IFMSA Policy Document
Healthy Ageing and Life Course

Proposed by Team of Officials
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Policy Statement

Introduction

As people age, various determinants that are changeable throughout the life course, continue impacting their health and wellbeing. Such impacts can be detrimental and lead to a major reduction in the quality of life of those affected. Therefore Healthy Ageing, which is defined as the process of developing and maintaining the functional ability that enables wellbeing in older age, is an imperative global health priority that ensures ageing does not hinder populations from leading a healthy life course.

IFMSA position

The IFMSA firmly believes in the utmost importance of healthy ageing due to the utmost importance of maintaining the physical and mental health of the ageing populations and effectively addressing the diverse determinants impacting their health and wellbeing. The IFMSA affirms the urgent need for an interdisciplinary approach led by all key stakeholders to ensure that healthy ageing is achieved by adopting targeted interventions that address the vulnerabilities and challenges the ageing population is facing.

Call to Action

- **Governments to:**
  - Create age-friendly environments by combating ageism, enabling autonomy and supporting healthy ageing and wellbeing through a legislative environment with strategies such as providing social support for older adults, providing security and freedom and providing adequate housing through supportive housing policies;
  - Design and implement policies that ensure seniors equitably access healthcare services, including those with intellectual disabilities, by ensuring access to Universal Healthcare Coverage for short and long-term services and integration in primary healthcare;
  - Facilitate interdisciplinary collaborations to address the needs of the geriatric population in a holistic and all-encompassing manner;
  - Integrate the priorities set by the WHO Decade for Healthy Ageing in national policies;
  - Improve measurement, monitoring and understanding of ageing issues through focused research and data collection with meaningful participation of the ageing populations;
  - Address healthcare worker shortages in order for an appropriate human resource to respond to the growing ageing population and provide targeted education, training and support;
  - Ensure equitable financial treatment of geriatrics and gerontology professionals, including salaries comparable to other healthcare professionals;
  - Address ageing elders' mental health issues, through promotion and prevention strategies, in national health planning and policies and encourage seniors to participate in their communities;
  - Implement elder abuse prevention strategies such as public and professional awareness campaigns, screening of potential victims and abusers, caregiver support interventions, school-based intergenerational programmes, etc.

- **World Health Organization, United Nations and International Agencies to:**
  - Collaborate with national governments and support local communities to spread awareness about healthy ageing, integrate the life course approach in health policies and advocate for the implementation of the indicators of the Decade of Healthy Ageing;
  - Formulate evidence and data collection on ageing-related issues and use such data to ensure adequate representation of ageing populations in health policies;

- o Establish toolkits, guidelines and protocols aimed at the ageing populations, especially during health emergencies such as COVID-19.

- **Healthcare facilities, Institutions and Universities to:**
    - o Incorporate geriatrics training and palliative care, in medical curricula, including the health specificities of vulnerable groups within ageing populations, such as seniors with intellectual disabilities and LGBTQ seniors, including training on discrimination, obstacles to healthcare access, and adequate interaction with patients, capacitating them of providing appropriate care to the entire geriatric population;
    - o Encourage and support research into the health of the geriatric population and emphasize the importance of including elderly populations in health-related research and data collection;
    - o Promote the integration of healthy ageing and the life course approach in national, regional and local public health strategies;
    - o Include more geriatric practitioners in decision-making and representative bodies to increase structural respect for workers in the field;
    - o Emphasize the importance of prioritizing and diversifying healthcare services with related specialties in aiding the older population at times of humanitarian emergencies;
    - o Establish rehabilitative programs directed at the older population following humanitarian emergencies for their healthy reintegration into the society;
    - o Develop age-friendly services and settings including the provision of comprehensive mental health care and supportive environments to seniors;

- **Long-Term and Residential Care Institutions and Nursing Homes to:**
    - o Use qualitative assurance audit tools to ensure that the quality of the facilities and the provided care;
    - o Establish policies that ensure each person benefiting from their services is being treated with dignity and personal respect, including being valued as an individual with physical and emotional needs which should be met;
    - o Ensure regular professional psychological support to residents, including those who are most vulnerable to social exclusion, such as seniors with intellectual disabilities and LGBTQ seniors;
    - o Develop innovative services and settings to connect residents with their families when in-person visits are not possible for the foreseeable future;
    - o Educate staff to be more vigilant and identify potential negative effects of humanitarian emergencies on residents, such as subtle signs of anxiety, PTSD and depression.

- **Health Workforce and Healthcare Professionals to:**
    - o Provide health related information in a language, format and technical level that is understandable to elderly patients;
    - o Adopt a life course approach to address the special needs of the ageing populations with multiple chronic illnesses, in order to avoid unnecessary polypharmacy and interventions;
    - o Address ageing populations' mental health issues, particularly under-diagnosis of mental illness, such as depression;
    - o Build capacity on caregivers about the health status and the needs of older populations to ensure an healthy ageing and better health outcomes;

- **IFMSA National Member Organisations (NMOs) to:**
    - o Empower medical students to advocate for healthy life course approach and ageing issues, and palliative care among key stakeholders including governments, organizations and the public;
    - o Advocate for appropriate needs-based geriatric education for medical students, residents and other health personnel;

Position Paper

Background Information

The world population has been growing rapidly in the past decades and is expected to exceed 9 billion people by 2050. [1] However, not only the population as a whole has been increasing, but the increase of the population aged 65 and over is relatively growing faster than all other population groups. By 2050, 1 in 6 individuals worldwide will be over age 65, compared to only one in 11 in 2019. [2]

With the increasing ageing population worldwide, the demand for health care will also increase. [3] This requires necessary action, in order to maintain the sustainability of global health care systems.

Decade of Healthy Ageing

As a result of the unprecedented increase in pace the populations worldwide are ageing at, the importance of focusing on healthy ageing from all perspectives arose. Thus, the Decade of Healthy Ageing (2021-2030) was proposed as a tool to bring all key stakeholders together. This multisectoral approach aims to improve the lives of ageing populations and their families as well as help develop the communities they are part of. The decade was proposed in the 73rd World Health Assembly as a result of the recommendation made by the 146th World Health Organization Executive Board Meeting. Following that, the proposal was adopted by the United Nations General Assembly in December 2020, highlighting the urgent need to direct more efforts towards healthy ageing. [4]

From active ageing to healthy ageing

In 2002, the WHO had published the policy framework on active ageing. Active ageing is defined by the WHO as "the process of optimizing opportunities for health, participation and security so as to reinforce the quality of life as people age." [5] Active ageing was replaced by healthy ageing in the WHO focus for ageing in the period 2015-2030. Healthy ageing focuses on the health of the ageing population with an emphasis on wellbeing rather than quality of life, as it is defined as the process of developing and maintaining the functional ability that allows wellbeing in older age.[6]

Discussion

Spheres of Health in Ageing Populations (NISSRINE)

Physical Health in Ageing Populations

In later life, many biological changes occur and lead to a gradual decrease in physical and mental capacity and therefore a growing risk of disease. However, the changes are only loosely associated with age. They are neither linear nor consistent. There are common morbidities associated with ageing and those "include hearing loss, cataracts and refractive errors, back and neck pain, osteoarthritis, chronic obstructive pulmonary disease and diabetes". [7] Another characteristic increased health risk of seniors is the experience of multiple diseases at once.

Furthermore, later life is characterized by the emergence of many complex health states that do not fit into specific disease categories. These are called geriatric syndromes. These syndromes are often a result of multifactorial risks and include frailty, delirium, falls, urinary incontinence and pressure ulcers. Geriatric syndromes have substantial implications for functionality and research suggests that, compared to the presence or number of specific diseases, they are better predictors of death. Nevertheless, countries that have not yet developed geriatric medicine overlook those syndromes in their healthcare system and research. [7]

Mental Health in Ageing Populations

Mental health problems are common among older adults. In fact, at least one in four seniors experiences some mental disorder and the highest suicide rate of any age group has been observed in people aged 85 and older. Moreover, the absolute number of elders with mental disorders is expected to double by 2030 due to the demography shift. Yet, there exists a treatment gap. The latter is the phenomenon in which two-thirds of seniors with mental health problems do not receive the treatment needed for their healing. [8]

Multiple risk factors are important determinants for mental health. At any point in life, many life stressors may be precursors to mental health issues. Older people may experience these, but have additional stressors that are more common in later life, such as those associated with significant ongoing loss in capacities. As a matter of fact, physical health impacts greatly mental health and the opposite is true as well. Reduced mobility, chronic pain, frailty and other health problems that may require long-term care have an impact on mental health. Additionally, other later life determinants include a drop in socioeconomic status, engendered by retirement, and the increased chance to experience bereavement. In addition, substance use problems affect almost 1% of adults above 60 years of age. Substance abuse problems among the elderly are often misdiagnosed or overlooked. [9]

They are also at an increased risk of facing loneliness (the feeling of being alone) and social isolation (the lack of social connections), because they are more likely to experience the following: living alone, loss of family or friends, chronic illness and hearing loss. It is strongly evidenced that social isolation greatly increases a person's risk of premature death from all causes and is linked with a 50% increased risk of dementia. Research also shows that loneliness or social isolation are associated with many other increased health risks. [10] Research suggests that supportive social connections and close personal relationships do help the seniors and that disrupted personal ties and loneliness make them suffer more. [8]

Consequently, the precedent stressors can result in psychological distress in seniors. The most prevalent disorder is depression, but other common problems include isolation, dementia, affective and anxiety disorders, sleep and behavioral disorders, psychosis, and cognitive deterioration or confusion states as a result of physical disorders. Contrary to the popular belief, dementia is not a normal part of ageing, but it affects 50 million people worldwide and imposes significant physical, emotional and economic pressures on the families and carers. Lastly, when compared to those with chronic medical conditions such as lung disease, older people with depressive symptoms have poorer functioning. [8]

Life Course Approach

The life course approach is an approach of utmost importance when it comes to addressing healthy ageing. The approach tackles healthy ageing from a wider perspective from just being diseases-oriented. It addresses the healthy ageing based on the fact that individuals are affected throughout their life course by various determinants of health, of which some of them are protective factors and others are risk factors. It focuses on the settings, transitions and critical stages throughout the life course, that opens the space for interventions for better health for the ageing populations. [11]
The life course approach to health has been further developed and explained by the WHO conceptual framework. This framework shows that individual health outcomes across different life stages are based on intrinsic capacity, which is the collection of internal physical and mental capacities and functional ability, which is the collection of environmental and individual attributes that enable the individual to be or do what they have the reason to value. However, the functional ability is much wider than the intrinsic capacity because it covers the intrinsic capacity together with the surrounding environments and the interaction between the individual and these environments. Both intrinsic capacity and functional ability are ever-changing across different life stages, which explains the reasoning behind their inclusion in a framework that is explaining the life course approach and highlights the fact that interventions are possible, to improve the health of the populations as they age. [12]

The life course approach can also be further understood through several different related models, which explain how our health can be affected as we age. The critical period model is based on the concept that at certain periods of our life course, our biological structure can be affected by certain exposures that can have long-lasting effects on our health and can only be changed slightly by modifiers later on. This model has also been referred to as key social transitions due to the interactions between the biological and social factors which produce a social variation in our health. Another model is the pathway model, which according to its name, shows that a person is set on a pathway depending on an early exposure to advantage or disadvantage which leads one to get exposed to the etiologically important factor event later. This model highlights how timing is important in measuring disease risks in the context of the integration of biological and psychosocial factors. Another model is the accumulation model which suggests that accumulation of protective and/or risk factors can accumulate gradually throughout the life course, affecting health positively or negatively respectively. All these models emphasize the fact that people age and their life courses progress, many factors can interact in different ways resulting in a huge impact on their health. [13]

Determinants of Healthy Ageing

Healthy ageing can be determined by several surrounding factors that can influence the way in which we age and how our health can be impacted. These determinants can vary between culture, gender, health and social services system, behavioural and social determinants and many more. All these determinants can together affect the pathway of our healthy ageing. [14]

Culture is one of the most important determinants of healthy ageing. This arises from the fact that the culture is surrounding us all the time and consequently affecting all other determinants. In addition, gender is considered a lens through which the appropriateness of decisions and policy options are decided and further discussed how well they fit men and women depending on gender and cultural norms in the society. [14]

Health and social services systems involve the utilisation of available health care services and an experienced health workforce, both of which contribute significantly to health status. This can involve periodic medical checkup, screening for risk factors, appropriate treatment of ailment and providing preventive counselling interventions. All these interventions take place on different levels of healthcare and contribute apparently to healthy ageing.[15]

Behavioural determinants can vary between protective and risk factors. They include but are not limited to smoking, alcohol consumption, physical activity, obesity and diet, etc. In a study conducted on behavioural determinants of healthy ageing, it was also found that associations exist between different behavioural determinants, e.g physical exercise and smoking, and can have a significant impact on the health of the ageing populations. It was also found that modifiable behavioural risk factors when controlled, such as smoking cessation, physical activity, weight maintenance within normal ranges and moderate alcohol consumption, all contribute to healthy ageing, which highlights the importance of inclusion of lifestyle modifications in healthy ageing policies while following a population-based, life course perspective. [16]

Social determinants can have a paramount influence on healthy ageing. They are defined as non-medical factors that affect health outcomes. "They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems influencing the conditions of daily life. These forces and systems include but are not limited to economic policies and systems, development agendas, social norms, social policies and political systems". [17] The determinants can include adequate access to food and nutrition, gainful employment and stable income, safe and affordable housing, safe neighborhoods, and reliable transportation. All these determinants can represent challenges to any individual, but can be a bigger and more impactful challenge as populations age. That is why these determinants represent a major field for intervention on local, national and international community levels for the betterment of the health of the ageing populations. [18]

Vulnerabilities in Ageing Populations

Ageing in Vulnerable Populations

Seniors with intellectual disabilities

The United Nations Convention on the Rights of Persons with Disabilities, ratified or acceded by 164 state parties, recognizes that "persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the idea of disability". [19] However, there is significant evidence to support the conclusion that this goal has unfortunately not been completely reached to date. Increased longevity in populations with intellectual disabilities thanks to healthcare advances and other factors has resulted, in recent decades, in a larger proportion of seniors in this population. [20] [21] This means that healthcare systems must now adjust to this increased demand, an adjustment that entails adaptation to the specific needs of seniors with intellectual disabilities. Experts have been calling upon these kinds of adjustments for decades. [22] [23] [24]

For example, an issue central to healthy ageing in populations with intellectual disabilities is the transition from in-home intergenerational care (i.e. people receiving care from their parents, as is common in younger populations with intellectual disabilities), to other sources of support such as group homes. This process can be problematic if not properly structured by mechanisms and guidance in government policy. Even in countries where public policy addresses the importance of providing appropriate healthcare to ageing populations with intellectual disabilities, these policies can often be vague and omit concrete paths of action. [22]

In the absence of such governmental and community strategies, seniors with intellectual disabilities can find themselves sometimes in the best of cases receiving inadequate care in nursing facilities or care homes structured to provide health and living services to the general senior population. [25] [26] [27] [28] This is just one example illustrating that seniors with intellectual disabilities face specific vulnerabilities when interacting with health systems that can impede their right to healthy ageing.

LGBTQ Seniors

Another subpopulation of seniors that are confronted with unique vulnerabilities is the ageing LGBTQ community. According to a number of studies, this group is frequently excluded from gerontological practice and theory, resulting in their isolation and a troubling lack of adequate care. [29] [30] [31]

This isolation exists not only within the sphere of ageing populations (i.e. LGBTQ seniors not being included in considerations on the rights and needs of senior populations), but also within the sphere of LGBTQ populations (i.e. LGBTQ seniors not being included in considerations on the rights and needs of LGBTQ populations). Advocacy and advancements related to LGBTQ issues can generally be said to focus on youth and adult populations, with discussions of the place of seniors in problematic realities remaining minimal. [32]

A large body of evidence shows that discrimination of LGBTQ populations is present in senior healthcare, with obvious negative consequences on the wellbeing of this group, and that education of healthcare providers on this topic is important in order to combat this unequal experience in health. However, few advocacy and education efforts aimed at LGBTQ issues in healthcare consider LGBTQ senior-related care. This results in a sustained environment of discrimination in healthcare towards the ageing LGBTQ population despite possible advances for other members of this community. [33]

Other Vulnerabilities in Ageing Populations

Seniors, as a whole, face additional vulnerabilities in accessing adequate healthcare compared to other populations. One of these obstacles, that is often overlooked, is the exclusion of ageing populations in healthcare advancement efforts. According to the United Nations Department of Economic and Social

Affairs (UNDESA) programme on ageing, elderly populations are often insufficiently included in health-related research and data collection, especially in developing countries. For example, indicators widely used to measure population health (e.g.: HIV rates) can be less applicable to seniors, distorting their proportionate representation compared to younger groups. [34] In addition, ageing populations are often underrepresented in clinical trials, a reality that can negatively impact their receival of healthcare services. [35] [36]

Ageism and Abuse

The World Health Organization defines ageism as "the stereotyping and discrimination against individuals or groups on the idea of their age." Ageism can take many forms, including prejudicial attitudes, discriminatory practices, or institutional policies and practices that perpetuate stereotypical beliefs." An example is the stereotyping of older adults as frail, weak and dependent. These discriminatory attitudes exist widely across societies and transcend ethnic groups. It has serious consequences as it legitimizes and sustains inequalities between age groups. This impacts negatively seniors and society at large for instance by being a barrier to the development of good policies. [37]

Ageism can be experienced by the elderly themselves, which has multiple harmful effects on their health. A research by Levy et al. shows that elders with negative attitudes about ageing may reduce the length of their life by 7.5 years compared to those with positive attitudes about ageing. [38] Negative ageist attitudes have been shown to be precursors to cardiovascular stress, lowered levels of self-efficacy and decreased productivity. These attitudes do exist everywhere and are paradoxically widely present within the health and social care settings. When ageism is socially rooted and inherent, it can become self-fulfilling. It does so by promoting in older people stereotypes of social isolation, physical and cognitive decline, lack of physical activity and economic burden. [37]

These negative attitudes may be contributing to the fact that, in community settings, around 1 in 6 older people of 60 years and older experienced some form of abuse in the past year. The World Health Organization defines elder abuse as "a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person." These sorts range from physical, sexual, psychological, and emotional abuse to financial and material abuse, abandonment, neglect and serious loss of dignity and respect. The consequences are severe as it can lead to serious physical injuries and long-term psychological consequences, of which the consequences on older adults are especially serious and the recovery longer. [39] A 13-year follow-up study found that seniors who are victims of abuse are twice more likely to die prematurely than those who are not victims. [40]

Good evidence-based on self-report by older adults suggests that the rates of abuse are much higher in institutions settings, such as hospitals, nursing homes and other long-term care facilities. Elder abuse in institutional may include depriving patients from dignity (e.g. by leaving them in soiled clothes), physically restraining them, intentionally providing insufficient care, depriving them from choice over their daily affairs, overmedication or undermedication, etc. Many risk factors exist such as poor physical and mental health, shared living situation, an abuser's dependency on the older person (often financial), an abuser's mental disorders and substance abuse, etc. Seniors abuse by caregivers does exist and an important risk factor for the latter is the social isolation of caregivers and older persons as well as a continuing lack of social support. [39]

Health Systems for Ageing Populations

Service Delivery

The interactions of health systems with ageing populations must take into account the specificities of this group in order to ensure adequate delivery of services. Among these, reduced mobility in seniors can have a significant impact on the quality of delivery.

Reduced mobility in ageing groups can reduce accessibility to healthcare services due to physical difficulties that come with commuting to facilities. [41] A general downward tendency for trip-making in seniors can thus have a significant impact especially on interactions with healthcare institutions, as these interactions are currently structured around direct contact with healthcare professionals in specific geographical locations, the distribution of which cannot easily take into consideration senior mobility behaviour, which can vary significantly and is therefore difficult to model. [42]

A possible solution that can serve to improve the delivery of health services to ageing populations is the use of telemedicine. The aforementioned vulnerabilities of this group put them in a position to benefit from a health system that facilitates remote and in-home access to services. [43] [44]

Health Workforce

A considerable component of adequate health systems for ageing populations is a sufficient geriatrics and gerontology health workforce. Unfortunately, multiple studies warn of a current and future shortage in this workforce. This shortage is present across countries as well as health disciplines central to elderly care, including medicine and nursing. [45] [46] [47] [48]

There are several contributing factors to this issue. Notably, there is a noticeable variability in geriatrics education that negatively impacts the number of qualified health professionals able to provide adequate care to seniors. [49] [50] The origin of a lack of healthcare workers in geriatrics also seems to be linked to an image of the field that persists among health trainees, resulting in a low popularity of this discipline. [51] It can easily be postulated that this effect is at least partly induced by the social and economic treatment of geriatrics and gerontology professionals, characterized by insufficient structural respect and low salaries. [52]

Within ageing-related healthcare, palliative care also faces additional specific obstacles in its health workforce. This field, centred on the quality of life of patients who are severely ill, is often misunderstood and overlooked, whether by governmental actors, patients, or health workers themselves. This is linked to a lack of policies ensuring access to palliative care, limited public awareness of what palliative care is, and inadequate education of healthcare workers on the subject. This general neglect of palliative care can be said to be both a consequence and a cause of the current workforce shortage in the field, resulting in insufficient access to this form of healthcare. [53] [54]

Health Information Systems

Health information systems are an important building block of health systems. However it has also got its challenges and issues that may influence its efficiency. One example can be derived from a study conducted in Iran, which found that the health information system for the elderly was present. However, some issues were identified, such as manual documentation, analysis and reporting of data, in addition to the fact that the data flow was not automated. This resulted in the delayed provision of information to the decision-makers. This problem highlighted the fact that the increasing change and development of health management systems, in addition to the increase in ageing populations, require a more developed infrastructure with the prioritization of the development of an efficient health information system for the elderly. [55]

Additionally, health information should be of easy access and use by individuals to enable them to meet the needs and support patients and families for ageing. Unfortunately, it is not that easy to use due to barriers that the elderly may experience which include but are not limited to issues with familiarity, willingness to ask for help, trust in the technology, privacy, and design challenges. These issues should all be addressed to increase acceptance and use of this information by the ageing populations. [56]

In conclusion, the number of older people is rising quickly due to increased social welfare, improved health and economic indices, and increased life expectancy. Taking into account the older adults' dominating social and health conditions, it is apparent that there is a constant need for a wide range of care and social services. This emphasizes the importance of having integrated and continuous care for older adults for the sake of better management, improved service delivery quality, optimal use of health

resources, and reduced cost and this can be done through the development of an integrated information system. [57]

Access to Essential Medicines

Access to essential medicines should always be ensured to be a right rather than a luxury. As each year, about 15 million people die from a NCD between the ages of 30 and 69 years, they need to ensure having regular access to their treatments, which needs to be of sufficient quality, as interruptions in daily treatment can lead to severe complications and, ultimately, death. [58] In addition, older persons should be able to deal with disabilities and always be able to access the required aids for doing so, which include but are not limited to visual, hearing and mobility aids. [59]

Financing

The financing of healthcare is an essential component of health systems for the general population. This importance is increased when it comes to health systems for ageing populations due to the unique vulnerabilities that this group often faces.

Many ageing populations are more at risk of experiencing financial insecurity due to reduced savings and insufficient income. [60] [61] [62] This problematic reality is only further exacerbated by the financial burden frequently created by the significant healthcare needs of seniors. Though several countries provide healthcare coverage that protects ageing populations from this danger, internationally there remains a lack of adequate coverage. This underlines the urgent need for universal health coverage, the absence of which has exacerbated consequences in the elderly compared to the general population: though non-covered healthcare services can constitute a significant expenditure in non-senior groups, studies show that personal expenses related to health are higher in senior households and can become virtually untenable. [63] Additionally, even countries that recognize the increased healthcare needs of seniors and thus offer certain coverage can often overlook the financial burden of long-term care, focusing only on acute health services. [64] [65] Due to this increased vulnerability in the elderly, financing of healthcare constitutes a central aspect of ensuring the viability of health systems for this population, and seniors stand to greatly benefit from adequate policies in this area. [66]

Leadership/Governance

All the previously mentioned building blocks for health systems can be effectively achieved by efficient health governance. Governance in health refers to a wide range of functions related to steering and rule-making implemented by governments and decision-makers as they work towards achieving national health policy objectives that are needed to achieve universal health coverage. [67] This requires collaboration between the state in the form of the governmental organizations and agencies, public and private health service providers, in addition to the citizens themselves, which, in our case, would include the ageing populations, who become service users when they interact with the healthcare providers. [68]

Healthy Ageing in Health and Humanitarian Emergencies

Procedural planning and established guidelines to follow at times of crisis tend to address the general population, disregarding the actual physical and socioeconomic conditions of the elderly. This results in a miscalculation of their actual capacity of action at times of emergencies, proving too generalized guidelines to be inefficient with below expectation outcomes and leaving more of the older population behind without assistance compared to the younger. Lack of data specific to the elderly results in the failure to determine their priorities, take related precautions and incorporate these factors into standardized courses of action for times of emergencies, which further increases their susceptibility to harm at these times. [69]

The elderly population is less likely to flee their homes at times that require so, due to cognitive and physical obstacles presented with older age. Especially the portion that is normally assisted by formal or informal caretakers will thus require special support and protection at such times, since they are more prone to abrupt abandonment and/or exploitation by caregivers and acquaintances at times of and following emergencies. It is vital to address the roles of caretakers, nursing home personnel and any other assistance provider to the housebound. [70]

Existing measures of crisis management also fail to address the special needs of the elderly including increased physical sensitivities towards environmental extremities; specific nutritional, shelter related, medicational and treatment needs as well as a higher disposition towards chronic conditions at times of stress, which is itself a major factor contributing to the progression of such conditions. [71] [72] [73]

The COVID-19 Pandemic

Statistical analysis and research show the most dire results of the present pandemic are exhibited in older age groups. When compared with the control group of ages 18-29; mortality is 90 times more likely for people aged between 65-74, and this rate increases up to 630 fold for the population aged above 85. [74] The immune system weakens with age - older people thus appear less likely to repel infection, whereas the tendency of additional self-harming anti-inflammatory responses against the virus continues with increased production of cytokines and inflammatory mediators in infected individuals. [75] Significant evidence shows that the progression of the viral infection is supported by the presence of additional chronic conditions, in which aging proved to be a major risk factor of, given that the people aged above 65 are the major constituents of those suffering from one or more chronic conditions. [76]

Increased needs of hospitalization and ICU during the pandemic exhaust availability of resources, calling a need for revision of expenditure partitioning that will be in the best benefit the majority of the population that requires it. [77]

Relief and rehabilitation programs directed at reorienting people to their daily lives become a secondary concern and usually aren't as critically addressed as they should be. This situation is especially problematic for the elderly population as it requires rapid adaptation and responding to changing conditions, which upon failing to do so increases their levels of isolation and marginalization within the society. [78] Approach to the elderly through the COVID 19 pandemic has mostly been their complete shielding from the social environment and minimizing visits of the homebound individuals rather than increased precaution taking, only worsening this social aspect. [79]

SDGs and Healthy Ageing

According to the Decade of healthy ageing mentioned earlier in our position paper, several sustainable development goals (SDGs) have been found to be relevant to healthy ageing and bring to us a wider perspective of issues facing the ageing population and possible areas of intervention to ensure healthy ageing together with their indicators of success. [80] [81] [82] [83]

SDG 1: No Poverty

Examples of this SDG's indicators that are distinguishable by age include "1.3.1: Proportion of population covered by social protection "floors" or systems, by sex, distinguishing children, unemployed people, older people, people with disabilities, pregnant women, newborns, people with work injuries, the poor and the vulnerable, 1.4.1: Proportion of population living in households with access to basic services, distinguishing older people and 1.4.2 Proportion of total adult population with secure tenure rights to land, legally recognized documentation and who perceive their right to land as secure, by sex and type of tenure, also distinguishing older people." [83]

Poverty is directly linked with ageing since as people age, their ability to work for long hours or even work at all decreases, which may result in their retirement, which is directly proportional to a decrease in their income and in the absence of social protection system, income security can be insufficient to meet the needs of the ageing individual resulting in the detrimental impacts on the individuals. [84]

SDG 2: Zero Hunger

Examples of this SDG's indicators that are distinguishable by age include "2.1.2 Prevalence of moderate or severe food insecurity in the population, also distinguishing older people and 2.3.2 Average income of small-scale food producers, by sex and indigenous status, also distinguishing older people". [83]
Food insecurity is defined as a lack of sufficient affordable food that is required to lead a healthy and active life. Unfortunately, ageing populations worldwide are facing food security that reached its double values since the turn of the century. As ageing populations rise in number, challenges brought by food insecurity are expected to rise dramatically too. Food insecurity is an important contributor to the increase in comorbidities with an increase in the prevalence of chronic diseases, which highlights the importance of tackling this issue through SDG 2. [85]

SDG 3: Good Health and Wellbeing

Examples of this SDG's indicators that are distinguishable by age include "3.4.1: Mortality from cardiovascular disease, cancer, diabetes or chronic respiratory disease, including adults aged ≥ 70 years, 3.4.2: Mortality rate from suicide, by age and sex across the life-course and 3.8.2: Proportion of population with a large share of household expenditure or income on health, also distinguishing households with older people." [83]
According to the WHO, health is defined as the state of complete physical, mental and social well being and not just the absence of diseases or infirmity. [86] In addition, according to the universal declaration on human rights, it is mentioned in Article 25, that health is a right for everyone. [87] This explains the utmost importance of caring for the ageing population's health, which is described more in detail in the "Spheres of health" section in this document as older people contribute to society longer and have the right to access opportunities for good health at all life stages which include but not limited to, universal health coverage and integrated, people-centred, transforming health and social systems rather than diseases-based systems. [83]

SDG 4: Quality Education

Examples of this SDG's indicators that are distinguishable by age include "4.4.1: Proportion of young people and adults skilled in information and communications technology, by type of skill, also distinguishing older people and 4.6.1: Proportion of population in each age group who have achieved at least a fixed level of functional literacy and numeracy, by sex." [83]
Quality education, as mentioned in the decade proposal, requires skills-based training, literacy, in addition to barrier-free participation, including in digital skills. This will allow life-long learning that will enable older individuals to do what they value, preserve their purpose, identity and independence and be able to make their own decisions. [83]

SDG 5: Gender Equality

Examples of this SDG's indicators that are distinguishable by age include "5.2.1: Proportion of women and girls aged ≥ 15 years who have ever had a partner who has been subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age, 5.2.2: Proportion of women and girls aged ≥ 15 years who have been subjected to sexual violence by people other than an intimate partner in the previous 12 months, by age and place and 5.4.1: Proportion of time spent in unpaid domestic and care work, by sex, age and location, as a basis for the provision of public services, infrastructure and social protection policies." [83]

Gender gaps in many aspects including but not limited to care, employment, pension and earnings, are considered an apparent issue in our communities especially in older age, thereby increasing the risk of women being disproportionately disadvantaged by the results of population ageing, facing double and triple shifts of paid, domestic and care work at the detriment of their own health, earnings and savings which can increase the accumulated risk of poverty, social isolation and unmet care needs in their own advanced age. This arises from the fact that population ageing increases the strain put on resources that are responsible for enabling social security and the problem lies in the differences in the access of resources between men and women and unfortunately social protection systems do not address these differences. [88]

SDG 8: Decent Work and Economic Growth

Examples of this SDG's indicators that are distinguishable by age include "8.5.1: Average hourly earnings of female and male employees, by occupation, age and disability status, 8.5.2: Unemployment rate, by sex, age and disability status and 8.10.2: Proportion of adults ≥ 15 years with an account at a bank or other financial organization or with a mobile money-service provider." [83]

In regards to economic development, older people are able to contribute significantly to the economy through their participation in the formal or informal workforce (often beyond retirement age), taxes and consumption, and transfers of assets and resources to their families and communities, in addition to their broader retention in the workforce (among those who wish or need to continue working) has the potential to enhance labour productivity. Today more older people are contributing to an entrepreneurial ecosystem, while embracing new technologies. Moreover, older persons, particularly older women, are playing an important role in providing unpaid care for spouses, grandchildren and other relatives, including those with disabilities.[89] All these factors explain the need for job opportunities and decent work conditions for the working populations as their income and access to financial services will contribute to access to health services and products and reduce the risk of catastrophic expenditure. [83]

SDG 9: Industry, Innovation and Infrastructure

An example of this SDG's indicators that are distinguishable by age includes "9.1.1: Proportion of rural population who live within 2 km of an all-season road, also distinguishing older people." [83]
According to the decade of healthy ageing, it is emphasized the need for appropriate infrastructure for healthy ageing which requires affordable, age-inclusive access to the Internet; research and evidence-based interventions that can aid in making older people visible with the aid of age-disaggregated data and analysis; new technologies and eHealth. [83]

SDG 10. Reduce inequalities

Examples of this SDG's indicators that are distinguishable by age include "10.2.1: Proportion of people living at < 50% of median income, by sex, age, also distinguishing older people and people with disabilities and 10.3.1: Proportion of population who reported personal discrimination or harassment in the previous 12 months on the basis of grounds of discrimination (age) that are prohibited under international human rights law." [83]
The majority of diversity between elderly people springs from the physical and social environments that they live in. The effect of the environment on the individual differs depending on individual differences, such as ethnicity, educational level or underlying medical conditions. This altogether could lead to unequal access to necessary services or support. When tackling the issue of healthy ageing, it is essential to consider inequalities within the geriatric population when developing policies for all. [80]

SDG 11. Safe, inclusive and sustainable cities and communities

Examples of this SDG's indicators that are distinguishable by age include "11.2.1: Proportion of population that has convenient access to public transport, by sex, age and disability status, also distinguishing older people, 11.3.2: Proportion of cities with direct, regular, democratic participation of civil society in urban planning and management, also including older people or their representatives, 11.7.1: Average proportion of the built-up area of cities that is for public use, by sex, age (including older people) and people with disabilities, 11.7.2. Proportion of persons who were victims of physical or sexual harassment in the previous 12 months, by sex, age, disability status and place of occurrence, in the previous 12 months." [83]

SDG 11 addresses the need for safe, inclusive and sustainable cities and communities. [90] As of 2018, 55% of the world's population lives in an urban area and this number is only projected to increase to 65% by 2050. [91] In addition, elderly people are also increasingly moving to cities. The proportion of older people in urban communities in developing countries is projected to multiply 16 times from about 56 million in 1998 to over 908 million in 2050. The need for age-friendly cities across all sectors is thus bigger than ever. Cities that are sustainable and accessible for all have to respond to the needs of the elderly and promote the inclusion of the geriatric population in their local communities. [92]

SDG 16. Peace, justice and strong institutions

Examples of this SDG's indicators that are distinguishable by age include "16.1.3: Proportion of population subjected to physical, psychological or sexual violence in the previous 12 months, including older people, 16.1.4: Proportion of population that feels safe walking alone in the area in which they live, including older people and 16.7.1: Proportion of population who consider decision-making to be inclusive and responsive, by sex, age, disability status and population group, distinguishing older people." [83]

Promoting just, peaceful and inclusive societies for sustainable development is relevant to healthy ageing. Widespread stereotypes of frail and dependent elderly people limit participation and appreciation of the older population in our society. Ageism takes on many forms and affects the physical and social health of the elderly through several mechanisms. It prevents institutions from creating just policies that address the needs of the entire population. To ensure that our societies are just and effective on all levels, it is necessary to tackle ageism and contribute to the empowerment of the geriatric population. [80]

SDG 17. Partnerships for the goals

Examples of this SDG's indicators that are distinguishable by age include "17.8.1: Proportion of individuals using the Internet (disaggregated by age), 17.16: Enhance the global partnership for sustainable development and 17.17: Encourage effective partnerships are most applicable to ageing." [83] Partnerships are relevant as healthy ageing can not be achieved if tackled from one perspective only. It requires interdisciplinary collaboration to create policies across all sectors, on all levels, in order to achieve healthy ageing in light of all other 16 SDGs. [83]

Education in Healthy Ageing

As virtually all countries will face a demographic shift as their populations' age, there lies an opportunity for a change towards medical education that includes appropriate training in geriatrics and healthy ageing. Given the extent of ageing within the population, the challenge lies in the suitable training for all medical professionals as all physicians will work with older patients, and such training must not be limited only to geriatric specialists. [93]

The geriatric patient more than often presents with co-morbidities, polypharmacy and bodily discomfort. The care for geriatric patients certainly necessitates an interdisciplinary strategy to be implemented in medical schools curricula. [94]

It is evident that geriatric education in medical schools worldwide is currently insufficient to meet the needs of a growing geriatric population. [95] In addition, a study by Drickamer et al., assessing perceived needs for geriatrics education under medical students, residents and faculty members, has shown special focus areas for geriatric training. These training gaps could be found in the areas of (1) recognizing and addressing the complex, multifactorial nature of illness in the elderly; (2) setting priorities and goals for preparation and intervention; (3) communication with relatives and with patients with cognitive disorders; (4) assessment of an elderly patient before discharge from the hospital and the services at different out-hospital care sites. The respondents in this study reported feeling overwhelmed by complex patients and the accompanying complex social situations while acknowledging the different methods needed to connect with and care for older patients. [96]

A proper curriculum should educate students in the differing physiology and anatomy of patients, such as the changes in pharmacodynamics and pharmacokinetics and what its consequences on prescription. [97] It has been shown that among seniors with the mean age of 76.9 years (25.4% male), 40.6% used multiple drugs and 35.6% had polypharmacy. Of these seniors, about 57% had contraindicated drug combinations, this implies the widespread ill-preparedness of physicians to combat with an appropriate therapeutic response to the intricacy of ageing and the complications that come with it. [98]

Furthermore, Medical pedagogy in an indirect way predispose to ageism by focusing on textbook definitions of pathologies, that mostly allude to singular definitions of disease and in return cause a fair deal of frustration among medical trainees when the time comes for them to diagnose highly complex cases in the older population, thus predisposing to ambiguous terminologies to describe the frail state of most older patients, such as ''acopia''. [99]

Palliative care is the natural path that goes hand in hand with the aforementioned strategies that benefit healthy ageing, it is a primal aspect that should be interwoven into medical training, as palliative care is an approach directed at bettering the life expectancy and quality, but also managing any complication and suffering among complex health cases among people. The need for such a philosophy of care will increase as populations age and require a special set of skills that is specialised in mitigating these specific needs. [54]

Role of Youth in Healthy Ageing and Advocacy Efforts

With the physical advantages and passion that young age brings, youth are able to address a much larger audience to advocate comprehensively for the elderly. They are prominent ambassadors for the issue with a capacity to succeed in making a statement, interacting with the educational systems and curriculums due to their already existing involvement, finding sources and reaching out to related stakeholders, ability to keep up with the most accurate technologies and thus come up with efficient solution options; and formation of effective responses to issues identified as significant. [100]

Young persons take the leading role in fitting in with the rapidly changing conditions of modern life and technology. Developments that proceed with this rate require advanced adaptation skills, and thus the generation that grew with these conditions are best qualified to lead, teach and encourage this adaptation process. As birth rates drop and lifespan continues to increase globally at different levels, a global human community with a more even age distribution is destined. [101] This situation further underlines the existence and importance of the older population and a need to incorporate them into processes of everyday life.

The younger population aims to keep the age gap to a minimum. Sustainable interaction and experience exchange between the younger population and the old provide a great chance to integrate them into

the society and to keep it a whole, as well as creating a mutually beneficial network of information flow. Keeping this in mind, it is again the role of the proactive youth to voice the needs, ideas, visions and questions of those who are relatively less able to do so. This will further raise awareness in the general population and thus have the desired impact. By attaining this, the spontaneous blending of all age groups into the society and decision-making processes will likely occur, allowing the older population to express themselves more, make their challenges and inefficiencies regarding them more visible actively through the strengthened connections of all age groups within communities. [102]

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Bylaws Paragraphs concerning Policy

17.2 Definitions
a) Policy Statement: Short and concise document highlighting the position of IFMSA for specific field(s). A policy statement does not include background information, discussion related to the policy, a bibliography and neither does it quote facts and figures developed by outside sources. The maximum length of a policy statement is 2 pages, including introduction, IFMSA position and call to action.
b) Position Paper: A detailed document supporting the related policy statement that contains background information and discussion in order to provide a more complete understanding of the issues involved and the rationale behind the position(s) set forth. A position paper must cite outside sources and include a bibliography.
c) Policy commission: A policy commission is composed of three people, with 2 representatives of the NMOs and one Liaison Officer. The proposer of the draft is part of the policy commission and is responsible of appointing its members. The tasks of the policy commission are the following:
  a. They are responsible of the quality of the policy document with the approval of the proposal.
  b. Ensuring the content is based on global evidence.
  c. Collecting and incorporating NMO feedback after the call for input.
  d. Coordinating the discussion during the General Assembly.

Adoption of policies
17.3. A draft policy statement, position paper and the composition of the policy commission must be sent to the NMO mailing list by the proposer and in accordance with paragraph 9.4. Input from NMOs is to be collected between submission of the draft and submission to the General Secretariat.
17.4. The final policy statement and position paper are to be sent in accordance with paragraph 9.4, using the template provided in the call for proposals. The proposal must be co-submitted by two NMOs from different regions or the Team of Officials. A corrected version of this document may be submitted according to paragraph 9.5. Correction may not be used to add members to the policy commission.
17.5. Policy statements and position papers must be presented to NMOs during the first working day of the IFMSA General Assembly.
17.6. A motion to adopt the policy statements and position papers must be submitted the day before the relevant plenary by two NMOs from different regions or an IFMSA Official, the IFMSA Team of Officials or the IFMSA Executive Board. Adoption requires ⅔ majority.
17.7. Amendments may be sent to the proposer in accordance with Annex 1. Amendments made during a General Assemblies or after the deadline stipulated in Annex 1, shall be submitted to the Chair at the latest 23:59 observed in the timezone of the relevant General Assembly on the day before the scheduled start of the session in which the policy will be voted on. These amendments require ⅔ majority to pass.