Credit: Dorcas

Driving equitable action on NCDs and healthy ageing to achieve health for all at all ages

HelpAge International

Key messages

- Non-Communicable Diseases including mental health and neurological conditions (NCDs) are the leading cause of death and disability globally. Their alarming impact is contributing to an increasing gap between life expectancy and healthy life expectancy, with profound implications for people, systems and societies, and achievement of the Sustainable Development Goals.
- Older people are the age group most at risk from NCDs, yet all too often they are left behind in policy and practice.
- While men are likely to die earlier from NCDs, women experience a greater burden of ill health and disability from NCDs across the life-course. At the same time women of all ages – including older women – are the main providers of health and care for people living with NCDs.
- Older people face multiple barriers to accessing integrated NCD prevention and care, including those related to the availability, accessibility, acceptability and quality of services, as well as ageism and age discrimination in their funding, design and delivery.
- While early life interventions are critical, there is no age limit to the individual and economic benefits of prevention.
- A focus on vertical disease programming and a failure to invest in the systems, services and workforce needed to deliver integrated, person-centred and community-based care that holistically responds to older people's more complex needs whilst promoting healthy ageing, means opportunities are being missed for tackling NCDs and achieving better outcomes for all.
- Global health funding is not keeping pace with demographic and epidemiological shifts, hampering progress on NCDs and healthy ageing.
- Data systems present an immediate threat to driving equitable progress on NCDs by excluding older people or rendering them invisible through a lack of disaggregation.
- While the challenge of NCDs is significant, their impact is not inevitable. By mainstreaming NCD prevention and care into progress towards universal health coverage (UHC) and primary health care (PHC), whilst investing in multi-sector 'health in all policies' approaches that tackle NCD risk factors, address health inequities and promote health and wellbeing across the life course, we can reap the benefits of healthy ageing for people, systems and societies.

Calls for action

We join with the NCD Alliance in their calls to **accelerate implementation, break down silos, mobilise investment, deliver accountability,** and **engage communities**. Considering older people's needs and rights within the NCD agenda, we specifically call on governments and health stakeholders at all levels to:

- Recognise and respond to the disproportionate burden of NCDs on older people to ensure an equity-based approach within the funding, design and delivery of action on NCDs at all levels.
- Mainstream NCD prevention and care within UHC and PHC as part of efforts to reorientate health systems and services to meet the needs of increasing numbers of older people and promote healthy ageing for all. This must include:
    - Investing in age- and disability- inclusive and gender-responsive health and care systems that deliver equitable, integrated and person-centred care through strong primary health care approaches that engage and empower people and communities.
    - Including NCDs within UHC benefit packages and ensuring people's access to the full continuum of services – from health promotion and disease prevention to early diagnosis, treatment, rehabilitation, palliative care, and long-term care and support, alongside access to the medicines, vaccines and assistive technologies needed by older people living with NCDs in all settings.
    - Ensuring financial protection from catastrophic and impoverishing health costs.
- End the discriminatory focus on 'premature mortality' within the NCD agenda, including by removing upper age caps in NCD monitoring frameworks and data systems; strengthening sex, age and disability disaggregated data; and giving greater attention to NCD-related mortality, morbidity and disability across the life-course, including in research.
- Invest in the workforce needed to deliver person-centred and integrated NCD prevention and care and promote healthy ageing, including through recognizing, reducing and redistributing unpaid care, and rewarding and representing paid care, to advance the rights of women and girls of all ages, in line with the Beijing Platform for Action.
- Advance action on mental and psychosocial health and wellbeing, and neurological conditions, including dementia, ensuring their full integration within health systems and services.
- Integrate essential NCD services into every part of the emergency cycle and ensure services and the workforce delivering them are able to respond to the unique needs of older people living with NCDs.
- Commit to advance action on the environmental, social, economic and commercial determinants of health and tackle health inequities across the life-course, adopting an intersectional, gender transformative and equity-based approach.
- Engage older people living with NCDs and civil society organisations working with them in the design and delivery of responses at all levels, recognising them as agents of change in achieving health for all at all ages.

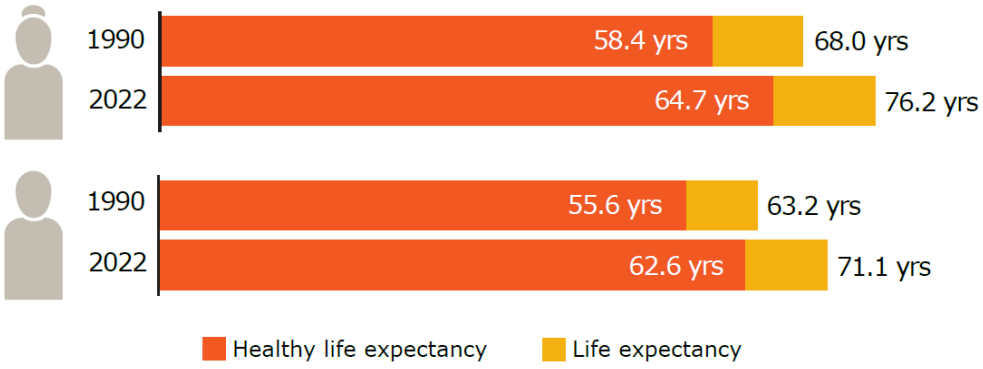
Introduction

The world is ageing. By 2030, 1.4 billion people globally will be aged 60 and over, making up 17 per cent of the total population.[1] By 2050, this figure will rise to 2.1 billion when older people will constitute 22 per cent of the population. The majority of these older people (more than 70 per cent) live in low- and middle-income countries and this will rise to 80 per cent by 2050.

The global 'demographic transition' towards population ageing has been accompanied by an 'epidemiological transition' with all countries in the world experiencing a shift from a predominance of infectious, communicable diseases towards non-communicable diseases (NCDs). NCDs include conditions such as cancers, cardiovascular disease, stroke, chronic respiratory diseases and diabetes, as well as mental health and neurological conditions, including dementia. Prior to the COVID-19 pandemic, NCDs contributed to 74 per cent of deaths globally – an equivalent of 41 million deaths each year – and 82 per cent of all years lived with a disability (YLDs).

Population ageing is a triumph of human development, but our ability to reap the benefits of this longevity for people and societies is currently threatened by the alarming impact of NCDs which are contributing to a growing gap between life-expectancy and healthy life expectancy, especially for women.[2] This means that while people are living longer, they are spending a greater proportion of their lives in ill health or with a disability. (See Image 1).

Image 1



As with healthy ageing more broadly, NCDs are influenced by social, economic, environmental and commercial determinants of health shaping the conditions in which we are born, grow, live, work and age. These determinants interact with individual characteristics, including age, gender and disability, and influence people's exposure to key NCDs risk factors, including tobacco use, physical inactivity, the harmful use of alcohol, unhealthy diets, overweight and obesity, and air pollution, all of which increase the likelihood of experiencing and dying from NCDs. These determinants also shape the extent to which people are able to benefit from NCD prevention, early diagnosis, treatment and care, often resulting in those with the highest need facing the greatest barriers in access. Across all settings, these inequities mean the greatest burden of NCDs, both in terms of mortality and morbidity, is faced by low- and middle-income countries and by the poorest communities, particularly those facing multiple and intersecting inequalities and living in insecure, fragile and climate

affected settings. These inequities are also often exacerbated by NCDs which are both a consequence and a cause of poverty.

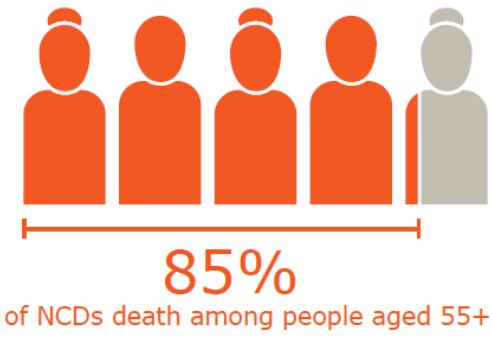
Across age groups, older people face the greatest risk of ill health, disability and death from NCDs. Despite this, limited attention and action has been focused on the needs and rights of older people within the NCD agenda globally or addressing the unique issues they face. This gap is reinforced by the exclusion of older people from NCD monitoring frameworks and by ageism in the funding, design and delivery of health at all levels.

Addressing NCDs across the life-course – including in later life – is therefore an issue of equity. But it is also one of economics. Tackling inequalities in social determinants of health and promoting access to NCD prevention and care across the life-course as part of progress towards Universal Health Coverage (UHC) can ensure we prevent, delay and reduce ill health, disability and death caused by NCDs for people of all ages. Failing to do so, will undermine progress towards UHC, health equity and the Sustainable Development Goals more broadly.

As countries drive progress in commitments made in the Political Declaration on Universal Health Coverage in 2023, and look ahead to the Fourth High Level Meeting on NCDs taking place in September 2025, this briefing considers the intersection of older age with NCDs and disability, and their importance for health systems and societies alike. It outlines the unique challenges facing older people living with NCDs in low- and middle-income countries, and the barriers they face to accessing NCD prevention and care as part of integrated and person-centred health and care services that respond to their needs and rights. The briefing concludes with key actions that governments and health actors at all levels must take to drive equitable action on NCDs as part of progress towards achieving UHC fit for an ageing world.[3] This will ensure we meet the needs of older people whilst reaping the benefits of healthy ageing for individuals, systems and societies.

Older people are the age group most at risk from NCDs

While there is great diversity in how people age, experiencing one or more NCD becomes more common in later life and older people consequently face greater risk from these conditions. In 2019, prior to COVID-19, 85 per cent of all deaths from NCDs globally were among people aged 55 and over, while rates of Years Lived with a Disability caused by NCDs were highest for older people.[4]



Globally, the five leading causes of death among older people in 2019 were NCDs, including cardiovascular disease, cancer, chronic respiratory diseases, neurological disorders, including dementia, and diabetes and chronic kidney disease. Analysis shows that between 1990 and 2019, while improvements in death rates among people aged 70 and over from some NCDs were seen to decrease, including from cardiovascular, chronic respiratory diseases, and some cancers, increased death rates were noted for a number of conditions, including Alzheimer's disease and other dementias (+29 per cent), lung cancer (+12 per cent), diabetes (+16 per cent), and chronic kidney disease (32 per cent).[5]

While globally the focus on the challenge of NCDs tends to be on mortality, critically, NCDs are also the largest cause of ill health and disability across the life course, especially in later life, with NCDs contributing to 88 per cent of all Years Lived with Disability (YLD) among people aged 55 and over in 2019. Leading causes of YLDs among older people include musculoskeletal disorders, sense organ diseases, cardiovascular diseases, diabetes and chronic kidney diseases, neurological disorders, including dementia, and mental health conditions.[6]

Many of these NCDs are associated with more intensive health and social care needs, including, particularly, Alzheimer's Disease and other dementias. These were estimated to cost economies globally 1.3 trillion US dollars in 2019, with approximately 50 per cent of these costs attributable to care and support provided by informal caregivers – mostly women of all ages – providing on average five hours of care and support per day.[7]

Mental health conditions also have a profound impact on older people but often receive limited attention. According to the World Health Organization, around 14 per cent of adults aged 60 and over live with a mental health condition.[8] These conditions account for 10 per cent of all Years Lived with Disability among older people, while over a quarter (27.2 per cent) of deaths from suicide globally are among people aged 60 or over.[9,10] The most common mental health conditions for older adults are depression and anxiety which older people may be at increased risk of because of higher incidence of poverty, physical or neurological health conditions, or lack of access to quality support and services. This is particularly the case for older people living in humanitarian settings (see Box 2 below).

Older people are also more likely to experience adverse events such as bereavement, or a drop in income or reduced sense of purpose with retirement.[11] Social isolation and loneliness, which affect up to a third of older people,[12] are key risk factors for mental health conditions in later life, as well as violence, abuse and neglect of older people. One in six older adults is estimated to experience abuse, often by those providing care and support, and abuse of older adults has serious consequences, including leading to depression and anxiety.[13]

The majority of older people are living with more than one condition

As NCDs increase with age, older people are also at greater risk of experiencing two or more conditions at the same time, with more than half (51 per cent) of older people living in the

community globally estimated to be living with two or more long-term conditions ('co-' or 'multi-' 'morbidity').[14] Multimorbidity is associated with greater and more complex health and care needs and poorer levels of functional ability, quality of life and higher rates of mortality.

NCDs also often increase the risk someone faces from infectious diseases. For example, people living with NCDs are at heightened risk of respiratory illnesses. During COVID-19, an estimated 60 to 90 per cent of mortality in COVID-19 cases was attributable to the presence of either one or more NCD.[15] Certain NCDs are also associated with even higher risk from respiratory illnesses. For example, people with diabetes face a two-to-four-fold higher risk of active Tuberculosis (TB) and up to 30 per cent of individuals with TB are estimated to have diabetes.[16]

The interaction between NCDs and HIV/AIDS is also a critical area for health and care but often overlooked. With increasing access to antiretroviral therapy for HIV and the growth of new infections amongst older people, an "ageing" of the epidemic is now occurring. UNAIDS estimates that the number of people aged 50 years or older with HIV infection globally increased from 5.4 million in 2015 to 8.1 million in 2020.[17,18,19] Older people with HIV have higher levels of multimorbidity compared with people of similar age without HIV,[20] including a higher frequency of NCDs and the need for multiple treatments and medications ('polypharmacy').[21] While a considerable research gap exists in this area, emerging evidence illustrates how the two epidemics of NCDs and HIV interact with one another within a context of poverty, inequality and inequitable access to healthcare resulting in compounded challenges for older people living with HIV and NCDs, including experience of stigma and discrimination.[22]

There are important gender differences to NCDs in later life

Globally, although men outnumber women until the age of 50, women outnumber men at older ages due to their longer life expectancies. By 2030, 54 per cent of the world's 1.4 billion older people will be women, rising to 60 per cent among people aged 80 and over.[23] However, in part due to their longer life expectancies, women spend a greater proportion of their lives in ill health or with a disability compared to men, including experiencing more years living with disability related to NCDs and a higher likelihood of experiencing co- or multi-morbidity.[24,25]

Gender plays a key role in shaping social determinants of health and exposure to NCD risk factors and access to services. Women and girls are more at risk of multi-dimensional poverty compared to men, with significant impact on their health and wellbeing.[26] Women and girls often receive less education than men, thus limiting their capacity to inform and protect themselves against risk factors for NCDs, including unhealthy diets, air pollution, tobacco and alcohol use. In some settings, women present lower levels of physical activity compared to men as a result of social and cultural customs related to gender and mobility, and are also at greater risk of indoor air pollution due to household tasks. [27,28]

Gender differences result in older women being at greater risk of certain NCDs, including heart disease, risk of stroke and osteoporosis, cervical and breast cancer, and risks and complications related to their sexual and reproductive health, including menopause and post-menopause.[29] Women are also disproportionately affected by Alzheimer's disease and other dementias, experiencing higher morbidity and mortality due to dementia than men.[30]

At the same time, women of all ages – including older women – are the main providers of health and social care for those living with NCDs and other health conditions, both formally and informally.[50] As many as 70 per cent of the global healthcare workforce is female,[51] while women and girls are estimated to do at least two and a half times more unpaid household and care work than men, including care for older people.[52] This care need/care provision dynamic can place women in a precarious position in later life, compounded by the effects of power imbalances and gender inequalities experienced by women and girls across their life-course. The result leaves women often facing accumulated disadvantage, exclusion and discrimination on the grounds of gender, age and other factors in later life, increasing their risk of experiencing violence, abuse and neglect.[31,32] These conditions have a profound impact on older women's physical and mental health and wellbeing, and on their access to services and support that meets their needs.

The consequences of NCDs are not inevitable and there is no age limit to prevention

Despite their significant impact, many of the consequences of NCDs are avoidable. Acting on the determinants and risk factors for NCDs across the life-course, and inequalities in people's exposure to these, whilst ensuring access to integrated NCD prevention and care as part of progress towards UHC, offers the opportunity to prevent, reduce and delay more acute health and care needs and many deaths.

While the role of health promotion and disease prevention from an early age is critical, the benefits of prevention extend across the life-course, with continued potential for significant positive impact in later life. In 2019, 58 per cent of Disability Adjusted Life Years – that is, the sum of the years of life lost due to premature mortality and the years lived with a disability – were attributable to risk factors in people aged 70 and over.[23] The top five risk factors were high blood pressure, high blood sugar, smoking, high cholesterol, and overweight/obesity, many of which are influenced by modifiable behaviours, such as tobacco use, physical inactivity, unhealthy diet, exposure to air pollution and the harmful use of alcohol.[33]

An example is the case of diabetes. In 2021, an estimated 537 million people aged 20–79 globally had diabetes with prevalence increasing with age. This number is projected to reach 783 million by 2045. Type 2 diabetes, which accounts for the majority of the cases, can lead to multiple organ complications and heightened risk of a range of other health issues and complications. Yet by addressing modifiable risk factors, it is possible to prevent and/or delay the onset of Type 2 diabetes and its complications. Despite this, an estimated 240 million people globally are living with undiagnosed diabetes, meaning almost one-in-two adults with

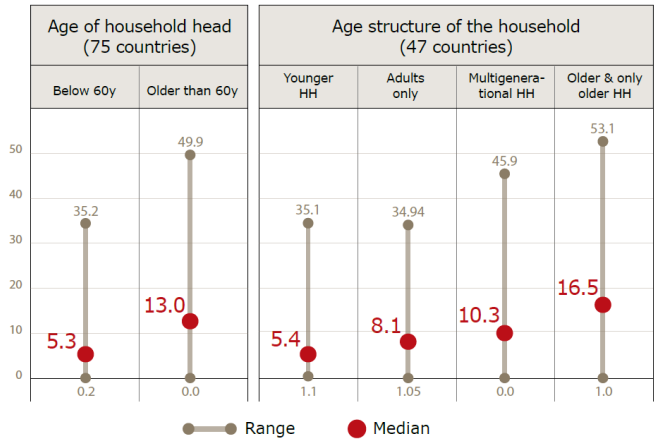
diabetes are unaware they have the condition. Almost 90 per cent of people with undiagnosed diabetes live in low- and middle-income countries, with more than half of people living with diabetes in Africa, South-East Asia and the Western Pacific undiagnosed.[24]

To drive progress, countries must accelerate equitable action on the major NCDs and their leading risk factors, in line with WHO's five-by-five approach and evidence-based and cost-effective interventions outlined in WHO's "Best Buys".[34] This must include investing in primary health care approaches that prioritise prevention and promote healthy ageing across the life-course within progress towards UHC, recognising this as an investment rather than a cost. To reap these benefits, communities must be engaged and empowered in their own health and wellbeing (see Box 1) and barriers older people face to accessing integrated and person-centred NCD prevention, screening, early diagnosis and care must be addressed.

Older people face multiple barriers to accessing integrated and person-centred NCD prevention and care

Despite older people being the age group most at risk from NCDs, they are often furthest behind in accessing NCD prevention and care. For example, while people living with NCDs are, in general, more likely to experience catastrophic and impoverishing health spending than those without NCDs, older people face the greatest risk.[35] (See Image 2).[36]

Image 2: Percentage of population experiencing catastrophic health expenditure



In many settings, limited funding for NCDs and meeting older people's health and care needs means that key services, medicines, goods and products needed to effectively prevent and manage NCDs and promote healthy ageing are unavailable. Countries have demonstrated almost no progress since 2000 in meeting SDG target 3.8 on expanding service capacity and access to prevention, screening, early diagnosis and treatment for NCDs.[37] Only 54 per cent of 194 countries surveyed by WHO in 2021 reported general availability of 11 essential NCD medicines, with one in five countries reporting that only six or fewer were generally available.[38] Access to rehabilitation, assistive technologies (AT), palliative care and long-term care and support are also critical gaps related to meeting the needs of older people living with NCDs and promoting healthy ageing. WHO estimates that 2.5 billion people – or 1 in 3 people – need one or more assistive products, rising to two thirds (69 per cent) of older people, but that nearly one billion people of all ages are denied access.[39] This is particularly the case in low- and middle-income countries, where, on average, only 10 per cent for those who need AT are able to access it.[40] Over 56.8 million people are estimated to require palliative care, with NCDs account for almost 69 per cent of adult need.[41] Yet worldwide, only about 14 per cent of people who need palliative care currently receive it.[42]

Only 54%

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

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

low as 3%

in some countries.

The failure to promote disability inclusion within health systems, and in action on NCDs specifically, in line with WHO's Global report on health equity for persons with disabilities, is another major barrier to older people living with NCDs accessing the services and support they need.[43] Considering the strong interplay between ageing, NCDs and disability, with both older people and persons with disabilities facing greater risk of NCDs, and NCDs being the leading cause of years lived with disability globally, this failure exacerbates health inequities and contributes to worse outcomes for those living with NCDs.

Even when services are available and accessible, older people often report that ageism and age discrimination affect their access to services that meet their needs on an equal basis with others. This includes assumptions from health care providers that NCDs are just a normal part of ageing.[44]

More generally, a focus on vertical disease programming and a failure to invest in the systems, services and workforce needed to deliver integrated, person-centred and community-based models of care that holistically respond to older people's more complex health and care needs whilst promoting healthy ageing for all, means opportunities for addressing NCDs and promoting health and wellbeing across the life-course are being missed. As countries progress towards UHC, it is critical to address this gap and mainstream NCD prevention and care, and interventions that promote healthy ageing more broadly, within UHC benefit packages and all health system building blocks.

Box 1: Scaling up NCD prevention and care through primary health care interventions engaging older people and their communities

Scaling up Non-Communicable Disease Interventions in Southeast Asia (SUNI-SEA) was an action research project implemented through a consortium of partners including HelpAge in Vietnam and Myanmar between 2019-2023. It highlighted the value of engaging people and communities to drive progress on NCDs.

Community NCD interventions were implemented by community-based organisations with the support of volunteers in Vietnam and Myanmar. Following skills building, the volunteers conducted community level screening for NCDs, planned and facilitated health promotion sessions, motivated people for peer support and self-care activities, referred people at risk of NCDs to health facilities and monitored, reported and evaluated their activities.

In Vietnam, the project activities were implemented at primary health care facility level by government partners, in-country research institutes and older-people led Intergenerational Self-Help Groups. Activities included strengthening the quality of NCD care and treatment services through health centre management training, capacity building, updated service guidelines, development of user-friendly job aids, supportive supervision, and strengthening the linkages between the community and local health facilities. Digital technology was used to support stronger community-based NCD screening, management and data and 295 health volunteers were trained in best practice screening and health promotion alongside 126 commune-health staff who strengthened their capacities around screening, diagnosis and treatment for NCDs.

In Myanmar, where the context was different, 30 health volunteers were trained and a self-screening mobile application tool was used to reach close to 2000 people who are now able to regularly screen for diabetes, hypertension and cardiovascular disease, alongside common mental health conditions.

Through its activity, the consortia demonstrated that community interventions, led by older people, boost self-care and increase awareness about NCDs, underlining that adopting a community-based approach, integrated with strong primary health care, is key to achieving UHC and improving health outcomes. To work well, community health services must be community-led, people-centred, and delivered through co-ownership. They must be gender responsive and ensure the meaningful engagement of diverse communities. Finally, sustainable scaling up requires engaging local authorities and advocating for bottom-up funding to support implementation.

Read more **here**.

Global health funding is hampering progress on NCDs and healthy ageing

The barriers older people face to accessing services that meet their needs are compounded by ageism and age discrimination in health financing. This is seen in the limited funding for older people's health and wellbeing, as well as NCD financing. Analysis of Development Assistance for Health (DAH) from 2017, for example, found that DAH targets younger more than older age groups relative to their disease burden, with 90 percent of DAH going to people younger than 60.[45] Rather than responding to population ageing, this trend was seen

to be increasing, with analysis finding that diseases causing health burden at older ages were actually deprioritised between 1990 and 2013, despite the demographic and epidemiological changes that increased their importance.[46] Meanwhile, funding for NCDs received just 2.3 per cent of funding in 2023, despite being the leading cause of disease, disability and death globally.[47]

More broadly, the focus of DAH on single, largely infectious disease funding is also missing opportunities for investing in health system strengthening and integrated primary health care approaches that would benefit people living with NCDs across the life course.[48]

Data systems present an immediate threat to driving equitable progress on NCDs

Despite facing the greatest risk from NCDs, older people are excluded from official statistics on NCDs at local, national and global levels or rendered invisible through a lack of age, sex and disability disaggregated data.

WHO's NCD Global Monitoring Framework uses an age-bracketed indicator on unconditional probability of dying from four main NCDs, limited to the ages of 30-70. This focus on 'premature mortality' is discriminatory and is mirrored in other indicators in the framework, including the indicator on cervical cancer screening which is limited to the ages 30-49, despite cervical cancer continuing to occur in older women. The framework also fails to incorporate broader indicators on the impacts of NCDs beyond mortality, including both morbidity and disability related to NCDs.

Another critical gap is the WHO STEPwise approach to surveillance (WHO STEPS), a survey mechanism for collecting national level data on risk factors for NCDs which is also used to monitor global level progress. Again, despite the prevalence of NCDs amongst people in older age, WHO STEPs typically only includes people between the ages of 18-69, while in a number of countries the cut off is even lower. For example, analysis by HelpAge in 2017 found that only six of around 40 countries in Africa that had conducted a STEPS survey had included people over the age of 64 in their most recent survey.[49] Analysis of the Global Burden of Disease study data, meanwhile, highlighted that coverage of risk factor data for the population aged 70 and over actually decreased in almost 30 per cent of the GBD locations between 1990 and 2019, while since 1990 no information is available for nine risk factors in older adults.[50]

Older people are also excluded from wider data systems that inform NCD policy and practice. For example, current measures of UHC, including the 'access' indicator (3.8.1) in the SDG indicator framework, do not include indicators such as physical access to health facilities, or staff skills, knowledge and attitudes – factors that are critical to understanding the barriers faced by older people. There are also shortcomings in the data sources typically used to populate these indicators, including WHO STEPs mentioned above and the Demographic and

Health Survey (DHS), which typically excludes women over the age of 49 and men over the age of 59, rendering older people with and without NCDs invisible.

Even where data is collected on older age groups, systems often fail to analyse, report and use sufficiently disaggregated data for understanding the diversity of older people's health and care needs and preferences, including disaggregation by sex, age, disability, location and socio-economic group to measure inequalities and inequities in relation to health status, access to services and outcomes.

Such data challenges pose one of the greatest threats to measuring and driving equitable progress on NCDs. The indicators also serve to reinforce and exacerbate age discrimination in NCD policy, practice, research and funding from global to local levels and must be addressed as an urgent matter of human rights.

Box 2: Older people living with NCDs in humanitarian settings

A large and rapidly growing number of older people are affected by humanitarian crises, in which they are often among the most at risk, yet most overlooked. Globally the proportion of the population aged 50 and over in fragile countries, where humanitarian emergencies are more likely to occur, is expected to rise from 12.3 per cent (219.9 million) in 2020 to 19.2 per cent (586.3 million) in 2050.[51]

Humanitarian emergencies include natural disasters, armed conflict, outbreaks and other health emergencies, and may combine multiple crises, such as war and the ever-increasing threat from climate change which presents significant and growing risk to older people living with NCDs who are more at risk from its consequences.[52] Over time, an acute emergency can become protracted, with people potentially displaced from their homes for decades.

Despite their high levels of need, older people in humanitarian emergencies often find themselves systematically excluded. In addition to the barriers older people face in general to accessing the services they need, natural disasters, conflict, climate or other crises can cause disruptions in access to existing services and support and impair the capacity of systems to meet people's essential needs.

In some settings, health systems and services that were previously provided within a country may be seriously undermined or completely destroyed, along with access to other goods and services that people living with NCDs may rely on to manage their condition or conditions, including medicines, foods, assistive technologies or other products, increasing the risk of life-threatening complications. The impact of emergencies and disruption in care also has a profound impact on people's mental health and psychosocial wellbeing further exacerbating existing conditions.

While attention to NCDs in humanitarian response is increasing, including through the development of the WHO NCD kit for emergency settings and processes such as the high-level technical meeting on NCDs in humanitarian settings in 2024, there is urgent need to accelerate progress.[53]

Older people's needs and rights must be addressed within these efforts, as one of the groups at most risk. This means ensuring age and disability inclusive and gender responsive approaches are promoted throughout humanitarian preparedness and response, in line with the Humanitarian Inclusion Standards, including by ensuring that humanitarian actors at all

levels are trained in how to respond to the needs and rights of older people in general and those living with NCDs and multimorbidity specifically.

To support this, NCD prevention and care in humanitarian settings must move away from disease specific interventions towards more integrated approaches that better respond to older people's more complex health and care needs. This includes their need not only for NCD prevention and disease focused management but also for rehabilitation, palliative care, and long-term care and support which must be recognised as essential components of NCD services in humanitarian settings. It is also critical to ensure mental and psychosocial health are fully integrated into emergency preparedness and response at all levels.

Older people living with NCDs, caregivers and communities must be engaged and empowered at all stages of emergency preparedness and response, to ensure their experiences shape the design and delivery of activities. This must include strengthening the collection, analysis, reporting and use of sex, age and disability disaggregated data on people of all ages to inform equity-based responses.

A call to action: tackling NCDs and promoting healthy ageing for all

Three political declarations on NCDs have committed Heads of States and governments to provide strategic leadership and to scale up action for the prevention and control of NCDs and the promotion of mental health, recognising them as major challenges for the health and well-being of all people and more broadly for sustainable development. At the High-Level Meeting on UHC in 2023, Heads of States and Governments also committed to promote and implement policy, legislative, regulatory and fiscal measures to minimise the exposure to main risk factors of NCDs and to scale up efforts in primary and specialised health services for NCD prevention, screening, treatment and control.

Yet today, despite significant policy progress and strong leadership in some countries, implementation has lagged behind.[54] In 2024, the world is off track to meet the global NCD targets that are set to expire in 2025 and 2030, with many promises made at the last High-Level Meeting in 2018 unmet. COVID-19 has put the response even further off-track with the greatest impact on those most at risk, including older people living with NCDs and mental health and neurological conditions.

The NCD Alliance highlights that projected figures for NCD prevalence are even more cause for concern.[55] Health systems already struggling to handle the NCD burden are unprepared for the future. The number of people living with diabetes is expected to more than double globally by 2050, to at least 1.3 billion. Cancer too will double, with 35 million new cases per year foreseen by 2050. Cardiovascular diseases accounts for 18 million deaths per year – this figure will reach 23 million by 2030. Chronic kidney disease is increasing worldwide at a rate of 8 per cent per year; by 2040, it is projected to be the fifth highest cause of death. And the number of people living with dementia is projected to nearly double every 20 years, reaching 139 million people by 2050.

Despite these figures and the ever-increasing challenge of NCDs, multisectoral action plans to address their causes and consequences are still lacking in roughly half of countries, and

despite some improvement, only 57 per cent of countries have set time-bound national NCD targets and indicators. Equally, despite commitments made within the UN political declarations on UHC in 2019 and 2023, in many places, NCDs are failing to be integrated into action on UHC, leaving behind an estimated 20 per cent of the global population living with NCDs.[56] This is especially true for those who are at highest risk, including older people.

Considering the disproportionate impact of NCDs on older people, the invisibility of them and the unique issues they face in the NCD agenda seems a clear example of how ageing populations continue to be marginalised in global health and development, despite a focus on leaving no one behind and reaching the furthest behind first. This failure is not just one of equity, but also of economics. Analysis by the World Bank found that 77 percent and 75 percent deaths of those aged 40–59 and 60–79 respectively were avoidable in 2019, alongside 88 percent of deaths in those aged 20–39.[57] Estimates for Latin American countries shows one of the highest levels of avoidable mortality in older age groups, with heart disease leading the ranking of the prevalence of chronic diseases that are responsible for most of these deaths, alongside respiratory infections. Their analysis estimates that investing in a minimal "starter" package of NCD interventions, could contribute to at least 150 million deaths across all LMICs being avoided by 2050, including those among older people, and about 8 million in 2050 alone. They estimate the economic value of this avoidable mortality at over US$3.2 trillion in 2050.

As countries drive progress in commitments made in the Political Declarations on Universal Health Coverage in 2023 and look ahead to the Fourth High Level Meeting on NCDs taking place in September, we need transformative leadership to drive progress on NCDs for people of all ages and reap the associated benefits for individuals, systems and societies. Action must place those most at risk, including older people, at the centre and take a twin track approach of addressing the social, economic, environmental and commercial determinants of NCDs, while meeting the needs and upholding the rights of those living with NCDs.

We join with the NCD Alliance in their calls to **accelerate implementation, break down silos, mobilise investment, deliver accountability,** and **engage communities**. Considering older people's needs and rights within the NCD agenda, we also call on governments and health stakeholders at all levels to:

- **Recognise and respond to the disproportionate burden of NCDs on older people to ensure an equity-based approach**. This must ensure older people's needs and rights are at the centre of the NCD agenda and that equity guides funding and action on NCDs at all levels.
- **Mainstream NCD prevention and care within UHC and PHC as part of efforts to ensure health systems meet the needs of older people and promote healthy ageing for all**. This must include:
    - Investing in age- and disability-inclusive and gender-responsive health and care systems that deliver equitable, integrated and person-centred care through strong primary health care approaches that engage and empower people and communities.
    - Including NCDs within UHC benefit packages and ensuring people's access to the full continuum of services – from health promotion and disease prevention to early diagnosis, treatment, rehabilitation, palliative care, and long-term care and

support, alongside access to the medicines, vaccines and assistive technologies needed by older people living with NCDs in all settings.

  - Ensuring financial protection from catastrophic and impoverishing health costs

- **End the discriminatory focus on 'premature mortality' within the NCD agenda** by removing upper age caps in NCD monitoring frameworks and data systems; strengthening the collection, analysis, reporting and use of age, sex and disability disaggregated data on people of all ages; and giving greater focus to measuring and addressing morbidity and disability caused by NCDs among people of all ages. This should be supported by greater resources for research on NCD mortality, morbidity and disability in later life and effective interventions for addressing these.
- **Invest in the workforce needed to deliver person-centred and integrated NCD prevention and care and promote healthy ageing**, ensuring a well-paid, well-trained, well-resourced, multidisciplinary and gender equal workforce able to respond effectively and holistically to the diverse and more complex health and care needs of ageing populations. This must include action to **recognize, reduce, and redistribute unpaid care and to reward and represent paid care** to advance the rights of women and girls of all ages, in line with the Beijing Platform for Action.
- **Advance action on mental and psychosocial health and wellbeing, and neurological conditions, including dementia**, recognising the profound and rapidly growing impact they have on people and communities and ensuring their full integration into the funding, design and delivery of health systems and services.
- **Integrate essential NCD services into every part of the emergency cycle and ensure services and the workforce delivering them are able to respond to the unique needs of older people living with NCDs**, including the need for inclusive, person-centred and integrated health and care services across preparedness and disaster risk reduction, through the immediate emergency response.
- **Commit to advance action on the environmental, social, economic and commercial determinants of health across the life-course** to address the leading risk factors for NCDs in line with WHO's 5x5 approach, adopting an intersectional, gender transformative and equity-based approach that recognises and seeks to mitigate how inequality and discrimination experienced by people across their lives contributes to compounded disadvantage in later life and inequitable health outcomes. This should promote inclusive approaches that reach those who face the greatest risks but are furthest behind, whether related to their age, gender, disability, socio-economic status, educational level, literacy, migrant or refugee status or other factors.
- **Engage older people living with NCDs and civil society organisations working with them in the design and delivery of responses at all levels**, recognising them as agents of change in achieving health for all at all ages.

Endnote

[1] United Nations Department of Economic and Social Affairs, Population Division (2022), *World Population Prospects 2022*. POP/03-1: Total population (both sexes combined) by select age group, region, subregion and country, annually for 1950-2100 (thousands), Medium variant, Online edition.

[2] World Health Organization (WHO), Global Health Estimates: Life expectancy and healthy life expectancy 2021

[3] HelpAge International, 2024, Achieving Universal Health Coverage fit for an ageing world.

[4] Institute for Health Metrics and Evaluation (IHME), *Global Burden of Disease (GBD) 2019*, Results Tool, vizhub.healthdata.org/gbd-results/result/989fb4795f2407d0820617c767 8126e4 (11 March 2024)

[5] Global, regional, and national burden of diseases and injuries for adults 70 years and older: systematic analysis for the Global Burden of Disease 2019
Study *BMJ* 2022; 376 :e068208 doi:10.1136/bmj-2021-068208

[6] Ibid.

[7] WHO, Dementia fact sheet . Accessed on 10.09.2024.

[8] WHO, Mental health of older adults fact sheet. Accessed on 13.10.2024.

[9] IHME, Global Burden of Disease 2021, GBD results VizHub - GBD Results (healthdata.org) Accessed on 13.10.2024

[10] WHO 2019, 'Global health estimates: Summary tables: Death by cause, age and sex'. Geneva, Switzerland https://www.who.int/data/gho/data/themes/mortality-and-global-health-estimates

[11] WHO, Mental health of older adults fact sheet.

[12] WHO 2021, Social isolation and loneliness among older people: advocacy brief. Geneva: World Health Organization; 2021. Licence: CC BY-NC-SA 3.0 IGO.

[13] WHO, Abuse of older people fact sheet. Accessed on 17.10.2024.

[14] Saifur Rahman Chowdhury, Dipak Chandra Das, Tachlima Chowdhury Sunna, Joseph Beyene, Ahmed Hossain, 'Global and regional prevalence of multimorbidity in the adult population in community settings: a systematic review and meta-analysis', *Lancet eClinical Medicine*, VOLUME 57, 101860, March 2023

[15] Palmer K, Monaco A, Kivipelto M, Onder G, Maggi S, Michel JP, Prieto R, Sykara G, Donde S. The potential long-term impact of the COVID-19 outbreak on patients with non-communicable diseases in Europe: consequences for healthy ageing. Aging Clin Exp Res. 2020 Jul;32(7):1189-1194. doi: 10.1007/s40520-020-01601-4. Epub 2020 May 26. PMID: 32458356; PMCID: PMC7248450.

[16] Krishna S, Jacob JJ. Diabetes Mellitus and Tuberculosis. [Updated 2021 Apr 18]. In: Feingold KR, Anawalt B, Blackman MR, et al., editors. Endotext [Internet]. South Dartmouth (MA): MDText.com, Inc.; 2000-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK570126/

[17] The Lancet Healthy Longevity. Ageing with HIV. Lancet Healthy Longev. 2022 Mar;3(3):e119. doi: 10.1016/S2666-7568(22)00041-1. Epub 2022 Feb 23. PMID: 36098283.

[18] Belaunzaran-Zamudio, P. F., Caro-Vega, Y., Giganti, M. J., Castilho, J. L., Crabtree-Ramirez, B. E., Shepherd, B. E., . . . Sierra-Madero, J. G. (2020). Frequency of noncommunicable diseases in people 50 years of age and older receiving HIV care in Latin America. PLoS One, 15(6), e0233965. https://doi.org/10.1371/journal.pone.0233965

[19] Goldstein D, Kiplagat J, Taderera C, Whitehouse ER, Chimbetete C, Kimaiyo S, Urasa S, Paddick SM, Godfrey C. Person-centred care for older adults living with HIV in sub-Saharan Africa. Lancet HIV. 2024 Aug;11(8):e552-e560. doi: 10.1016/S2352-3018(24)00123-1. Epub 2024 Jul 9. PMID: 38996592.

[20] Ibid.

[21] Belaunzaran-Zamudio et al. 2020.

[22] Knight L, Schatz E, Mukumbang FC. "I attend at Vanguard and I attend here as well": barriers to accessing healthcare services among older South Africans with HIV and non-communicable diseases. Int J Equity Health. 2018 Sep 18;17(1):147. doi: 10.1186/s12939-018-0863-4. PMID: 30227859; PMCID: PMC6145370.

[23] UNDESA, 2022, *World Population Prospects 2022*. POP/03-1: Total population (both sexes combined) by select age group, region, subregion and country, annually for 1950-2100 (thousands), Medium variant, Online edition.

[24] IHME, GBD2019.

[25] Saifur Rahman Chowdhury et al, 2023

[26] HelpAge 2024.

[27] The NCD Alliance and The George Institute for Global Health, 2019, Delivering healthy lives and well-being for women and girls: Non-communicable diseases and Universal Health Coverage.

[28] Verma A, Gudi N, Yadav UN, Roy MP, Mahmood A, Nagaraja R, Nayak P. Prevalence of COPD among population above 30 years in India: A systematic review and meta-analysis. J Glob Health. 2021. Aug 21;11:04038. doi: 10.7189/jogh.11.04038. PMID: 34484706; PMCID: PMC8397327

[29] HelpAge 2024.

[30] WHO, Dementia fact sheet. Accessed 17.07.2024.

[31] HelpAge 2024.

[32] WHO, 2024, 'WHO calls for greater attention to violence against women with disabilities and older women'. News article, 27.03.2024.

[33] Ibid.

[34] WHO, Noncommunicable Diseases, Rehabilitation and Disability factsheet. Accessed 20.10.2024.

[35] NCD Alliance and The George Institute, 2023, Paying the Price: A deep dive into the household economic burden of care experienced by people living with noncommunicable diseases.

[36] WHO and World Bank, 2023, Tracking universal health coverage 2023 Global Monitoring Report.

[37] WHO, Noncommunicable Diseases, Rehabilitation and Disability factsheet. Accessed 20.10.2024.

[38] WHO, 2023, Assessing national capacity for the prevention and control of noncommunicable diseases: report of the 2021 global survey. Geneva: World Health Organization; 2023. Licence: CC BY-NC-SA 3.0 IGO

[39] WHO and United Nations Children's Fund (UNICEF), 2022, Global report on assistive technology.

[40] Ibid.

[41] World Hospice and Palliative Care Alliance (WHPCA) Global Atlas of Palliative Care, 2nd Ed 2020.

[42] WHO, Palliative care fact sheet. Accessed 17.10.2024

[43] WHO, 2022, Global report on health equity for persons with disabilities.

[44] HelpAge 2023, Healthy ageing for us all: what older people say about their right to health and health services.

[45] Skirbekk V, Ottersen T, Hamavid H, Sadat N, Dieleman JL. 'Vast majority of development assistance for health funds target those below age sixty', *Health Affairs*, 2017 May; 36(5):926-930. doi: 10.1377/hlthaff.2016.1370

[46] Ibid.

[47] Institute for Health Metrics and Evaluation (IHME). Financing Global Health. Seattle, WA: IHME, University of Washington, 2023. Available from http://vizhub.healthdata.org/fgh/(link is external). Accessed March 11 2024.

[48] Jonathan E. Cohen (2023) 'How Can US Global Health Assistance Adapt to Population Aging?' Online article, Just Security. November 2023. How Can US Global Health Assistance Adapt to Population Aging? (justsecurity.org)

[49] HelpAge International, 2017, How data systems leave older people behind.

[50] Saifur Rahman Chowdhury et al, 2023

[51] HelpAge, 2020, If not now, when? Keeping promises to older people affected by humanitarian crises

[52] WHO, 2022, Decade of Healthy Ageing Connection Series No. 3 - The Decade in a Climate-changing World

[53] NCD Alliance, 2024, NCDs_neglected_crisis-humanitarian_brief-2024.pdf (ncdalliance.org)

[54] NCD Alliance, 2024, NCD Alliance Advocacy Priorities for the 4th High-level Meeting of the UN General Assembly on the prevention and control of NCDs in 2025

[55] Ibid.

[56] Ibid.

[57] World Bank, 2024, Unlocking the Power of Healthy Longevity: Demographic Change, Non-communicable Diseases, and Human Capital (worldbank.org)

HelpAge International is a global network of organisations promoting the right of all older people to lead dignified, healthy and secure lives.

Driving equitable action on NCDs and healthy ageing to achieve health for all at all ages

Published by HelpAge International
PO Box 78840
London
SE1P 6QR
UK

Tel +44 (0)20 7278 7778

info@helpage.org
www.helpage.org

Registered charity no. 288180