

Adding life to years

AGE position on prevention and health promotion

Prepared by the AGE Task Force on Dignified and Healthy Ageing

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Executive Summary

The increase of longevity is one of the greatest achievements in our societies. **However, healthy life expectancy has not kept track**, adding statistically a longer time to our lives where we can expect face one or more major challenges to our ability to do the things we value. Health is one of the human rights enshrined in international conventions and is framed not as simply the access to health services, but to the aspirational goal of 'the highest attainable standard of health'. Therefore, the promotion of healthy habits, prevention of the vulnerability to disease and the slowing of a disease's progression is the first step to guaranteeing this right – together with accessible, quality health care services. Yet, **ageist assumptions and barriers can create barriers for older people to benefit from these policies**.

The principles of health promotion and prevention are mentioned in many European Union and Member State policies, lately in the European Care Strategy, but their implementation is not that visible in policymaking. **In particular, we found implicit and explicit age barriers in benefitting from promotion and prevention policies.**

In this paper, AGE wants to make the case for **stepping up promotion and prevention as a lever of guaranteeing a fundamental right** throughout the lifespan, mitigating the economic impact of longevity and allow for higher, more equal quality of life.

AGE spells out the main principles that should guide a stepped-up ambition to promote health and prevent disease, based on the equal right to health for all. We also highlight challenges and good practices in each domain, and conclude with an outlook on the impact of the expected changes in the sector linked to artificial intelligence, wearable devices and other technologies. **Our argument is that technology should support, not replace care and needs to be approached with accessibility, inclusiveness and offline alternatives in mind**.

Key principles for **health promotion**	Key principles for **disease prevention**
Inclusiveness to all ages and other characteristics	Health in all policies and integration of prevention
Integration across policy fields and levels and central steering	NGOs and media as partners in health
Important role for local authorities	Co-creation and person-centredness
Civil society organisations as key partners for outreach	Need to address the social determinants of health
Independence from industry	Accessibility and inclusiveness of initiatives
Social prescribing as a key driver	Life-course approach and the elimination of ageist barriers

Recommendations for the European Union health policies

These principles are to be implemented at all policy levels, as health promotion and prevention affects all of them. Specifically on EU level, AGE formulates the following recommendations:

- Remove **age barriers and age discrimination** in access to prevention, screening and vaccination.
- Make healthy ageing and prevention **a core pillar of the EU Care Deal**.
- **Invest through EU4Health and its follow-up budgetary instruments** in health promotion, prevention and adult vaccination across the life course, setting adequate **health spending targets** in the Performance Framework of EU Funds.
- **Measure progress** through healthy **life expectancy and prevention indicator**s in the European Semester, including **health prevention spending as % of GDP** and indicators for spending on health promotion.
- Ensure that **digital and AI-based health solutions support, rather than replace, human-centred care**.

These principles should **also find their place in the drafting of a Human Rights Instrument** on the Rights of Older People at the UN level.

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With kind contributions from Wenche Malmedal, Norwegian Pensioners Association; Mirosława Wojciechowska-Szepczyńska, Alzheimer Polska, Michael Fenech, National Association of Pensioners (Malta); Joke de Ruiter, Older Women's Network Netherlands; Herman Fonck, OKRA (Belgium); Guido De Cuyvers, Vlaamse Ouderenraad (Belgium); Francesca Carpenedo, Older Women's Network Europe (EU/Italy); Cees Vermeeren, Association of Dutch Pensioners Living Abroad; Irene Cobo Junquera, Cruz Roja (Spain); Monika and Przemek Belchnerowski, Fundacja Ostatnia Warta (Poland); Patrick Swain, International Longevity Centre UK.

Introduction

Longevity is one of the greatest achievements of humanity. In Europe, except for a short-term dip due to the COVID-19 pandemic, longevity has continued to rise across the past decades, by roughly 10 additional years in the past five decades and is still increasing by about two months per year. Combined with the demographic shift from higher-fertility to lower-fertility generations, this means that a rapidly rising share of the population is in older age and can expect to live for longer.

However, health life years have been stagnating at 63.3 years for women and 62.8 years for men (2023)[1]. With life expectancy being assessed at birth at 78.9 years for men and 84.1 years for women (2024), this translates into a statistical period of disability or disease of almost 21 years for women and 16 years for men. Gender is just one driver for health inequalities – social inequalities across the lifespan, experiences of discrimination and exclusion, all shape the individual's health outcomes in later life, often reinforcing earlier inequalities. This constitutes an individual challenge to every single person concerned and their family, who have to find support, treatment and relief throughout ill-health. Many see this period as a threat to our societies and economies, as ill-health induces spending on health and long-term care and reduces social participation of persons living with a disability or disease and the many informal carers who provide support to them, as there is a shortage of formal care.

However, this does not need to be a fatality. We know many of the risk factors of diseases developing over time or more prevalent in older age. This knowledge is an opportunity to 'add more life to years', as the UN Decade of Healthy Ageing puts it. It is also an opportunity to ensure that every individual in our society is entitled to the 'highest standard of health', as enshrined in the Covenant of Social, Economic and Cultural Rights. Health promotion has even a potential beyond addressing age-related difficulties: properly implemented, it prevents diseases and reduces vulnerability at any stage of life.

More specific than health promotion, disease prevention focusses on specific conditions, whether a person has contracted it already or not. Prevention has also a role in slowing the development of a disease in a person, keeping the person in better health for longer.

Health promotion and disease prevention are in essence also undertakings of intergenerational fairness, as a healthier older population leads to fewer healthcare costs and the benefits of healthier lives benefit all generations.

However, to seize this opportunity, governments must prioritise coordination between different areas of government, and especially between the health and social sector. It requires clear allocation of resources to invest in health promotion campaigns and activities, encourage and fund early screening and intervention, make social prescribing work, empower local authorities and civil society organisations to deliver public health

[1] Eurostat, Healthy Life Years Statistics.

messages and services, fund support for mobility and assistive devices such as hearing or visual aids before impairments become a risk factor for other diseases.

In a time of tight budgets, we must not lose sight of the importance of investment into longer-term improvements of health status, instead of only focusing on curing acute diseases. A frequently quoted finding is that one dollar invested in health promotion gives a 14-dollar return, an effect that should be similar when labelled in Euros.[2]

With this paper, AGE wants to contribute on registering health promotion and disease prevention higher on the agenda, highlight some promising example and pinpoint remaining bottlenecks for public action.

Healthy lifespans: health promotion

For the sake of this paper, we call health promotion any action, such as communication campaigns or community initiatives, with an effect of improving health determinants generally, without targeting a specific disease.

Principles for health promotion across the lifespan

The gap between increasing life expectancy and stagnating healthy life expectancy showcases the unrealised potential of health promotion in increasing individual health outcomes, social integration and cohesion, as well as the potential for limiting increased health needs weighing on individual and public budgets in a context of demographic change. Health promotion is key in transforming increased longevity into increased healthy lifespans.

When surveying our members, the following aspects emerged which should be taken into account as general principles for health promotion in relation to ageing:

- It should be accessible to people of all ages, without barriers directly linked to age or linked to social status, income or literacy, digital inclusion, absence of disability, life in rural or urban areas etc.
- It needs to be embedded in all relevant policy fields, especially the ones closest to the citizens, such as local authorities or service provision.
- It needs to be steered by a coordination point at national or regional level.
- Local authorities have to be on board to promote initiatives.
- Civil society organisations are a key partner at local level to reach out to the community and bridge medical services with daily life.

[2] Masters, R. et al (2017): 'Return on investment of public health interventions: a systematic review' In: *Return on investment of public health interventions: a systematic review*, Vol. 71(8). AGE member International Longevity Centre UK (2020) calculated that a 0.1 percentage point increase in prevention spending can unlock 9% returns in spending and economic activity in over-60s.

- Initiatives should be independent from industry; however, collaboration with health insurance companies and employers can be recommended.
- Social prescribing, as a way to support prevention, should be upscaled, such as by referring older person to social, volunteering or companionship programmes where they exist. This requires training to those who could be in contact with people in vulnerable situations to identify them and know what could be prescribed.
- The roles between the different stakeholders should be clearly defined:

Stakeholder	**Key role**	**Why?**
Central government	Policy-setting & funding	They determine the reimbursement rates for preventive care and the taxes on unhealthy products.
Local government	The direct environment	Closest to the public and able to adapt the physical living environment (parks, people, cycle lanes).
Business sector	Workplace well-being	People spend a large part of their life at work. Investing in ergonomics and mental health support yields 4€ per euro invested.
Healthcare	Early Detection	General practitioners (GPs) and pharmacists are trusted professionals who can be the first to identify medical risks.
Non-profit organisations	Inclusion and Outreach	reach vulnerable groups, e.g. persons at risk of poverty.

Gaps in health promotion

- **Social inequalities persist in older age**
  Health promotion often benefits healthier and more resource-strong older adults, while frailer groups are less reached. They are not sufficiently tailored to reach vulnerable groups and therefore risk reinforcing existing inequalities.

- **Limited tailoring to diversity among older people**
  Insufficient adaptation for very old adults (80+), people with multimorbidity, and older migrants.
- **The digital nature of most initiatives**
  This limits outreach to older persons who are digitally excluded. We are leading away from general awareness campaigns ('eat more fruit') towards very personalised interventions based on real-time data. This change needs to be thoroughly thought through and the benefit of generalist campaigns not forgotten.
- **Low focus on emotional well-being and social isolation**
  Health promotion initiatives seldomly focus on emotional well-being alongside physical well-being. Given the importance of emotional well-being for resilience and its links with physical, mental and cognitive health outcomes, there should be a stronger focus. Similarly, social isolation and social relationships are insufficiently integrated into health promotion. They are as well strongly associated with physical, emotional, functional and cognitive health outcomes and are key determinants of health in older age. Loneliness and isolation are too often solely treated as social issues, rather than a component of health policy.
- **Lower physical activity among older adults**
  Compared to other Nordic countries, Norway reports relatively low physical activity levels among older people, indicating unmet potential.
- **Risk of over-emphasis on "active/successful ageing"**
  Policies may place responsibility on individuals, with less focus on structural and environmental support for those with declining function.
- **Lack of information in various languages**
  This is especially the case for EU citizens ageing in a different EU country than the one they spent most of their life/careers in, as well as for populations of migrant background, as there are language barriers to accessing the full information of health promotion and disease prevention campaigns.

Good Practices

The good practices mentioned hereunder have been assembled by AGE Task Force members, AGE has not assessed their effectiveness or inclusiveness, however, they can serve as an inspiration to show what is possible when health promotion is addressed at different levels.

Belgium

- The **Vity ecosystem** is a public-private partnership including a pharmacy chain and a mutuality using an app and face-to-face coaching to focus on micro-habits. In 2026, the focus has shifted towards mental health, sleep quality and exercising without suffering, using gamification to obtain sustainable behavioural change.
- The **ROBUST passport**, launched by a hospital (Ziekenhuuis aan de Stroom) as the adult counterpart of the children's health booklet. The tool systematically maps physical and mental health reserves of people over 65 to detect frailty at an early stage.
- The "**Health Municipality**", a concept developed by the Flemish Institute for Healthy Living. Local authorities create an environment that encourages physical activity and healthy eating.
- The '**Blue Zone Project'** identifies public spaces where people live measurably longer and healthier lives and inspire themselves from these areas, by weaving exercise and social interactions into daily routines.

Netherlands

- The recently announced "**schijf van vijf"** – circle of five, visualising how much and what kind of food is healthy for people and the planet.
- **Local municipalities** have initiatives about lifestyle, food, welfare and support for informal carers via libraries.

Norway

- **Healthy Life Centres (Frisklivssentraler)**
  Municipally run centres offering low-threshold support for physical activity, diet, smoking cessation and coping with chronic disease.
  Best placed to deliver: Local authorities, with national guidelines from the Norwegian Directorate of Health.
- **Public Health Act & "Health in All Policies" approach**
  Integrates health promotion across sectors such as transport, education and urban planning, aiming to reduce health inequalities.
  Best placed to deliver: National authorities (policy and legislation) and municipalities (implementation).
- **National lifestyle and prevention strategies** (physical activity, nutrition, tobacco control, mental health). Includes partnerships with industry (e.g. salt reduction, healthier diets) and strong regulation (tobacco).
  Best placed to deliver: National authorities in cooperation with industry and NGOs.
- **Voluntary and community-based initiatives**
  Sports clubs, senior associations and NGOs promoting social participation and physical activity.
  Best placed to deliver: Not-for-profit organisations, supported by municipalities.

Spain

- **Home-based support and ageing in place**
  The Spanish Red Cross delivers integrated services to support ageing in place, including home assistance, telecare, support for informal caregivers, prevention of abuse and neglect, as well as the promotion of healthy behaviours, prevention of cognitive decline.
  These programmes aim to maintain autonomy and independence, within a human rights-based approach, and to delay institutionalisation, reaching over 240,000 older people annually.
- **Community-based healthy ageing programmes**
  The Spanish Red Cross implements community-based programmes combining health promotion, social participation and individual monitoring to support healthy ageing and prevent deterioration.
  These programmes include group activities (physical activity, digital skills, cognitive stimulation), health education (nutrition, physical activity, emotional well-being), individualised follow-up including biophysical measures (e.g. blood pressure), home visits and accompaniment.
  They promote healthy behaviours while strengthening social connections, targeting older people in situations of vulnerability or at risk.
- **Innovative hybrid digital-human models (assistive technology + volunteer support)**
  Recent initiatives combine voice-based technologies, telecare and volunteer support to address loneliness and the digital divide. These models require no advanced digital skills (voice interface), integrate continuous human support, improve autonomy, communication and emotional well-being.
  More than 25.000 people have benefited from these newer voice-based systems.
- **Health promotion with a focus on dementia:** In Spain, the Spanish Red Cross developed an innovative initiative in collaboration with an academic partner, which aims to translate evidence from the Lancet Commission on dementia prevention into practical, user-friendly tools for everyday life.
  The project includes the development of a self-assessment questionnaire, allowing individuals to reflect on modifiable risk factors and receive tailored, general recommendations to support the prevention of cognitive decline and dementia.
  This approach helps bridge the gap between scientific evidence and real-life application, supporting early awareness, prevention and individual empowerment.
- **Community-based active ageing**
  Innovative participatory model based on co-creation with older people and community stakeholders.
  A core group of older persons identifies needs, maps resources and co-designs solutions using participatory approaches, strengthening social cohesion, local coordination and active participation.

Mitigating disease impact: prevention

Principles

While health promotion aims to reduce the vulnerability to disease in general and promote social inclusion across the life span, prevention aims to target specific risk factors, reduce the incidence, prevalence or progression of diseases. It is sometimes difficult to distinguish health promotion from disease prevention, as the reduction of risk factors of specific diseases often means promoting healthy lifestyles generally.

Dementia stands out in this regard, as there is no treatment yet to cure the disease, and treatment amounts to reducing the risk factors to slow its progression.[1] 40% of the risk factors of dementia have been shown to be preventable, and many are in common with other non-communicable diseases, such as obesity, smoking, alcohol consumption, physical inactivity or social isolation. Others are linked to the treatment of other impairments or diseases, such as mental health, hearing and visual health, diabetes or hypertension.[1]

> "Today it is a race against time. Of the estimated 600,000 persons living with dementia in Poland at least half do not know about the diagnosis because they were not recognized as patients"

Health in all policies

Health is naturally the responsibility of national ministers of health, but sometimes, funding for disease prevention is left to local authorities, and other ministries might have their own health-related sources of information and regulation (e.g., agriculture, food safety). **The Ministry of Health should have a clear mandate to streamline a Health in All Policies approach**, able to influence policies in other, related areas, in the interest of prevention: agriculture, industry, finance, mobility, environment, regional or local government, etc. This should not preclude **ministers of justice and social affairs to oversee the application of fundamental rights**, such as equality based on age and disability.

NGOs and media as partners in health

NGOs can reach out to vulnerable or excluded groups and must be included as full partners in and prevention programmes, as they have often a unique, trusted relationship with citizens. Regarding older persons, this includes seniors' clubs, Third Age Universities, community centres and other popular initiatives, but also patient and carers' organisations. The same holds true for the **media, who has the capacity to reach beyond** the groups of people who could be reached solely by (national or local) governments.

Co-creation and person-centredness

Prevention and health promotion campaigns cannot function if they are not sensitive to the specific challenges and needs of older persons. They should be **designed via co-design methods in the community** to first collect data and then design social and health policies locally to best respond to older people's needs. This also involves giving local government and civil society a say in prevention and health promotion campaigns as full partners.

Specific prevention interventions should be person-centred to avoid overgeneralisation and to **fit the lived reality of every person**, avoiding for example to discourage persons with severe challenges by upholding the activity level achievable by persons without major disabilities as the gold standard.

Tackle the social determinants of health

As outlined in the preceding section on promotion, the social determinants of health play a major role in the vulnerability to and in the progression of many diseases. **Prevention must not stay restricted to medical interventions, but must include the full spectrum of social determinants of health**, including community interventions, mental health care, help in accessing social benefits etc.

Accessibility and inclusiveness of prevention

Prevention campaigns run the risk of addressing mainly those who are already less vulnerable because of their social determinants: achievement of higher education, ability to perform sports, social inclusion and activity, being less exposed to occupational hazards throughout working life etc. **Prevention campaigns must be open to all but have a special focus on targeting the most vulnerable and excluded**, including digitally excluded, people with preexisting disabilities or conditions, less literate, lower income levels or any other ground of discrimination or exclusion.

In the same line**, prevention should be gender-inclusive**. Women statistically face a longer period of life in bad health or with disability, despite higher life expectancy. Some gender-specific health aspects, such as the impact of menopause or sexual and reproductive health are not sufficiently valorised. Regarding men, the higher prevalence of suicidality and depression among older men shows that **there is potential for gender-specific prevention especially regarding mental health**.

Prevention should not stop with the onset of disease, on the contrary. Especially **in situations of long-term care needs, prevention should be integrated into care pathways to avoid further deteriorating health**.

Prevention in a life-course approach

Prevention plays a strong role in early life, with quasi-mandatory exams for children, free and comprehensive vaccination recommendations and integration of health into the school systems via physical education. The reduction of neonatal and child mortality in the past decades is one of the key drivers of increased life expectancy, so the effectiveness of these policies is proven – which does not mean that it could not be strengthened, and AGE is in full solidarity of the demands of Eurochild, Eurohealthnet and other organisations in this regard. Strong prevention in early life has important health outcomes also in adulthood and later life[3], however, the more people age, the more prevention seems to fade from the preoccupation of public policies. Occupational health and safety policies have often a narrow approach to maintaining employability in the current job, rather than aiming for longer health-spans. Some prevention policies are only linked to working life and stop when one reaches retirement age. **Prevention policies could gain much effectiveness and impact from aiming to reach all generations, including the older ones.** As an example, the return on investment of vaccination in older age has been estimated at 19:1[4]. Key to this is the fight to combat ageism and age barriers in health and care and wider society.

Prevention priorities regarding ageing

Many ageing-related conditions have common risk factors, and therefore there are specific areas for disease prevention which can stand out for the number of conditions they are preventing.

Priority seems to be given in most member states to information and prevention campaigns on nutrition, cardiovascular and cerebrovascular diseases, vaccination for flu and COVID-19 and prostate cancer, but to a lesser extent on pneumococcal disease, shingles, strength and balance, hearing health.

AGE suggestions:

- Similarly to routine examinations for children, more **comprehensive geriatric assessments**, adapted to peoples' age and conditions, should be upscaled for every person approaching older age – these should not only look at physical factors, but also psychological, social and functional aspects. The focus should not be based on fear.
- **Regular frailty screening**, using simple tests, to predict who is most at risk of functional decline can give rise to early preventative interventions.

[3] See, for instance ILC UK's report 'Mind the Age Gap' report on mental health, emphasising how adverse childhood experiences (ACEs) have a detrimental physical and mental health impact on children and often define future health outcomes. And that child poverty is often matched by experiences of risk of poverty in adult life.

[4] Office of Health Economics (2024): Adult vaccination programmes deliver socio-economic benefits up to 19 times initial investment, according to new report.

- **States should improve early diagnostics and screening uptake in for a certain number of conditions, in particular functional capacity, cancer, cognitive decline and dementia**
  For example, relatively easy to use mini-COG tests can be used for screening the risk of **dementia** by nurses, allowing them to refer people early to a specialist for a proper diagnosis. Early diagnosis is indispensable. The sooner one knows they have been diagnosed with dementia, the longer they can live independently and decide about the future themselves.
  Similarly, biomarkers for **kidney disease and Alzheimer's** can be tested to identify conditions early enough to allow for early prevention.
  Reduced **functional capacity, frailty and loss of intrinsic capacity** are key risk factors for other types of health issues, making them a unique lever for prevention. To adequately target people with beginning loss of capacity, it is important to develop early detection and systematic, early stage interventions.
- **Adult vaccination**
  An increasing number of infectious diseases can be prevented by newly available and more effective vaccines, but which are not yet widely taken up. The International Longevity Centre UK has drafted important reports on adult vaccination programmes, pointing out that there is a significant health and economic benefit in increasing vaccination, notably against pneumococcal disease, pertussis, shingles and other vaccine-preventable diseases.
- **Mental health prevention**
  Prevention strategies must extend beyond physical health and clinical diseases, to include mental health. In particular, screening should involve testing for feelings of loneliness and depression, as these are risk factors for other diseases. Informal carers should also be in the focus to prevent burnout and stress-induced diseases. In a life-course perspective, rising mental health problems across the life-course (youth and older adults) require stronger early detection and low-threshold preventive services in primary care and municipalities. AGE has developed recommendations specifically on the mental health of older persons which are important to take into account. ILC UK also has established a major report on Mental Health in older age.
- **Preventing premature institutionalization as a prevention strategy**
  Premature institutionalization of older persons can lead to inactivity, loss of social connections and stress, further aggravating the condition for which institutionalization has been envisaged. By supporting the person and their family to receive care at home and giving access to community-based care services can prevent degradation of a persons' health due to the loss of social inclusion, activity and connectedness.
- **Prevention of non-communicable diseases (NCDs)**
  Cardiovascular disease, hearing impairments; type 2 diabetes, chronic respiratory disease and cancer, but also dementia and mental health challenges remain the main

drivers of morbidity and mortality, linked to physical inactivity, diet, tobacco and alcohol use. Most risk factors of these diseases are in fact common and can be broadly addressed by health promotion, with more targeted intervention and information provided in a health prevention programme with an at-risk population.

- **Cancer**
  Breast, prostate, colorectal and cervical cancer are priorities, with prevention via regular screening over a certain age, HPV vaccination and tobacco control; lung cancer prevention through smoking reduction remains critical.

Challenges

AGE members report different challenges linked to prevention; policies do not reap all of their potential benefit.

Age barriers

Age barriers are the most common form of not making prevention available to older persons. They can be explicit, such as in cut-off ages for certain programmes, or implicit, such as in not promoting programmes in media spaces which many older persons use. Examples are provided below

- **Upper age limits in screening programs**
  In **Norway**, organized screening stops at age **69** for breast and cervical cancer, and colorectal screening currently starts at **55**, with no routine population screening beyond older ages, despite rising or remaining cancer risk. In **Malta**, breast cancer screening for women stops at 65 to be free of charge. In **Belgium, Italy and the Netherlands**, the limit is 74 or 75, in Italy this limit includes several types of cancer (cervical cancer, colorectal cancer), depending on the Region.
- **Ageism in mental health campaigns and services**
  There are many campaigns offering mental health support for young people, but regarding people over 80, symptoms are often dismissed as being a normal part of ageing, dementia or grief. As a result, older persons are less likely to receive a psychological assessment and support, despite the fact that talking-therapy seems to be more effective in older adults than in working-age adults[5].
- **Implicit access barriers for older adults**
  Co-payments, digital booking systems and reliance on self-initiative may reduce access to preventive care and vaccination among the oldest and frailest groups.
- **Younger age thresholds**
  Some preventive diagnostics (e.g. cardiovascular risk, diabetes) are largely opportunistic and depend on GP contact, which may delay early detection in middle-aged adults. Catching-up of child-age vaccination is rarely done among the

[5] ILC UK (2025): Mind the Age Gap

older population, so that for example there is a significant risk of infections among older adults in some countries for various diseases (chickenpox, measles, polio, pertussis etc.)

- **Lack of information**
  In many Member States, there is a lack of information about the availability of preventive treatments and vaccines. Health education campaigns should run permanently in programmes addressed to older persons, general practitioners and nurses. Particularly when people offset early diagnosis because they fear the result, it is important to inform about the benefits of early treatment.
- **Geographical barriers**
  Some areas where many older persons live are remote and/or rural and may not be covered by the same extent by information or services to deliver prevention. Local municipalities should organise public transport for such persons to health-related initiatives.

Lack of priority

When GPs have very little time to dedicate to each patient, they will focus on the acute condition the patient sees them for – not looking further to perform preventative diagnosis or treatment.

Costs

Especially for **vaccination**, AGE members report barriers linked to costs. The **Norwegian Pensioners' Association** demands that vaccines are free of charge to older persons in a context where Nordic countries seem to demand higher out of pocket costs than others, for example for vaccination against pneumococcal disease. Similarly, in the **Netherlands**, shingles vaccine can cost up to 350 euros if one is not above 60 but in a risk group.

Costs for preventive devices can also be excluding. In **Belgium**, **hearing aids** require a high personal payment from users. This concerns costs of about 4,000 euros after the deduction of the contribution from the health insurance, despite hearing aids being an indispensable help for social inclusion. However, only increasing the contribution from the national health insurance will likely further raise the prices, as it has been observed that hearing aids cost half the price in other EU member States. AGE member OKRA calls for **decoupling information about the costs of the device of the costs for maintenance and adjustment**, to increase transparency, as well as the reduction of incentives to audiologists for selling higher-price devices. Providing a device should come with a guarantee of changing it if the ordered devices turn out not to fit the needs of the person. It should not be more expensive to repair or replace a device than buying an initial one.

Fragmentation

An older person often has a General Practitioner, a cardiologist, a home nurse and a physiotherapist. They need to be able to exchange information and to coordinate. For this, case management has proven to be efficient, where an older person in need of care is assigned to a dedicated coordinator, a specialist nurse or a social worker, maintaining this link in the care ecosystem.

Silo funding means that government often pays for specific procedures, but not for consultation and coordination between care providers, impeding an integrated approach

Mental well-being is often overlooked, leading to late or underdiagnosis of dementia or other forms of cognitive decline. The high prevalence of informal care means that partners and children are exposed to overburdening, which can lead to burnout and the entire home care system collapsing; Monitoring must also follow the informal carer.

Fragmentation of care leads to less-effective interventions. In the UK, for example, ILC UK argues that better post-diagnostic support, greater investment in prevention and a shift to community-based care could help people with dementia live longer and better, easing pressure on services and informal carers.[6]

Limitation of vaccination programmes

- Certain important **vaccines are not included in certain adult vaccination programmes** (combined Diphtheria, Tetanus, Polio and Pertussis vaccine, shingles, RSV, where relevant tick-borne encephalitis are often not covered.
- In **Norway**, despite the new Adult Immunisation Programme (since 2025), uptake of **influenza and pneumococcal vaccines** among people 65+ remains below desired levels, partly due to co-payments and fragmented delivery at municipal level.
- In the **Netherlands**, **shingles** vaccine is still not yet covered (contrary to flu, pneumococcal disease and COVID-19), but it will be introduced in 2027 for over-60-year-olds; the alternative is a total private payment of 350€. Vaccination rates for smallpox are low for older adults and are not included in catch-up programmes.
- **Shingles** vaccine is also available but very expensive in Denmark.
- In **Belgium**, vaccination amongst older people remains too low for COVID-19, flu and pneumococcal disease, as well as shingles.

[6] ILC UK (2025) Living better with dementia through care and support: it's not rocket science

- ILC UK compared **nine European countries**, finding that 20% of adults vaccinated against shingles did so because it was free of charge[7], and that 25% of non-vaccinated adults would do so if it was provided for free[8][9].
- Adult vaccination rates are very different among EU member states, e.g. **Poland** has only 15% of vaccination coverage of older persons regarding influenza although vaccination is free and can be done in pharmacies. number is further depressed by the arrival of a large number of older Ukrainian displaced people, who have lower vaccination rates.

Information and digital divide

Information forms one of the greatest barriers for accessing prevention programmes. In particular, it is necessary to remind older persons and particularly more vulnerable groups of beneficial **vaccination** – a special emphasis should be put here on communities with a migration background.

Much communication and information to promote disease prevention is now **bound to digital media**, leaving those who are digitally excluded out of some important programmes, without a specific offline outreach strategy.

Influence of myths and disinformation are a recurring challenge, and: there needs to be a continuous effort to educate, inform, counter disinformation around vaccines and other aspects of health prevention

Evaluation and Deployment of new vaccines

The EU has a key role to play in funding the evaluation and deployment of new vaccines which are more efficient and cover more diseases. This is an important role for the current EU4Health programme and its successor in the next Multiannual Financial Framework.

Good Practices

Fragmentation and integration

In **Poland**, the Public Health Council is tasked with intersectoral cooperation with other ministers (family, labour and social policy, finance) to include them in decisions on older persons' health and health promotion.

[7] Free of charge in France, Greece, Italy and UK, depending on age group and other risk factors
[8] Countries with partial or no reimbursement in the study are Austria, Belgium, Netherlands, Spain and Sweden.
[9] ILC UK (2024): Painfully unaware improving understanding of shingles vaccination

Health information and promotion

In **Malta**, the Ministry of Health designs leaflets and sends them through the post. They produced leaflets on Healthy Eating and Exercise; Managing and Living with Diabetes, Healthy Heart. These leaflets are usually in both English and Maltese

Screening

- **'Integrated Care for Older People – ICOPE' (France)**
  This is a dependency prevention program developed by the WHO. This five-step program aims to reduce the number of dependent people worldwide by 15 million by 2025, or 150 000 in France. It combines screening, in-depth assessment, a personalised care plan, monitoring of the care pathway and community involvement and support for carers. Screening is made in 10 minutes, repeated every six months and screening for six essential functions. When one or more functions decline, the in-depth screening look at the affected areas and pathologies, together with the persons' social and environmental needs, leading to a personalised care plan.
- **National cancer screening programmes (Norway)**
  High-quality, registry-based programmes (BreastScreen, CervicalScreen, BowelScreen) with systematic invitations, reminders and quality assurance.
- **Healthy Life Centres (Frisklivssentraler) (Norway)**
  Municipal, low-threshold services supporting prevention of NCDs through lifestyle change and early intervention (good practice bridging prevention and care).
- **Free medical check-ups for all adults (Poland)**
  Every person over 20 is eligible to the 'My own health' (Moje Zdrowie) Programme. It starts with an on-line questionnaire available on the Internet Patient Account. Then a package of medical tests is generated, and after taking them, the person is referred to a doctor and a nurse for a visit, where the results are discussed and an individual health plan is created together with an individual calendar and recommendations. It includes morphology, cholesterol, glucose level, liver, creatinine level, urine tests, as well as a Prostate Specific Antigen test. In addition, during the summing up visit a doctor or a nurse might do a cognitive function test (mini-COG scale), which is a recommended screening test for dementia.
  In **Malta**, health centres and hospitals are free of charge, making access to early diagnosis relatively good. If there is a need, transportation to a Health Centre can be organized free of charge.
- **Free test kits (Malta)**
  After age 65, there is an invitation to get tested for 'Abdominal Aortic Aneurysm'. Every 2 years national health authorities send a kit through the post to test for Faecal Occult Blood Test.

Early intervention

In **Belgium and the Netherlands**, the "Valpoli" service screens people who have fallen once to undergo a full assessment (vision, footwear, medication, muscle strength), leading to targeted programmes which can avoid a second, often fatal, fall.

Vaccination

- **Adult Immunisation Programme (Norway)**
  First national framework for adult vaccination, establishing a platform for scaling up prevention among older people.
- **Vaccination through pharmacies**
  Practiced in Norway, Poland and Belgium. **In Poland**, this is free for flu and pneumococcal disease, COVID-19 and RSV for 65+ and risk groups. Shingles is free only for 65+ who also are in a risk group and reimbursed 50% for others. However, these require prescriptions from a doctor
- "**Vaccines are for everyone, and not only children (Poland)**" is a slogan of a health promotion campaign by which Poland aims to make disease prevention a priority. This is in keeping with a nationwide drive to reframe vaccination as a central feature of maintaining good health at all ages and stages of life, as well as shifting the public mindset from thinking about vaccines as a positive voluntary element of staying healthy, rather than a mandatory children's health measure.
- **Media presence (Poland)**: The Chief Sanitary Inspector, Dr. Grzesiowski, managed to be invited to hundreds of broadcasts in popular media, debunking myths about vaccination.

Treatment

- **Free medication (Poland)**: In Poland, for certain conditions, medication is free for 65+, and there is a programme to promote this. Prescriptions for medication for 65+ persons have a special label so that it can be provided for free.
- **'Buurtzorg' (Belgium)**: a neighbourhood-focussed approach to care in which nurses not only carry out medical tasks, but also take a preventive look at the older persons' environment and social network

National Strategy

In **Spain**, there is a national strategy integrating health promotion and prevention across the life-course, including local implementation through municipalities and primary care

Digital devices and AI as an opportunity and a challenge

Digital tools can **fill existing gap in monitoring peoples' health** and **refer to a health professional** early on. Wearables recording heart rate, sleep and falls and in-home sensors which can **detect unusual behaviour** (e.g. the fridge has not opened in 24 hours, the toilet is used very often). **Teleconsultations** enable monthly video check-ins with a health professional to discuss adherence to medicines and mental well-being. With wearable devices, GPs can potentially have access to a stream of heart rate data of several months, rather than one reading from time to time, enabling us to **detect conditions** such as sleep apnoea or arterial fibrillation earlier. This, combined with artificial intelligence, can lead to **increasing citizens' autonomy, but also places a large responsibility on the individual.**

Some of the shortcomings of digital tools mentioned later can be mitigated through **hybrid digital-human models**, which can particularly be helpful in overcoming social isolation and accessibility issues.

With the **decreasing number of medical staff**, AI-based health advice seems inevitable sooner or later. There are some risks involved, such as mistakes, fake information, inaccurate diagnosis.

AGE has developed a position on digitalisation, emphasising the opportunities, but also the risks of digital technologies in the context of older persons. AGE's principles develop there can also be applied to health and prevention.

- **A rights-based approach** must guide the development and use of digital tools and artificial intelligence in health and care. Individuals must always remain rights-holders, and technology should adapt to this reality, rather than displacing the person from the centre of care. The key question is not only what technology can do, but also what it should not replace.
- It is important to distinguish between technologies that support and enhance care, reinforcing autonomy and freeing time for human interaction, **and those that risk substituting human presence** and relationships, particularly in contexts where care systems are under pressure.
- Digital technologies on health promotion and disease prevention should be **developed with older persons** to ensure they encode their lived realities, challenges and user experience. Artificial intelligence and technology are often developed with an **implicit ageist bias**, being developed 'for' older people, or being developed only with younger persona in mind, while all generations could benefit from it.
- **Privacy**: persons need to know which data is collected from them and who has access to it. The long discussions about the electronic patient file in Germany is

one example that privacy actually matters to patients and that they will not embrace such intrusive technology without safeguards. The EU's principles deriving from the GDPR and the AI act should apply in the field of health and prevention, but their application needs also to be clearly and simply explained to the end-user.

- **Security**: a wave of cyberattacks in recent times, on government data, including on health care data, shows one fundamental vulnerability of relying on digital-only solutions: sensitive personal data can be stolen and misused, or can be made unavailable by ransomware attacks. Enabling offline solutions also means remaining resilient to these forms of criminal attacks.
- Digital technologies should be developed in a **fully accessible** way, using universal design principles, to ensure all can use the technology. **They should be flexible to adapt to peoples' evolving capacities to use them**, e.g. when developing impairments after a stroke.
- Patients should have the **choice to use digital technologies or not.** There should always be an offline alternative to digital health solutions, as the digital gap may lead to exclusion of a large share of people if digital-only solutions are deployed
- Technology should **never be a replacement for human contact**. Across Europe, there is a shortage of healthcare professionals, and digital solutions can make their work easier and should be used to increase the time they spend with patients. Diagnosis of difficult conditions, detection and treatment of mental health issues.

There is a more pervasive risk to the use of technology in health promotion and disease prevention, the risk of **the emergence of a two-tier healthcare** system:

- People with higher education and income can embrace these tools quicker – these are the "**worried well-off**". Other groups, experiencing the highest disease burden and risk, are left behind due to a lack of accessibility, finances, or digital skills
- AI data is primarily trained on inputs from well-off, relatively healthy, younger people, rather than from chronically ill or minorities, leading to **algorithmic bias**
- There is also a risk of age-based inequality, whereby **older people are more likely to receive remote or less personalised forms of care** as a result of age, place of living, or other criteria.

In Belgium and the Netherlands, there is going to be an attempt for a 'Digital Inclusion Escape Game', a method designed to let healthcare providers experience how complex digital healthcare can be for people with low literacy skills – such a test should be conducted on all new digital developments.

Recommendations for European Union policies

- **Remove age barriers and age discrimination in access to prevention, screening and vaccination.**

Our examples have shown that ageism and age discrimination, implicit and explicit age barriers are increasing vulnerability to develop conditions in older age. The EU and Member States should undertake a systematic review of age barriers and ageism in health and care systems, especially in the fields of screening and early intervention. The UN process in the Intergovernmental Working Group on the Rights of Older Persons can serve as an inspiration, and the EU should provide technical guidance and promote its experiences in tackling age-related health inequalities in this process.

On the international level, the EU and Member states should also fully embrace the new Ageing is Living Regional Strategy of the World Health Organisation's European Region.

- **Make healthy ageing and prevention a core pillar of the European Care Deal.**

The EU Care Strategy has been instrumental in advancing person-centred care, channelling recommendations from the European Semester and investments via European Funds – in particular NextGenerationEU into more person-centred care systems. This momentum should be continued with the introduction of the EU Care Deal in 2027.

However, while prevention is one of the principles of the EU Care Strategy, action on this has not been in the priorities. Health promotion and disease prevention, in particular diseases associated with a future care need and prevention of aggravation of already-present conditions, should be fully included in the upcoming EU Care Deal.

- **Invest in health promotion, prevention of NCDs and adult vaccination across the life course, including for people who already face the onset of a disease or condition. This should be channelled through EU4Health and rigorous spending targets in health promotion prevention and adult vaccination in the spending targets of the next MFF.**

The investment case for health promotion and prevention is clear. EU4Health is the EU's vehicle for research, reforms and investment in health and should further focus its efforts in these areas. It is concerning that the visible programme is possibly diluted in a larger competitiveness fund in the future Multiannual Financial Framework. As the MFF regulation foresees a Performance Framework to channel investment targets and recommendations towards National and Regional Partnership Plans, these targets should reserve a decisive percentage on investment into health promotion and disease prevention, including non-communicable diseases and infectious diseases

- **Integrate vaccination of older persons and care staff into future policies, such as the EU Safe Hearts Plan, recommendation on respiratory health and in the EU Care Deal.**

There are various European plans and strategies in the field of health, targeting specific areas, such as the new EU Cardiovascular Health Plan. These should streamline One Health approaches, putting forward the links between disease groups, such as between cardiovascular health, frailty, mental health and neurodegenerative diseases. Vaccination is one of these powerful levers to prevent other conditions to develop or worsen than only the ones directly targeted by vaccines.

- **Measure progress through healthy life expectancy and prevention indicators in the European Semester and include a minimum percentage of GDP spending on policies for health investment and prevention, and create an indicator for spending on health promotion.**

Beyond the spending indicators in the performance framework mentioned above, progress on healthy life expectancy and investment into healthy lives should be a key indicator in social scoreboards guiding the European Semester process: growth is only possible if it includes growth of healthy lifespans.

- **Ensure that digital and AI-based health solutions support, rather than replace, human-centred care.**

AI and digitalisation can enable significant progress in the quest to longer and healthier lives but come with significant risks as well. A guiding post for regulation and innovation in these fields should be to improve the quality and quantity of human contact with the help of technologies, rather than to reduce it, and to co-design solutions with concerned older persons, tackle ageist biases and other stereotypes which risk being replicated by machine-learning and other innovations.

Conclusion

There is big and unexplored scope for better addressing ageing by strengthening health promotion and disease prevention, across the lifespan and particularly among older persons. It has a solid rights-based argument, as health promotion and prevention allow for the best possible implementation of the right to health. By reducing the need for curative health and care services, it also has significant economic benefits to the whole of society. Above all, it allows for increased quality of life in a world with longer lifespans.

We have sketched out the limitations of current prevention & promotion policies in this paper, but also some promising examples which could be rolled out in other Member States. However, the bottom line is that the challenges to achieving better health promotion and prevention across the lifespan are manifold: the first one being ageist barriers, but also costs, fragmentation of health-related policies and lack of ambition. The current simplification agenda might even signify a rollback of already achieved policies in terms of the protection from air pollution, pesticides or other substances that are related to disease. However, we cannot afford low ambition regarding health. The COVID-19 pandemic has shown how societies might have to grind to a halt when faced with a major health threat, as prevention policies form the 2010s had been rolled back for the sake of austerity. In a world with greater geopolitical threats, investment into our resilience is of utmost importance and frees resources for other important policies.

The current wave of AI-driven digital revolution holds many promises and opportunities, but should not be followed blindly – full care should be taken to have inclusive learning data for AI and to specifically reach out to digitally excluded populations.

The discussion on the rights of older persons at UN level are a key moment to reflect on the barriers to the right to health and the right to prevention and health promotion policies as key levers to ensure the broadest possible guarantee of the right to health. The EU should seize this opportunity to showcase its good practices, but at the same time harness the potential of these policies to transform the demographic challenges it faces into the opportunity of longer, healthy lives for its citizens.

AGE therefore calls on the European Union and Member States to:

- invest more systematically in prevention and health promotion across the life-course;
- remove age barriers to screening, vaccination and preventive services;
- better integrate health, care and social support systems;
- ensure that digital innovation strengthens rather than replaces human-centred care.

Annex

Norwegian adult vaccination programme

Norway's Adult Immunisation Programme

The national programme covers vaccines for adults and certain children who are at increased risk of severe illness. The included vaccines are:

- Influenza vaccine — offered to everyone 65+ and to adults/children in risk groups.
- COVID-19 vaccine — recommended for 75+, but available through the programme for 65–74 as well as risk groups.
- Pneumococcal vaccine — offered in the year you turn 65 (first cohort: those born in 1960).

These three vaccines are the only ones included in the national adult programme.

Co-payment of vaccines

There is no single national co-payment amount. Each municipality sets its own price, though the Norwegian Directorate of Health provides *recommended* rates.

To give a realistic sense of cost, Oslo's 2025 prices (publicly published) are:

- Influenza vaccine: NOK 301(EUR 27)
- COVID-19 vaccine: NOK 110 (EUR 10)
- Pneumococcal vaccine: NOK 110 (EUR 10)
- If taken together: COVID-19 and pneumococcal vaccines drop to NOK 85 each (EUR 8).

Other vaccines that *may* be relevant for older adults (not in the programme)

These are *recommended based on individual risk*, not part of the national programme:

- Tetanus/diphtheria/pertussis/polio booster every 10 years

Costs: A tetanus/diphtheria/pertussis/polio booster (the combined DTP-polio vaccine) typically costs about NOK 417–500 (EUR 38-45) for the vaccine itself in Norway, depending on the brand and provider. An administration fee (usually NOK 150–200 (EUR 14-18) in pharmacies, NOK 100–300 (EUR 9-27) in clinics) is added on top.

- Herpes zoster (shingles) vaccine

Costs: Vaccine price: ~ NOK 2,257–2,300 (EUR 203- 207) per dose. Total for two doses: ~ NOK 4,500–6,000 (EUR 405-540), depending on where you take it. Not covered by the adult immunisation programme (co-payment applies fully).

- RS-virus vaccine

Costs: The RS-virus (RSV) vaccine in Norway costs about NOK 2,300–2,500 (EUR 207-225) per dose, depending on which of the two approved vaccines you receive. You must also pay an administration fee (usually NOK 50–200, EUR 14-18) at pharmacies).

You can stop the perpetuation of ageism!

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

About AGE Platform Europe

AGE Platform Europe is a European network of organizations working for the interests and rights of older people. With the vision of "Toward A society for ALL ages," AGE advocates for an inclusive society that focuses on well-being, autonomy, and equal participation in all stages of life.

Contact

For more information, contact: Philippe Seidel philippe.seidel@age-platform.eu

AGE PLATFORM Europe

Av de Tervueren, Tervurenlaan 168, box 2
- 1150 Brussels, Belgium
Tel: +32.2.280.14.70

info@age-platform.eu

WWW.AGE-PLATFORM.EU

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