NGO Committee on AGEING UNITED NATIONS, NY

THE NGO COMMITTEE ON AGEING

BUILDING A SOCIETY FOR ALL AGES

Welcome to the May 2025 Issue of the UN NGO Committee on Ageing/NY Newsletter

What's in this Issue?

Our Chair, Bill Smith starts us off with a moment of celebration for the announcement that the UN Human Rights Council has resolved to begin drafting a convention on the human rights of older persons. We will follow the process and report on it in future newsletters.

We are now at the midpoint of the UN Decade of Healthy Aging. Member States and NGOs are assessing progress and remaining challenges to achieving their goals. While longevity is increasing worldwide and health care is advancing overall, there are still significant gaps in health and health care between rich and poor countries for people of all ages. **Maud Bruce About** explores this issue and its impact on human rights. **See *A Deeper Dive*.**

Adriane Berg covers issues of ***Longevity Equity*** in ***Words That Are Trending***. She argues that the longevity dividend is the place to look for justification in spending on prevention, social determinants of healthy ageing, and health maintenance for all ages.

Dementia is a health condition requiring a complete medical diagnosis and thoughtful planning with patients, families, and care professionals to preserve the dignity of those affected. When the term is used loosely, it is often inaccurate, but more importantly, it stigmatizes, marginalizes, and psychologically defeats its sufferers. This is true no matter what the culture or region of the world. **Dr. Imran Ali** draws on his experience as a physician of Geriatric Medicine to remind us not to let the dementia label put shackles on individuals with the disease. See ***Dementia-The Stigmatized Disease of Ageing***

Next month, on June 15, the UN will hold its annual observance of World Elder Abuse Awareness Day (WEAAD). Readers of this Newsletter are surely aware of the long-standing problem of elder abuse in families, communities, and long-term care facilities. However, a new form of elder abuse seems to be taking place in some long-term care facilities—the posting on social media of demeaning photos of patients by staff caregivers. You will want to read this disturbing piece, ***Raising Awareness About a New form of Elder Abuse***, by **Dr. Gloria Gutman**, Gerontological researcher and Professor Emerita at Simon Fraser University.

We note with sadness the recent passing of James O'Neal, a member of our NGO Committee on Ageing, a representative to the UN from the International Federation on Ageing, and a longtime advocate for the rights of

older persons. At the time of his death, he was the President of the New York State chapter of AARP, where he was described as “bringing an unwavering commitment to AARP’s mission and the power of volunteerism touching countless lives. His thoughtful leadership, warmth, and tireless service will be remembered with deep gratitude.”

Warmly Yours,

Martha Bial, Editor and Chair of the NGOCoA Communications Committee, Representative to the UN, International Association of Gerontology and Geriatrics

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A Word from The Chair

Dear Readers,

This has been a very busy time at the United Nations both in New York and in Geneva.

The first major announcement comes from Geneva with a Landmark Year for Older Persons Rights. On April 3, 2025, the United Nations Human Rights Council adopted a resolution, establishing a new intergovernmental working group to draft an international legally binding (UN convention) on the human rights of older persons.

Appreciation is to be rendered to the Global Alliance for the Rights of Older Person and the NGO Committee on Ageing in Geneva which organized and coordinated the advocacy at the 58th session of the HRC. Many other NGOs contributed through their tireless advocacy to result in this major outcome.

With the resolution now in place, the focus shifts to consultation and drafting of this important document. Civil Society organizations will meaningfully engage and play a crucial role in providing expertise and advocacy.

The Commission on the Status of Women also had significant result insuring that Women and Older women will be part of the Commission’s ongoing deliberations through 2026.

The Commission on Population and Development also delivered their Ten Key Messages including universal health coverage, healthy ageing requiring a life-course approach along with urging that mental health receive a higher priority by all countries.

Our collective advocacy must continue.

Yours,

William T. Smith, Ph.D. Chair, NGO CoA in NY

A New Form of Elder Abuse: Raising Awareness of Social Media Abuse

By Gloria M. Gutman, PhD

June 15 is world elder abuse awareness day (WEAAD). Originating with the International Network for the Prevention of Elder Abuse (INPEA), for some years now (since 2006), WEAAD has been an official UN day. Around the world older adults and their advocates engage in activities around the mid-June date designed to raise awareness of the ubiquitous and pernicious nature of elder abuse and to celebrate seniors' resilience.

Why did WEAAD catch on?

Numbers talk. The INPEA website (httpt://www.inpea.net/) and that of WHO (https://www.who.int/news-room/fact-sheets/detail/abuse-of-older-people) present statistics that indicate that the five internationally recognized forms of elder abuse (physical, psychological, sexual, financial, neglect) affect approximately 10% of the world's older adult population at any point in time. Rates are thought to be exacerbated during emergencies and disasters as has been well established to occur in the case of child abuse and domestic violence.

What can we/you do about it?

Both the INPEA and WHO websites and those of national elder abuse focused websites such as that of the Canadian Network for the Prevention of Elder Abuse (https://cnpea.ca/en) and the US government's National Center on Elder Abuse (https://ncea.acl.gov/home#gsc.tab=0) provide many resources including definitions, guidelines on how to identify elder abuse and neglect and, who, when, and where to report it.

Readers are urged to consider these resources and the nuances that they suggest, in order that interventions not put the victim at an increased risk of harm. They caution not to forget the rights of older adults for self-determination while recognizing that unlike children or young and middle-aged adults, consideration needs to be given to the very real possibility that the victim (and/or perpetrator) may have compromised cognition due to a diagnosed or as yet undiagnosed neurodegenerative disease. We also need to be aware that the landscape continues to evolve with new forms of elder abuse emerging.

Social media abuse in nursing homes: a new form of elder abuse

While most elder abuse takes place in the community which is where most older adults live, and we tend in that setting to focus on family as potential (and most often) the perpetrator, we must not forget that at any point in time some 5% of older adults are residents of a skilled nursing facility. Data is sparse when it comes to staff perpetrated abuse and it's not something we want to think about.

Although I am a longtime advocate and elder abuse researcher, a webinar I attended in April was a wake-up call. Sponsored by the Long-Term Care Community Coalition, the speaker, Eilon Caspi, provided examples from a

study he and colleagues have been conducting since 2017 in 100 nursing homes in thirty-one states. A total of 152 victims were identified, 85% with some level of cognitive impairment, where care staff had taken photos or videos of older adults with demeaning and/or abusive content and posted them on social media platforms such as Snapchat, Facebook, or Tik Tok. The webinar may be viewed at https://nursinghome411.org/webinar-social-media-abuse/

Examples included photos of older adults whose extremities were covered in excrement – with the caption “this is a sh--y job.” Other photos were of individual’s private parts again with derogatory comments. Some of the perpetrators justified their action as a way of blowing off steam or coping with a frustrating work environment with the comment that the victim’s face was covered or that the victim was asleep or unconscious or demented and thus unaware that their privacy was being violated. Victim blaming is common in institutional or community-based violence instances. But in my opinion, there should be zero tolerance for this type of behavior on the part of individuals caring for our most vulnerable older adults.

Dementia-The Stigmatized Disease of Ageing

By Dr. Imran Ali MD, MS, MPHAssistant Clinical Professor, Icahn School of Medicine at Mount Sinai (Department of Hospital-Based Medicine), Medical Contributor ABC News 8 Good Morning Connecticut

Dementia is often a word that we hear casually spoken around the hospital or even in the local neighborhood but never has a single word meant so much. When the average person hears dementia automatically, there are so many assumptions that come about, ranging from a mere disability to a hopeless loss of individuality.

Although we are still in the pilot stages of better understanding the various types of neurocognitive impairment, the general society's attitude toward dementia is plagued by stigma. Gone are the terms senile and demented, or maybe not. The stigma surrounding those with dementia still exists, and society's perceptions shape it. As we continue to struggle with ageism globally, dementia compounds that struggle.

The World Health Organization (WHO) defines health as "complete physical, mental, and social well-being” and not merely the absence of disease or infirmity. Everyone deserves dignity and respect; being denied these further diminish a person's sense of well-being and, in turn, is detrimental to their health.

The WHO recognizes that individuals experiencing mental health conditions, for example, are entitled to a life of dignity. Dementia is more than a mental health condition. However, it is a neurodegenerative disease often caused by genetic predisposition or cerebrovascular disease that is beyond a person's control. As a physician of geriatric medicine, I have seen firsthand how dementia affects individuals and their families deeply, in part due to societal

norms and expectations. I see patients come in with families to the clinic where the patient, even those afflicted with mild neurocognitive impairment, is treated like a child or even, in some cases, like a pet who has no say of their own.

I see physicians in training speak about a dementia patient in front of them as if they believe the patient is not listening or aware. This diminished respect and dignity strip the autonomy of the individual. The feeling of autonomy can be considered a fundamental human right, and this trend of assuming that dementia patients have surrendered it is disturbing. I always involve or at least try to involve a patient with cognitive impairment in any decision-making. If they cannot make decisions or get frustrated, I ask if it is ok to speak to their surrogate. We must never lose sight of the individual who is covered, so to speak, by the shroud of a dementia diagnosis.

If the stigma of dementia were relegated to non-medical society only, it would be one thing. Still, sometimes, it is present in the healthcare community as well. Often, dementia is a diagnosis that is given and entered into a medical record with complete abandon to the principles of medical diagnosis. Frequently, I see patients who present for rehabilitation after surgery who have an opening line: "77-year-old with a past medical history of hypertension, hyperlipidemia dementia, and arthritis…." When I dig deeper, I find no neurocognitive assessment or amyloid biomarkers to support a diagnosis of "dementia."

Often, mere observation is all that is done, leading to confusing delirium, which is transient, with dementia. I see that sometimes my older adult patients, who may be slightly confused by the effects of anesthesia post-operatively, get a diagnosis of "dementia." Would this occur in a younger individual?

A story that drives this point of dementia's stigma creating artificial shackles is that of my patient, whom I'll call Jane. She was a lovely woman who came to my clinic with her family as the family was concerned that this once vibrant and social person became very withdrawn and depressed. I was told that she had dementia diagnosed by another healthcare provider. I did a complete assessment and found that she had a hearing impairment, and after adjusting for this, her cognitive assessment did not indicate dementia whatsoever. However, merely reassuring Jane was not enough; I had to remove the diagnosis of dementia from her record with much difficulty.

She told me that she withdrew from her friends and her activities because she was told that she had dementia. The impact of this misdiagnosis on her mental health was profound. She had internalized the label of being "demented" and felt she had lost her place in society. It took a great deal of time to help Jane realize that she was misdiagnosed and that misdiagnosed dementia does not define her. As a doctor, I was shocked at how the disease process itself was not destroying the dignity of my patients but society's perception of that disease. This was a turning moment that fueled my desire to help my patients beyond the confines of the clinic and hospital.

As we explore the needs of the aging population globally, the dignity and respect that we are all advocating for through combating ageism must also include the unique challenges patients with dementia and their families face. It's not just about medical treatment but also about providing social support and respecting the patient's autonomy. A holistic approach to dementia care is

essential in combating the stigma and ensuring the patient's well-being.

A Deeper Dive: The Right To Longevity Equity-Life, Health, Equality

By Maud Bruce-About, UN Representative, International Federation of the Association of Older People (FIAPA), Chair NGO CoA Sub-Committee on Older Women

This article reviews progress towards The United Nations Decade of Healthy Ageing (2021–2030) goals of ***improving "the lives of older people, their families, and the communities in which they live" (and its vision is of a world where "all people live long and healthy lives and that recognizes the right to the highest attainable standard of health of older people."***

Our initial focus will be on the life course and Sustainable Development Goal 3. SDG 3 strives toward "healthy lives and promoting well-being for all, at all ages.". It recognizes that health is affected by genetic, biological, behavioural, economic, social, and environmental factors that interact and accumulate over the life course. Next, we will explore achievements towards the Decade of Healthy Ageing.

Only a comprehensive health life course approach - at all ages - can reduce the length and intensity of the care needed at older ages and deliver the highest attainable standard of health.

As stated in the World Social Report: "*population ageing needs to be widely understood as more than just a set of discrete concerns mainly for one group of people who have advanced beyond a given age.*" That notwithstanding, specific efforts towards older persons are vital. The United Nations Decade of Healthy Ageing (2021–2030) complements SDG3 and MIPAA (the Madrid International Plan of Action on Ageing, 2002), as it calls for specific actions regarding older persons.

The three reasons why reviewing progress on healthy ageing is quite timely.

First is the increased longevity - globally, by about 7 years from 2000 to 73.5 years in 2025, with a projection of about 77.0 years in 2050. We commonly connect progress towards healthier lives with successful policies. Yet, increased longevity can mask issues regarding who benefits and how well and healthy these extra years achieved are lived. Increased longevity has consequences for both human rights and economic distribution.

Second, there are challenges to the current demographic transformation. For instance, many low- and lower-middle-income countries with relatively rapid population growth and increasingly limited resources already lack essential healthcare services whilst needing heavy healthcare investment to keep pace

with growing populations - let alone achieve universal health coverage vital to living long, healthy lives.

Third, we face risks of reversal caused by the pandemic, conflicts, crises, and political decisions.

The Report of the Secretary-General to the Commission on Population and Development points out that despite expanding health service in the last decades, progress in coverage for infectious diseases, reproductive, maternal, newborn, and child health, and non-communicable diseases has advanced slowly been stalled, or even reversed.

There are currently considerable inequalities in who lives a long life.

Although the gap in life expectancy between low-income and high-income countries has narrowed over the past decades, life expectancy at birth in 2025 in low-income countries was barely 65.3 years, compared with 81.7 years in high-income countries. Even as we know, Covid-19 affected populations differently. Whilst longevity dropped globally by 1.6 points during COVID-19 (2019-2021), the drop was 3.7 points in Latin America and only 0.3 in East Asia.

So, too, longevity varies between and within high-income countries and is gendered - with women living longer. European Union (EU) life expectancy at birth was estimated at 80.6 years in 2022, reaching 83.3 years for women and 77.9 years for men. European Union's life span at 65 was estimated at 19.5 years - 21.1 years for women and 17.7 years for men - in 2022. The highest life span at 65 in 2022 could be observed in France and Spain (21.3 years) and the lowest in Bulgaria (15.4 years)

According to the World Social Report, persons of higher socioeconomic status consistently live longer than those of lower education - citing a 2-year difference in Spain and an 8-year difference in Lithuania.

In the US, life expectancy at birth was 75.8 for men and 81.1 for women in 2022; at 65, it was 22.2 for women and 19.3 for men in 2023. Further, in the US, there are also notable differences between states and ethnic groups.

As to how well extra years are lived - the quality dimension of life, how the remaining years are in good health, free of disease or disability - current statistics tend to indicate that the share of time older persons spend in bad health has increased and risk differentials linked to socioeconomic factors.

Indeed, available recent research over the whole life course - restricted to parts of Asia, Western Europe, and North America - tends to indicate that the number of years lived without disability as a share of total life expectancy remains constant - years of good and bad health are added equally. Statistics on the 60+ point to an increasing share of the time older persons spend in bad health. Systematic WHO data of health-adjusted life expectancy at 60 between 2019 and 2000 shows that, on average, life expectancy at 60 has increased faster than health-adjusted life expectancy for both men and women.

In 2021, according to "healthy life-years" - an EU indicator of disability-free life span calculated regularly - on average across OECD countries participating in the survey, the number of healthy life-years at age 65 was 10 years for women and 9.6 for men)

Data also indicate that socioeconomic factors matter. For instance, healthy life expectancy at age 65 was close to or above 14 years for both men and women in Norway and Sweden and around 5 years or less for both men and women in the Slovak Republic and Latvia. In these latter countries, women spend three-quarters of their advanced years in poor health, compared to one-third or less in Norway and Sweden.

Additionally, according to the 2023 World Social Report, recent increases in inequality within countries - widening the gaps between rich and poor - are at risk of increasingly distancing those who enjoy old age in good health from those who will not.

To better understand health issues over the life course - especially how they accumulate throughout life - the need for a comprehensive health care approach - including Universal Health coverage - and the need for a Decade of Healthy ageing …. we will proceed by age:

Newborn and child health

According to the Report of the Secretary-General to the Commission on Population and Development, child health is *"one of the most cost-effective ways to improve the health of a population"* - with direct and indirect societal returns in the level of education, productivity, and lower public expenditure on healthcare.

With less developed immune systems, children are prone to infectious diseases and vulnerable to adverse effects of air pollution, water contamination, heat waves, and chemical hazards, all of which lead to ill health later in life.

Furthermore, nutrition - for physical and cognitive development - impacts well-being throughout life. While stunting has decreased globally since 2000, overweight has increased, and many low- and lower-middle-income countries face malnutrition.

Adolescent and youth

Today, adolescents and youth - 15 to 24 years - represent 15.6 percent of the global population. In low-income countries, this age segment will increase by 60 percent between 2025 and 2050, demanding rapid expansion of healthcare.

Deaths are low compared with other age groups, but 80% of them are injury-related - road traffic, self-harm, interpersonal/collective violence.

At this age, social and emotional skills, healthy habits - essential for mental and physical well-being throughout life - and risk behaviours - use/abuse of alcohol, narcotic drugs, and tobacco - develop.

Mental health issues - depression, anxiety, and behavioural disorders - affect one in seven persons between 10 and 19 years of age.

Furthermore, decisions concerning sexual and reproductive health are made, with early childbearing having negative impacts on young girls' education/future employment/income prospects. Girls in sub-Saharan Africa account for more than half the global births of adolescent mothers aged 15 to 19 years and more than two-thirds at 10 to 14 years.

Adult Health

The segment between 25 and 59 - today, 3.7 billion - will grow more rapidly than other age groups combined and reach 4.3 billion by around 2050.

At this most economically productive stage, we begin to experience age-linked gradual physical and cognitive changes.

Globally, the leading causes of death are non-communicable diseases - especially cardiovascular ones and cancers. Non-communicable diseases - including diabetes and chronic respiratory diseases - that impact well-being and reduce work productivity are projected to increase over the next few decades due to population ageing and an epidemiological transition.

Injuries, work or non-work-related, are a compelling cause of death, disease, and disability. Annually, four hundred million workers have a non-fatal occupational injury, and 330,000 die in work-linked accidents.

Workers in agriculture, forestry and fishing, mining, construction, and manufacturing are the most affected.

As people live and work longer, the cumulative effects of occupational exposures - including risks related to climate change - and lower functioning risk make older workers more vulnerable to occupational diseases and fatalities. Health policies could reduce the risk factors, especially for those in low-wage occupations and precarious or informal employment.

Persons in this age group - especially women - often care for members of their family and community, like children, older persons, and persons with disabilities.

At this stage of life, sexual and reproductive healthcare partially varies by age. Some issues are specific to reproductive age - fertility and others - or linked to menopause or perimenopause, whilst others are non-age-specific, such as the promotion of sexual health, like prevention of sexually transmitted infections.

Older Age

The population aged 60+ will increase by 72 percent, from 1.22 billion in 2025 to 2.11 billion by 2050, especially in lower-middle-income countries where their numbers will increase by 90 percent, compared to 25 percent in high-income countries. During the same period, the number of persons aged 80+ is expected to double in high-income countries and triple in lower-middle-income countries.

Non-communicable diseases cause nine of the ten deaths among persons aged 60 years or older - the leading causes being cardiovascular disease, cancer, chronic respiratory disease, and neurological conditions. Communicable and nutritional conditions are also responsible for many deaths in this age group, followed by injuries. COVID-19 had a disproportionate impact on older persons - 75% of all COVID deaths between 2020 and 2023 were among people aged 60+.

The primary causes of disability and dependence are neurological conditions - Alzheimer's, Parkinson's, and other types of disease and dementia. Dementia is notably more common among women than men - 8.1 percent for women compared with 5.4 percent for men among the 65+. Age-related musculoskeletal conditions - arthritis and osteoporosis - also cause disability, affecting the mobility and quality of life.

Today, access is often limited to vital healthcare and rehabilitation services for older individuals facing challenges in daily activities - due to neurological conditions or physical disabilities.

One in six face mental challenges, with social isolation, loneliness, and ageism being key contributors, often in combination with the loss of a partner, reduced mobility, or changed living situations. As older women are twice as likely as men to live alone, they face a higher risk of dementia, stroke, and coronary heart disease.

By 2050, the number of older persons needing long-term care globally will more than double, with the most significant increases expected in lower-middle-income countries where the population of older persons is growing faster than the capacity of long-term care systems and practices. This risks increasing the need for unpaid care work performed by ageing women. So far, public spending is insufficient to cover expansion - in OECD countries, funding decreased from 1.7% of GDP in 2017 to 1.5% in 2019.

Women live more years in poor health than men - with disparities in health status beginning early and often widening with age. To learn more about the living conditions of older women and their societal contributions, please revisit our February 2025 Newsletter and our September 2022 Newsletter.

To enable older persons to stay socially integrated and healthy, ageism needs to be eliminated, and society should be made more inclusive and accessible - including transportation and housing and access to community-based social services. To learn more, please revisit our March and June 2023 Newsletters.

Given population ageing, how health issues accumulate throughout life, and the specificities and needs of older persons, the Decade of Healthy Ageing needs to be supported by firmer rights FROM WHICH WE WILL ALL BENEFIT,

The Decade of Healthy Ageing aims to impact "*the lives of older people, their families, and the communities in which they live* by actions to attack ageism - change how we think, feel and act towards age and ageing -; make communities foster the abilities of older persons; deliver person-centered integrated care and primary health services for older people and provide acceptable long term care.

So far, progress has been slow. Resources remain insufficient, and, as in the case of MIPAA implementation, too few member states prioritize mainstreaming and adapting societies to ageing populations.

Nevertheless, according to The Lancet, progress on The Decade of Healthy Ageing has been made since its launch and baseline report. In 136 out of the 194 countries submitting data:

- Eighty-three percent of countries reported national legislation in 2022 against age-based discrimination, compared with 60% in 2020,
- Seventy-seven percent reported a national programme to support age-friendly communities, an increase from 52% in 2020.
- Seventy-eight percent reported a policy for long-term care for older people, compared with 67% in 2020.
- Seventy-one percent reported national policies supporting comprehensive assessments of health and social needs for older people, up from 48% in 2020.
- Seventy-four percent have a national multi-stakeholder forum/committee on ageing and health, compared with 67% in 2020. Older people are included in such forums or committees in two of three countries.

https://iris.who.int/bitstream/handle/10665/374192/9789240079694-eng.pdf?sequence=1

However, The Lancet reports that resources remain insufficient, resulting in only 39% of countries collecting longitudinal data on older people's health status and needs.

Lack of resources is severe in low-income and middle-income countries, where 80% of the world's older population will live by 2050. Hence, ageing remains underprioritized - only 11% of low-income countries have national guidelines on geriatric care and training - and long-term care falls on informal caregivers, with merely 16% of low-income countries providing training and support.

As for the economic situation of older persons, our January 2024 Newsletter signaled a slide with increased poverty levels, inequality, and risks of "widening disparities in both health and life expectancy among future cohorts of older persons."

The latest MIPAA review also highlighted disparities in implementation within and across regions and the need to ensure meaningful participation of older persons, especially in digital literacy, crisis recovery, reinforcement of social protection, access to health and long-term care, and poverty alleviation.

In light of this lack of prioritization, we congratulate that the Open-Ended Working Group of Ageing (OEWGA) has fulfilled its mandate to: *"present to the General Assembly, at the earliest possible date, a proposal containing, inter alia, the main elements that should be included in an international legal instrument to promote and protect the rights and dignity of older persons, which are not currently addressed sufficiently by existing mechanisms and therefore require further international protection."*

(For more on the works of OEWGA, see our May 2024 Newsletter. The deliberations on an international legal instrument to promote and protect the rights and dignity of older persons have now progressed to the UN Human Rights Council (UNHRC).

Regardless of our perspective, we all live or will be living in ageing societies, and we need rights to adapt existing systems, services, and infrastructure to the realities of population ageing.

Let's Age With Rights!

Longevity Equity: Who Will Have Access to Longer Lifespan?

By Adriane Berg, Representative to the United Nations from the International Federation on Ageing, Board Member of The Global NGO Executive Committee (GNEC), Host of On The Ground, the podcast of GNEC, Member of NGO Committee on Ageing NY

Longevity is a positive indicator of overall quality of life.

As generally understood, longevity means long lifespan. As such, it is a comparative phrase measured against the Life Expectancy norm of a population or humanity. Most policymakers, scientists, and the public see Life Expectancy at birth as one measure of the overall quality of life in a country or community. Thus, longevity is a positive for which we strive communally and personally.

Life Expectancy has risen globally, with a backside due to COVID-19.

Life Expectancy is rising globally. According to the United Nations World Population Prospects 2024, "Monaco has the highest life expectancy at 86.50 years, followed by San Marino (85.82 years). Hong Kong, Japan, and South Korea occupy the following three positions. Fifty-seven countries have life expectancy above 80 years, sixty-seven have between 75-80 years, and forty-nine have between 70-75 years. In the United States, life expectancy is 79.5 years. The lowest life expectancies are found in Africa, with Nigeria having the lowest at 54.64 years. Nevertheless, even in shorter-lived countries, longevity is increasing.

This global expansion of expected lifespan poses the question of the right to access those factors that increase lifespan, which we shall call Longevity Equity.

Q. What causes differences in life expectancy?

A. Life expectancy is partially determined by genetics; however, the impact of genetics is decreasing in favor of other factors such as health care, nutrition, exercise, and other lifestyle and behavioral health components.

Background: The most recent findings reveal that genetics accounts for ONLY 25% of life expectancy. Within countries, those with the longest life expectancies have the least disparities in lifespan and experience the most equal access to healthy lifestyles within their populations. In populations where specific individuals are excluded from equity, the role of genetics in how long they will live becomes more paramount.

In 2008, the United Nations World Health Organization (UN WHO) released its Commission on Social Determinants of Health Report. The report determined that "The social conditions in which people are born, live, and work" are inextricably related to longevity. Life Expectancy is largely "determined by what is commonly called bread and butter issues – food, transportation, housing, education, a living wage –affect life expectancy."

From 1900 to 2000, life expectancy rose by 30 years in the US. The Centers for Disease Control and Prevention (CDC) determined that twenty-five of the 30-year improvement was attributed to bread-and-butter factors. Only 5 years were due to health care. In another finding, Dr. Andre Perry of the Brookings Institute determined that obtaining a high school diploma added 10 years to life expectancy.

This nexus between longevity and public policies that create social equity has been called "the zip-code factor." In 2019, Live Longer Project's Pittsburgh published findings that affirmed the UN WHO Report that longevity equity is inexorably linked to social equity. In Pittsburgh, Longevity ranged from 62-84, with 22-year life expectancy differentials depending on the neighborhood where the subjects lived.

Q. What are the elements that increase HALE- healthy adjusted life expectancy?

Long-lived, healthy communities are designated as "Blue Zones," pockets where people routinely live to be over one hundred years old. Most people living in Blue Zones are free of Alzheimer's or other debilitating diseases of aging. Key factors of HALE are personal health habits, connection, and contribution to community, friends, and a robust social life.

Background: . Geroscientists and policymakers have recently focused on HALE (health-adjusted life expectancy) rather than longer years. HALE quantifies the number of years individuals can expect to live in full health, free from disease and disability.

Richer countries do not have a monopoly on healthy longevity. Healthy Life Expectancy improved worldwide in 2021, from 61.9 in 2000 to 62.7. Yet, countries like the United States saw a decline in healthy longevity, attributable to multiple factors, such as poorer health behaviors related to smoking habits and obesity, social inequality, and the failure of disease prevention measures covered by insurance or Medicare.

Q. Does genetics still play a significant role in lifespan?

A. Genetics accounts for about 25% of how long humans live. Geroscientists *have* discovered genes that influence how we age. These genes control how cells repair themselves, how the body processes food, and how it manages stress.

The other 75% is shaped by how one eats, moves, sleeps, and connects socially. Science Alert sums it up as follows, "Differences in Longevity between humans are not primarily determined by genetics. Regular exercise and a healthy diet may be the 'secret' to longevity. "

Background: Epigenetics is a geroscience field that researches how genes express themselves depending on factors, including lifestyle, which can "dial up" or "dial down" the activity of specific genes. Gene expressions are influenced by everything from diet to stress levels. One may have inherited a risk for a disease, but that doesn't mean it has to "turn on."

The pioneers in this field have shown that genes tied to energy metabolism, nutrient sensing, and cellular repair are big players in how long (and how well) we live.

In the United States, The Healthspan Action Coalition (HSAC) and the Kitalys Institute have jointly introduced the Therapeutic Healthspan Research, Innovation, and Validation Enhancement Act (THRIVE) in Washington, DC. THRIVE aims to incentivize and streamline the development and regulatory approval of healthspan-extending products such as drugs, nutritional devices, and diagnostics. "This legislative proposal seeks to shift healthcare towards proactive aging management by establishing a tiered approval system based on scientific evidence." The fate of THRIVE will be instructive to all nations interested in incurring longevity and the scientific modalities that influence it.

Q. Given what we know about the determinants of longevity, how can Public Policy ensure Longevity Equity?

A. Several elements of public policy emerge as paramount for societies that seek to increase the longevity of their population

equitably:

- Universal inoculation against infectious disease for the reduction of child mortality rates.
- Access to healthcare for curative measures
- Access to chronic disease prevention measures
- Focusing on bread-and-butter issues to equalize the social determinants of longevity, such as education, financial stability, food security, environmental quality, clean water, and inclusiveness as valued members of society.
- Access to proven scientific modalities to improve health in those with aging diseases, especially Cardiovascular Diseases and Cancer. These interventions account for an increase in lifespan of 5 years in the last 2 decades and 2 years in the previous 10 years.
- Access to new modalities for longevity, such as Longevity drugs and interventions, as they are proven effective in humans after appropriate trials.

Q. What allocation of longevity resources should be made to older people?

A. The factors that affect our longevity are not without budgetary cost. Policymakers have grappled with the finances of healthcare and Longevity Equity. Older adults are usually considered a more considerable "cost," draining limited healthcare resources, especially regarding the cost of long-term care. Given costs and the systemic ageism in many cultures, the continuing danger is that older people will be short-changed and denied practical access to health care, disease prevention, and the opportunities for the elevated quality of life required for longevity.

We see this every day in age: discrimination in the workplace, continuing education, age-biased technology, lack of accessible transportation, and attitudes that make age the defining factor in how we are regarded in society.

Background: We now know that bread and butter issues, rather than genetics alone, are a significant longevity factor. In accessing the allocation of "Longevity Resources," equitable access must be available at any age. In a limited resource arena, how do we justify making Longevity Equity a human right for all, along with the right to traditional healthcare?

The answer comes from a review of the cost statistics. Spending on those social determinants that upgrade longevity measurably prevents disease and decline throughout the life continuum. Healthy longevity saves trillions of dollars worldwide and within countries.

Increased HALE saves on the expense of caregiving, a global problem. In addition, a long, health-filled life yields what has been called "The Longevity Dividend." Not just cutting healthcare costs but increasing the GNP of long-lived nations. To incentivize Longevity Equity, we must ask the correct question. The question is not: how shall we quantify the cost of Longevity Equity? But how shall we quantify the gain?

Longevity Equity may come down to a bookkeeping measure.

Look at the overall budget for social spending and make budgetary considerations equal for all ages. Do not allocate longevity funding solely from a healthcare budget. Then, we will measure the cost against the Longevity Divided created when we spend and contribute longer to the economy and the healthcare savings when HALE is increased and the cost of chronic care is reduced. **Viewed in this way, Longevity Equity pays for itself!**

Discussion Points

In this new feature of our Newsletter, we encourage you to discuss these issues in your meetings and writings:

- the theme of elder abuse,
- the rights of older persons and longevity equity, and
- dementia as a stigmatized disease

By all means, let us know what caught your attention about these issues. Contact us **here.**

Thank you for reading this issue of our newsletter. We welcome any feedback! Feel free to drop us a line here.

You can find back issues of our newsletter on our website. And while you are there…pay your 2025 dues and be credited with paid membership through December 2025! Pay online or get directions for mailing a check. ngocoa-ny.org

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