (family, friends, professionals and peers).

4 Training healthcare providers in providing culturally sensitive and age-appropriate care

All elements of diversity are present in the ageing process, including cultural diversity, sexual orientation, religion and belief etc. Therefore, healthcare providers should receive specialised training adequate to the individual needs of older adults. This should involve making sure that they are aware of the diverse needs of older people related to mental health, fighting ageism and other forms of discrimination, and providing healthcare professionals with training to meet older adults where they are rather than expecting them to navigate the complex healthcare systems.

Examples such as the "Healthy IDEAS program"[39] which integrates depression awareness and management into existing case management services provided to older adults. To help professionals implement these, guidelines for psychological practice with older adults must be created and put in place to ensure a solid, standardised framework is being followed. Relevant stakeholders can draw inspiration, if lacking at the local or national level, from the recently approved "American Psychological Association's guidelines for psychological practice with older adults"[40] which is used as a comprehensive evaluation tool to assess the readiness of healthcare professionals to work with older adults.

By equipping healthcare providers with the necessary skills and knowledge to deliver culturally sensitive and age-appropriate care, we can ensure that older adults receive comprehensive, empathetic, and effective mental health services tailored to their unique needs.



[39] https://www.ncoa.org/article/evidence-based-program-healthy-ideas

[40] https://www.apa.org/practice/guidelines/guidelines-psychological-practice-older-adults.pdf

5 Cross and inter-sectorial collaboration for comprehensive support

It is important that older adults are being listened to not just by other members of the community but by healthcare professionals and providers too. Debates and events at the local level, attended by professionals, where older adults explain their wants and needs and whether they are being appropriately addressed. An annual event attended by local media, politicians and other relevant stakeholders would make sure that ongoing progress, reflection and evaluation could take place in a constructive environment. This would ensure close cooperation between critical stakeholders in society and make sure that older adults' healthcare needs are kept as a community-wide priority.

Various cities and communities also have models of co-decision-making by older adults on matters that concern them, such as the regional councils of older persons in some German länder.

Community-based programmes that focus on behavioural health for older adults can help reduce stress and improve mental health for both caregivers and those receiving the care. Examples such as Wellness Recovery Action Plan (WRAP)[41]should be followed and adapted for the local context. These involve providing structured support for older adults via group interventions to increase their ability to self-manage their conditions.

Finally, to make sure that initiatives are truly cross-sectional, it is important to create meaningful partnerships between healthcare entities and community-based organisations. These partnerships can help address the health-related social needs of older adults, reduce health disparities, prevent unnecessary hospitalisations, and support older adults to remain in their homes. Organisations such as "The Better Care Playbook"[42] provide strategies and frameworks on how such partnerships can be implemented in practice. The EU Care Strategy and the Council recommendation on access to affordable, quality long-term care also promotes person-centred care which is best provided in one's home or community-based settings.

Fostering cross and inter-sectorial collaboration is essential for providing comprehensive support to older adults, ensuring their healthcare needs are met through a community-wide, inclusive approach that promotes ongoing progress, reflection, and meaningful partnerships between healthcare entities and community-based organisations.

[41] https://copelandcenter.com/

[42] https://bettercareplaybook.org/resources/addressing-complex-needs-older-adults-through-strong-community-based-organization-and

6 Adequate budget

For all the aforementioned policy recommendations to be effective, they must be supported by adequate budgets at both local and national levels. Financial investment is essential to cover the costs of integrating mental health services into primary care, establishing and maintaining community-based resources, providing specialised training for healthcare providers, and fostering cross-sectoral collaboration. Ensuring a sufficient budget allocation will facilitate the implementation of these initiatives, leading to improved mental health outcomes for older adults, reduced healthcare disparities, and enhanced overall community well-being.

A committed and well-funded approach will enable sustainable progress and comprehensive support for the mental health needs of older adults across diverse healthcare systems and infrastructures.



[41] https://copelandcenter.com/

[42] https://bettercareplaybook.org/resources/addressing-complex-needs-older-adults-through-strong-community-based-organization-and

Policy Recommendations at EU level

Acknowledging that health policy is not an EU-level competency, it is still crucial to address mental health for older adults at the supranational level due to the significant public health implications. The EU can play a pivotal role by facilitating collaboration, providing funding, and setting guidelines that member states can adapt to their specific contexts.

1 Promote social inclusion



Develop and fund initiatives aimed at reducing social isolation among older adults, such as community engagement programmes and support networks. Through the EU4Health programme or the European Social Fund (ESF+). EU-wide campaigns to raise awareness about mental health in older adults, aiming to reduce stigma and encourage help-seeking behaviours. More specifically, the EU4Health programme, with one of its key priorities being health promotion and disease prevention, can fund or co-fund community-based programmes, and support the creation of social clubs and centres for older people particularly in rural or underserved areas.

The ESF+ can help fund community engagement programmes such as peer-support networks, universities of the third age and community centres that provide a safe space for older adults to engage with others and receive the necessary support. Social inclusion and social connectedness projects that are designed to better integrate older adults into society can also be funded by ESF+ and the EU4Health programmes.

These can offer the opportunity for local and community-based organisations to create innovative projects leveraging their experience to ensure that older adults are socially included in everyday life.

Finally, The EU can leverage its reach to implement wide-reaching campaigns to raise awareness about mental health and suicide prevention in older adults, aiming to reduce stigma and encourage help-seeking behaviours. These campaigns can be part of larger health promotion strategies funded by EU4Health and ESF+, ensuring that they reach diverse populations across member states.

Promoting social inclusion for older adults by using EU4Health and ESF funds to develop community engagement programmes, peer-support networks, and social clubs. EU-wide campaigns can raise mental health awareness, reduce stigma, and encourage help-seeking, ensuring older adults receive necessary support and integration into society.

2 Standardise data collection and monitoring

Establish a standardised system for collecting and monitoring data on mental health and suicidality among older adults to inform policy and targeted interventions. This can be achieved by building on successful initiatives such as the European Core Health Indicators to develop a unified framework and try to ensure all Member States use consistent methodologies. The ageing of society means that disaggregation of data by age has to evolve as well to cover the entire spectrum of human life.

Cross-border data sharing needs to be promoted through platforms such as the European Health Data Space. All the data should be stored in a centralised EU database for mental health and suicidality, managed by the European Centre for Disease Prevention and Control or a similar entity. It should also be accessible to policymakers, researchers, and healthcare providers to inform evidence-based interventions.

To ensure that data collection and monitoring are being correctly carried out, the EU should organise workshops and training sessions for national and regional health authorities to promote best practices in data collection and monitoring. As above, programmes such as the EU4Health and the European Social Fund (ESF+), can be utilised to fund and support the standardisation of data collection and monitoring systems.

By establishing a standardised system for collecting and monitoring data on mental health and suicidality among older adults across Member States, consistency can be ensured. Utilising the European Health Data Space for cross-border sharing and maintaining a centralised database managed by an EU entity will enhance data accessibility for policymakers and researchers.

Funding should be secured through EU4Health and ESF+, and workshops should be organised to promote best practices in data collection and monitoring as well as enhance research within this field.



3 Enhance training for healthcare professionals

Implementing EU-wide training programs for healthcare providers is essential for recognising and addressing mental health issues specific to older adults, such as depression and suicidal ideation. In the specific, the EU can facilitate the development of standardised training curricula tailored to the mental health needs of older adults. In addition, elder abuse and neglect are often undetected factors that can lead to worsening mental health. These curricula should include modules on:

- **Recognition and Diagnosis:**
  Training on identifying signs of elder abuse, depression, anxiety, and suicidal ideation in older adults.
- **Cultural Competence:**
  Ensuring healthcare providers understand the cultural and social contexts that impact mental health in older adults.
- **Intervention Strategies:**
  Providing practical skills and knowledge for effective intervention and support

A crucial tool would also be online training platforms to make training accessible to healthcare professionals across the EU. These platforms can offer flexible learning options, including webinars, interactive modules, and certification courses. This approach ensures that even healthcare providers in remote or underserved areas have access to quality training. Within these programmes, it is crucial to promote a multidisciplinary approach in training programmes, involving doctors, nurses, social workers, psychologists, and other allied health professionals.

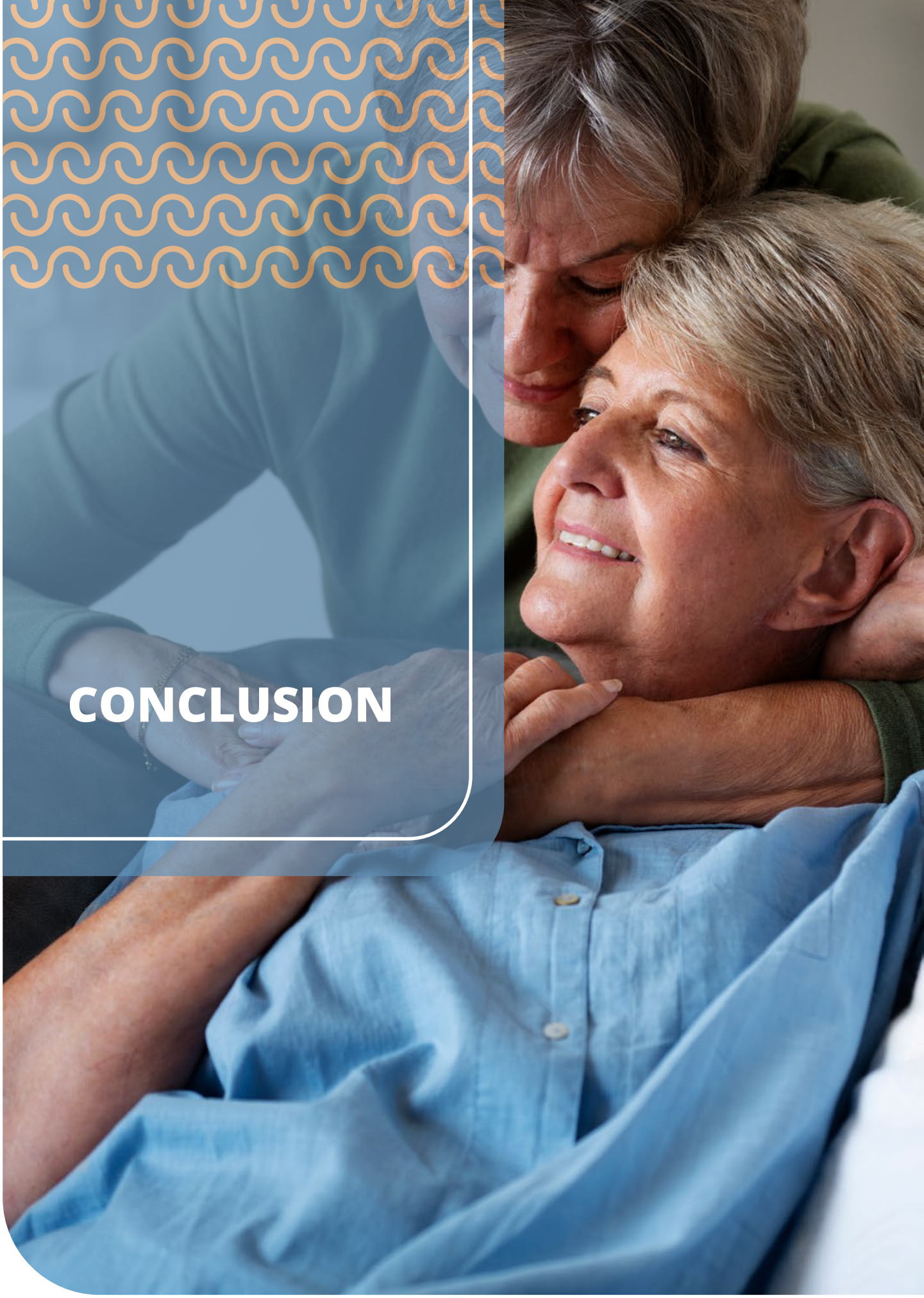
It is also important as part of the training to encourage Member States to integrate mental health training into the Continuous Professional Development (CPD) requirements for healthcare providers. This ensures that professionals regularly update their skills and knowledge on the latest best practices and research in mental health care for older adults.

By implementing EU-wide training programmes, the EU can ensure that healthcare providers are well-equipped to recognise and address the unique mental health needs of older adults.

This comprehensive approach will improve mental health outcomes, reduce the incidence of depression and suicidal ideation, and enhance the overall quality of care for older adults across Europe.



CONCLUSION



Conclusion

Suicidality disproportionately affects older adults with current demographic trends only likely to further increase the absolute numbers of older adult suicides. While the rates vary across different EU countries, they are always at higher levels than the overall suicide rates of the population.

Key specific, and more general, factors that are known to influence these rates are mental health and psychosocial problems, physical health and chronic illness, socioeconomic factors and stigma and discrimination.

There is an important role for healthcare systems by providing accessible, coordinated services, including comprehensive geriatric care and tailored mental health support that can facilitate early detection, continuous management of mental health issues, and suicide risk reduction, emphasising continuous training for healthcare providers and care integration. Welfare policies can help by providing economic security, enhancing mental well-being, and fostering social inclusion and support through robust welfare benefits, community involvement, and integrated mental health care.

The focus groups that were held highlighted the key issues related to suicidality for older adults such as social connections and isolation, detrimental cultural attitudes, post-work life and future planning, age-specific prevention, financial stability and the importance of meaningful community involvement.

The survey further emphasised the importance of gatekeeper services for early intervention, integrated care models for comprehensive support, and fostering close relationships to combat loneliness and suicidal ideation.

It also highlighted the need for policy changes to address financial instability, particularly in Eastern Europe, to reduce poverty-related mental health decline among older adults.



Given the scale and urgency of the issue, it must be addressed at both a national and EU level.

At the national level, integrating mental health services into primary care is essential, and proven to reduce suicide rates and improve health outcomes through efficient management of comorbid conditions.

Additionally, developing and monitoring comprehensive national suicide prevention strategies, supported by adequate funding and broad stakeholder involvement, is vital. This should include increasing community-based resources, providing culturally sensitive training for healthcare providers, and fostering cross-sectorial collaboration to ensure a holistic approach to mental healthcare. Adequate budget allocations are necessary to support these initiatives, ensuring sustainable improvements in public health and safety for older adults. At the EU level, promoting social inclusion, standardising data collection, and enhancing training for healthcare professionals are essential. Initiatives like EU4Health and ESF+ should fund community programs and support networks to reduce isolation. A centralised EU database will facilitate informed interventions, while EU-wide training programs will equip healthcare providers to address the unique mental health needs of older adults effectively. These coordinated efforts will improve public health outcomes and ensure a supportive environment for older individuals.

Policy must be transformed into practice, theory into action, and commitment to real change by united efforts. The incidence of suicide among our older populations can only be hoped to be reduced and the quality of life for all our citizens truly enhanced through collective, targeted interventions.

The time to act is now—every moment is counted in the fight against older adult suicidality.



Acknowledgements

We are grateful to our workshop participants who gave their insights based on their work in the field and their personal experiences of older relatives who have been lost to suicide. We are also immensely grateful to AGE Plaform Europe for their collaboration and co-production every step of the way.

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Joint Statement. Brussels, 10th October 2024

World Mental Health Day

Deliver on promises and honour commitments on mental health

On World Mental Health Day 2024, 33 European organisations call for substantive actions to shape a Europe where everyone's mental health thrives across their life course.

President Ursula von der Leyen, in her Political Guidelines 2024-2029, emphasised the urgent need to 'step up our work on preventive health, in particular for mental health'. She stressed that it is essential to respond to the real and legitimate concerns of Europeans about the instabilities and insecurities they face - including the cost of living, housing and energy, the wars- and recognised the impact of these changes and crises on the quality of life of the population[1]. She placed a special focus on the mental health of children and young people, especially online, and promised actions to tackle what she calls 'the greatest challenge in this decade'.

These promises by the European Commission President build on commitments made over recent years by several EU institutions[2], including the Communication on a comprehensive approach to mental health. However, as the EU and all member states are reckoning with the inability of our current mental health systems to address increased needs of the population[3], these initiatives should be considered as a starting point, and further actions are urgently required to prioritise mental health across Europe.

[1] According to the Eurobarometer (2023), 62% of European Union citizens think that recent world events (the COVID-19 pandemic, the Russian aggression against Ukraine, the climate crisis, unemployment, and the food and energy costs) affected their mental health.
[2] See Mental Health Europe's briefing on political developments here.
[3] More than half of respondents to the last EU Barometer survey experiencing a mental health problem have not received help from a professional.

The undersigned organisations welcome European Commission President's renewed ambition and call on all stakeholders to work together to translate this ambition into concrete actions.

Europe faces a clear choice. To address the concerns of the population or further contribute to persisting challenges. The second option will come with a cost, for our societies, economies, and democracies.

On this World Mental Health Day, the undersigned organisations call:

On the European Commission

To develop a comprehensive **European strategy on mental health**, with a clear timeline and adequate budget, as well as indicators to monitor and coordinate progress at the European and Member State levels.

The **European strategy on mental health** should:

- Adopt a '**mental health in all policies'** approach, by addressing the socio-economic and environmental determinants of mental health, in different policy areas within and beyond health and with a strong focus on prevention.
- Ensure that **nobody is left behind**, by recognising that some groups of people are particularly at risk of experiencing poor mental health and less likely to have access to tailored mental health support, because they live in **vulnerable situations, experience structural marginalisation,** or due to of **intersectional discrimination**.
- **Fight against mental health stigma and discrimination**, by promoting initiatives to support mental health and communication campaigns in the EU through **a European year of mental health**.
- Ensure that the **digital transformation** puts human rights at its centre and **supports children and all people to thrive through their life course**. It is crucial not to place the responsibility for better mental health outcomes **exclusively on the individuals or families** but to address structural issues, such as the business model and design of digital services and products and the related power imbalances.
- Propose a **legislative initiative**, in consultation with the social partners, on the management of **psychosocial risks and well-being at work**, with special attention to the health and care workforces.

- Ensure the **transition to community based, accessible, affordable, and human rights based mental health care,** and contribute to deinstitutionalisation.
- Put forward a comprehensive and **holistic approach to promote good mental health for children and young people** - online and offline - building on the commitments under the EU Strategy on the Rights of the Child, the EU Child Guarantee and the EU Youth Strategy. Strengthen preventative measures and early intervention programs.
- Adopt a **co-creation approach** when developing policies or practices related to mental health. Special efforts should be made to reach out to the groups structurally excluded from decision making processes.
- **Fund research and innovation in line with a psychosocial model** of mental health.
- Facilitate the **identification, collation, routine reporting, and use of core mental health data** disaggregated by race, gender, sex, age, disabilities, sexual orientation, sex characteristics, gender identity and other grounds to properly capture intersectionality issues.

On Member States

- To **elaborate action plans or strategies in coordination with the EU level action, with a cross-sectoral approach to mental health**, addressing not only health, but also employment, education, digitalisation and AI, culture, environment, and climate factors, among others, as recommended in the European Council Conclusions on Mental Health.
- To develop **community based, recovery oriented mental health services** in line with the United Nations Convention on the Rights of Persons with Disabilities and the European Strategy for the Rights of Persons with Disabilities.

On the European Parliament

- To establish an **Intergroup on mental health**, ensuring a formal structure to foster exchanges on mental health across different political groups and to strengthen collaboration between Members and civil society.

Signatories:



ADHD Europe aisbl



Alliance for Childhood



Autism Europe



Coface Families Europe



EMDR Europe Association



EPSA (European Pharmaceutical Students' Association)



EUPHA - European Public Health Association



EUREGHA – European Regional and Local Health Authorities



EUROCADRES



EUROCARERS – European Association Working with and for Informal Carers



Eurochild



Eurodiaconia



EuroHealthNet



European AIDS Treatment Group (EATG)



European Association of Service providers for Persons with Disabilities (EASPD)



European Disability Forum



European Federation of National Organisations Working with the Homeless (FEANTSA)



European Federation of Psychology Students' Associations (EFPSA)



European Medical Students' Association (EMSA)



European Network of (Ex)Users and Survivors of Psychiatry

European Public Health Alliance

European Youth Forum

5Rights Foundation

Gamian Europe

ILGA-Europe

Inclusion Europe

Learning for Well-being Foundation

Make Mothers Matter

Mental Health Europe

SOS Children's Villages

Standing Committee of European Doctors (CPME)

The European Alcohol Policy Alliance (Eurocare)

Volonteurope

Brussels, 15 November 2024

CPME, PGEU, BEUC, AGE, HOPE, AIM, EFN, EAHP
Joint Statement on Electronic Product Information (ePI)

Doctors, nurses, community and hospital pharmacists, hospitals and healthcare services, consumers, older people, health insurance funds and not-for-profit health mutuals, call on legislators to maintain paper package leaflets, and use electronic leaflets as a complementary tool.

Ahead of the future co-legislators' interinstitutional negotiations on the European Commission's Proposal for a revised pharmaceutical legislation in the European Union,[1] the signatory organisations appeal for inclusive provisions that leave no one behind and are respectful of privacy and personal data protection.

We call upon the co-legislators to:

Contribute to an inclusive society, without enacting discriminatory rules that increase the digital divide and limit individuals' choice

We call on the EU to guarantee the right to use digitalisation for those who wish to do so, and maintain the paper leaflet for those who do not,[2] or cannot. We also alert to the risks of imposing the use of a mobile device to access basic health information. An exclusive ePI implies possessing a smartphone or a tablet, sufficient connectivity, an internet data plan, and to have those devices at hand at the time of need. The ePI imposes a level of digitalisation without considering those who do not want to use a smartphone/tablet, or cannot, due to age, geographical location, disability, health, income, religion or social situation. The ePI is also disproportionate to what the paper alternative could offer in a simpler way.

Recognise the importance of the package leaflet as a key tool for information accessibility

We highlight that the package leaflet is a vital component of the information provided to patients on the safe and effective use of the medicines they take, which is a consideration under the benefit/risk analysis. It is furthermore a tool to improve health literacy. Paper leaflets offer immediate access to approved, complete and unbiased information that helps the patient to make an informed decision. Changes that make access to such information and its storage more difficult place the burden of seeking information on the patients. For example, studies conducted in other fields show that a low level of consumers scan product information made available through a QR Code[3].

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[1] Proposal for a Regulation of the European Parliament and of the Council laying down Union procedures for the authorisation and supervision of medicinal products for human use and establishing rules governing the European Medicines Agency, amending Regulation (EC) No 1394/2007 and Regulation (EU) No 536/2014 and repealing Regulation (EC) No 726/2004, Regulation (EC) No 141/2000 and Regulation (EC) No 1901/2006, COM(2023)193 final, and a Proposal for a a Directive of the European Parliament and of the Council on the Union code relating to medicinal products for human use, and repealing Directive 2001/83/EC and Directive 2009/35/EC, COM(2023)192 final, 26 April 2024.

[2] European Parliament resolution of 13 December 2022 on the digital divide: the social differences created by digitalisation (2022/2810(RSP)), OJ C 177, 17.5.2023, p. 57–62, point M.

[3] Rehm J, Ferreira-Borges C, Kokole D, Neufeld M, Olsen A, Rovira P, Segura Garcia L, Tran A, Colom J. Assessing the impact of providing digital product information on the health risks of alcoholic beverages to the consumer at point of sale: A pilot study. Drug Alcohol Rev. 2023 Sep;42(6):1332-1337, accessed on 24 October 2024: https://pubmed.ncbi.nlm.nih.gov/37132168/

Balance the advantages and disadvantages of ePI

Due to its semi-structured and accessible format and design, ePI offers opportunities to improve readability and meet specific patients' needs, such as of those with impaired sight. However, the possible attractiveness of ePI presentation material or speed of access to a medicine's latest information are not sufficient arguments to undermine the fundamental rights of individuals. A pilot conducted in Belgium and Luxembourg acknowledged that access to the internet, even in a hospital setting, was not always possible[4]. We further underline situations where internet can affect medical device usage and it needs to be turned off, or rooms where the connection is slow or out of range, making it impossible to provide the healthcare service to patients in such locations. At present, providing the paper leaflet in the medicine packages is a key regulatory responsibility of pharmaceutical companies, who also bear the costs. If the paper leaflets are removed from the packages, the burden, practicalities and costs (time, paper, printer, ink, internet connection, etc) of printing an ePI would fall on the pharmacist or on the patient.

Protect patients' privacy and guarantee that the information is not used for commercial purposes

Even if the ePI leaflet is introduced as a complementary tool and does not replace the paper version, it is of utmost importance to guarantee patients' privacy and data protection when accessing the online leaflet. It should be ensured that third-party applications do not store any personal information linked to the request of accessing ePI for a specific medicine, which could potentially lead indirectly to promotional activities. At the same time, it must be clarified how software, apps or websites will process and store citizens' data when searching for a medicine's ePI – be it a search query or by scanning a medicine's barcode linking to the ePI. The appropriate application of European and national data protection legislation should be guaranteed and closely monitored in these third-party applications or websites at all times.

It is also important to ensure that the ePI leaflet provides approved information only, and that it is not used to deliver promotional information. It should always be published as open data, freely accessible for use and reuse. To ensure that ePI remains a source of trusted and non-promotional information, it will be crucial that patients are directed to the ePI leaflet stored by independent and official sources such as the European Medicines Agency and National Medicines Agencies' websites.

Listen to patients and other end users as an evidence-base for action

Even if a phase-out period was established to allow an improvement of individual digital skills[5], evidence shows that 79% of consumers think paper leaflets should be available inside the package, even if there is a QR code alternative on it[6]. Survey respondents felt this would otherwise disadvantage older people (81%) and would make society too dependent on the internet (70%). In 2023, only 55.6% of people in the EU aged 16 to 74 had at least basic digital skills, and by 2030 the estimation is of 59.8%, falling short by more than 20% from the target[7]. We insist on the need to offer a non-digital solution to maintain a proportionate playing field between the online and offline world. The scaling up of ePI to the whole population, with the disparities that it entails, is a burdensome change the success of which is not evidence-based.

[4] The pilot advocated as a good example by the pharmaceutical industry was limited to highly qualified professionals (hospital pharmacists) and in a hospital setting, <https://pharma.be/sites/default/files/2022-04/2021_E-PIL%20pilot%20project_one-pager_final.pdf>.

[5] Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, State of the Digital Decade 2024, COM(2024)260 final, 2 July 2024 and respective annex 2, p. 5. Overall digital skills refer to five areas: information and data literacy skills, communication and collaboration skills, digital content creation skills, safety skills and problem-solving skills. To have at least basic overall digital skills, individuals must know how to do at least one activity related to each area.

[6] Surveys conducted between June and July 2022 by Altroconsumo (Italy), DECO (Portugal), OCU (Spain) and Test Achats/Test Aankoop (Belgium) as part of the Euroconsumers group, https://www.euroconsumers.org/wp-content/uploads/2023/06/Digital-Rules-Labelling.pdf

[7] Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, State of the Digital Decade 2024, COM(2024)260 final, 2 July 2024 and respective annex 2, p. 5. Overall digital skills refer to five areas: information and data literacy skills, communication and collaboration skills, digital content creation skills, safety skills and problem-solving skills. To have at least basic overall digital skills, individuals must know how to do at least one activity related to each area.

*The **Standing Committee of European Doctors** (CPME) is a European not-for profit association representing 37 national medical associations across Europe, giving voice to over 1.7 million doctors.*

*The **Pharmaceutical Group of the European Union** (PGEU) is the association representing 400,000 community pharmacists in 33 European countries.*

*The **European Consumer Organisation** (BEUC) is the umbrella group for 44 independent consumer organisations from 31 countries.*

***AGE Platform Europe** is the largest European network of non-profit organisations of and for older people. We elevate older people's voices, bringing their experiences and aspirations to the table to celebrate ageing and fight for equality at all ages.*

*The **European Hospital and Healthcare Federation** (HOPE) is a European not-for profit association representing 37 national public and private hospital and healthcare associations and hospital, health and social care services owners.*

*The **International Association of Mutual Benefit Societies** (AIM) is an international umbrella organisation of federations of health mutuals and health insurance bodies counting with 49 members from 26 countries around Europe, Latin America and Africa and the Middle East.*

*The **European Federation of Nurses Associations** (EFN) is a European not-for profit association representing 36 national nurses associations and represents as such 3 million EU Nurses*

*The **European Association of Hospital Pharmacists** (EAHP) represents over 29,000 hospital pharmacists across 36 member countries.*

Resources:

AGE Platform Europe: "Digitalisation and older people: our call to EU policy makers", June 2024.

BEUC: Position on the European Commission's proposal for a revised pharmaceutical legislation, Recommendations for improving access to medicines in Europe, December 2023.

PGEU: Position paper on the reform of the EU Pharmaceutical Legislation and PGEU position on electronic product information.

CPME: Proposed amendments to the Commission's Proposals for the Directive on the Union code relating to medicinal products for human use and the Regulation lying down Union procedures for the authorization and supervision of medicinal products for human use and establishing rules governing the European Medicines Agency, Medicine shortages and security of supply, October 2023.

EFN: EFN PS improving frontline nurses' time for direct patient care with digitalisation & responsible AI *(October 2024)* and EFN Policy Statement on EHDS *(April 2023)*

AGE member's views on an EU Pensioner's or Senior Citizens' Card

Collection of views

December 2024

AGE members voiced broadly support for the initiative, with points of caution, such as the fact that there might be more urgent, structural issues to address with policy attention towards older people. Only one member organisation expressed opposition to such a proposal.

Points of attention in general

- What difference is the card going to make? The question could rather be how to better include/involve older citizens
- A card should not be a window-dressing exercise replacing efforts to secure adequate pensions, fight old-age poverty, combat loneliness and isolation, provide quality, person-centred care, strengthen older perons' possibility to speak for themselves rather than being subject to other peoples' decisions on their lives, foster accessible built and digital environments, invest into social and cultural services and their outreach to older people etc.
- What is 'old' means different things in different member states. According to an IPSOS survey, one is considered 'old' at 69 on average in the EU, but for example 74 in Spain; similarly, pension ages are very different
- Members rather disagree to link a card to a level of income, because of the stigmatization linked to it, the complexity of means-testing mechanisms that would translate into non-take-up

Possible services connected to the card

- The availability of services/discounts in a more or less harmonized way would be a criterion for its usefulness (and the value of putting efforts into implementation)
- Treatment like an equivalent national person
- Cultural activities, sports, museums
- Mobility services
- Health services and especially prevention (screening for diseases)

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- Platform or database with services which recognize the card (but this might be costly or unused)

Arguments pro

- A card for 'senior citizens' / over 65s would be easily understood and easily implementable
- Helps in access to culture, segmentation by age group, facilitate mobility, social recognition of older persons
- 'Age' is neutral and does not reveal the financial status of a person, if it was limited to low-income pensions, there would be an effect of exclusion by (self-)stigmatization
- Could create a new sense of belonging in the transition phase between work and retirement

Arguments contra:

- Age can be proven by ID card already
- Could create a sense of stigmatization ('now, I am old')
- Privileges, just like discrimination, should not be attached to a certain age.
- A pensioner's card will create new inequality, for example most people of 65 years could claim benefits with this card in Denmark, while pension age in Denmark is 67 and rising.
- Shortcut for making everything more accessible and for a real age equality strategy
- Difficult to operationalize, but these difficulties can be overcome
- EU Disability Card is accessible to older persons with impairments and already gives some advantages
- Being a 'pensioner' may or may not be the sign of financial difficulty, there are many other factors at play
- May give rise to new equity problems
- The general purpose card to prove age and entitlement will always mean different things in different member states. Indeed often things vary municipality by municipality within the same EU state.
- Members appreciate the existence of the EU Social Security Card, giving access to medical care across Europe in the same conditions as nationals, as well as the new EU Disability Card

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Existing experiences

France

There are reductions for entries into cultural/historic sites or cinemas, but granted on the basis of age, not of pensioner status, but this is at the discretion of the management.

In the Ile de France region, the Navigo pass is half-price for people over 62, to compensate for the fact that most employers pay 50% of the price of public transport, a privilege that is lost when retiring.

Discounts in national trains can be obtained after the purchase of a special reduction card for seniors.

Portugal

many entities - museums, monuments and equivalents, some shows, railway transport, among others - treat older people as citizens with more economic difficulties, as if to compensate them for long working lives or even to encourage this public, with more time available, to access these goods and services

Poland

In Poland, there is a pensioner's card, which is formally a pensioner's ID. The advantage of such a document is that you don't have to have it in your wallet all the time. You can use its digital version on your smartphone in the mObywatel application. Adding the ID to the application also means that a network connection is not required if necessary.

What does such an ID actually give you? According to the regulations, it certifies in all situations when the age of a given person and the fact of being retired are checked. This means that it can be used in pharmacies (discounts for the elderly), in cultural institutions, sports facilities, as well as in public transport, trains, etc. It is also a document allowing cheaper access to health resorts and participation in rehabilitation sessions. The holder of such a card-ID can be a pensioner, i.e. a person who has reached retirement age.

There are also additional, independent Senior Cards issued by local governments and commercial institutions, such as the Nationwide Senior Card, which is issued for a fee: https://glosseniora.pl/ogolnopolska-karta-seniora/

Italy

In Italy, economic benefits exist in many sectors, but their accordance can depend not only on age but also on income. In some cases the benefit is subject to demand, in others upon showing the ID. It depends on the service in question. But we usually talk about Senior's Cards rather than Pensioner's Card

Germany

Some positive discrimination existed in Germany by granting a supplementary benefit on minimum pensions for people over 75, recognizing the objectively higher needs for income of this group.

Denmark

some discounts apply to persons with a disability (disability pension) or who are over the pension age (67 years). I.e. you are not entitled to the discount because you receive the old age pension, but because you are 67 years or more.

Hungary

In Hungary, people over 65 years of age are entitled to a number of discounts on production of their ID card, discounted museum admission, discounts on admission to other venues (usually 50%) and there are free days set aside for them.

Public transport is free for over 65s (only Intercity train tickets are required if travelling by IC).

NYOSZ card is available for members of NYOSZ pensioner clubs, and it provides limited discounts on books, and services. (attached).

City cards are issued in various cities and give access to additional discounts. This is not only available for pensioners. I enclose the city card of Debrecen of one of my colleagues. With this city card, free screening programmes, sports activities (e.g. osteoporosis gymnastics, senior dance, etc.) are available.

Greece

No pensioner's card, but reduced entry fees to public museums and archaeological sites, and reduced fares in public transport from 65 onwards, with no distinction of citizenship

Cyprus

All pensioner receive a card form the Social Insurance Service upon retirement (between 63 and 65 years, or earlier when there is preretirement for health reasons). It provides 50% discount on public transport, public theatres, museums etc.

Low-income pensioners can receive additional benefits and receive a certificate from the same service. This entitles to the same discounts, but 100%, as well as reduced municipality taxes and fees to public utilities

Malta

The Department for Care of the Elderly introduced a 60+ card for Maltese nationals at their 60th birthday some 20 years ago, including a photo, to complement the national ID card. The 60+ card gives entitlements to a limited range of services, such as paying a reduced fare to use public busses and enabling to jump certain queues, e.g. at the bank. It was discontinued after some years and older citizens only rely on their ID card. Some private banks accept to serve older persons only at specific banking hours, after presentation of their national ID.

At present, public transport is free for all holders of a valid public transport card. The card was introduced 10 years ago and has different colours for students, adults, older persons, residents of Gozo (smaller island part of the Maltese republic). Older persons have the cheapest price as blue card holders. Now, the card is free for all except for a small (annual?) fee to get the card, which is 5€ for older persons and children, 25 € for most.

https://www.publictransport.com.mt/tallinja-card (Tallinja card)

However, public transport is overcrowded and the barriers for older persons is not the price, but more the lack of accessibility and respect for the allocated reserved seats for older travellers in the public transport system.

Heritage Malta has a seniors' passport allowing free unlimited access for older persons and two younger persons accompanying them to eritage Malta sites and museums.

Other cases of preferential treatment exist, but are based on the appreciation of the private service or goods provider, usually based only on age rather than on pensioners' status.

United Kingdom

In London, everyone over 65 gets free travel after 9:30am, an age likely to increase because pension ages rises to 67. Some travel passes exist in other parts of the country, and reduced prices for national rail after the purchase of a transport card.

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