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Will the SDGs and the UN Decade of Healthy Ageing leave older people behind?

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Abstract

Since the 1950s, multi-national institutions have taken a number of positions towards population ageing and later life. In 1994, the World Bank (WB) saw population ageing as a crisis that needed "averting". The United Nations (UN) approach evolved from the individualized, compassionate ageism of 1981 to a developmental, 'society for all ages', perspective in 2002. Yet the UN made comparatively little headway. In 2021 the UN launched its Decade of Healthy Ageing to support the 2030 Sustainable Development Agenda's 'leave no one behind' goal. The UN rightly sees ageing as a lifelong, societal and developmental process and strongly supported the evidence that unequal resource distribution is the main contributor to health inequalities across the life span. Despite this evidence, the focus is now on a bio-medical framing of impaired health and on a multi-stakeholder approach that emphasises the Silver Economy's economic potential. The first two years of the Decade saw significant efforts to generate private sector support. While the Decade of Healthy Ageing is still young, there is much good, harm, and missed opportunity that can happen in a decade, justifying early consideration of what the Silver Economy bio-medical approach will do for older people in Low and Middle Income Countries (LMICs).

Introduction

This article connects multi-lateral policy on older people to the international development agenda. It will examine key UN policies on ageing and older people (60+), none of which are legally binding as there is no convention on the rights of older people. It will explore the extent to which the international development agenda supports UN policy on older persons. Most UN institutions have undertaken research on population ageing, later life, and older persons, and

some have developed frameworks and networks to influence policy, for example the World Health Organization's (WHO) Age-Friendly Cities Framework. The shifting policy weight between and within multi-lateral institutions on population ageing, later life, and older persons reveals a significant historical trajectory. As one article cannot cover all this, the UN's two International Plans of Action on Ageing, the application of the International Covenant on Economic, Social, and Cultural Rights to older people, the WB's key policy intervention on old age pensions and the UN's Millennium Development Goals (MDGs) and Sustainable Development Goals (SDGs), are discussed here to reflect on the potentials of the UN's Decade of Healthy Ageing in relation to older people.

This article uses policy documents and the work of key policymakers on ageing and on development to understand policy evolution, including the investigation of WHO websites to understand the divergent approaches to health equity that are at play within the WHO. Where this turn to original sources is not possible, the article draws on reviews of UN and WB policymaking and the measurement of outcomes. This strategy acknowledges the conditions under which policies are produced, navigated and evaluated. An examination of UN resolutions and development goals reveals that policy construction is a negotiation that combines lofty goals with fudged targets and let-out clauses in order to secure policy phrasing that all Member States will endorse. For example, the United Nation states for its 2030 (SDG) Agenda, 'It is accepted by all countries and is applicable to all, taking into account different national realities, capacities and levels of development and respecting national policies and priorities' (UN General Assembly, 2015: Point 5). Between lofty ambition and let-out clauses, UN policies create a discursive context that legitimise action while allowing governments with other priorities to dissimulate outcomes. Multi-lateral policies on older people have had less success than the International Development Goals in raising global awareness, political accountability, improved metrics, and public pressure for change.

This article applies a critical age-focused lens. I argue that the shifting policy directions outlined below are underpinned by assumptions about age, later life

capacities and the economics of population ageing. Identifying ageism in policy and public discourse is central to achieving the Decade of Healthy Ageing's eradicating ageism objective and to leaving no one behind. While the focus is on the UN, the article points to the limitations of wider concepts of ageing that emphasise health care access over the social determinants of health. As will be seen, older people's health and wellbeing are tied to the extent to which their and their family's rights are upheld. In LMICs, the social determinants of health erodes older people's capacity to adequately support themselves as well as their support from wider family networks. The latter is undermined by the social gradient in morbidity and mortality that punches holes into family networks, raising the need for older people to work deep into later life both to support themselves and to help support their wider family through their paid and unpaid work.

Multilateral institutions, population ageing, and stereotypes

The UN has considered population ageing since the 1950s (United Nations, 1956). Due to the higher ratio of older persons to working-age persons and the earlier and more widespread retirement of workers in developed countries, population ageing was initially considered a developed country issue. By 1991 UN discourse had changed. The UN's Proclamation on Ageing warned that "population ageing in developing regions is proceeding much more rapidly than it occurred in the developed world" and that "a revolutionary change in the demographic structure of societies requires a fundamental change in the way in which societies organise their affairs" (United Nations, 1992). In 1994, the World Bank (WB) published "*Averting the Old Age Crisis*", an influential but controversial report. By 2030, 80% of the world's "old" would live in developing countries, with over half in Asia (World Bank, 1994). To protect "the old" and encourage growth, the WB proposed a three-pillar "old age" support system with a mandatory, privately managed savings pillar, a tax-financed pillar, and a voluntary, private-sector annuity pillar. The privately managed, defined contribution scheme was heavily criticised (Beattie and McGillivray, 1995), especially in developing and post-communist, transition economies (Orzag and

Stiglitz, 2001; Deacon et al, 1997). The UN's International Labour Office opposed it, favouring public pension schemes and social protection floors to stabilise economies during economic downturns (Heneghan and Orenstein, 2019). In the new millennium, the WB reviewed its policy, finding that the benefits of the multi-pillar reform had been overstated, criticising their insufficient focus on initial conditions, pension coverage, exorbitant fees, and low returns on assets in the face of market volatility (ibid).

The 2008 global economic crisis exposed the macro-economic shortcomings of the multi-pillar pension model, reversing the ILO's and WB's standing in social protection debates, eventually leading to a common language and apparent consensus on pension and social protection policies; demonstrating how divergent viewpoints can merge to produce ostensibly compatible goals.[i] The ILO developed the "social protection floor" concept in recognition that 80% of the world lacked adequate social protection (Reynaud, 2002). Addressing internal debates about pension coverage versus benefit reduction, the ILO policy supported universal minimums on income security and medical care, and beneficiary contributions to extend social protection beyond the minimum floor (Heneghan and Orenstein, 2019). It also allowed national governments to set lower minimum standards for a variety of nationally-defined floors, diluting social protection (Deacon, 2013). Social protection floors were incorporated into five of the 17 UN Sustainable Development Goals through the combined efforts of the ILO, UNDESA, UNICEF, WHO, and HelpAge International. The main revelation of the 2008 crisis and the need for social protection floors was that the private sector frequently leaves people behind, irrespective of how well or poorly the economy is doing.

Ageist stereotypes and flawed ideology underpinned the World Bank approach to population ageing. The UN noted that the male retirement rate in developed countries was nearly twice that of developing countries, where 78.5% of men aged 65 and older worked (United Nations, 1956). The UN’s failure to provide data on women's activity rates suggests an erroneous presumption of female dependence. The UN's figure of 40% of men aged 65+ still working in developed

countries is not explained by a socio-economic positioning that favours people in their own businesses, as the UN claimed at the time. Rather, it is the outcome of being mal-included in the labour market. Stigmatised workers, because of their class, their gender and ethnicity/'race', did not have the means to retire (Moen, 2016). The World Bank's 'apocalyptic demography' argument, that population ageing threatens the economy and public services (Gee, 2000), relied on inconsistent reasoning and a scatter-gun blame game. The World Bank put forward three incompatible arguments: the rising tide of older people threatens economic growth, economic growth erodes later life support, economic growth enables social provision.

While the WB's argument that economic growth is breaking down later life support suggests that older people are passive victims, the WB chose another ageist legitimation for its 'averting crisis' argument. The WB claims that "*frequently* perverse (redistribution) – for example from poor young families to comfortable retireees" (World Bank, 1994 pxiii, emphasis added) disadvantages the younger generation. This frequency is unproven and unlikely in LMICs with high informal employment and few retirees. The WB's lead economist, Estelle James, described pay-as-you-go pension systems (which pay current public pensions out of taxes) as increasing payroll taxes, tax evasion, unemployment, and the informal sector, which "hurts the economy, since people who work in the informal sector are often less productive" (James, 1995, p4-5). The WB claimed public pensions encourage early retirement and reduce savings. This contradicts what is known about labour market segmentation, especially in developing economies where 90% of workers are informal workers in both formal and informal sectors (Bonnet et al, 2019). Informal workers have no choice but to work low-paid, insecure, intermittent jobs due to growth patterns favouring "low productivity" workers who are foundational to low-investment/high-profit business models.[ii] Here, working conditions prevent retirement savings. Further, in LMICs, public sector workers, particularly women workers, can be subject to retirement ceilings that force them out of secure work before age 60 and into informal work if pensions are delayed or inadequate to meeting family responsibilities (Beedi, 2015).

The WB's inability to expand the pension market in low-income and insecure contexts raises questions about the Decade of Healthy Ageing and the private sector's "stakeholder" status. Can the private sector reconcile universal health coverage with profit? In light of livelihood insecurity and the need for social protection floors, is a lack of health care access the main issue in healthy ageing?

UN World Ageing Assemblies

World Assemblies on Ageing were held in Vienna, in 1982, and Madrid, in 2002. Both produced UN-approved International Plans of Action on Ageing. The Vienna International Plan of Action on Ageing (VIPAA) recommended policies addressing seven areas of concern for older people: health and nutrition, consumer protection, housing and environment, the family, social welfare, income security and employment, and education. It urged Member States to study the effects of development and ageing on each other in order to reduce the negative effects of development on older people and to maximise the benefits of ageing for development. The 1991 UN General Assembly Resolution 46/91 adopted the UN Principles for Older Persons in support of VIPAA principles, urging Member States to incorporate the principles of independence, participation, care, self-fulfillment, and dignity into their programmes for older persons. The Proclamation on Ageing encouraged Member States to view older persons as contributors to their societies and to develop initiatives to give older women "adequate support for their largely unrecognised contributions to the economy and to the well-being of society" (United Nations, 1992, 47/5, Annex 2h). This was the only mention of older person inequalities. Health care was left to government and non-governmental organisations, while "businesses" were to co-operate with local authorities to find new ways to keep families and communities age-integrated.

Seeking Member State approval, the UN fudged the International Covenant on Economic, Social, and Cultural Rights' application to older people (OHCHR, 1995). 'Insofar as respect for the rights of older persons requires special

measures to be taken, State parties are required by the Covenant to do so to the maximum of their available resources' (GC6, Clause 10), including providing social security for older people. The Covenant calls on Member States to end age discrimination and protect older people's economic, social, and cultural rights. GC6 requires States 'within the limits of available resources (to) provide non-contributory old-age benefits and other assistance for all older persons, who...are not entitled to an old-age pension or other social security benefit or assistance and have no other source of income' (ibid: Clause 30). No other source of income is ambiguous, allowing India to set its social pension criteria as anyone without income. "Habitual beggars" and anyone with a living adult son are excluded, irrespective of whether a son can support their parent or not. Article 10 of the Covenant requires 'State parties (to) make all necessary efforts to support, protect and strengthen the family and help it, in accordance with each society's system of cultural values, to respond to the needs of its dependent ageing members' (ibid: Clause 31). This allowed countries such as India to legislate filial support of older people under the guise of cultural values, again leaving unanswered the question of whether adult children have the resources to support their parents (Vera-Sanso, 2016).[iii] This type of legislation, combined with non-existent, inadequate or exclusionary social security policies and a harsh and ageist labour market, undermines Article 11 of the Covenant, which states: "Older persons should have access to adequate food, water, shelter, clothing and health care through the provision of income, family and community support and self-help" (OHCHR, 1995: Clause 32). The Covenant's remaining rights include rights to stay integrated in society and actively participating in policymaking that directly affects older people's well-being. Despite VIPAA's intended universal applicability, Member States with proportionally smaller older populations and limited resources followed other policy priorities (Sidorenko and Zaidi, 2018).

While VIPAA promoted older people as a deserving group through compassionate ageism, the Madrid International Plan of Action on Ageing (MIPAA) addressed developmental issues by positioning population and individual ageing within the international development agenda (Sidorenko and Walker, 2004). With "A Society for All Ages" MIPAA stressed equal treatment and

self-determination. It promoted intergenerational solidarity and the realisation of everyone's potential, unlike the World Bank's "*Averting the Age Old Crisis*", which was rooted in ageism and promoted intergenerational conflict. MIPAA focused on age-specific needs like pensions, health, and care services while age-mainstreaming all policy areas, including employment and education. MIPAA prioritised older people and development, active ageing, and supportive environments. The Madrid World Assembly addressed elder neglect, abuse, and violence in addition to VIPAA rights. MIPAA laid out an implementation strategy to mainstream age across international and national development agendas, requiring international cooperation while giving national governments the primary responsibility for implementation and urging national partnerships with civil society and the private sector. MIPAA identified the institutional infrastructure needed to support a "Society for All Ages". It called for the creation of agencies on ageing, older people associations, training and research on ageing, data collection on gender and age for policy planning and evaluation, independent monitoring of progress, and the mobilisation of resources to support and represent older people (Sidorenko and Walker, 2004).

UN reviews of VIPAA and MIPAA express disappointment. The UN's final VIPAA review found that despite the rapid growth of the global population aged over 60, Member State's response to this population shift had been minimal and implementation of VIPPA was modest (Sidorenko and Zaidi, 2018). The review found developing countries prioritising non-older population policy issues. This comes as no surprise when the UN's International Covenant on Economic, Social, and Cultural Rights states that "in so far as respect for the rights of older persons requires special measures to be taken, State parties are required by the Covenant to do so to the maximum of their available resources" (GC6). VIPAA was deemed as having "no convincing appeal to other stakeholders like NGOs, the private sector and the media" (Sidorenko and Zaidi, 2018:147). The UN Commission for Social Development's 2007 MIPAA+5 review revealed Member States' lack of commitment. Country reports had few policy implementation or funding plans, and many countries, including European ones, did not participate in MIPAA

reviews (HelpAge International, personal communication; Sidorenko and Zaidi, 2018).

MIPAA tried to improve VIPAA by encouraging stakeholder involvement with clear targets and implementation strategies, but a lack of political will hindered improvements in national capacity on ageing, rises in resource availability and the mainstreaming of age in development agendas, thwarting MIPAA. The bottom-up participatory review of MIPAA progress did not generate enough pressure for implementation (Sidorenko and Zaidi, 2018). Alexandre Sidorenko, former head of the UN Programme on Ageing, a severely under-resourced UN office (Sidorenko and Walker, 2004), and a number of governments in the UN Open-ended Working Group on Ageing, established in 2010, believe that until there is a legally binding UN Convention on the Rights of Older Persons, all UN strategies will only produce "uneven progress" which Sidorenko calls a euphemism for failure (Sidorenko, 2021; Sidorenko and Zaidi, 2018; HelpAge International, 2020).

MDGs and SDGs

The MDGs were created to achieve the 2000 UN Millennium Declaration. The latter required Member States to fight poverty, hunger, disease, illiteracy, environmental degradation, and gender discrimination. The Declaration reiterated the UN's view that development is about people, not economic growth *per se*. The Millennium Declaration (MD) targeted developing and transitional economies. 'Making the right to development a reality for everyone and freeing the entire human race from want' was the objective (United Nations, 2000: III.11). The signatories pledged to "create an environment at the national and global levels alike – which is conducive to development and to the elimination of poverty" (ibid). The UN, World Bank, and others created the MDGs in 2000, setting goals and targets with measurable indicators to promote MD objectives (Vandemoortele, 2011). The goals were: ending extreme poverty and hunger, reducing maternal and child mortality, combating HIV/AIDS, malaria, and other

diseases, ensuring environmental stability, and creating a global partnership for development.

Despite the evidence that inequity drives poverty, a depoliticized technical approach won out in the debate as to what is needed to eliminate poverty—economic growth, more aid, better governance, or equity (ibid; Saith, 2007). This was most evident in the WB's use of a money-metric, the International Poverty Line (IPL) of $1/day (revised to $1.90/day in 2015), regardless of local context and despite the general recognition that poverty is multi-dimensional. Money-metric classification hides poverty. Hickel (2016) describes how the IPL was manipulated to make WB policies, including structural adjustment policies, appear to be alleviating extreme poverty. Just as Sidorenko expressed a lack faith in UN assessments of MIPAA's achievements, the UN's MDG report has been questioned, particularly regarding the goals of halving poverty and the associated child mortality rates (Vandemoortle and Delamonica, 2010). Three years before the MDGs ended, the methodology for counting hunger was changed in order to reverse a shameful upward trend in global hunger (Hickel, 2016; Moore-Lappe et al, 2013). Philip Alston, the former UN Special Reporter on Extreme Poverty and Human Rights described the revisions as widely misunderstood, flawed and yielding a deceptively positive picture feeding an 'undue sense of satisfaction and a dangerous complacency with the status quo' (Alston, 2020). Not only is 'much of the touted decline due to rising incomes in a single country, China' (ibid), but revisions to the ILP set energy requirements to one based on the caloric intake adequate to the minimum needs of a sedentary lifestyle for over a year multiplied by the average height of the population (Hickel, 2016). The significance of the ILP formula cannot be understated. By ignoring the fact that resource poor people are engaged in physically depleting work, including the search for work, water and fuel and unpaid care work, and by disregarding the well-established health and height deficits that this engenders, the ILP formula embeds under-nutrition and population stunting into the development agenda.

The MDGs prioritised maternal health, child mortality, primary education, youth unemployment, gender equality, HIV/AIDs, malaria, and other contagious diseases over older people's rights. At the end of the MDG period, in 2015, the UN published *The Millennium Development Goals Report, 2015* (UN, 2015). A word search for older, later life, ageing/aging, and old age yielded no results on older people or population ageing. Not only did the MDGs fail to put older people's rights to development on the same footing as other people's rights, but they did nothing to support the developmental role of older people. This is despite the evidence that older people care for and work to support both the current and the next generation of workers and in so doing support the national economy. They do so to: enable women to work (Vera-Sanso, 2017; Vera-Sanso and Hlabana, 2023; Vullnetari, this volume), enable rural-urban migration (Mtshali, 2016), enable family-based South-North migration (Nguyen et al 2022) and enable the generation of foreign exchange via international labour migration in global care chains (Yarris, 2017). They address the impacts of HIV/AIDs on family demographies and children's survival (Oduaran and Oduaran, 2010; Vera-Sanso and Hlabana, 2023) and do so not only for their own families but as adopters/foster parents and community care providers (Hamunakwadi 2011). Yet due to ageist assumptions about what older people should be doing, rather than recognizing older people's right to and involvement in development, older people are largely invisible in development discourse and institutionally marginalised in national statistics. It is an ageist failure of the imagination that causes policymakers to overlook older people's role in development, poverty reduction, and education. The Millennium Declaration and MDGs' silence on older people's development and developmental role may have spurred MIPAA's 2002 developmental focus.

The UN's 2030 Sustainable Development Agenda, a stark contrast to the MDGs, was adopted in 2015. The MDGs targeted poverty in LMICs, but the SDGs required all countries to address all SDGs. The UN included marginalised groups in the SDGs' economic, environmental, and social goals (Sachs, 2012) and focused on goal and target clarity using a dashboard of measurements. The objective was to establish baselines for each country in relation to each SDG so

that each country could re-orient its policymaking towards the SDGs in which they were weakest (Schmidt-Traub et al., 2017). The SDGs are an urgent call to action for governments, organisations, institutions, NGOs, and businesses to improve the world and the planet. Its motto, "Leave no one behind," exceeds the MDGs' objective of reducing deprivation. Its first eight goals were framed in absolute terms, for example, Goal 1 "End poverty in all its forms everywhere" and Goal 3 "Ensure healthy lives and promote well-being for all at all ages". Yet the Target 3.4 only aims to "reduce by one third mortality from non-communicable diseases (NCDs) through prevention and treatment" to achieve Goal 3's objective of ensuring healthy lives and well-being for all ages. According to WHO, "Each year, more than 15 million people die from an NCD between the ages of 30 and 69 year; 85% of the "premature" deaths occur in low- and middle-income countries" (WHO, Global Health Observatory, undated). Lloyd-Sherlock et al (2015) warn against a target that labels deaths before 70 as "premature", thereby implying that people of age 70 have less of a right to life, dignity and health than do people aged 69 or under. Further, given the known social gradient in mortality (Marmot, 2005), this is an ageist discourse that obscures social inequities. While SDGs are an improvement over the MDGs in that they include a target on NCDs, the chosen target and its justification do not challenge biases against older people's access to health care; instead they could reinforce or exacerbate extant biases. They could reproduce the reallocation of resources *towards* SDG specified targets as happened with the MDGs (Fukuda-Parr and Yamin, 2013) and encourage the allocation of health resources towards younger people, as happened in several countries' roll-out of Covid-19 vaccines (Lloyd-Sherlock and Guntupalli, 2022).

The SDGs include older people in stereotypical and potentially harmful ways. In Goal 1 on eradicating extreme poverty, the only indicator to mention older people, is on social protection. Other targets, such as access to basic services and secure tenure and rights to land, do not. Goal 8 on employment and decent work mentions "young people and persons with disabilities," "child labour," and "migrant workers," but not older workers. This is despite the UN's long-standing awareness, that goes back to 1956, that in all economies and especially in

developing ones where pension value and coverage are low or non-existent, people work deep into later life. Goal 11 on inclusive cities and human settlements mentions older people, perhaps reflecting the WHO Global Network for Age-Friendly Cities and Communities' work, begun in 2006. Many goals are ambiguous in relation to older persons: Goal 5, on Gender Equality and Women's Empowerment, does not mention older women but does mention "women and girls," leaving the term "women" open to interpretation. In practice, policymaking and implementation differentiates between young, 'prime-age', and senior women. Target 5.4 recognises and values unpaid care and domestic work by using the indicator "proportion of time spent on unpaid domestic and care work, by sex, age and location". Will this target capture and address older women's unpaid work as well as that of children and reproductive-age women? While older women are more likely to be care-givers than receivers this is rarely evident in policy or research documents on families, poverty or care, reflecting an ageist bias. Most SDGs are relevant to older people's rights irrespective of whether older people are highlighted in targets. The question is whether the implementation process will improve or worsen older people's position by shifting resources to SDG-identified groups. This would be a retrograde step for older persons as improvements in earlier life circumstances are not necessarily carried into later life: age is a relational category that frequently divests persons of their rights as they move into what is socially defined as 'old' (Vera-Sanso, 2017).

Age-based discrimination intersects with lifelong stigmatisation on the basis of gender, class, racialization, caste, religion, ability/disability and economic marginalisation. The strong correlation between gender (in)equality, life expectancy and healthy life expectancy for both men and women at age 60, all of which are measures of development (Bennet and Zaidi, 2016), demonstrates the need for an intersectional, relational, life course approach to social development.

Silver Economy and the Decade for Healthy Ageing

For the SDGs' final decade to 2030 WHO launched the Decade for Healthy Ageing (DHA) in 2021. WHO frames the DHA as a rights-based response to population ageing. It defines healthy ageing as the maintenance of functional ageing as a route to wellbeing in later life. It describes the DHA as a 'global collaboration' that brings together governments, civil society, international agencies, professionals, academia, the media and the private sector to improve the lives of older people, their families and communities (WHO, 2020).

MIPAA and WHO's precursor to the DHA, the Active Ageing Framework (WHO, 2002), link the two UN policy areas examined in this article. While MIPAA focused on intergenerational solidarity, throughout the Framework WHO oscillates between a discourse of intergenerational solidarity, which it sees as both goal and characteristic of contemporaneous intergenerational relations, and an alarmist discourse of population ageing. The latter is framed in terms of costs of care and loss of workers that must be averted via active and healthy ageing. WHO's Active Ageing concept aligns with VIPAA's and MIPAA's individual rights discourse by stating that everyone has the right to participate in social, economic, cultural, spiritual, and civic affairs regardless of retirement, physical capacity, or care needs. The Framework's physical, mental, and well-being goals are accompanied by two policy objectives: "fewer premature deaths in the highly productive stages of life... (and) lower costs related to medical treatment and care services" (WHO, 2002:16). The Framework identifies socio-economic inequalities, including gender and age discrimination, as determinants of both healthy ageing and NCDs, the latter being the leading cause of LMIC deaths and morbidity after midlife. It cites socioeconomic status as the "origins of risk for chronic conditions, such as diabetes and heart disease, beginning in early childhood or even earlier" (WHO, 2002:16). In particular, maternal socio-economic status conditions fetal development, as opposed to merely adding to a genetic pre-disposition to chronic disease risk (Wu et al, 2004; Christian and Stewart, 2010). Yet the Framework downplays socio-economic determination. Instead, it emphasises lifelong self-care, supportive environments to encourage healthy "choices," and longer working lives to offset pensions, medical, and social care costs. The Framework holds governments, NGOs, and the private sector

"responsible for the formulation of ageing policies and programmes" (WHO, 2002: 5).

By 2016 WHO's health goals had narrowed. The 2016-2030 Global Strategy and Action Plan on Ageing and Health (GSAPAH) underpins the DHA. It promotes self-care, and supportive environments for older adults with significant capacity declines. Using the language of the capability approach the GSAPAH substitutes the VIPAA/MIPAA rights-based discourse with a compassionate ageism, providing 'comprehensive guidance to countries and development partners on how to foster the functional ability of older people to be and do what they value' (WHO, 2017: iv). The WHO Director-General said the Global Strategy would 'help countries ensure that Universal Health Coverage is inclusive of older adults' (WHO, 2017: v). This is a striking oxymoron that reflects institutional biases against investing in older people's health: coverage without older people is selective and restrictive, not universal. This disregard of older people's health *rights* is a consequence of the longstanding prioritisation of population control in development policy, and can still be seen in the MDGs' focus on maternal and child mortality and in national health surveys that focus on women's health up to an assumed menopause (age 49) (Vera-Sanso, 2022). The GSAPAH urged countries to commit to action, create age-friendly environments, align health systems to older population needs, create sustainable and equitable long-term care systems, improve data collection, and involve older people in decision-making. The GSAPAH notes that the

> "crucial consequence is that in older age the people with the greatest health needs tend to also be those with the least access to the resources that might help to meet them" (WHO, 2017:3).

It calls for policy to be "crafted in ways that overcome, rather than reinforce, these inequities" (ibid), but the GSAPAH's goal is to encourage self-care through healthy behaviours. Yet people suffering multiple deprivations are not in a position to make the choices that will most improve their health. For example, air pollution far outstrips individual healthy behaviours as a cause for NCD (Pruss-Ustun et al, 2019) and poor and working class people are more exposed to air pollution (O'Neill et al, 2003). Similarly, the inability to afford fruit and

vegetables is linked to diabetes, and childhood poverty affects adult onset diabetes even when economic status improves (Shaikh and Kumar, 2018).

The DHA has four action areas: age-friendly environments, integrated care, long-term care and combating ageism. WHO created the Healthy Ageing Collaborative, comprising intergovernmental organisations, NGOs, older people's associations and business associations, with the objective of securing "the rights of all older people everywhere to the enjoyment of the highest standard of health and (to) harness the social and economic opportunities that population ageing provides" (WHO, 2022). All four action areas generate private sector opportunities for products, services and anti-ageism training. By contrast to the WB's *Averting the Old Age Crisis* approach in which older people were positioned as a drain on the economy and a threat to younger generations, they are now seen as a source of economic growth and employment (Heinze and Naegele, 2009, Das et al, 2022).[iv] While the economic power of the resource-and-time-rich older consumer has been heralded for some time (Kohlbacher and Herstatt, 2008; Kresl and Ietri, 2010), now the focus is not just on the better off older consumer but on the way the private sector can assume the status of 'stake holder' and can 'partner' States in fulfilling their developmental and rights-upholding duties.

Population ageing is now seen as generating a Silver Economy, comprising people aged over 50. The European Commission predicted the European Silver Economy would reach Euro 5.7 trillion by 2025, making it the third largest economy after the USA and China (The European Commission, 2018: 9). The World Economic Forum (WEF), an organization representing the interests of the world's top transnational corporations and consultancy firms, calls the ageing population the "most formidable market opportunity of the 21st century " (2016:2). Health is cited as the first core area for investment, specifying 'medical and long-term care goods and services, including pharmaceuticals' (ibid: 2); 'returns on investment are expected to be significant for age related diseases… (and) markets for devices… are forecasted to grow significantly' (ibid: 8). It reports that several inter-governmental organisations have recognized that 'population ageing can be, given the right strategic framework, a supremely

powerful market driver' (ibid:3). By referencing the 2015 G20 Principles on Silver Economy and Active Ageing regarding 'the development of products and services devoted to the ageing society, including medical treatments, healthcare and long-term care' for developing and emerging economies, the WEF not only argues that population ageing can be a 'supremely powerful market driver' but makes that conditional on the 'right strategic framework'.

Global institutions and a private sector lobby group, the Global Coalition on Aging (GCA), are aligning "business strategies and *workforce policies* with ageing market opportunities" (Global Coalition on Aging, undated, emphasis added). The latter sees population ageing as an opportunity for economic growth and has been campaigning for that perspective since at least 2011. In 2019, the GCA worked with the OECD to organise an international conference of government and business leaders, the Helsinki Silver Economy Forum, in order to "elevate the understanding of the (predicted 2020) $15 trillion Silver Economy" (ibid). In 2020, the lobby-group addressed the UN World Summit on the Information Society. In 2022, the reach of the GCA was significantly expanded with the Second High-Level Silver Economy Forum, held in New York, Dublin and Geneva. Participants in this second Silver Economy Forum was attended by 'more than 600 global leaders at the forefront of the aging megatrend, including government officials and executives from the Global Fortune 500 companies' (OECD-forum.org, undated).

The World Bank (Das et al, 2022:52) considers that "Innovation and entrepreneurship related to the 'silver economy' are also expected to happen predominantly in the technology sector", particularly in terms of artificial intelligence, telemedicine and robotics. An internet search of reports on the Silver Economy's potential value is resonant of gold rush hyperbole with exponentially rising claims of the size of the trillion(s) dollar market. By contrast, research on Japan, where the high rate of population ageing spurred the private sector's early pursuit of Silver Economy opportunities, shows that need, demand, and profitability are different and that "to turn a profit, you have to balance value delivery and value extraction" while considering the customer's "*ability and*

willingness to pay" (Lippert, 2008:185; emphasis added). The question is whether this repositioning of older people as an untapped market will address the social gradient in morbidity and mortality.

Who will be left behind?

> 'Universal Health Coverage (UHC) is defined by WHO as ensuring that *all* people and communities *receive the quality services* they need, and *are protected from health threats, without financial hardship*.' (WHO, 2022b, emphasis added)

The UHC concept identifies five key issues in achieving the DHA: universality, access, quality, health protection, prevention of financial hardship – in other words, it focuses on health *care* inequity. The 2011 Rio Political Declaration on the Social Determinants of Health (SDH) was adopted by the UN because 'social inequities are killing people on a grand scale' (WHO, 2008:4). Improving daily living conditions and tackling the inequitable distribution of power, money and resources is critical to addressing health inequalities. Yet orientating the health sector towards reducing health*care* inequities does not address SDH itself:

> 'social determinants (of health) can be more important than health care or lifestyle choices in influencing health…SDH account(s) for between 30-55% of health outcomes. In addition, estimates show that the contribution of sectors outside health to population health outcomes *exceeds* the contribution of the health sector. Addressing SDH appropriately is fundamental for improving health' (WHO, undated a, emphasis added.)

Income, social protection, unemployment and job insecurity, working life conditions, food insecurity, housing, basic amenities, environment, social inclusion and non-discrimination, structural conflict, education and affordable health services of decent quality all affect health equity. For example, fifty percent of under-5 child mortality reduction in LMICs is attributed to health-enhancing investments in non-health sectors (Kuruvilla et al, 2014).

Beyond a multi-sectorial approach what is needed is an understanding of the domino effect of social inequities on individuals, families and social networks. In LMICs working conditions are frequently hazardous. For the majority of the population the pay is poor and jobs insecure. In these conditions people are often mal-nourished and periodically pushed into food insecurity, including as a consequence of the global economic shocks (Harriss-White et al, 2013) arising from financial markets, spot markets, climatic factors, wars and pandemics. Not only does this make people more susceptible to injury and disease, including NCDs, but it makes it much less likely that they can afford health care or medicine. As important is the threat of income loss, including job loss, in taking time to access or support access to health care. The latter includes providing food and nursing in LMICs where hospitalization necessitates considerable family input (Balagopal, 2009). This makes health*care* inaccessible in urban and rural areas for disadvantaged people. Poor quality housing, lack of readily available potable water, sewage inundation during monsoons all impact health via environmental pollutants as well as undermining education and livelihood opportunities. Perhaps less well known is the global impact of road deaths, which is the largest killer of people aged 15-29, the third largest killer of people aged 30-44 and 75% of road deaths are amongst working age men (WHO, 2009). In LMICs the majority of deaths are vulnerable road users, ie pedestrians, cyclists and motorized two-wheelers (ibid). These deaths push families and kin networks into poverty or deeper into poverty. Having lost a key worker, families must send children, younger and older people into a labour market that discriminates on the basis of gender and age. This damages health now and in the future, passing it on from generation to generation through the social determinants of health. In these circumstances self-care has marginal impact. As Marmot, who led three UN Commissions on the SDH said "People cannot take responsibility if they cannot control what happens to them" (Marmot, 2015:51). Health-impacting multi-sectorial inequities can only be addressed collectively, requiring political determination both within and between countries.

In 2013 the WHO Director General, Margaret Chan, addressed the 8th Global Conference on Health Promotion, noting that "efforts to prevent non-communicable diseases go against the business interest of powerful economic interests" (cited in Kickbush et al, 2016). Initially WHO focused on combatting the corporate promotion of unhealthy products and choices, identifying "the aggressive use of trade deals" and the market penetration of LMICs via lobbying and extending supply chains that amplify corporate influence (WHO, undated b). By 2021 WHO defined the Commercial Determinants of Health as private sector activities that "worsen pre-existing economic, social and racial inequalities", especially in LMICs, which face "greater pressure" from multinational actors (WHO, 2021). The private sector's influence on economic systems impacts the determinants of the SDH, including through economic development, trade policies and the transfer of public sector resources to private companies and their greater role in health policy, regulation and provision.

> 'The emergence of non-State actors in the geopolitical arena, together with a shift in global governance, are fundamental to understanding the development of commercial determinants of health. Various authors have catalogued pathways of private sector health strategies and impact, including influencing the political environment, the knowledge environment and preference shaping" (ibid).

The increasing appeal to work with business that we have seen throughout this article took a qualitatively different turn with the SDGs when organisations such as the World Economic Forum became a key influencer, giving transnational corporations a more central role in formulating, funding and implementing development strategies (Sharma and Soederberg, 2019). SDG17 promotes public private partnership, particularly in terms of the "sharing" of technology on "mutually agreed" terms and finance for infrastructure to meet SDG costs. The radical shift from state-based development finance to unlocking private finance for development via Public Private Partnerships (PPPs) facilitates the penetration of multinational and transnational corporations in LMICs economies under cover of a "legitimating veneer" of development work (Mawdsley, 2018:193). While it is claimed that this will increase development funding from

"billions to trillions", the lack transparency and accountability due to claimed "commercial sensitivity" demonstrates a complacency towards the impacts of financialisation on borrowers, whether individual or national (ibid). Most importantly, assessments of PPPs need to evaluate the consequences of PPPs for the wider health system, not just for each project/programme, due to their higher project/programme costs and the marginalizing of people with the least capacity to access health care, thereby deepening inequalities (Gideon and Unterhalter, 2020).

Teleconsultation is being trumpeted as increasing inclusion while lowering health costs. The Government of India, for example, has recently introduced a teleconsultation service. In a flyer circulated on mobile phones, these services are being positioned as particularly suitable for "elderly people", "especially those with high blood pressure and diabetes etc (who) don't rush to the hospital for OPD" (Out Patients Department). The *e-Sanjeevani OPD, Stay at Home OPD*, which is housed within the Government of India's Ministry of Health and Family Welfare, claims to be bridging the urban/rural health gap by reaching rural and remote communities. As of September 2023 the website cites 148 million patients served out of a population of 1.4 billion, with average consultations lasting under 2.5 minutes. Access relies on having a smart phone, mobile connection and data. Yet the penetration of mobile and smart phones is concentrated in urban areas and in certain States, and ownership is directly linked to socio-economic status (Bino Paul and Murti, 2016). This comes as no surprise in a country that the UN's Food and Agricultural Organisation's Global Hunger Index describes as having a 'serious' level of hunger and a rising child wasting rate (Global Hunger Index, 2023). Beyond the question of accessing teleconsultation services is the question of pharmacy availability, the cost of medicines, the availability and cost of specialist medical skills and treatments. Teleconsultations do not address the social gradient in health care access; they entrench inequity. That inequity can fall hardest on older people in the lower reaches of the socio-economic hierarchy who will not take family resources for themselves at the cost of other family members' access to food, healthcare and education.

Despite the well understood causes of global poverty (Hickel, 2018) and the role of multinational corporations and TNCs in that impoverishment (Madeley, 2008), confirmed by the Coronavirus pandemic-generated transfer of wealth to the richest (Sharma, 2021), the SDG's framework placed "immense and mistaken faith in growth and the private sector, rather than envisioning states as the key agents of change and embracing policies that will redistribute wealth and address poverty" (Alston, 2020).

A conclusion by way of final reflections

We have seen that VIPAA and MIPAA set forth action plans based on older people's rights, setting those rights at the centre of development. In presenting older people as having a right to a full life they challenged the view that the key concern in later life is declining health. Importantly, we saw that good health is the result of fulfilled rights. The WHO's Social Determinants of Health programme demonstrated how rights, particularly in relation to living and working conditions, food security, road safety and environmental pollution, lead to good health. We saw that when addressing health inequalities in later life what is needed is not just an approach that focuses on the individual older person. What is needed is an integrated intergenerational perspective that recognises that later life health and access to health care is intimately tied to the contexts in which household members *and* the wider family network must operate. In contexts of considerable poverty across the life course, insufficient publically funded support for later life, reduced fertility and a social gradient in mortality the poorest in society are left with few means to maintain their health or access health care. This exposes older (as well as younger people) to bodily depleting work and consumption strategies that feed the downward spiral of early mortality, punching yet more holes into family networks.

Critically reviewing UN and World Bank policies, we saw that VIPAA and MIPAA offered a nuanced and positive vision of older people's rights and capacities that rejected the ageism inherent in policies rooted in apocalyptic demography. MIPAA expanded the concept of older person rights to include the right to

benefit from development and to contribute to development. While this is a significant step forward, that vision has been eroded in the international development agenda. Older people were not mentioned in the MDGs, implying that they are marginal to development. In the SDGs they figure as beneficiaries of some, not all, development goals. In the DHA older people are positioned as a key source of economic growth for the health-related industries. Where older people are included in the SDGs and DHA the focus is, once again, on staving off mental and physical decline and the prevention of 'premature death' before age 70. While health is evidently important, reducing older people to their individual physicality is not only profoundly ageist, it deflects attention from the key determinant of health: inequality at global and national scales.

We saw the diverging positions within the UN, particularly within WHO, as to what is the best route forward for securing development goals in the policy context of contracting government roles and reliance on the market. The WHO's Social Determinants of Health approach, the objective of which is to *produce* good health for all, is antithetical to a reliance on the market approach. The SDGs and DHA, by contrast, are not aimed at producing good health but at mitigating individual ill-health. They move the health burden to the individual despite knowing that 1) the main sources of ill-health fall beyond individual control, 2) social inequality accelerates health inequality in an increasingly negative spiral and 3) negative spirals emanate from economic and health crises at all societal scales, from the individual to the global. We have also seen that in 2013 the WHO Director General, Margaret Chan, spoke against the pressures that corporations place on countries' policies and that the prevention of NCDs "goes against the business interest of powerful economic interests" (cited in Kickbush et al, 2016). Despite this knowledge, and the skewed outcomes of Public Private Partnerships, the UN has been increasingly calling for private sector involvement in health care.

We have also seen that powerful corporate lobbies are working to increase their role in development. The World Economic Forum, for example, views global population ageing as the 'the most formidable market opportunity' (WEF,

2016:2) of this century. The private sector organisations have been working with inter-governmental organisations focused on economic growth, such as the OECD, G20 and Asia-Pacific Forum, to promote a Silver Economy approach to meeting the SDG/DHA health goals that countries are expected to address. With this meshing of private sector and inter-governmental organization interests, via the UN's increasing call for the private sector to become development 'partners', the DHA is propelling what may well turn out to be the corporate capture of the international development agenda. This is despite the WHO's Commercial Determinants of Health programme's recognition that 1) private sector activities worsen pre-existing inequalities, 2) private sector influence on health policy 'incentivizes politicians and political parties to align decisions with commercial agendas' (WHO, 2021) and 3) new tools and strengthened capacity to understand and address the commercial determinants of health are needed. Despite this knowledge the WHO made the private sector a central pillar of the DHA agenda in a final drive to meet some SDG targets by 2030.

There are alternatives. Central is developing policies that produce good health. This starts with investigating how older people are located within the economy as workers (Vera-Sanso, 2012) and protecting their livelihoods, which are frequently in jeopardy due to older people's invisibility as workers. Second is effective social floors that enable older people to match their work participation to their needs and capacities, allowing them to withdraw from work as and when they need, including intermittent withdrawal. Third is to find new forms of integrated health and social care that enable older people to stay at home while strengthening the local community's economic base. The Brazilian city of Belo Horizonte has implemented a long-term care model that integrates mainstream health services for care-dependent older people in disadvantaged communities (Lloyd-Sherlock et al, 2022). The scheme hires and trains people of the *favelas* to act as the link between up to four families each and the local health centre. They provide care, providing some respite for families, and ensure the older person receives needed medical attention by escorting older people to appointments. Here the funding stays in the local economy, generating positive inputs into the social determinants of health of the wider *favela* population. Further, the scheme

can overcome the intra-household social determinants of health where older people will usually ensure that others' needs are not impinged upon by their needs, particularly if their needs threaten family livelihoods or young people's life chances. This strikes at the heart of the fallacy of development – that improvements secured in early and prime age life will 'naturally' be carried forward to later life. The Social Determinants of Health framework, which is well aligned with MIPAA's vision of older people as having the right to benefit from and contribute to development, is where the focus needs to be.

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[i] See Heneghan and Orenstein (2019) for account of how the WB's and ILO's internal politics shaped international policy agendas.

[ii] For more information on tax policies in low-income countries, including who is being under-taxed, see Moore and Prichard (2017).

[iii] The extent of poverty in India is revealed by its ranking within the UN's Food and Agricultural Organisation's Global Hunger Index. India is ranked in the bottom 12% of 121 countries, has a level of hunger classed as 'serious' and a rising child wasting rate (Global Hunger Index, 2023).

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