

STUDY

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Ageing policies - access to services in different Member States



Policy Department for Economic, Scientific and Quality of Life Policies
Directorate-General for Internal Policies
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PE 662.940 – October 2021

EN

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Abstract

The study focuses on active ageing policies and access to services for the ageing population in the EU-27 in five areas: economic activity, social participation, health and well-being, long-term care, and supportive environments including housing, transportation, and securing financial independence. It presents the challenges and trends in achieving active ageing policy goals in those areas, as well as the impact of the COVID-19 pandemic. Eight country studies for selected Member States provide a comparative assessment as well as examples of policies and good practices undertaken in recent years.

This document was provided by the Policy Department for Economic, Scientific and Quality of Life Policies at the request of the committee on Employment and Social Affairs of the European Parliament (EMPL).

This document was requested by the European Parliament's committee on Employment and Social Affairs

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Original: EN

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Manuscript completed: October 2021

Date of publication: October 2021

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This document is available on the internet at:

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For citation purposes, the publication should be referenced as: Sowa-Kofta, A., Marcinkowska, I., Ruzik-Sierdzińska, A., Mackevičiūtė, R., 2021, *Ageing policies – access to services in different Member States*, Publication for the committee on Employment and Social Affairs, Policy Department for Economic, Scientific and Quality of Life Policies, European Parliament, Luxembourg.

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CONTENTS

LIST OF BOXES	6
LIST OF FIGURES	7
LIST OF TABLES	9
LIST OF ABBREVIATIONS	10
EXECUTIVE SUMMARY	12
1. INTRODUCTION	15
2. EVOLUTION OF THE ACTIVE AGEING APPROACH	17
2.1. Healthy and active ageing in the international policy agenda	19
2.2. Monitoring active ageing	24
3. FOSTERING ACTIVITY AND ACCESS TO SERVICES IN THE EU-27	26
3.1. Economic activity	27
3.1.1. Pension reforms	27
3.1.2. Flexible working arrangements/working time adjustment	29
3.1.3. Health and safety in the workplace	32
3.1.4. Lifelong learning	33
3.1.5. Digital upskilling	37
3.1.6. Age discrimination	40
3.1.7. EU funding instruments	42
3.1.8. COVID-19 impact	44
3.2. Social participation	45
3.2.1. Level of social participation in the EU Member States	45
3.2.2. Internet access and types of digital services used in different age groups	47
3.2.3. Challenges in social participation	52
3.3. Health and well-being	53
3.3.1. Health status of the older population	53
3.3.2. Access to healthcare services	56
3.3.3. Health promotion and prevention	60
3.3.4. COVID-19 vaccinations	60
3.3.5. Challenges in healthcare policy	61
3.4. Long-term care	62
3.4.1. Use of long-term care in the EU Member States	62
3.4.2. Quality of services	65
3.4.3. Innovations in LTC	65

3.4.4. Impact of COVID-19	66
3.4.5. Challenges in long-term care	69
3.5. Supportive environments	70
3.5.1. Housing	70
3.5.2. Transportation	77
3.5.3. Financial independence	80
3.6. Key features of Recovery and Resilience Facility with regards to ageing	85
3.6.1. Economic activity	85
3.6.2. Social participation	86
3.6.3. Health and well-being	86
3.6.4. Long-term care	87
3.6.5. Supportive environment	87
4. ACTIVE AGEING POLICIES AND SERVICES IN SELECTED EU MEMBER STATES	89
4.1. Active ageing policies	91
4.1.1. Policies and programmes aimed at active ageing	91
4.1.2. Participatory governance supporting the quality of active ageing policies	93
4.2. Economic activity	94
4.2.1. Measures undertaken to support older workers	94
4.2.2. Impact of policies and activities supporting older workers	98
4.3. Social participation	99
4.3.1. Policies and programmes encouraging social participation	99
4.3.2. Access and affordability of social activities	102
4.3.3. Digitalisation and social participation	103
4.4. Health and well-being	103
4.4.1. Access and affordability of healthcare	103
4.4.2. Health promotion	104
4.4.3. Digitalisation in healthcare	105
4.5. Long-term care	106
4.5.1. Differentiation of LTC	106
4.5.2. Access and affordability of LTC	108
4.5.3. Digitalisation in long-term care	109
4.6. Supportive environments	110
4.6.1. Housing	110
4.6.2. Transportation	111
4.6.3. Financial independence	112

5. CONCLUSIONS AND RECOMMENDATIONS	113
REFERENCES	125

ANNEXES

ANNEX I - Country study on Austria (only online)

[http://www.europarl.europa.eu/RegData/etudes/STUD/2021/662940/IPOL_STU\(2021\)662940\(ANN01\)_EN.pdf](http://www.europarl.europa.eu/RegData/etudes/STUD/2021/662940/IPOL_STU(2021)662940(ANN01)_EN.pdf)

ANNEX II - Country study on France (only online)

[http://www.europarl.europa.eu/RegData/etudes/STUD/2021/662940/IPOL_STU\(2021\)662940\(ANN02\)_EN.pdf](http://www.europarl.europa.eu/RegData/etudes/STUD/2021/662940/IPOL_STU(2021)662940(ANN02)_EN.pdf)

ANNEX III - Country study on Germany (only online)

[http://www.europarl.europa.eu/RegData/etudes/STUD/2021/662940/IPOL_STU\(2021\)662940\(ANN03\)_EN.pdf](http://www.europarl.europa.eu/RegData/etudes/STUD/2021/662940/IPOL_STU(2021)662940(ANN03)_EN.pdf)

ANNEX IV - Country study on Italy (only online)

[http://www.europarl.europa.eu/RegData/etudes/STUD/2021/662940/IPOL_STU\(2021\)662940\(ANN04\)_EN.pdf](http://www.europarl.europa.eu/RegData/etudes/STUD/2021/662940/IPOL_STU(2021)662940(ANN04)_EN.pdf)

ANNEX V - Country study on Lithuania (only online)

[http://www.europarl.europa.eu/RegData/etudes/STUD/2021/662940/IPOL_STU\(2021\)662940\(ANN05\)_EN.pdf](http://www.europarl.europa.eu/RegData/etudes/STUD/2021/662940/IPOL_STU(2021)662940(ANN05)_EN.pdf)

ANNEX VI - Country study on The Netherlands (only online)

[http://www.europarl.europa.eu/RegData/etudes/STUD/2021/662940/IPOL_STU\(2021\)662940\(ANN06\)_EN.pdf](http://www.europarl.europa.eu/RegData/etudes/STUD/2021/662940/IPOL_STU(2021)662940(ANN06)_EN.pdf)

ANNEX VII - Country study on Poland (only online)

[http://www.europarl.europa.eu/RegData/etudes/STUD/2021/662940/IPOL_STU\(2021\)662940\(ANN07\)_EN.pdf](http://www.europarl.europa.eu/RegData/etudes/STUD/2021/662940/IPOL_STU(2021)662940(ANN07)_EN.pdf)

ANNEX VIII - Country study on Sweden (only online)

[http://www.europarl.europa.eu/RegData/etudes/STUD/2021/662940/IPOL_STU\(2021\)662940\(ANN08\)_EN.pdf](http://www.europarl.europa.eu/RegData/etudes/STUD/2021/662940/IPOL_STU(2021)662940(ANN08)_EN.pdf)

LIST OF BOXES

Box 1:	German Senior's Day	93
Box 2:	Code of the Third Sector in Italy	94
Box 3:	The Law on Older Persons in Poland	94
Box 4:	Flexible types of contracts for older people	96
Box 5:	Age management strategy in Energetix, France	96
Box 6:	Good practices in improving working conditions in Austria	97
Box 7:	Mid-career reviews in France	97
Box 8:	Supporting older workers in Italy	98
Box 9:	Increase of income limit for working pensioners in Germany	99
Box 10:	Protection measures in Italy	99
Box 11:	Federal programme to combat loneliness and isolation in Germany	100
Box 12:	Community day centres in Poland and Germany	100
Box 13:	The Universities of the Third Age in Poland	101
Box 14:	Telephone support lines	101
Box 15:	Increasing digital literacy in older people in Germany	103
Box 16:	Projects to minimise regional differences in access to medical services in rural areas of Germany	104
Box 17:	The pilot programme Prevention 40+ in Poland	105
Box 18:	Using new technology to support independent life and healthcare in the Netherlands and Sweden	106
Box 19:	Emergency management in Austrian home care during the pandemic	107
Box 20:	Quality management in Germany and the Netherlands	108
Box 21:	Polish project Care 75+	109
Box 22:	The project Living at home for longer in the Netherlands	109
Box 23:	Housing adaptation programmes in Germany, Lithuania, Sweden, and Italy	111
Box 24:	Special transport services in the Netherlands, Sweden, France, Lithuania, Germany, and Italy	112

LIST OF FIGURES

Figure 1:	Active Ageing Index at a glance	24
Figure 2:	AAI score overall and by domain, EU-27, 2018	25
Figure 3:	Activity rate by age, EU-27, 2020	28
Figure 4:	Gap between effective and statutory retirement age, by gender, 2018	29
Figure 5:	Gender differences in the at-risk-of-poverty rate (65+), 2019	31
Figure 6:	Main reason for pensioners to continue working, in %, 2012	32
Figure 7:	Adult participation in education and training, in %, 2016 and 2020	34
Figure 8:	Participation rate in education and training by age, in %, 2016	35
Figure 9:	Mean instruction hours spent in education and training by participant, 2016	35
Figure 10:	Participation rate in education and training by education, in %, 2016	36
Figure 11:	People using internet daily by age, in %, 2020	38
Figure 12:	Difference between share of individuals with above basic digital skills in 2015 and 2019 by age, in %	39
Figure 13:	People with above basic digital skills by age, in %, 2019	40
Figure 14:	Experienced age discrimination, in %, 2015	41
Figure 15:	Employees experiencing age discrimination in the past 12 months by age, in %	41
Figure 16:	Internet use in the 55-64 and 65-74 age groups, in %, EU-27	47
Figure 17:	Internet use in the 55-64 age group, in %, 2020	48
Figure 18:	Internet use in the 65-74 age group, in %, 2020	48
Figure 19:	People (50+) who never contacted their children since the outbreak of the pandemic, in %, 2020	51
Figure 20:	People (50+) who never contacted their parents since the outbreak of the pandemic, in %, 2020	51
Figure 21:	People (50+) who never contacted their relatives (other than children or parents) since the outbreak of the pandemic, in %, 2020	52
Figure 22:	People (50+) who never contacted neighbours, friends, or colleagues since the outbreak of the pandemic, in %, 2020	52
Figure 23:	Average life expectancy at age 65, in years, 2020 compared to 2019	54
Figure 24:	Limitations in usual activities due to health problems by age group, in %, 2020	54
Figure 25:	Income inequalities in long-standing limitations in usual activities (65+), in %	55
Figure 26:	Mental health during the COVID-19 pandemic by age group, in %	56
Figure 27:	Unmet needs for medical care by country (65+), in %, 2019	57
Figure 28:	People (65+) with unmet needs for medical care, in %, EU-27, 2011-2019	57
Figure 29:	People (50+) receiving e-prescriptions/consultations, in %	58

Figure 30:	Unmet needs for medical treatment during the COVID-19 pandemic, in %	59
Figure 31:	Reasons for unmet medical care in the population aged 50+, in %	59
Figure 32:	People with at least one dosage of COVID-19 vaccination by age group, in %	61
Figure 33:	People (65+) receiving institutional, home care, and cash benefits, in %, 2019	63
Figure 34:	People not using professional home care services for financial reasons, in %, 2016	64
Figure 35:	Recipients of home care (50+) before the COVID-19 pandemic by age group, in %	68
Figure 36:	People reporting difficulties in obtaining home care during the COVID-19 pandemic	69
Figure 37:	People (65+) living alone, in %, EU-27, 2019	71
Figure 38:	People (65+) living alone, in %, EU-27, 2011-2019	72
Figure 39:	People (65+) having tenant or owner status, in %, EU-27, 2019	74
Figure 40:	People (65+) having tenant status, in %, EU-27, 2011-2019	74
Figure 41:	Housing cost overburden rate by age group, in %, EU-27, 2019	75
Figure 42:	Households facing noise, environmental problems, or crime in their local areas, in %, EU-27, 2018	76
Figure 43:	People reporting difficulty accessing public transport by degree of urbanisation, in %, EU-28, 2012	78
Figure 44:	Relative median income ratio (65+), 2019	81
Figure 45:	Relative median income ratio (65+) by gender, EU-27	82
Figure 46:	At-risk-of-poverty or social exclusion rate by age group, in %, EU-27, 2019	83
Figure 47:	At-risk-of-poverty or social exclusion rate (65+), in %, EU-27	83
Figure 48:	At-risk-of-poverty or social exclusion rate (65+) by gender, in %, EU-27, 2019	84
Figure 49:	Employment rate of people aged 55-64 in selected EU Member States, 2011-2020	98

LIST OF TABLES

Table 1:	European Skills Agenda for sustainable competitiveness, fairness, and resilience	33
Table 2:	Internet use by males aged 55-74 by main type of activity, 2020	49
Table 3:	Internet use by females aged 55-74 by main type of activity, 2020	50
Table 4:	Main performance indicators for selected Member States	90
Table 5:	Policy pointers for encouraging healthy and active ageing in national policy	114
Table 6:	Policy pointers for encouraging the economic participation of older people	115
Table 7:	Policy pointers for encouraging the social participation of older people	117
Table 8:	Policy pointers to strengthen access to healthcare services for older people	118
Table 9:	Policy pointers to strengthen long-term care for older people	120
Table 10:	Policy pointers to address housing-related challenges for older people	122
Table 11:	Policy pointers to address transportation-related challenges for older people	123
Table 12:	Policy pointers to address financial vulnerability in older people	124

LIST OF ABBREVIATIONS

AAI	Active Ageing Index
AES	Adult Education Survey
CEE	Central and Eastern European
COST	European Cooperation in Science and Technology
COVID-19	Coronavirus disease 2019
CVET	Continuing vocational education and training
EC	European Commission
ECDC	European Centre for Disease Prevention and Control
EIP	European Innovation Partnership
EMPL	Committee on Employment and Social Affairs
EP	European Parliament
EPSR	European Pillar of Social Rights
ERDF	European Rural Development Fund
ESF(+)	European Social Fund
EU	European Union
EU-OSHA	European Agency for Safety and Health at Work
EU-SILC	European Union Statistics on Income and Living Conditions
GDP	Gross Domestic Product
HLY	Healthy Life Years
ICT	Information and Communication Technology
LE	Life expectancy
LFS	Labour Force Survey
LTC	Long-term care

MS	Member States
NGO	Non-Governmental Organisation
OECD	Organisation for Economic Co-operation and Development
PCR	Polymerase chain reaction
pp	Percentage points
PPE	Personal Protective Equipment
RRF	Recovery and Resilience Facility
RRP	Recovery and Resilience Plan
SDGs	Sustainable Development Goals
SHARE	Survey of Health, Ageing and Retirement in Europe
TEMPiS	Telemedical Project for Integrative Stroke Care
TFEU	Treaty on the Functioning of the European Union
UN	United Nations
UNECE	United Nations Economic Commission for Europe
VET	Vocational Education and Training
WHO	World Health Organisation

EXECUTIVE SUMMARY

Background

This study on active ageing policies and access to essential services stems from the demographic pressure faced by the 27 European Union (EU) Member States. Demographic projections show a decrease in the size of the EU population and an increase in the share of older people (aged 65 years or more) from 20.3 % in 2019 to 31.3 % in 2100 (Eurostat 2021). Given these changes, active and healthy ageing policies are being promoted on international and national agendas with the aim of creating the environments and opportunities for well-being and maintaining functional ability. Active ageing policy has been strengthened through various European initiatives such as evaluating the costs related to sustainable pensions, healthcare, and long-term care systems and creating an Active Ageing Index (AAI). Recent European Commission policy documents (European Commission 2021a, b), the European Pillar of Social Rights, and a European Parliament resolution on possibilities and challenges related to ageing policy post 2020 (European Parliament 2021c) put the challenges of active ageing high on the agenda.

Aim

The aim of the study is to provide the Members of the committee on Employment and Social Affairs (EMPL) with a comparative assessment of ageing policies and access to services essential for active ageing in the EU. It focuses on the core elements of active ageing: economic (labour market) participation, social engagement, health and well-being, long-term care, and supporting environments (housing, financial situation, and transportation) and evaluates the accessibility, affordability and – whenever feasible – the quality of services. The study also provides an assessment of the impact of the COVID-19 pandemic on services. The analysis is comprised of both quantitative and qualitative information and is supported by eight case studies on selected EU Member States: Austria, France, Germany, Italy, Lithuania, the Netherlands, Poland, and Sweden (published as a supplement to this report). Countries were selected to provide a representative balance based on geography, different welfare state traditions, and the varying activity levels among older people as measured by the AAI. The country case studies enable the identification of good practices in ageing policy regarding access to services and the challenges for further development.

Key Findings

The eight EU Member States examined have **active ageing high on their policy agendas**. However, formulating active ageing policy is an on-going process. Several Member States already have strategies or policies in place (e.g. Austria, Poland, Germany and Sweden), while in others (e.g. Italy), the formulation of a single active ageing policy is being debated. These policies aim at increasing social participation, encouraging lifelong learning and the employment of older people, and preventing cognitive impairments and health deterioration. Services supporting active ageing are rooted in social protection systems, including pension systems, healthcare, long-term care, social assistance, and social services. Social partners and organisations representing older people have an important role to play in supporting active ageing policies and programmes. Further debate is needed on how active ageing could be strengthened and included in professional training and the education system.

The main instruments for stimulating the **economic participation** of older people are regulations regarding the pensionable age and decreasing early retirement benefits, both of which aim to keep older workers in the labour market longer. The labour market activity rate of people aged 55-64 in the EU-27 has been continuously increasing since 2002, albeit with differences between individual

countries. In Sweden, 25 % of men and 35 % of women are keen to work beyond the statutory retirement age, whereas in Poland, older people expect to retire as early as possible. At the same time, more than half of European workers report that their workplace is not adapted to their needs, which is a barrier to prolonging working lives. It is still too early to assess the impact of the outbreak of the COVID-19 pandemic and rapid transformations in digitalisation on the changes in the activity rate of people aged 55-64. Nevertheless, the regular monitoring of their labour market activity is recommended, especially for those with a lower level of education. Lifelong learning and vocational education and training need modernising by increasing the volume and quality, opening access to Continuing Vocational Education and Training (CVET) services, or introducing new investment packages and incentives to support adult participation in learning, especially in countries where it is currently very low.

Social participation is one of the most important prerequisites for active ageing. A number of Member States have experienced low levels of social participation among older people, even before the pandemic, whereas other (mainly Nordic countries) are above average in this regard. Before 2020, a slow increase in some aspects of social participation could be observed, but COVID-19 unexpectedly hindered social engagement. In the future, active ageing policies should support the development of community day centres as a tool to stimulate the integration and participation of older people in more remote areas or opportunities for older and younger people to meet and jointly engage in social activities. Some practices from the times of the pandemic show that further support for internet access in remote areas and for people with lower incomes, as well as an increase in digital literacy, may mitigate the loneliness and social exclusion of older people in the future.

The average life expectancy worsened during the COVID-19 pandemic in most EU Member States (with the exception of Finland and Denmark), and the risk of depression and loneliness for older people increased. Given the still somewhat limited data on the impact of the pandemic, there is a need for further analysis of the changes in mortality, functional abilities, and healthy life years among older people at different ages. National screening programmes for non-communicable diseases, taking into account gender and age profiles, are useful in preventing an increase in morbidity and mortality due to forgone or postponed medical treatment. Barriers in access to **healthcare services** for older people are particularly visible in rural and depopulated areas. Some Member States stimulate access to services by introducing quotas for medical students who plan to take up employment in rural areas and by introducing mobile medical teams and teleconsultations. Healthcare information systems as well as online and telephone consultations have been particularly useful during the COVID-19 pandemic. EU Member States need to undertake actions to further improve digital infrastructure, providing older people with digital tools and improving their digital literacy.

The monitoring of the development of **long-term care** (LTC) in the EU-27 has improved. Still, there is a need to introduce long-term care-related indicators regarding the use and financing of LTC in the Eurostat database and Social Scoreboard. Increasing the affordability of LTC via social protection systems is a necessity as 40 % of older people in the EU-27 report financial barriers in access to care and being overburdened with care costs. Digital technologies are a promising development in supporting care provision for people with low and moderate care needs, but should be complemented with training to increase digital competencies in the cared for and their careers. Investment in the LTC workforce and the regulation of migrant care work is essential to improve the supply of LTC for older people. E-platforms, reskilling, and service provision via social entrepreneurship are used to encourage employment in LTC.

Three key challenges associated with **housing** create a significant threat to successful active ageing. First, about one-third of older people in the EU live alone and this number is steadily increasing, which

leads to the growing demand for home-based care services as well as social initiatives and innovations aimed at decreasing social isolation, such as telephone support lines for older people. Second, more than one-fifth of the ageing population in the EU need to allocate a significant part of their income to paying rent, while more than one-tenth of the population suffers from the burden of housing costs. Partial compensation for rent or utility costs has been introduced by some national governments to increase the affordability of housing for older people. Third, even though older people are relatively unlikely to face challenges related to the general quality of housing, few homes are adjusted to the specific needs of older people. Measures addressing this challenge include public grants or low-interest loans for housing adaptations, as well as counselling services regarding the adaptation of homes to specific needs.

There are several areas of public intervention that could significantly increase the accessibility of **transportation** for older Europeans. On the one hand, only some public transport vehicles have been designed to meet the specific needs of older people. On the other hand, the more active development of public shuttle services for older people could solve at least a few of the challenges related to the limited accessibility of transportation, for example, the lower availability of public transportation in rural areas, the low affordability of taxi services, or the significantly decreased accessibility of public transport services for older people in the context of the global pandemic.

Concerning the **financial situation**, in the majority of EU countries, older people are less likely to be at risk of poverty or face material deprivation in comparison to younger people. Nevertheless, some challenges related to the financial independence of older people might require a stronger focus on the political agenda. First, some demographic groups of older people such as migrants or single people face a higher financial risk. The gender gap also becomes more pronounced in old age, mostly determined by lower pensions for women than for men as a result of the gender pay gap and the shorter working life of women. These challenges have been addressed in some Member States through the introduction of special allowances in addition to pensions for some specific groups (e.g. an allowance for older people who live alone). Second, the financial situation for older people in Central and Eastern European Member States is especially threatening because of the poorer adequacy and limitations of their national pension systems that remain even after the recent pension reforms implemented in these countries over the last several years.

1. INTRODUCTION

The need for this study stems from demographic pressure – population ageing – which is set to rise further in Europe in the decades to come. In addition, the COVID-19 pandemic has been putting a strain on access to services for older people, including those who are vulnerable and disabled. Combined, these dynamics create an urgent need to collect lessons from across the European Union (EU) regarding the types of ageing policies and actions that can be effectively introduced, as well as what can be learned from recent pandemic-related experiences. The 2019-based population projections show that the median age of the population is projected to increase from 43.7 years in 2019 to 48.8 in 2100 (Eurostat 2021). At the same time, the proportion of the working-age population (15-64 years) is expected to decrease from 64.6 % (288.5 million) at the start of 2019 to 54.8 % (227.9 million) by 2100 and the proportion of older people (65 years and above) is projected to increase by 11 pp – from 20.3 % (90.5 million) at the start of 2019 to 31.3 % (130.2 million) by 2100.

The analysis, requested by the European Parliament's committee on Employment and Social Affairs (EMPL), focuses on the subject of *Ageing policies – access to services in different Member States*. The aim is to provide Members of the committee with a comparative assessment: identifying good practices on ageing policies as regards access to services in the Member States which trigger active ageing, looking into the challenges this presents, and reflecting on policy actions that could be pursued at the EU level. Active ageing means creating the conditions for people to stay independent and be in charge of their own lives for as long as possible and, whenever possible, contribute to the economy and society.

The study concentrates on the conditions for access to services by older people, often disabled and vulnerable, for each of the core elements of active ageing: economic (labour market) participation, social engagement, health and well-being, long-term care, and supporting environments (housing, financial situation, transportation) creating opportunity structures. Particularly, the impact of the COVID-19 pandemic on services is assessed. The study is based on the assumption that ageing is a cross-cutting issue and thus analyses different social and economic policies that are important from the active ageing perspective. Whenever feasible, the study addresses aspects of access, availability, quality assurance, and effectiveness of services and identifies good practices provided by the country studies. It aims at tackling new phenomena with regards to ageing, such as digitalisation and the use of telecare and telemedicine, which grew in importance during the COVID-19 pandemic. When possible, differences in access to services by the type of provider (public vs. private) as well as territorial and gender differences are identified.

There is no uniform definition of older age. It is essentially the final stage of a life span, but it is also individually and socially defined. In the Eurobarometer survey conducted in 2011, 51 % of Europeans aged 55+ perceived themselves as middle aged and 42 % as older (European Commission 2011). In economic and social policy, it is assumed that older age begins with withdrawal from the labour market and entering retirement, which in European countries is typically between 60 and 67 years of age (see Chapter 3.1). The ability to age healthily and actively changes across a person's life span and as care needs grow. In the study presented, older age is extended to also cover people who are still economically active and will only enter older age and retirement in the years to come. According to the silver economy concept, people aged 50 and above contribute to economic growth not only via their labour market participation, but they also generate a great demand for private and public services, and this sector of the economy is foreseen to grow as European populations age (European Commission 2018). Subject to data availability, the indicators and analyses are presented separately for the following population groups:

- 50 to 64 years of age. These are older workers and people entering the retirement period. They are typically still active on the labour market, though at a high risk of exclusion. They also frequently become dual carers: raising children and caring for older parents simultaneously.
- 65 to 74 years of age. These are people who have entered the retirement age but might still be economically active. They have great potential for social participation, including volunteering and care duties, but they may also become more frequent users of medical services due to health deterioration and multimorbidity and they might require home care services or community living arrangements.
- 75 years of age and above. These are people for whom medical and care needs are rising due to multimorbidity, as well as increased risk of disability and dependency. They frequently require support from their social network and family as well as formal home care and nursing services. In the last stage of life, they might turn to residential care options.

The study is divided into several chapters. Following the Introduction, Chapter 2 discusses approaches to active ageing in the scientific literature and European level policy documents.

Chapter 3 presents basic comparative indicators at the EU and national level regarding accessible services that are crucial for creating active ageing opportunity structures with particular attention given to the changes and challenges brought by the COVID-19 pandemic. The chapter is divided into several sections discussing trends; the latest policy changes and challenges in the fields of economic participation, social participation, well-being, and health status; the use of long-term care; and supportive environments for older people. The analysis uses comparative quantitative data for European countries: Eurostat data, OECD data, the Eurofound Working Conditions Survey, the Eurofound Living, Working and COVID-19 survey (fielded in February-March 2021), as well as the SHARE (Survey of Health, Ageing and Retirement in Europe) wave 8 and COVID-19 survey (fielded from June to August 2020), and other sources. In the last section the use of Recovery and Resilience Funds with respect to supporting access to services for older people is discussed.

Chapter 4 presents an overview of the approaches to active ageing in the national policies of the eight EU Member States selected for case studies: Austria, France, Germany, Italy, Lithuania, the Netherlands, Poland, and Sweden. It provides an assessment of the differences in approaches to ageing in national policies, discusses access to services, their affordability and quality whenever feasible, and provides examples of good practices that stimulate activity in older age. The selection of countries is balanced in terms of geographical region, institutional structure and welfare regime, and the capabilities of older people with respect to active ageing as measured by the Active Ageing Index.

The report ends with Chapter 5, which presents the conclusions and recommendations stemming from the comparative analysis and successful policies and good practices in selected European countries.

2. EVOLUTION OF THE ACTIVE AGEING APPROACH

KEY FINDINGS

Healthy and active ageing and lifelong learning are key ageing policy concepts.

Healthy and active ageing require adequate healthcare, long-term care, and access to other services supporting independent living for as long as possible.

The European Pillar of Social Rights is a key policy instrument to stimulate sustainable ageing in Europe and a rights-based approach for EU citizens.

Innovations, and particularly digital technology, create a new ageing environment and new opportunities for active ageing and access to services.

The Active Ageing Index is a useful tool for monitoring national progress in healthy and active ageing in several domains, though more work is needed on its application in the policymaking process at the subnational level.

Ageing populations pose a significant challenge to European economies and welfare systems, with the European Commission (EC) naming the change of the demographic structure as one of the key challenges facing the EU¹. The perception of ageing as a social and economic phenomenon and its consequences has, however, evolved over the years, with the first research in the field in the mid-20th century. Back in the 1960-70s, research on the ageing phenomenon was pointing mostly to the negative perception of old age as a period of withdrawal from earlier activities, in particular, labour market activity and family life focused on bringing up children (the so-called disengagement theory). Older age was perceived mainly from the perspective of slow health deterioration, a decrease of social capabilities, and lowered functioning in the public sphere (Verbrugge and Jette, 1994).

The idea of successful and active ageing was formulated as contrary to the above (Havighurst, 1961). It underlines the conditions that are necessary to experience maximum satisfaction from the last decades of one's life. The idea acknowledges differences in the lifestyles of older people, as some disengage from their previous lifestyle while others continue their previous engagement in various spheres of life. These individual life paths and the capacity to stay healthy and active are dependent upon multiple factors, including biological predisposition, lifestyle factors, individual choices, and socio-economic position, as well as external factors such as a friendly environment, lack of social and physical barriers to participation, and the conditions created by social protection systems.

Over time, numerous definitions of successful, healthy, and active ageing have been formulated. Typically, the term *healthy* refers to physical, mental, and social well-being, and *active* underlines the ability to continue participation in social, economic, cultural, spiritual, and civic affairs (Oxley, 2009). Healthy and active ageing means the absence of disease and disability, sustaining healthy living and engagement in social life, experiencing high cognitive and functional capacity, and good psychological standing (Bowling and Ilfe, 2006). *Successful* is commonly used in gerontology and geriatrics and refers to the optimisation of life expectancy while minimising physical and mental deterioration and disability. Definitions of successful ageing underline psychosocial conditions as crucial for leading a healthy and active life in older age. Individual perception of life fulfilment, life satisfaction, and maintenance of satisfactory family and social ties is one of the elements of successful ageing and a

¹ European Commission, Ageing and welfare state policies. Available at: https://ec.europa.eu/info/business-economy-euro/growth-and-investment/structural-reforms/ageing-and-welfare-state-policies_en.

stimulus for social participation and activity.

Despite differences in terminology, all these concepts are oriented towards the same goal of maximising individual opportunities and the ability of older people to lead a participatory life that brings benefits in terms of avoiding disability, being in good mental health, and staying independent.

Additionally, social environment and social connectedness play a great role. Rowe & Kahn (1997) defined active ageing as a triangle of coexisting conditions: low probability of disease and disease-related disability, high cognitive and physical functional capacity, and active life engagement. This approach is most commonly referred to as identifying the basic components of healthy and active ageing, further used by the World Health Organisation (WHO). Social relations, satisfying social roles and activities, as well as financial independence, which favour autonomous and participatory living, also increase quality of life and well-being in older age (Bowling et al., 2003).

Successful and active ageing is described as a dynamic process and the outcome of a lifetime of experiences. It is perceived as an ability to grow and learn from the past, building on experiences accumulated from previous decades of life (Poscia et al., 2015). People who led an active life – were labour market active, had a fruitful family and social life, and were engaged in volunteering – are more often socially engaged. The ability to age healthily and actively is shaped from the early years, through adulthood, and is an effect of accumulated experiences and habits. Therefore, the concepts of active ageing and lifelong learning are perceived as processes increasing the potential for well-being in later life (European Commission 2021a).

Older people might continue their previous activities or engage in new ones. They tend to select activities and decide to undertake those that bring the greatest individual benefits and a sense of satisfaction (Baltes & Baltes, 1990). Activity in later life allows to maintain health and prevent or postpone disability and sensory dysfunctions that occur with age (Galenkamp & Deeg, 2016). It might also compensate losses that occur in other spheres of life at an older age, including health deterioration, broken family ties, loss of a spouse, a feeling of uselessness, or lacking purpose in life. From a societal point of view, ageing often requires a person to redefine social roles and search for new ones.

Given this, active ageing is a complex behavioural strategy oriented at adjusting to the needs and abilities that change with age. Its aim is to optimise the potential stemming from individual biological characteristics and socio-economic conditions and allow for an independent and healthy life for as long as possible thanks to participation in social life and secure basic living conditions (Walker and Zaidi, 2016).

At the population level and in economic terms, the demographic change implies the need to strengthen intergenerational solidarity, particularly when it comes to social transfers and services. Ageing also changes the composition and ways of functioning of the labour market, as well as the consumption of services (Szukalski, 2006). The concept of the silver economy is promoted to refocus markets on the provision of services for older people, including rehabilitation and care that will support independent living while becoming a productive part of the economy.

In recent decades, the contribution of digital technologies to ageing has been discussed. Developments in information and communication technologies are transforming the work environment, social participation, and healthcare systems. Innovations are perceived as encouraging the activity of older people by contributing to flexible employment and the silver economy and enabling the communication, social networking, and continuous learning process of older people (OECD, 2015). Smart home automatic devices, telecare and telemedicine, as well as fall prevention and detection systems are supporting independent living in the home environment for older people and

increasing their security. Still, the rapid development of new communication technologies creates pressure for lifelong learning and increasing the digital literacy of older people in order to pursue digital ageing as an essential component of active ageing (Yang and Lin, 2019).

It is necessary to note that activity requires individual and social structures that support older people in sustaining health and undertaking activities. These are created within the family, in the neighbourhood and community, as well as by social welfare policies. The latter is the competence of national policies, while the EU has mainly a supporting role, as stated in the Treaty on the Functioning of the European Union (TFEU).

2.1. Healthy and active ageing in the international policy agenda

The concept of healthy, successful, active, or positive ageing has become increasingly common as populations age. It was adopted in the international agenda at the beginning of the 2000s and in many national policies in the following decades.

The definition of healthy and active ageing was developed and promoted by the World Health Organisation (WHO). The definition adopted in 2002 states that "active ageing is the process of optimising opportunities for health, participation and security in order to enhance the quality of life as people age" (WHO, 2002, p. 12). It has three components: stimulation of activities contributing to the improvement of physical and mental health; social connectedness and continuous participation in social, economic, cultural, spiritual, and civic affairs; and the provision of security and care, which are crucial components of individuals' well-being at an older age. Among the determinants of active ageing, the WHO points to economic status, access to social protection and social security, adequate physical environment, as well as personal factors such as lifestyle.

The idea was further developed by the WHO in 2015, where the concept of active ageing was replaced by the idea of healthy ageing, constituting a policy framework until 2030. Healthy ageing is a process of developing and maintaining a functional ability that enables well-being in older age. Similar to the concept of active ageing, it continues the earlier focus on actions in health and social policy. It also underlines the diversity in individual intrinsic capacities and the inequalities arising from social environments that accumulate over a lifetime. Healthy ageing, similarly to active ageing, is about creating the conditions for participation: meeting basic needs, learning, staying mobile, maintaining social relations, and contributing to the society. The WHO concentrates on the components necessary from the perspectives of health policy and long-term care, including preventing disability and excessive and premature mortality and reducing behavioural unhealthy living risk factors. However, it also notes the need to create ageing-friendly environments and improve access to social services. The ten components of a global healthy ageing policy framework include: establishing a platform for the exchange of innovations; developing national policies and strategies oriented at health and ageing; collecting global data on healthy ageing; promoting research that focuses on ageing and health both now and in the future; providing age-related guidelines and tools in healthcare systems; establishing a long-term care system; ensuring human resources for the provision of integrated care; undertaking a global campaign to prevent ageism; prioritising research on the economic impact of ageing; and enhancing a global network for ageing-friendly cities and communities (WHO, 2017).

Activities towards healthy and active ageing have also been stimulated by the EC and the European Parliament. Initially, the EC concentrated mainly on the evaluation of economic costs, particularly those related to healthcare and social protection systems, including retirement and long-term care. Further, a number of initiatives stimulating Member States to undertake policies and programmes towards active ageing were undertaken, including the European Innovation Partnership (EIP) on Active and

Healthy Ageing² and the European Year for Active Ageing and Solidarity Between Generations (2012).

Recently, the EC has focused on promoting a rights-based approach and the need for policy actions oriented at creating equal access to the services crucial for active ageing within the European Pillar of Social Rights (EPSR) adopted in 2017 (European Commission, 2017). The EPSR is strongly rooted in the values of quality of access to social protection typical for European welfare states, however it also brings in the ideas promoted by the UN within the Sustainable Development Goals (SDGs)³ adopted in 2015 and earlier with the Political Declaration and Madrid International Plan of Actions on Ageing⁴ adopted in 2002. The latter builds an agenda for governments, non-governmental organisations, and other stakeholders regarding the necessity to address population ageing by focusing on key priority areas: older persons and development, health and well-being, and creating supportive environments for older people.

The key priority of European active ageing policy is to create a social and physical environment fostering social and economic participation and enabling EU citizens to lead healthy, active, and – as long as possible – independent lives. For this purpose, various preconditions are needed, including access to healthcare, rehabilitation and care services, sufficient financial resources and poverty prevention for older people, adequate housing and living conditions, as well as access to innovative solutions and technologies. Challenges related to the cost of the provision of services for the growing number of older people and the burden to social security are perceived from the active ageing perspective as a social investment and an opportunity for creating an ageing friendly environment. The provision of services and benefits necessary in an ageing friendly society become a social right of every citizen.

This approach, reflected in the EPSR, underlines the need for the greater coherence of social policy across EU Member States, endorsing social justice and support for vulnerable populations, including disabled, dependent, and older people and the prevention of ageism and discrimination. Several principles are particularly relevant for active ageing. Principle 1 states the right to quality and inclusive education, training, and lifelong learning that aim to allow people to acquire and maintain skills to enable them to participate fully in society and in the labour market. Principle 10 points to the right of establishing a working environment suitable to the abilities of workers and creating the conditions for prolonging professional activity. Principle 15 states that every older person has a right to adequate financial resources, enabling dignified living. Principles 16, 17, 18 and 20 set the agenda for creating a sustainable environment for population ageing and activity in older age by access to services:

- assuring timely access to affordable and high-quality healthcare;
- providing disabled people with income, supportive services for an inclusive labour market, and an adequate work environment;
- providing good quality and affordable long-term care and particularly home care services;
- supplying access to essential services of good quality, including water, sanitation, energy, transport, financial services, and tools for digital communication.

The EC has placed demography high on the EU policy agenda. In March 2021, the European Commission (2021b) published an Action Plan on the implementation of the EU Pillar of Social Rights.

² Innovation Union, the European Commission. Available at: https://ec.europa.eu/info/research-and-innovation/strategy/goals-research-and-innovation-policy/innovation-union_en.

³ UN Department of Economic and Social Affairs – Sustainable Development, The 17 Goals. Available at: <https://sdgs.un.org/goals>.

⁴ UN Department of Economic and Social Affairs – Ageing, Madrid Plan of Action and its Implementation. Available at: <https://www.un.org/development/desa/ageing/madrid-plan-of-action-and-its-implementation.html>.

The plan covers ageing policies and access to services in a wider sense in several ways. Among others, the Commission published a long-term care report (European Commission and Social Protection Committee 2021a) together with EU-27 country studies and a pension adequacy report (European Commission and Social Protection Committee 2021b) with EU-27 country profiles. It will publish the EU report on access to essential services in 2022. Next, the EC will propose a framework for policy reforms in long-term care in 2022 and tools to better measure barriers and gaps in access to healthcare in 2021-2022 and will promote access to health data for better healthcare, research, and policymaking and better use of digital services in healthcare through the European Health Data Space (EHDS) in 2021.

The importance of rights and investments needed to stimulate active ageing was also highlighted in the European Commission's Green Paper on Ageing (European Commission, 2021a), meant to ignite a broad policy debate on ageing and discuss options on how to respond to the challenges and opportunities linked to ageing. The Green Paper states that although healthy and active ageing is an individual responsibility, public policies play a significant supportive role, creating an economic and social environment enabling activation. While competencies for dealing with the effects of ageing are predominantly the domain of the Member States, the EU can identify the most important issues and trends and can help the Member States to develop ageing policies at the national, regional, and local levels. Ways to minimise the negative consequences of the ageing of societies include promoting healthy and active ageing, improving the sustainability of health and care systems, improving labour market performance, launching a debate on the conditions for the labour market participation of older workers, and fostering legal migration. The Green Paper has a strong territorial dimension, underlining the need for tackling territorial differences in access to healthcare in rural and peripheral areas (i.e. "medical deserts"), problems with territorial differences in access to education over the life span which to some extent can be overcome by digital education, and differences in employment and productivity across European regions. The Green Paper also referenced the UN Decade of Healthy Ageing 2021-2030, a global initiative aimed at fostering healthy ageing, focusing on age-friendly environments, combatting ageism, integrated care, and long-term care (WHO 2021). Regarding the territorial aspects of demographic change, the EC launched an EU Atlas of Demography – a publicly available interactive tool to measure changes in support to older people in various policy areas: employment, health, education, access to services, as well as cohesion policies⁵.

During the COVID-19 pandemic, enormous pressure has been placed on the European healthcare systems, which struggle to ensure adequate access to care. The EU has undertaken unprecedented measures to support Member States through the Coronavirus Response Investment Initiative, reallocating financial resources to strengthen national healthcare systems in a collective effort to fight the pandemic. Further, the EC set an agenda to build a European Health Union (European Commission 2020a), taking into account the need to stay prepared for future health crises, changes in demographic structures, and related health vulnerabilities. The European Health Union builds on experiences from the COVID-19 pandemic with the need for strengthened security and enforced coordination between the EC and Member States with respect to medicines supply (including vaccinations), crisis response planning, and epidemiological surveillance to avoid cross-border threats to health. Focusing on health, the EC has launched EU4Health, the EU's fourth health programme, running in 2021-2027. EU4Health will distribute EUR 5.1 billion over seven years to improve health in the EU, by protecting people from cross-border health threats, strengthening national health systems, and improving the availability, accessibility, and affordability of medical supplies such as medicines. The pandemic has uncovered the need for the health systems to become better coordinated and more resilient throughout the EU.

⁵ European Commission, Atlas of Demography. Available at: <https://ec.europa.eu/jrc/en/news/commission-launches-interactive-tool-monitor-and-anticipate-demographic-change-eu>.

Next to this, the pandemic brought attention to occupational safety and health, which is addressed in the European Commission Health and Safety Strategy 2021-2027 (European Commission, 2021c). The Strategy is an element of the EPSR action plan, setting key priorities regarding the improvement of worker health and safety, taking into account the need for synergy between occupational health and public health. The framework focuses on three objectives, including anticipating changes in the world of work related to the green, digital, and demographic transition, improving the prevention of workplace accidents and illnesses, as well as increasing preparedness for any potential future health crisis.

The European Semester reports and Country Specific Recommendations address the problems of (in)adequate support of older people within labour and social policy. The reporting is not oriented on active ageing *per se*, but it provides a regular assessment of the situation for older people with respect to their vulnerabilities arising from the risk of labour market exclusion, pension inadequacy, and long-term care needs. Country specific recommendations underline the needs for the following: to create the right incentives within national policies to increase the employment of older cohorts in countries with low employment rates of people aged 55-64; to introduce pension reforms extending working life; to invest in the provision of long-term care in countries with high unmet needs for care; and to increase the quality of care and need for investment in healthcare in countries with overall low healthcare spending and problems with access to healthcare services.

Apart from efforts to foster a wide policy debate on ageing and implement policy initiatives – among which is motivating Member States to use EU funding such as the Recovery and Resilience Facility and the ESF+ (European Social Fund) 2021-2027 for activities contributing to active and healthy ageing – the EC is continuing to invest in research on the effects of ageing on societies as well as identifying ways to mitigate its negative consequences. Recent reports include: the *2021 Ageing Report* (European Commission, 2021f), containing economic and budgetary projections for the EU Member States up to 2070; the *2020 Strategic Foresight Report* (European Commission, 2020b), which focuses on "megatrends" like ageing which are long-term forces likely to greatly influence the future; *Challenges and prospects in the EU: Quality of life and public services* by Eurofound (2019); and a report by the Joint Research Council (Grubanov et al., 2021) entitled *Health and Long-term Care Workforce: Demographic challenges and the potential contribution of migration and digital technology*.

In line with the EC's attention to demographic changes, the European Parliament and the Council of the European Union are addressing the topic of ageing in various ways. The European Parliament (2021a) recently published the Demographic Outlook for the European Union, which examines existing demographic trends and focuses on how poverty relates to demographic indicators such as fertility and migration rates. The European Parliament's committee on Employment and Social Affairs (2021b) in 2021 organised a hearing, titled *Consequences and lessons from the COVID-19 crisis for people living in residential institutions*, in which the effects of COVID-19 on long-term care facilities were discussed. The European Parliament adopted a resolution entitled *Old continent growing older – possibilities and challenges related to ageing policy post-2020* (European Parliament, 2021c). The resolution states that the EU should motivate Member States to make more use of EU funds, such as ESF+ and ERDF (European Rural Development Fund), to address the challenges of population ageing, for example by adjusting infrastructure and public spaces to the needs of older people. The report also highlights the need for action in combating loneliness among the older and strengthening intergenerational bonds, for example by promoting mentoring and volunteering activities and organising day care centres for the older. Also, the report proposes a European Year for Dignified Ageing meant to target loneliness and support intergenerational ties. It also draws attention to territorial disparities in ageing and the need for strengthening the sense of security of older people by promoting the use of digital

technology. Another recent activity by the European Parliament is the *Opinion of the Committee on Employment and Social Affairs for the Committee on Regional Development on reversing demographic trends in EU regions using cohesion policy instruments* (European Parliament, 2020). This contribution focuses on the effects of the ageing population, particularly on rural areas that are already lagging behind, and aims to encourage the Member States to use the Recovery and Resilience Facility (RRF) and Cohesion Fund resources, in particular the European Regional Development Fund and the ESF+, to improve the attractiveness of areas experiencing significant and long-lasting demographic challenges by improving social and health services and enhancing the accessibility of public spaces in those areas. The opinion underlined the importance of improvements in monitoring the situation of older people by collecting more comparable data allowing the monitoring of the situation of older people in various age cohorts.

As for the Council of the European Union, Germany, Portugal, and Slovenia, the Member States holding the presidency of the Council of the European Union from July 2020 to December 2021, presented a joint *Trio Declaration on Ageing*⁶. In this declaration, they call for the adoption of an age-integrated, rights-based, life-course perspective approach to ageing (p. 4), urging the Member States to take more action against violence, neglect, and discrimination against older persons, strengthen lifelong learning, promote healthy ageing, and more actively involve older people in decision making. During Germany's presidency, the Council of the European Union adopted *Conclusions on Human Rights, Participation and Well-Being of Older Persons in the Era of Digitalisation* (Council of the European Union 2020) which among others highlights the need for the Member States to ensure that the digital gap between generations is resolved and that non-digital services are maintained. Most recently, under Portugal's Presidency, the Council adopted *Conclusions on Mainstreaming Ageing in Public Policies*, encouraging the Member States to put in place coherent, coordinated, and integrated public policies to respond to ageing (Council of the European Union, 2021).

After two decades of the promotion of active ageing in European and national policies, the COVID-19 pandemic put the possibility of successfully implementing healthy and active ageing policies into question. The pandemic had the greatest impact on the lives of older people, who became the most at risk of complications from the disease and faced the highest risk of death. The pandemic has also changed older people's routines and their potential to maintain active life engagement and stay socially connected by imposing physical (and often social) distancing. It has also – at least temporarily – undermined the ability of local communities to provide adequate care due to lockdown measures and quarantine. This raises the question of the needs and ways to support the older population during the pandemic and in a post-pandemic world. The WHO⁷ as well as other stakeholders⁸ have underlined the necessity to undertake a global strategy towards ageing and health post-COVID-19 concentrated on strengthening communities and public authorities to address the health, psychological, economic, and overall impact of the pandemic to ensure dignified living and prevent ageism.

⁶ Germany, Portugal and Slovenia (2020). *Trio Presidency Declaration on Ageing*. Available at:

<https://www.bmfsfi.de/resource/blob/163180/c2173339af6c7568dbd168b29a31b06e/trio-presidency-declaration-on-ageing-data.pdf>.

⁷ COVID-19 and the Decade of Healthy Ageing, Decade of healthy ageing, 1 October 2020, Available at https://www.who.int/docs/default-source/decade-of-healthy-ageing/decade-connection-series---covid-19-en.pdf?sfvrsn=d3f887b0_7.

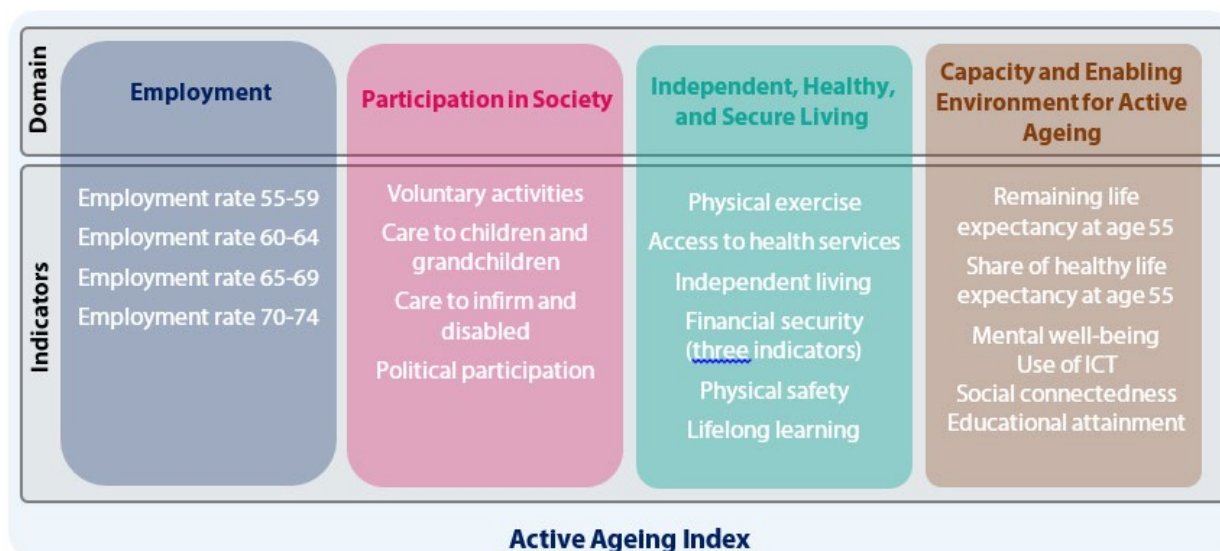
⁸ Coronavirus (COVID-19), AGE Platform, available at <https://www.age-platform.eu/coronavirus-covid-19>.

2.2. Monitoring active ageing

The EC together with the United Nations (UN) introduced a composite indicator to measure and monitor active ageing policies across the EU and UNECE countries – the Active Ageing Index (AAI)⁹.

Given its multidimensional character, the AAI captures different facets of active ageing, including capacity to actively age¹⁰ and actual active ageing experience¹¹. Being constructed based on 22 indicators across four domains, the index is measured for women and men separately, which further enables mapping gender gaps in the area of active ageing. It thus provides a flexible framework for assessing the baseline state of active ageing at the national and local levels, mapping existing policy gaps and potential gains, and monitoring progress.

Figure 1: Active Ageing Index at a glance



Source: UNECE 2019.

The latest assessment (2018) showcased the presence of substantial performance gaps across the EU with almost a 20-point difference between the countries with the highest (Sweden – 47.2) and lowest (Greece – 27.7) rankings.

In terms of AAI applicability, a number of EU Member States (e.g. Czech Republic, Malta and Poland) have already used the index for benchmarking and defining national active ageing policies and strategies. Examples of the subnational application of the AAI can also be found in other Member States, including Poland, Italy, Germany, and Spain. Specifically, the AAI was used by the Polish Ministry of Labour and Social Policy to map active ageing policy gaps across the 16 Polish regions and identify areas for policy involvement of the local and regional authorities. The results of the assessment were considered in the development of the Polish National Programme for the Social Participation of Older People (ASOS) for 2014-2020. Similarly, the 2016 pilot study in Germany provided for the development of an AAI for 30 out of 403 NUTS 3 (Nomenclature of territorial units for statistics) regions in Germany (UNECE 2019). However, the study highlighted the need to adjust AAI indicators by allocating a stronger focus to the locally relevant aspects of active ageing policymaking (Bauknecht et al., 2017). Aside from the country-wide initiatives to develop a subnational AAI, the Biscay Province of Spain has

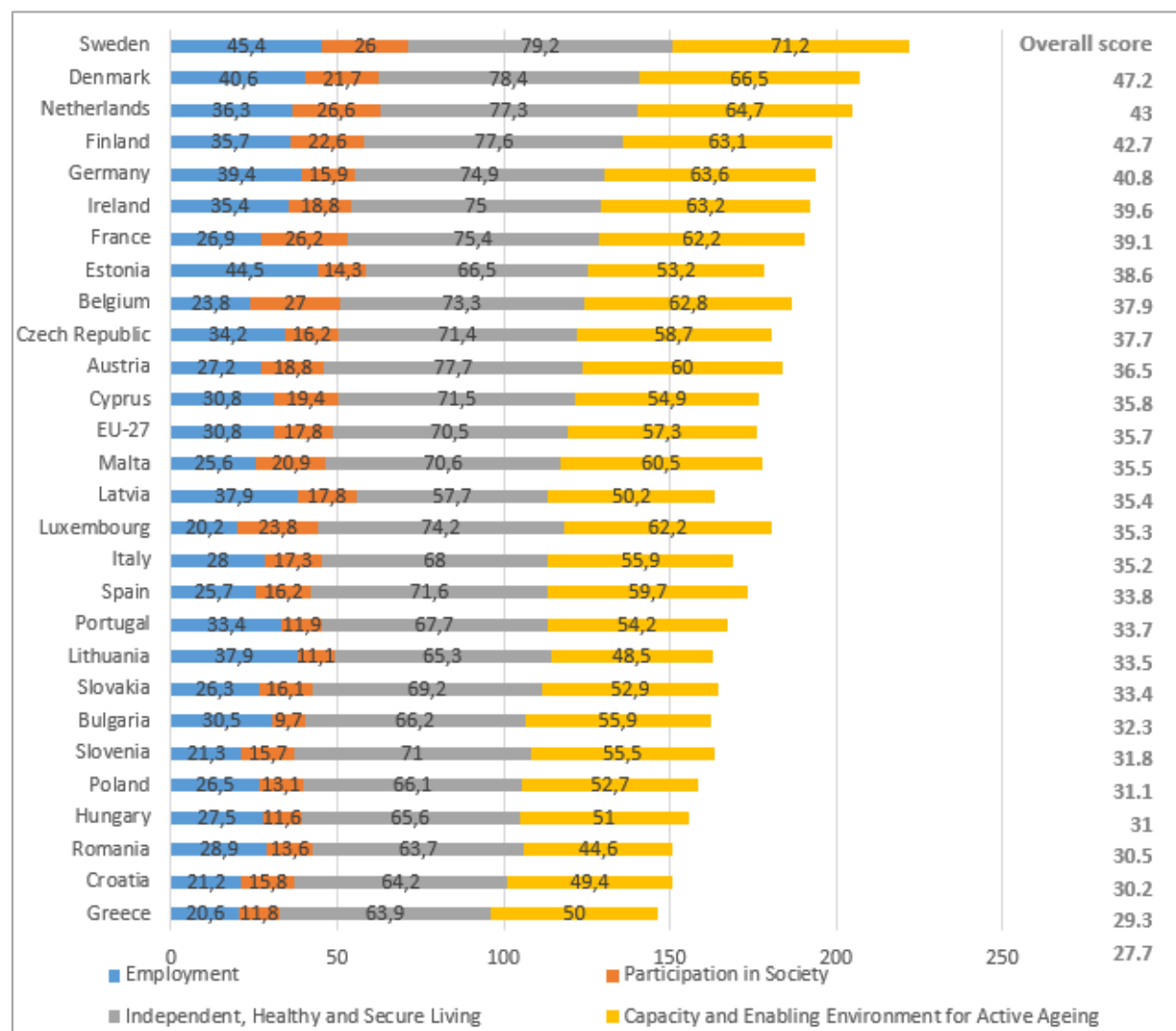
⁹ Active Ageing Index. Available at: <https://unece.org/population/active-ageing-index>.

¹⁰ As measured by 'Capacity and Enabling Environment for Active Ageing' domain.

¹¹ As measured by 'Employment', 'Participation in Society', and 'Independent, Healthy and Secure Living' domains.

been using the AAI to monitor the implementation of the regional plan on active ageing since 2013 (UNECE, 2019).

Figure 2: AAI score overall and by domain, EU-27, 2018



Source: AAI, 2018. Available at:

<https://composite-indicators.jrc.ec.europa.eu/active-ageing-index/active-ageing-index/explorer>.

While it is the first measure that allows for a comparison of the activity of older Europeans, its performance indicators are highly dependent on social protection systems and – at least partly – measure the opportunity structures created by the welfare systems. Further, considering the difficulty in obtaining relevant data at the subnational level (Perek-Biała & Zwierzchowski, 2015, Bauknecht et al., 2017), the AAI does not allow for a continuous and comparable assessment of the ageing experiences at the local and regional levels.

Further efforts should thus focus on the adjustment of the AAI indicators to better capture the local dimension of the active ageing policies. The individual-level composite active ageing index based on the SHARE data provides in this sense an alternative measure as it allows to disaggregate the assessment of the ageing experience within the countries (Barslund et al., 2017).

3. FOSTERING ACTIVITY AND ACCESS TO SERVICES IN THE EU-27

KEY FINDINGS

The COVID-19 pandemic has changed working routines for people aged 55-64 by decreasing the number of weekly hours worked and temporarily not working due to pandemic restrictions.

The EU-LFS records a slight increase in unemployment of people aged 55-64 between the first quarter of 2020 and the first quarter of 2021, but no major changes in employment rates. Nonetheless, further monitoring of economic activity of different age cohorts is recommended.

The pandemic has facilitated the transition to flexible working arrangements with around 55% of people aged 55-64 preferring to work from home at least several times a month also in future.

Before 2020, a slow increase in some aspects of social participation could be observed; however, the pandemic hindered social activity in 2020, with the exception of some voluntary activities.

The share of people aged 55-64 having above basic digital skills differs significantly among countries and ranges from 5% in Bulgaria to 40% in Ireland.

Access to the internet among older people can mitigate their isolation and social exclusion as well as improve their access to social services in future. However, considerable differences exist between countries in the availability of ICT infrastructure and knowledge of older people on how to use ICT.

Increases in life expectancy and healthy life years have been halted by the COVID-19 pandemic. Mental well-being of older people has also deteriorated, most notably for the people aged 50-64.

Unmet needs for medical care grew in 2020, particularly in countries with lower healthcare spending and where people had experienced difficulties in access to medical care in the past. Long-term care provision during the COVID-19 pandemic has required numerous supportive measures: guidelines, support for LTC workers, additional funding, and reorganisation of service provision. Older individuals living alone are especially vulnerable during the pandemic because of the lack of social contacts and decreased opportunities to receive care or help with everyday activities.

More than one tenth of the older population suffer from housing cost overburden. Older women are more likely to be overburdened by housing costs than men.

Older people living in poor housing and housing not adjusted to their specific needs were especially negatively affected by the lockdown regime.

The accessibility of public transport during the pandemic, especially for the older people, has significantly decreased. Older women are more financially vulnerable than men, often due to their lower pension benefits. The financial situation of pensioners in most of the cases was not affected by the pandemic.

Active ageing policies are not a separate funding target in the RRP, but they are indirectly addressed throughout several RRF pillars, particularly healthcare, long-term care and digital investments.

3.1. Economic activity

Deciding whether to leave the labour market and enter retirement is an individual decision of people entitled to a pension. This decision can be affected by diverse factors: health status, family situation, personal preferences, socio-economic situation, and pension policies, but also the policy incentives that support people's well-being in economic activity. In the last decade, the majority of EU countries have implemented substantial pension system reforms in line with the increased life expectancy. A key element to most pension reforms has been the gradual increase in the pensionable age, thus adjusting benefits and financial resources to changes in life expectancy and an increase in the dependency ratio. These reforms have been combined with policy measures that aimed to extend working lives and the employability of older workers, for example through flexible working arrangements that allowed them to gradually transition from full-time to part-time to very part-time (European Commission, 2016). On top of this, many countries introduced incentives to support the employment of the older workers through lifelong learning programmes encouraging them to upskill and reskill, and several measures and projects increasing their chances of employment¹². Over the past two decades, a continuous and stable increase in the economic activity of people aged 55 plus has been observed. Some researchers suggest that the phasing out of the country-specific routes to early retirement, including strengthening financial incentives (or "penalties" for early retirement), may have played the biggest role in extending working lives (Konle-Seidl, 2017). As the most recent statistics show, the share of the employed aged 55 in total employment in the EU continuously increases since 2002¹³.

Nevertheless, significant differences across the EU countries still persist in this respect, with the Nordic countries performing the best when it comes to the economic activity of the older people, and the eastern European and southern European countries performing much worse. The most recent EU-LFS data shows almost no change in the employment rate¹⁴ and only a slight increase of unemployment of people aged 55-64 (+0.7 pp) following the outbreak of the COVID-19 pandemic¹⁵. The SHARE database, measuring the activity rate among people aged 50-54 during the first wave of the lockdown showed a slight decrease in their labour market participation. Close monitoring of the labour market situation of different older age groups of people is therefore recommended.

3.1.1. Pension reforms

The EU-wide implementation of reforms that aim to increase the retirement age and support the labour market participation of older people has resulted in a continuous increase in the activity rates of people aged 55-64 since 2002, with a limited impact on other age groups.

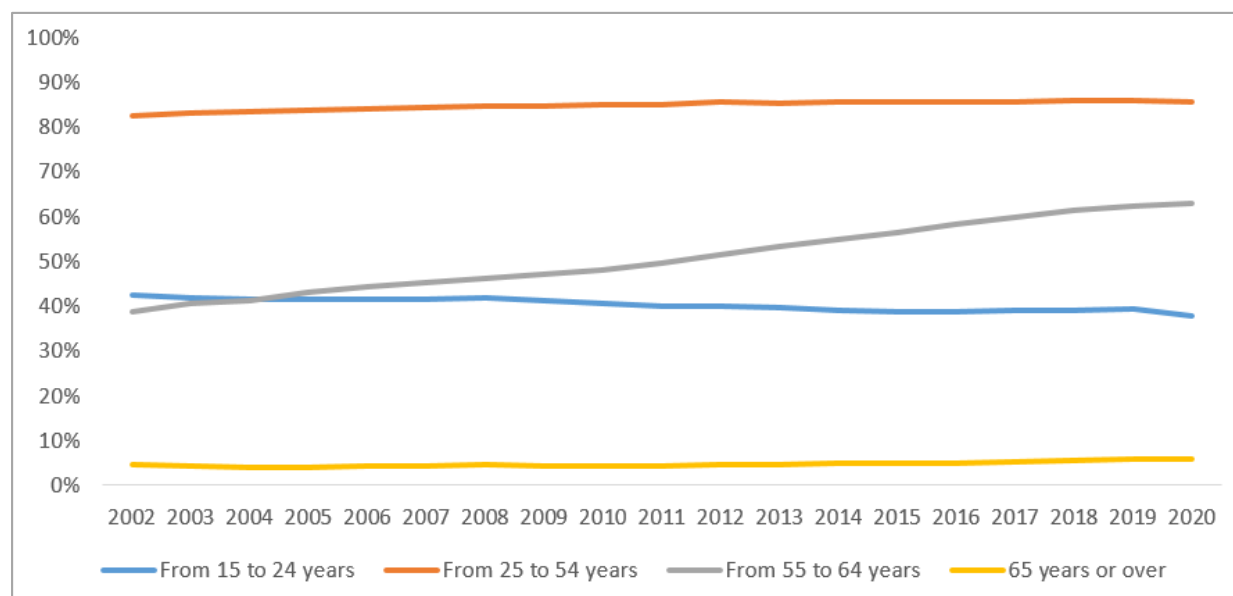
¹² See for example the results of the FP7 MOPACT project.

¹³ Eurostat, Population by sex, age, country of birth and labour status [lfsa_pgacws], 2020 (latest available). Available at: https://ec.europa.eu/eurostat/web/products-datasets/-/lfsa_pgacws.

¹⁴ Eurostat, Employment rates by sex, age and citizenship (%) [LFSQ_URGAN]. Available at: https://ec.europa.eu/eurostat/databrowser/view/LFSQ_URGAN_custom_1342905/default/table?lang=en.

¹⁵ Eurostat, Unemployment rates by sex, age and citizenship (%) [LFSQ_URGAN]. Available at: https://ec.europa.eu/eurostat/databrowser/view/LFSQ_URGAN_custom_1342837/default/table?lang=en.

Figure 3: Activity rate by age, EU-27, 2020



Source: Eurostat, Population by sex, age, country of birth and labour status [lfsa_pgacws], downloaded 2021 (latest available).

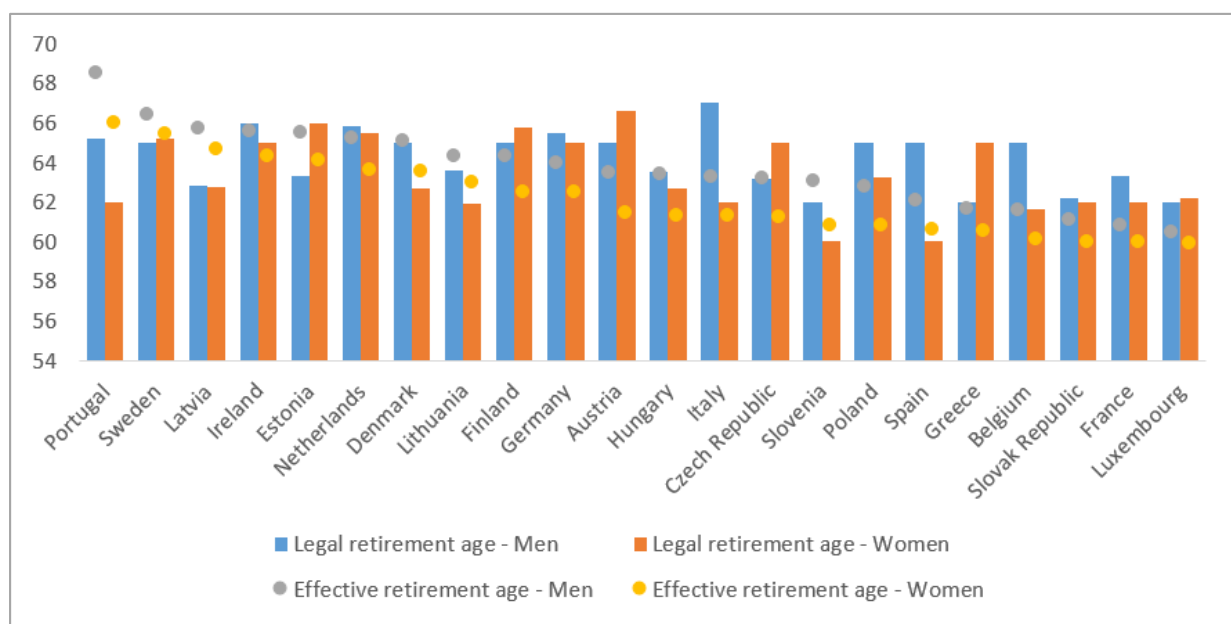
Note: Activity rate is measured as share of active population (employed or unemployed) in the total population for each age group.

The reforms that increase the retirement age can be associated with an increase in the duration of employment. In this light, Staubli and Zweimüller (2013) estimated that increasing the early retirement age (ERA) in Austria led to a 9.75 % and an 11 % increase in labour market participation among men and women, respectively. Considering financial factors, Qi (2018), Hanel (2010), and Berkel (2004) estimated that the reduction of benefits in the case of Swedish and German pension reforms led to an increase of the average effective retirement age for both men and women.

Yet, statutory retirement age and pension schemes appear to be only one of the many factors affecting the retirement decision of an employee. Other non-financial factors, including, among others, health, social and psychological well-being, leisure valuation (Jaworski et al., 2016) and labour demand aspects (Duval 2003) are significant elements of a retirement decision.

This is confirmed by the presence of gaps between the effective and statutory retirement age throughout the EU Member States. Defined as the actual age people withdraw from the labour force, the effective retirement age was higher than the statutory retirement age for both genders in only six analysed countries, i.e. Portugal, Sweden, Latvia, Denmark, Lithuania, and Slovenia. Whereas in the rest of the countries, both men and women tend to retire earlier than is foreseen by the statutory retirement age.

Figure 4: Gap between effective and statutory retirement age, by gender, 2018



Source: OECD. Ageing and Employment Policies – Statistics on average affective age of retirement, downloaded 2021 (latest available).

3.1.2. Flexible working arrangements/working time adjustment

A key element to most pension reforms is the introduction of the mechanisms which increase the retirement age, thus adjusting to the new demographic dynamics in the EU, including the growing life expectancy and higher dependency ratio, and ensuring the sustainability of financial pensions systems.

Considering the importance of the inclusion of the older groups for sustained economic growth, a number of countries, including Belgium, Denmark, and Estonia, shifted the focus of their retirement reforms towards introducing incentives and flexible working arrangements to extend the duration of working life (OECD, 2019). Thus, traditional pension age reforms have been combined with policy measures that aim to extend working lives and the employability of older workers, for example through flexible working arrangements allowing the older to gradually move from full-time to part-time to very part-time (European Commission 2016). This includes, in particular, the possibility to combine the pension benefit with part-time or full-time employment and higher incentives for deferred retirement (EC, 2021 and OECD, 2017).

The European Institute for Gender Equality (EIGE)¹⁶ defines flexible work arrangements as a mixture of work structures, which allows for flexibility in the scheduling of working hours, the possibility to move between part-time and full-time work, as well as flexibility in the place of work. This type of employment aims to provide an employee with a greater ability to balance work, family, and personal life. EU-SILC (European Union Statistics on Income and Living Conditions) statistics (EU-SILC, 2017) show that in 2017 only around 9 % of employees could choose between several working schedules determined by the company, 19 % could adapt their own working hours within certain limits, while over 55 % did not have the possibility to change their working time arrangements. Existing research highlights that older employees are more keen on maintaining a work-life balance (Richert-Kaźmierska & Stankiewicz, 2016), work flexibility, and moderate physical activity. These are the key elements of

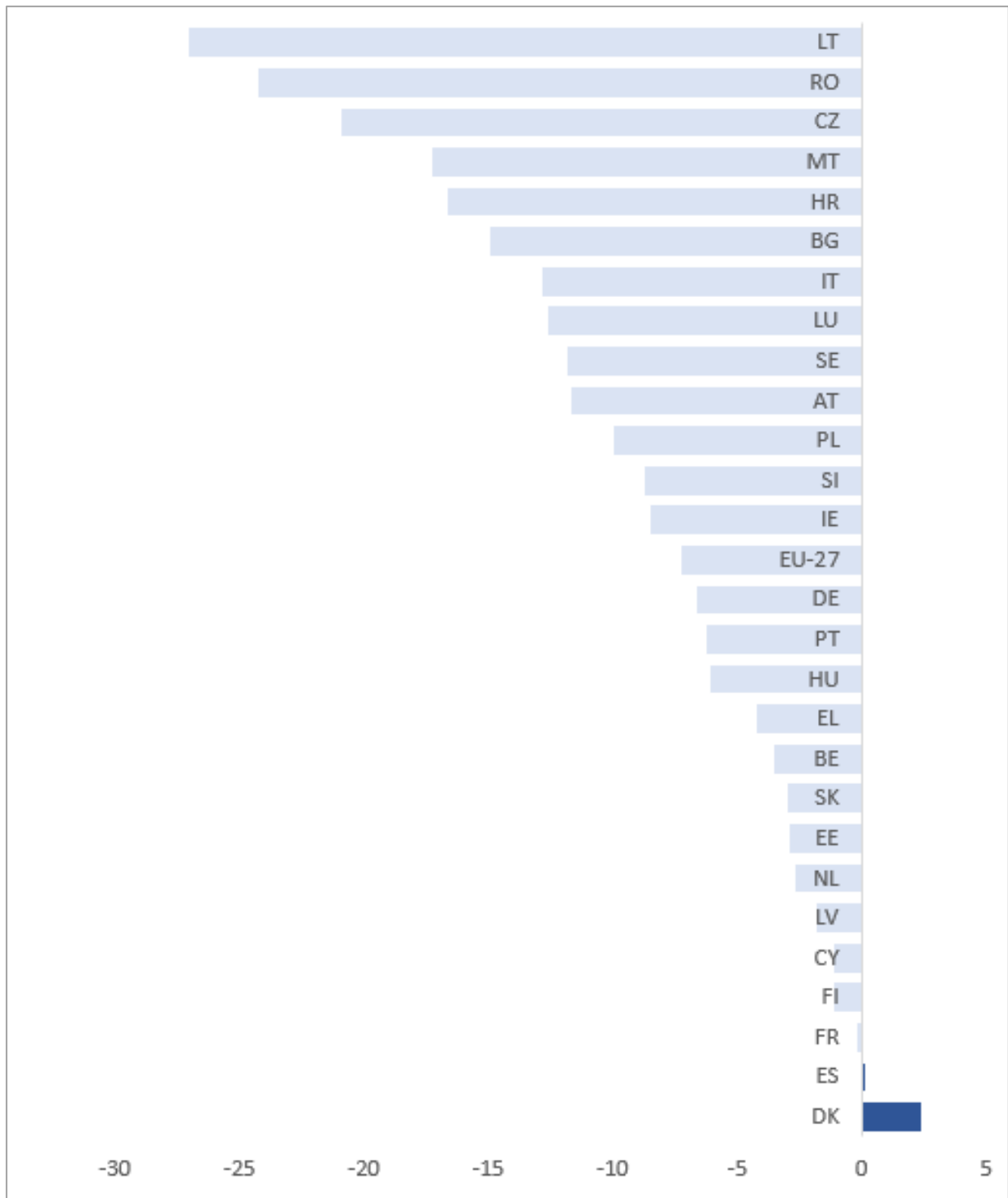
¹⁶ European Institute for Gender Equality (EIGE). Work-life balance. Available at: <https://eige.europa.eu/gender-equality-index/thematic-focus/work-life-balance/flexible-working-arrangements>.

their job satisfaction.

Enabling a better work-life balance across the life-course has been a priority of the EU policy goals for many years now. Defined as a satisfactory state of equilibrium between the individual's work and private life, it is aimed at ensuring that the work is sustainable for all (Eurofound, 2021). The Work-Life Balance Directive (Directive (EU) 2019/1158) is aimed at establishing minimum standards for parental leave, carers' leave, flexible working arrangements for parents and carers, and security against unfair dismissals. A minimum period of four months of parental leave is guaranteed under this Directive, and the return to work from parental leave should be secured in the contract. The Directive adopted in June 2019 obliged all EU Member States to transpose the Directive in their national law within the next three years.

While the Directive is an important milestone for the implementation of flexible working arrangements, it only responds to family needs. It does not address the preferences of other working groups, like older employees, to let them smoothly move from full-time employment to more flexible forms of work. Further, considering gender asymmetry in assuming caring responsibilities beyond parenthood, flexibility of working arrangements and part-time work, in particular, was found to support the labour market participation of women across all age groups. Prolonged periods of reduced working hours, however, tend to result in lower income, social security contributions, and long-term job stability for women. At the retirement age, this means lower benefits and the continuation of income inequalities beyond the working life or the need to extend the duration of working life to access benefits and achieve a sustainable and adequate pension level for women. In this light, both the OECD (2019) and recent Eurostat data underline a higher relative old-age income poverty for women. A certain degree of correlation can be noticed between the lower generosity and flexibility of the pension schemes, a higher at-risk-of-poverty rate for women, and a later than statutory effective retirement age across CEE countries, in particular.

Figure 5: Gender differences in the at-risk-of-poverty rate (65+), 2019

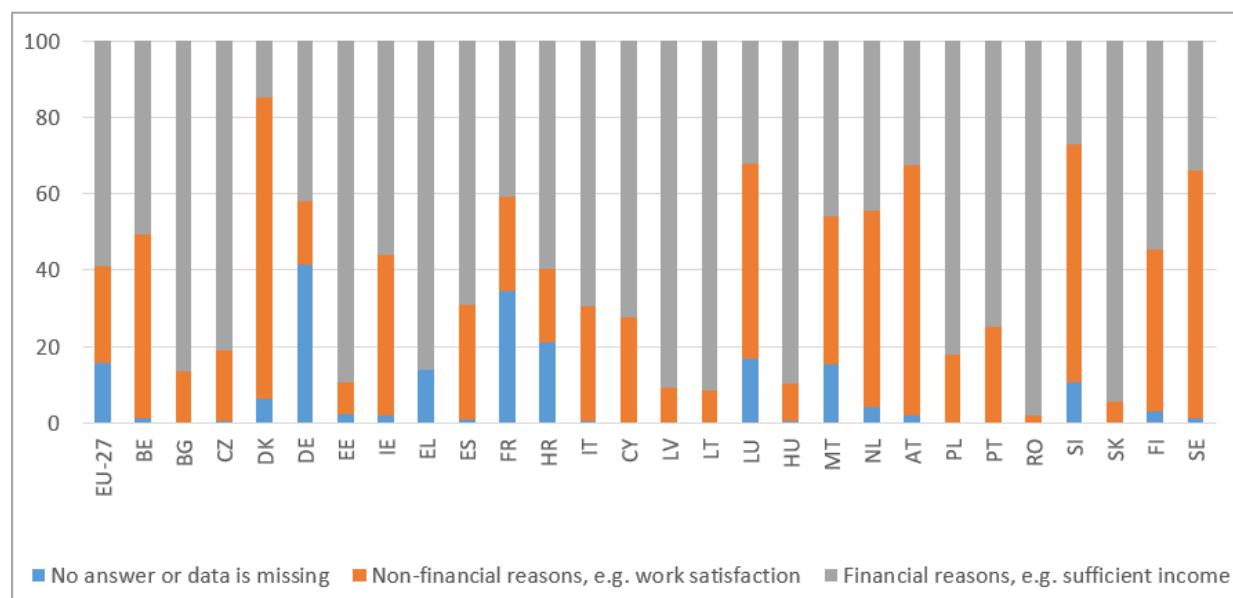


Source: Eurostat, EU-SILC survey, [ILC_PNP12], downloaded 2021 (latest available).

The latest (2012) Labour Force Survey dedicated to the transition from work to retirement confirms the role of both financial and non-financial factors in retirement decisions. Thus, non-financial reasons to continue working appear to have a higher role in Nordic countries which traditionally offer more flexible and generous retirement schemes. Financial aspects, and in particular, the "provision of sufficient household income" was found to be the primary reason for continued employment for people entitled to a pension in the CEE and Baltic states, where rates of income poverty tend to be

higher for the population over 65 years of age, compared to other age groups (OECD 2019).

Figure 6: Main reason for pensioners to continue working, in %, 2012



Source: LFS AHM, [lfs0_12staywork], downloaded 2021 (latest available).

Note: "Financial reasons" studied by the LFS include (i) to provide sufficient personal/household income; (ii) to establish or increase future retirement pension entitlements; and (iii) both combined.

3.1.3. Health and safety in the workplace

87 % of people across the EU believe that good occupational safety and health (OSH) is an important factor encouraging people to work longer (EU-OSHA, a). On the other hand, many Europeans express their concern that their workplace conditions might not be satisfactory to allow them to work while ageing. 42 % of them admitted that they will be able to stay in the same work until the age of 65 or more, while almost 20 % express their concern that they will not be able to carry on the same type of job. More than half said that their workplace is not adapted enough to the needs of older workers (Flash Eurobarometer, 2012).

Promoting high standards in the areas of health, safety, and well-being in the workplace is a key priority in the EU's activities. The European Framework Directive on Safety and Health at Work (Directive 89/391 EEC) was adopted in 1989. Since then, several steps and changes have been introduced and promoted in order to adjust workplaces to new occupations and new societal challenges and needs.

One is workplace health promotion, implemented by the European Agency for Safety and Health at Work (EU-OSHA, a). It is defined as a combination of activities of employers, employees, and society, aimed at improving the health and well-being of people at work. It focuses on such issues as health education and training, delivering work-life balances, decreasing stress and mental well-being, as well as changing people's lifestyles. Specifically, EU-wide policy development on these topics has benefited from the 2012 comprehensive analyses on best-practices and policy initiatives aimed to ensure workplace safety in the context of an ageing workforce (EU-OSHA, b). The results of the project were later used to feed into the 2016-2017 Healthy Workplaces for All Ages Campaign (EU-OSHA, c) dedicated to the promotion of a safe and sustainable work environment. To further support awareness raising among stakeholders and facilitate the development of new initiatives in the context of ageing, EU-OSHA has launched a data visualisation tool on ageing and OSH (EU-OSHA, d) as well as a guide on managing OSH for an ageing workforce (EU-OSHA, e).

At the national level, all Member States' legislation must comply with the minimum standards set up by the EC. Although, they are allowed to adopt stricter rules, which leads to a situation where national safety and health legislation differs across Europe. The evaluation report (COWI, 2014) on the practical implementation of the EU Occupational Safety and Health Directive shows that the regulations are, as a rule, well implemented by countries.

3.1.4. Lifelong learning

In a rapidly changing world, lifelong learning activities are an essential element that allow people to stay active in economic and social life throughout the life-course. Lifelong learning activities include participation in non-formal and formal education, as well as training.

The strategic framework for European cooperation in education and training (ET2020) has previously defined the target of at least 15 % of adults taking part in lifelong learning by 2020¹⁷. Yet, as the latest Eurostat data shows, the target participation rate has only been achieved in a fraction of countries, with the EU-27 average remaining at around the 9 % level in 2020, despite a slight increase in the participation rates between 2012 and 2013, i.e. the Year for Active Ageing.

In a continuation of EU priorities, lifelong learning activities are at the core of the European Skills Agenda for sustainable competitiveness, fairness, and resilience¹⁸ adopted in 2020. The 2025 objectives set by the Agenda include the objectives presented in the table below.

Table 1: European Skills Agenda for sustainable competitiveness, fairness, and resilience

Indicators	Objectives by 2025	Current level (latest year available)
Participation of adults aged 25-64 in learning during the last 12 months (in %)	50 %	38 % (2016)
Participation of low-qualified adults 25-64 in learning during the last 12 months (in %)	30 %	18 % (2016)
Share of unemployed adults aged 25-64 with a recent learning experience (in %)	20 %	11 % (2019)
Share of adults aged 16-74 having at least basic digital skills (in %)	70 %	56 % (2019)

Source: European Skills Agenda. Available at: <https://ec.europa.eu/social/main.jsp?catId=1223&langId=en>.

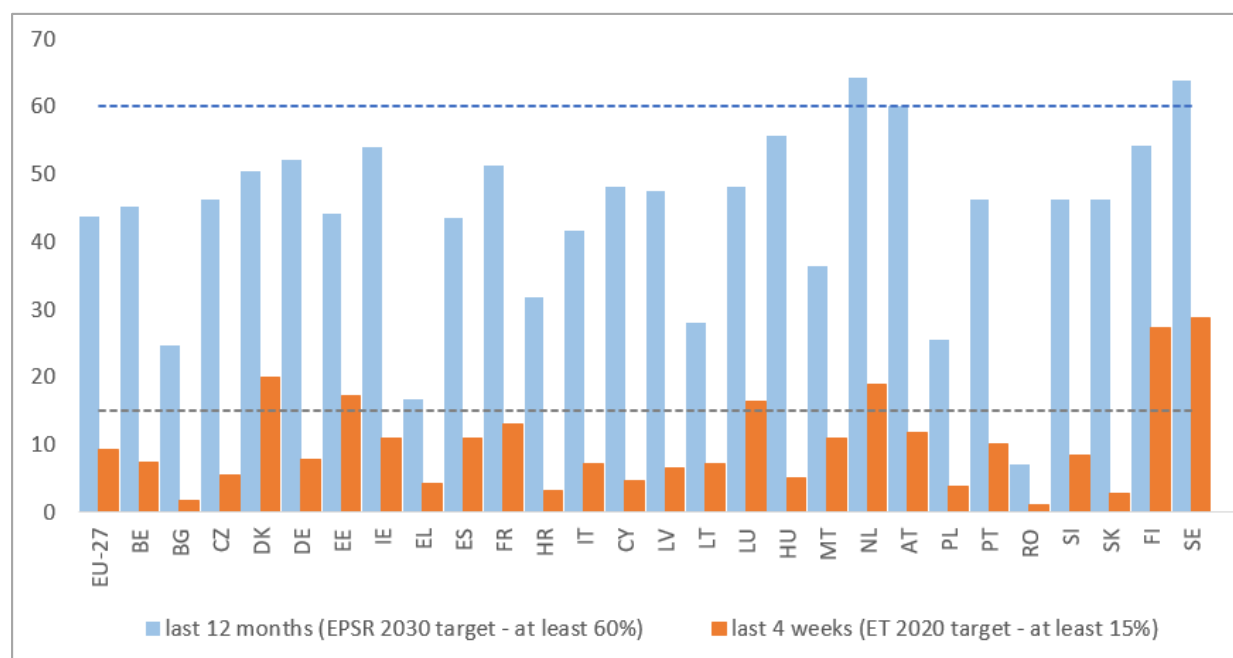
The newly introduced EU 2030 target shifts towards a more comprehensive measure by focusing on adult participation in learning in the last 12 months. Set to achieve at least a 60 % level by 2030, the new indicator has only been collected on a five-year basis until recently, limiting the possibility for an up-to-date assessment. In line with the new priorities, however, relevant data will be collected on a biennial basis starting from 2022 and will fully replace the "last four weeks" indicator in future policy monitoring¹⁹.

¹⁷ European Commission. ET 2020 framework. Available at: https://ec.europa.eu/education/policies/european-policy-cooperation/et2020-framework_en.

¹⁸ European Commission. Employment Skills Agenda. Available at: <https://ec.europa.eu/social/main.jsp?catId=1223&langId=en>.

¹⁹ Eurostat. Adult learning statistics. Available at: https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Adult_learning_statistics.

Figure 7: Adult participation in education and training, in %, 2016 and 2020



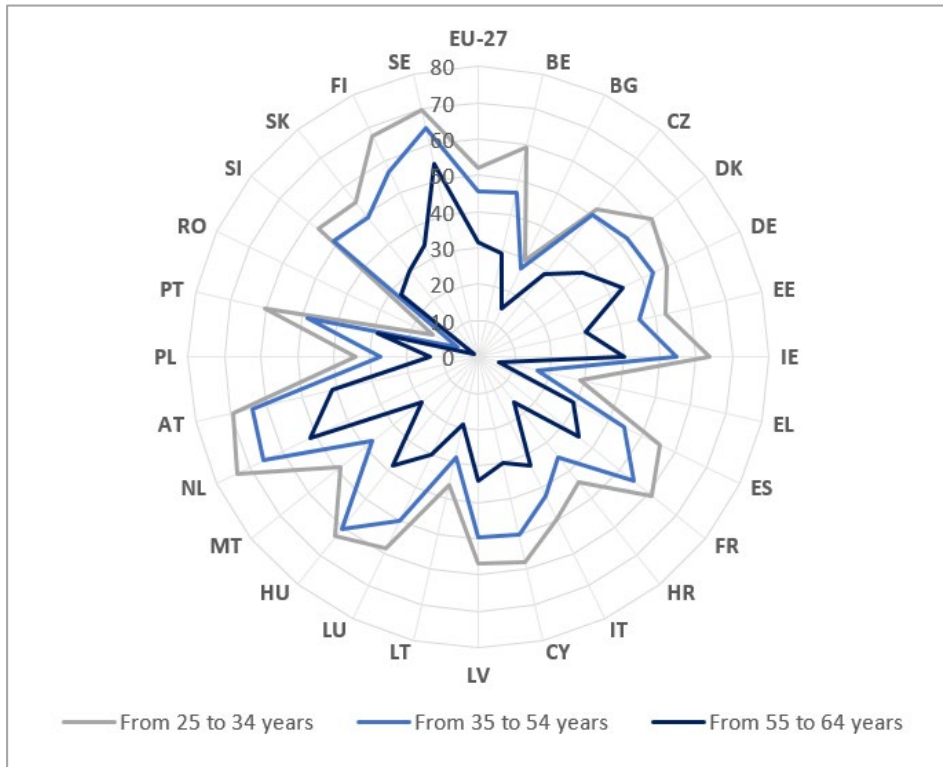
Source: Eurostat [trng_lfse_01], downloaded 2021 (latest available) and Eurostat [trng_aes_100], downloaded 2021 (latest available).

Note: data on participation in education and training over the last 4 weeks are for 2016 and over the last year are for 2020.

Country differences are visible in this respect, with participation rates in countries like the Netherlands, Austria, and Sweden already standing at a 60 % level. A substantial gap is present in most of the CEE countries, with participation rates for the "last 12 months" standing as low as 7 % in Romania.

In general, vocational education and training (VET) is aimed at "*equipping people with knowledge, know-how, skills and/or competencies required in a particular occupation or more broadly on the labour market*" (Cedefop, 2014). Despite the growing awareness of the role of CVET in active ageing policies, the participation of older-age groups remains relatively low. The results of the most recent (2016) Adult Education Survey (AES) thus show a clear decline in learning participation throughout the life cycle. While the rates of participation for 55-64 years old are substantially lower than for other age groups, the mean hours spent in learning is also declining throughout the life cycle. Thus, among those that participate in CVET at all, the 55-64 years old group spends on average 70 % fewer hours in learning compared to the 25-34 years old group and 30% fewer compared to the 35-54 years old group.

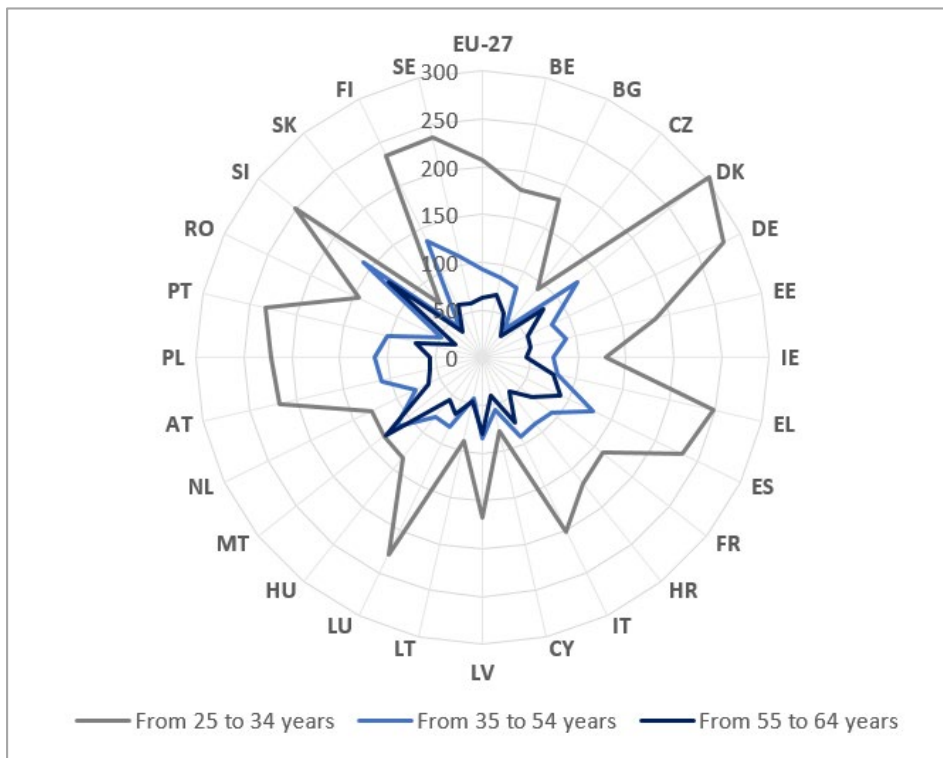
Figure 8: Participation rate in education and training by age, in %, 2016



Source: Eurostat [trng_aes_101], downloaded 2021 (latest available).

Note: data cover the last 12 months before the survey was taken.

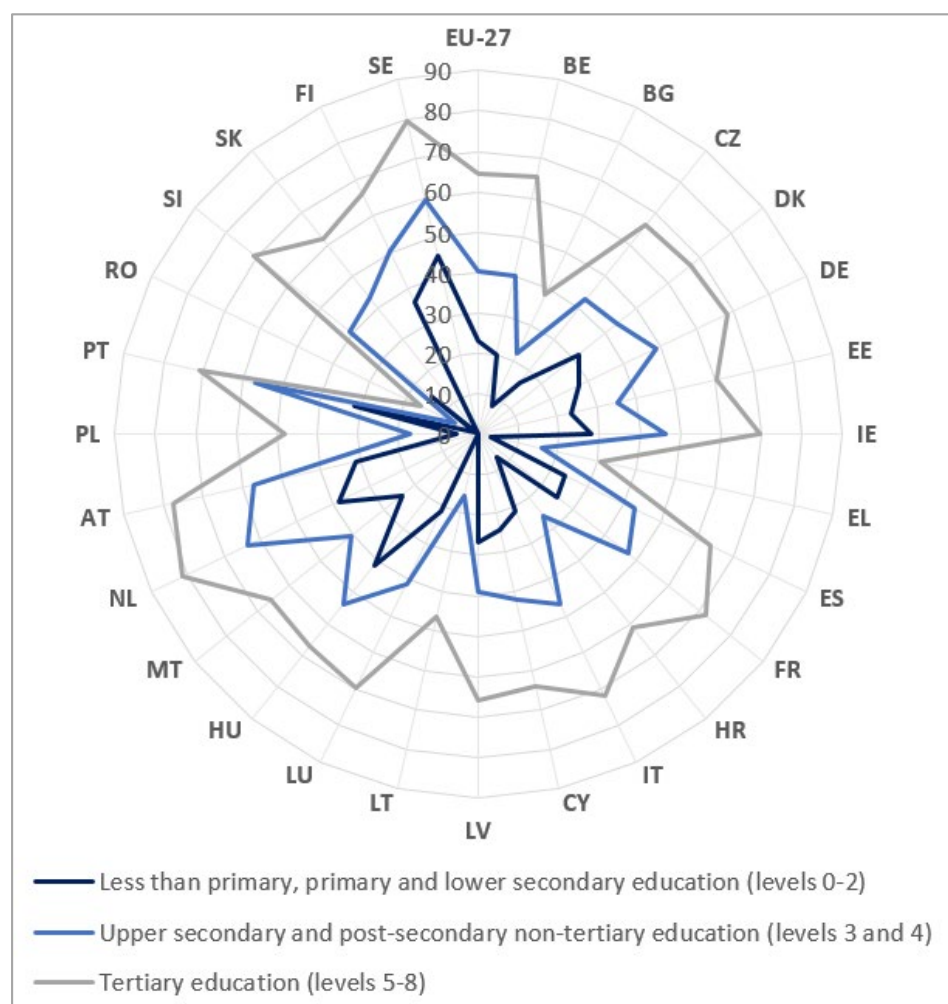
Figure 9: Mean instruction hours spent in education and training by participant, 2016



Source: Eurostat [trng_aes_147], downloaded 2021 (latest available).

Considering the reasons for non-participation in learning activities, non-willingness to participate has been reported by 87.4% of AES respondents in the 55-64 years old group (about 9.4% and 14.1% more than that for the 35-54 years old and 25-34 years old groups) (Eurostat, 2016). This is related to, among other things, uncertainty over the future pay off of investing in learning (Osiander and Stephan, 2018), particularly for those close to retirement age. Low-skilled workers who, as a rule, have lower career growth opportunities and are at the highest risk of early exit from the labour market (Riekhoff, 2020) tend to have a lower interest in developing own human capital. At the same time, the participation of low-skilled workers is often undermined by the lack of financial resources to invest into learning, higher self-perceived skills sufficiency, and less learning opportunities provided by the employer (Osiander and Stephan 2018). The stratification of the AES results based on education level confirms a substantial learning participation gap between low- and high-skilled workers across all EU Member States.

Figure 10: Participation rate in education and training by education, in %, 2016



Source: Eurostat [trng_aes_102], downloaded 2021 (latest available).

Note: data cover the last 12 months before the survey was taken.

Although the older-age group is not specifically targeted in the 2020 European Skills Agenda, there is a focus on building skills throughout life in continuation of the 2016 Skills Agenda that emphasised the importance of VET as a key tool to address skills gaps and mismatches in the EU. The

2020 initiatives include, in particular, a Council Recommendation on VET²⁰ that calls on Member States and stakeholders to modernise VET and jointly work towards the implementation of inclusive, fit-for-purpose, and competitive VET policies including ensuring that VET programmes are accessible for vulnerable groups, such as the low-skilled or people at a socio-economic disadvantage.

At the national MS level, the CVET landscape is often placed at the nexus of a multitude of providers, governance frameworks, and policy priorities and thus lacks cohesion and systemic governance which undermines its responsiveness to emerging skills needs and the rapid transformation of the labour market (OECD, 2019).

A number of EU Member States consider lifelong learning and the modernisation of the CVET system as one of the priorities for increasing the activity of older people, while others approach the topic more gradually. For example, Sweden – a country with the highest proportion of adults aged 55-64 (around 20 %) and people aged 65 plus (14 %) in lifelong learning activities – has an extensive framework programme supporting lifelong learning through diverse types of VET activities (Cedefop, 2018). Sweden has taken several measures in many aspects: increasing the volume and the quality of work-based learning; opening access to VET services by boosting adult education; and implementing the new operational version of the national qualification framework. More recently, the government of Sweden introduced a new investment package to support adult participation in learning in response to the COVID-19 crisis (European Commission, 2020b).

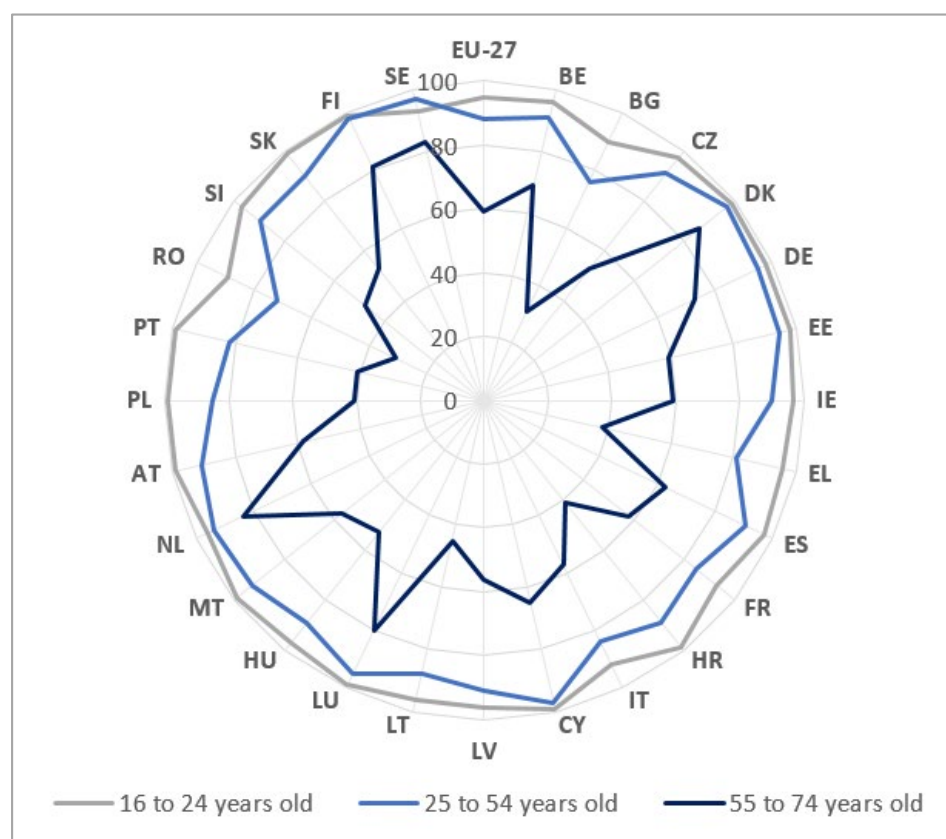
On the other hand, there are countries where lifelong learning regulations are very poor (or non-existent) and with the results of recent reforms yet to come. For example, in Croatia, where only 16 % of adults aged 55-64 participated in learning activities in the last 12 months (Cedefop, 2018), a new initiative for the modernisation of the VET system was launched in 2017, aiming to develop flexible curricula in VET supporting labour market needs. Strategic frameworks for the promotion of lifelong learning were built in order to guide the strategy and priorities for lifelong learning. As of 2020, however, efforts have been progressing slowly despite a 2019/2020 Ministerial campaign and scholarships promoting enrolment in VET, with VET participation rates and the employment rates of recent VET graduates remaining below the EU-27 average (European Commission, 2020c).

3.1.5. Digital upskilling

The use of the internet by people aged 55-74 in EU countries is on average lower than that of the younger age cohorts. It is the lowest in Greece (50 %), then followed by Portugal (52 %) and Poland (58 %). Countries with the highest proportion of the older people aged 55-74 using the internet are the Nordic countries – Denmark (96 %), Sweden, (94.13 %), and the Netherlands (92 %).

²⁰ Council Recommendation on vocational education and training (VET) for sustainable, competitiveness, social fairness and resilience (2020/C 417/01), 24 November 2020. Available at: <https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A32020H1202%2801%29#~:text=The%20Recommendation%20of%20the%20European%20Parliament%20and%20of%20EU%20credit%20system%20in%20vocational%20education%20and%20training.>

Figure 11: People using internet daily by age, in %, 2020



Source: Eurostat, [isoc_ci_ifp_fu], downloaded 2021 (latest available).

Note: Data for France and Ireland is from 2019 (latest available).

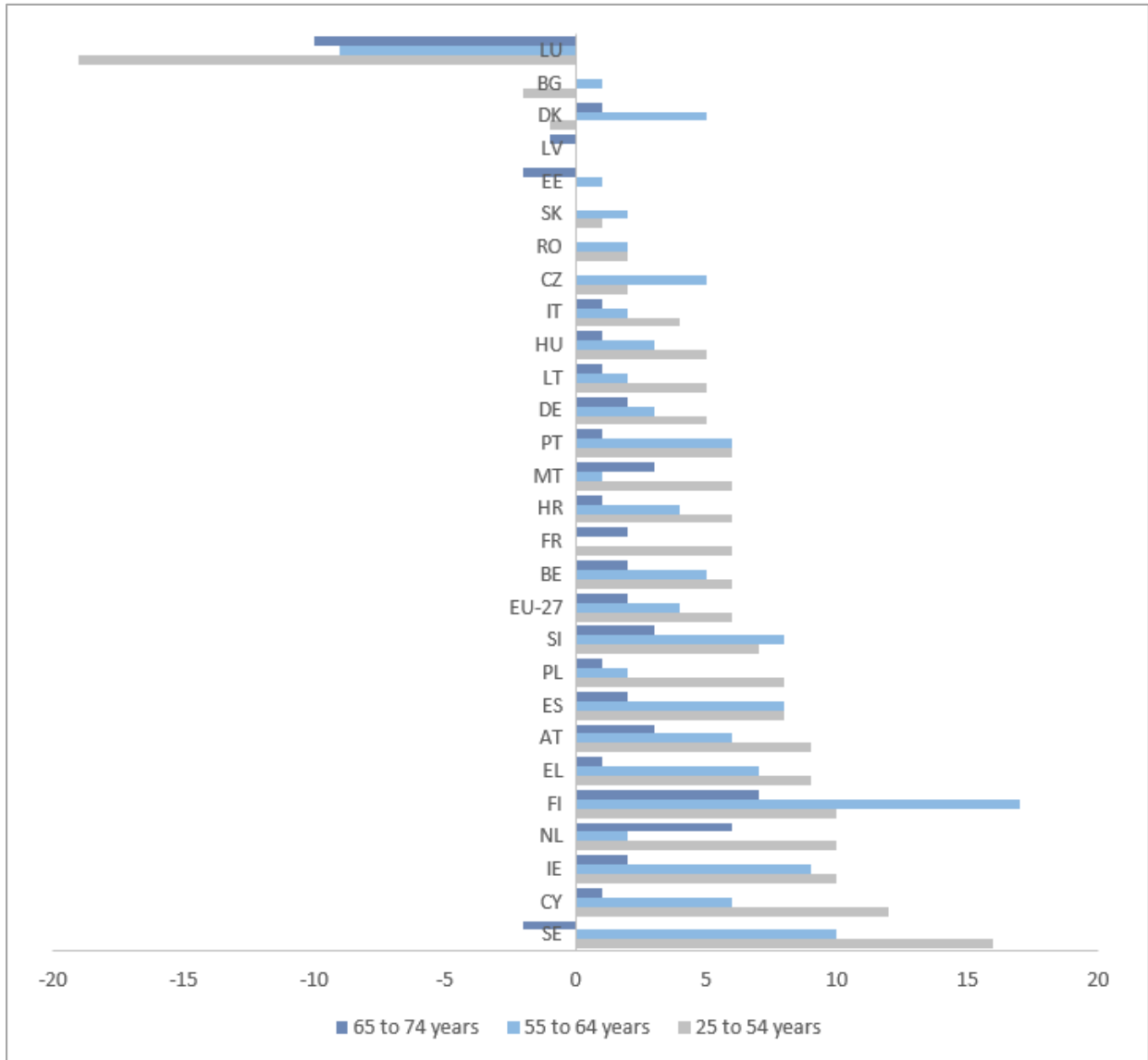
The EU, in line with its ambitious aims of the Europe 2020 Strategy, introduced the 2010 Digital Agenda for Europe (DAE) initiatives with the aim to exploit the potential of ICT for the wealth and well-being of European societies alongside the strategy for the creation of a Digital Single Market and the first Digital Education Action Plan (2018-2020). The most recently launched Digital Education Action Plan will guide EU digital skills strategy for the 2021-2027 period. Closely linked to the rapid digitalisation of the labour market and post-COVID-19 recovery, the implementation of the Action Plan will focus on two priority areas: (i) development of a high-performing digital education ecosystem, including improvement of infrastructure, competence of trainers, and quality of the offered curricula; and (ii) improvement of digital skills with a particular focus on digital literacy and the inclusiveness of digital careers²¹.

While the COVID-19 pandemic is often considered as a turning point for digitalisation and the use of technology in learning (European Commission, 2020d), the Action Plan will build upon decade-long achievements in the area of digital education and upskilling. The latest Digital Scoreboard (2019) data thus show a substantial yet uneven increase in the share of individuals having above basic digital skills. According to the Scoreboard, the relative improvement for the 65-74 years old group appears to be substantially lower compared to other age groups. More importantly, however, a number of countries have registered a substantial decrease in the share of people with above basic digital skills, including Bulgaria, Denmark, Latvia, Estonia, Sweden, and Luxembourg. Luxembourg is a particularly striking example, with a 19 pp decrease for the 25-54 years old group and an approximate 10 % decrease for

²¹ European Commission. Digital Education Action Plan (2021-2027). Available at: https://ec.europa.eu/education/education-in-the-eu/digital-education-action-plan_en.

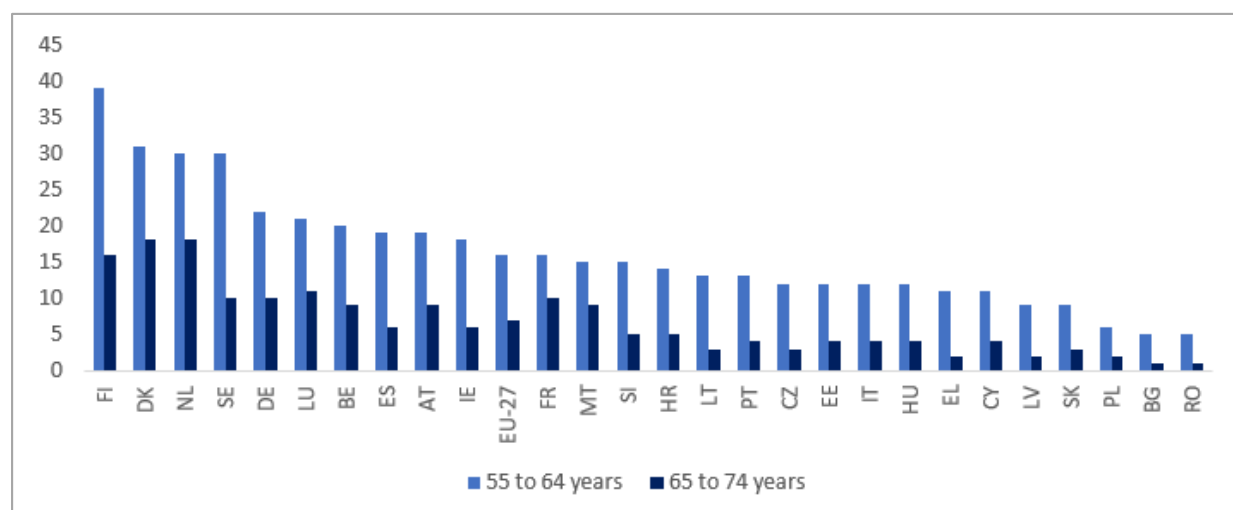
the 55-64 and 65-74 age groups. At the same time, the share of people with low or no digital skills increased between 2015 and 2019.

Figure 12: Difference between share of individuals with above basic digital skills in 2015 and 2019 by age, in %



Source: Eurostat [isoc_sk_dskl_i], downloaded 2021 (latest available).

Figure 13: People with above basic digital skills by age, in %, 2019



Source: Digital Scoreboard, downloaded 2021 (latest available).

Considering the state of skills as of 2019, significant differences between countries are observed. In countries like Finland and Sweden, where the foundations for digital agendas are implemented at a more advanced level, ICT infrastructure²² and the lifelong learning system are more developed, the share of the older with above basic digital skills is at a level of around 30 % and is increasing. In the CEE and some southern European countries, however, the share of people aged 55-64 with above basic digital skills remains well below the EU-27 average and has experienced a much slower increase throughout the years.

3.1.6. Age discrimination

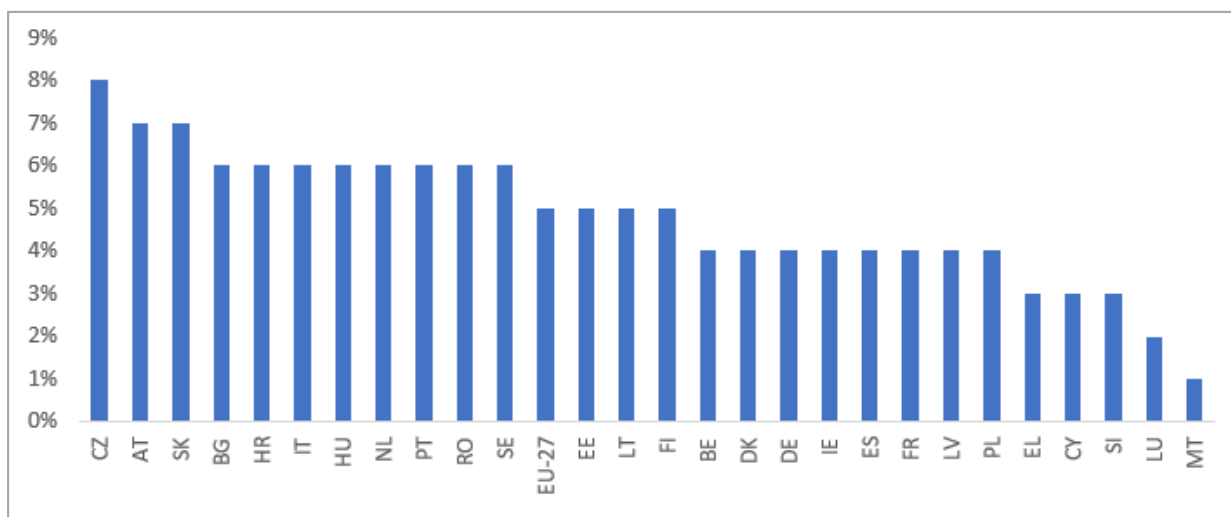
The EU legal approach with respect to any type of discrimination in the workplace is one of the core EU principles. Nonetheless, both EU and national legislation lack comprehensive and up-to-date legislation protecting against age discrimination, including protection against prohibitive practices as age limits on payments of welfare benefits (Georgantzi, 2020).

The EU framework for equal treatment in employment and occupation was established by the Council Directive 2000/78/EU in 2000. Since then, several legislative steps have been undertaken to combat age discrimination at the EU and national levels, including the 2008 proposal for a Directive on implementing the principle of equal treatment between persons irrespective of age (among other grounds)²³ that remains unadopted as of 2021. Broader protection against age discrimination is also provided by Article 14 and Protocol 12 of the European Convention of Human Rights (ECHR) and decisions of the Court of Justice of the European Union (Dewhurst 2020).

²² European Commission, 2020, The Digital Economy and Society Index (DESI). Available at: <https://digital-strategy.ec.europa.eu/en/policies/desi>.

²³ Proposal for a Council Directive on implementing the principle of equal treatment between persons irrespective of religion or belief, disability, age or sexual orientation. Available at: <https://eur-lex.europa.eu/legal-content/en/ALL/?uri=CELEX%3A52008PC0426>.

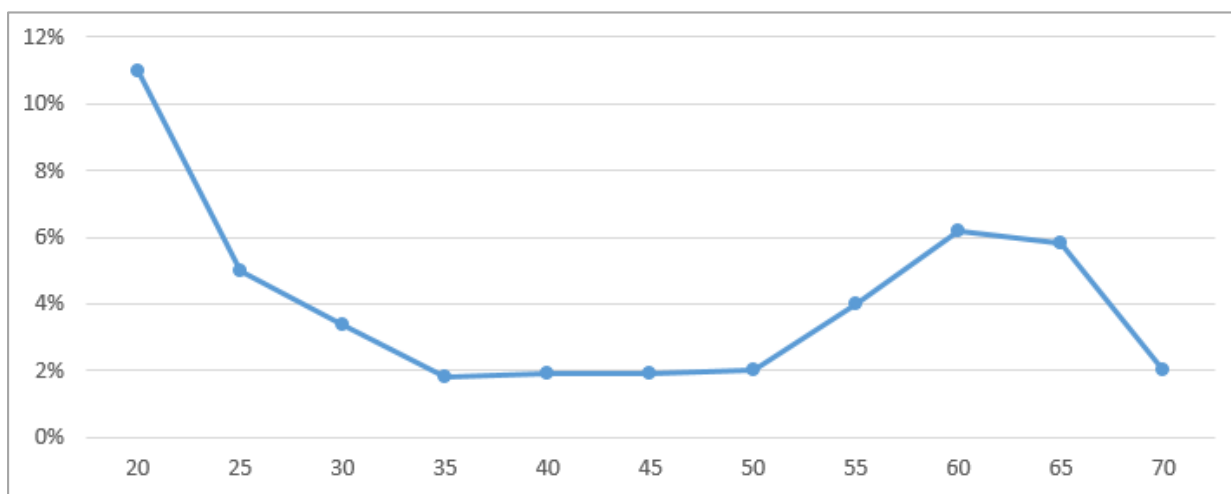
Figure 14: Experienced age discrimination, in %, 2015



Source: Eurobarometer 2015 (No.437), downloaded 2021 (latest available).

The most recent statistics reveal that age discrimination still remains one of the most relevant forms of discrimination (European Commission, 2020e). Discrimination experienced on the basis of age stands at 4 % in the EU-28, and it differs among countries. Employees that declare to experience age discrimination the most are those around the age of 20 and at the age of 55-65. 6 % of those aged 60+ report having faced age age discrimination at their workplace.

Figure 15: Employees experiencing age discrimination in the past 12 months by age, in %



Source: Eurofound, European Working Conditions Survey, 2015, downloaded 2021 (latest available).

While the workplace age discrimination of younger employees is often due to a perceived lack of experience or competence and reduces rapidly in the first years of work, the discrimination of older workers tends to have a more structural character. Thus, two types of age discrimination might be distinguished: direct and indirect (concealed). Direct age discrimination includes all activities which openly treat older workers less favourably than other employees. Such examples include compulsory retirement at a fixed age, vacancy announcements imposing an age limit, limited access to training, and difficulties in finding employment when losing a job. Indirect discrimination encompasses behaviours such as forced early retirement, which is presented as non-compulsory, quiet withdrawing, or not offering services which are necessary to older workers (like working conditions), which force an

older worker to leave the working place (AGE 2021).

The 2020 report on the implementation of Directive 2000/78/EC has thus called Member States to improve efficiency in the implementation of EU legislation on ageing policies and resolve outstanding discrimination regarding upper age limits for jobs and loans. It also pointed to the need to avoid differentiation between promoting the employability of young people and older people. The adoption of the proposed 2008 Directive would fill the non-discrimination regulatory gaps in the areas of social protection, education, and access to goods and services²⁴. The main outstanding issues that still block the voting are related to disagreements over the wording of the Directive, including concerns over subsidiarity, costs associated with the implementation of the new disability provisions, and legal uncertainty. Agreement on, among others, the scope of protection and its balance with the subsidiarity principle as well as the provisions on justified difference of treatment on the grounds of age has yet to be achieved in the Council²⁵.

Difficulties in defining and measuring age discrimination, especially in its indirect forms, undermine possibilities for the development of comprehensive national legislation on the matter as well as effective law enforcement. While a number of legal cases²⁶ have allowed challenging age limits in job advertisements and other structural workplace inequalities, Article 6 of Directive 2000/78/EU allows for justifications of age discrimination based on a legitimate aim, thus allowing room for deviation for national legislation. Having been used to setting maximum age limits for certain types of job and legitimising assumptions on declining skills with age²⁷, Article 6 creates a substantial protection gap in matters of age-based discrimination (AGE 2021).

Addressing prejudice and negative stereotypes about older employees thus remains one of the elements of national strategies aimed at combatting age discrimination. Research and promotion campaigns that raise awareness about negative age stereotypes and their effects on individuals' well-being, the economy, and society take place in different Member States. One of the examples from previous years includes the EU-funded action (European Cooperation in Science and Technology, COST) on *Ageism: A Multinational Interdisciplinary Perspective* implemented in 2014-2018 at the EU level (COST 2014). It provided for the participation of 33 European countries and aimed to enhance the scientific knowledge on and attention to ageism, by bringing together and integrating stakeholders from different disciplines, sectors, and countries.

3.1.7. EU funding instruments

A number of European programmes have been developed to support innovative projects and exchanges around active ageing policy in line with the Europe 2020 Strategy and the EPSR Action Plan targets for 2030²⁸. The latter include reaching (i) at least a 78 % employment rate for the population aged 20-64; (ii) at least a 60 % yearly training participation rate for all adults; and (iii) a reduction in the

²⁴ Proposal for a Council Directive on implementing the principle of equal treatment between persons irrespective of religion or belief, disability, age or sexual orientation – Progress report. Available at: <https://data.consilium.europa.eu/doc/document/ST-9109-2021-INII/en/pdf>.

²⁵ Ibidem.

²⁶ e.g. Kleist case (C-356/09). Available at: <https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A62009CA0356>.

²⁷ e.g. Colin Wolf v Stadt Frankfurt am Main (C-229/08). Available at: <https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A62008CJ0229>; and Domnica Petersen v Berufungsausschuss für Zahnärzte (Case C-341/08). Available at: <https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A62008CJ0341>.

²⁸ European Commission. The European Pillar of Social Rights Action Plan. Available at: https://ec.europa.eu/info/strategy/priorities-2019-2024/economy-works-people/jobs-growth-and-investment/european-pillar-social-rights/european-pillar-social-rights-action-plan_en.

number of people at risk of poverty or social exclusion by at least 15 million²⁹. Improvement of digital skills among adults has also been identified as a precondition for the efficient delivery of training activities and adaptation of the labour market to the ongoing digital transformation. These objectives would not be possible to reach if active ageing policies were not developed and supported.

In 2011, the European Commission launched a pilot European Innovation Partnership on Active and Healthy Ageing³⁰. The initiative aimed at strengthening the partnerships between different stakeholders engaged in active ageing activities in order to leverage financing and investments in innovation in active ageing. Another example of active stakeholder engagement and awareness raising networks in the area of active ageing includes the AGE Platform Europe³¹, which is supported through EU-funded grants and support mechanisms.

The main EU funding instruments included several programmes supporting active ageing projects. These include projects funded under the European Social Fund (ESF)³², as well as four ongoing – EU_SHAFE³³, ITHACA³⁴, InnovaSPA³⁵, and TITTAN³⁶ – and one completed – HoCare³⁷ – Interreg Europe dedicated to active and healthy ageing. All projects have wide regional coverage, including partner mixes from 17 of 27 EU Member States with 12 countries having participated in more than one project³⁸. The projects have served, *inter alia*, to identify many good practices to support active ageing at national and local levels, including the development of age-friendly infrastructure in Germany³⁹, the creation of an open platform for collaboration of active ageing stakeholders in Portugal⁴⁰, and facilitation of smartphone usage by older groups to improve delivery of services in Slovenia⁴¹.

The new European Social Fund (ESF+) for 2021-2027 will support the implementation of the EPSR Action Plan with a budget of EUR 88 billion for the modernisation of labour market institutions, the improvement of labour market inclusiveness with a focus on youth and older workers, as well as the promotion of lifelong learning through upskilling and reskilling⁴².

Other programmes, including the Technical Assistance Instrument for 2021-2027⁴³, will provide broader support to labour market, education, social and healthcare services, digitalisation, and inclusiveness reforms, thus complementing national recovery and resilience plans and ageing policies.

²⁹ Ibidem.

³⁰ European Commission. European Innovation Partnership (EIP) on Active and Healthy Ageing, Available at: https://ec.europa.eu/eip/ageing/home_en.html.

³¹ AGE Platform Europe. Available at: <https://www.age-platform.eu/>.

³² e.g. Demographic consulting (*Demografieberatung*) that helps businesses to create age-friendly work environments. For further details see, EC. *Encouraging age diversity to benefit businesses*, Projects, 02 June 2020. Available at: <https://ec.europa.eu/esf/main.jsp?catId=46&langId=en&projectId=3677>.

³³ EU_SHAFE (2019-2023). Available at: <https://www.interregeurope.eu/eushafe/>.

³⁴ ITHACA (2017-2021). Available at: <https://www.interregeurope.eu/ithaca/>.

³⁵ InnovaSPA (2018-2022). Available at: <https://www.interregeurope.eu/innovaspa/>.

³⁶ TITTAN (2016-2021). Available at: <https://www.interregeurope.eu/tittan/>.

³⁷ HoCare (2016-2020). Available at: <https://www.interregeurope.eu/hocare/>.

³⁸ These include Denmark, France, Germany, Hungary, Italy, Lithuania, the Netherlands, Poland, Portugal, Romania, Slovenia, and Spain.

³⁹ Interreg Europe. Living in Place Innovation Infrastructure: LebensPhasenHaus (LPH). Available at: <https://www.interregeurope.eu/policylearning/good-practices/item/2089/living-in-place-innovation-infrastructure-lebensphasenhaus-lph/>.

⁴⁰ Interreg Europe, Ageing@Coimbra. Available at: <https://www.interregeurope.eu/policylearning/good-practices/item/4208/ageingatcoimbra/>.

⁴¹ Interreg Europe. Developing a user-centred approach to investigate the use of mobile phones among older people. Available at: <https://www.interregeurope.eu/policylearning/good-practices/item/1344/developing-a-user-centred-approach-to-investigate-the-use-mobile-phones-among-older-people/>.

⁴² European Social Fund (ESF+). Available at: <https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A32021R1057>.

⁴³ Technical Assistance Instrument for 2021-2027. Available at: https://ec.europa.eu/info/overview-funding-programmes/technical-support-instrument-tsi_en.

Similarly, the 2021-2027 financing under the ERDF⁴⁴ will be dedicated to the development of skills and supporting inclusive employment. Compared to the 2014-2020 funding period, the new ERDF provides for a more holistic thematic coverage of funding priorities with a relatively higher share of funds being allocated to the competitive and smart Europe and green transition objectives⁴⁵.

EU funding also provides for significant investments in digital skills development. The dedicated mechanisms include:

- Recovery and Resilience Facility with 20 % of its fund being dedicated to supporting digital transition and skills development;
- Digital Europe Programme⁴⁶ with digital skills as a core element of its EUR 200 million total funding for 2021-2022;
- European Globalisation Adjustment Fund⁴⁷ which helps laid-off workers find another job or set up their own business by supporting trainings on digital skills; and
- Horizon Europe⁴⁸ with its EUR 95.5 billion (2021-2027) support for innovation and research activities on, among others, digital transformation provided through the dedicated Marie Skłodowska-Curie actions and the European Institute of Innovation & Technology.

3.1.8. COVID-19 impact

The European labour market has been profoundly affected by the COVID-19 pandemic. The present situation differs significantly from the previous crisis since the lockdowns affected various sectors differently. While there were sectors like tourism, transport, or hospitality which have been strongly and negatively affected by the lockdowns and the unpredictability of the situation, other sectors, like housing, the IT sector, or the pharmaceutical sector, performed much better than before the COVID-19 pandemic. The uneven situation has caused uneven opportunities for different workers.

The COVID-19 pandemic has also affected age-based discrimination. While the latest quarterly LFS data⁴⁹ show limited effects of the COVID-19 pandemic on the employment rate of the 55-64 years old group, the results of the 2020 Survey of Health, Ageing, and Retirement in Europe (SHARE) dedicated to COVID-19 effects underlined the high employment vulnerability of older groups (Börsch-Supan 2020). On average, 19% of EU⁵⁰ respondents over 50 years old indicated losing a job (permanently or temporarily) due to COVID-19, with the highest reported loss in France – 39%. There is a risk that these people will experience more difficulties, when attempting to re-enter the labour market, they are at higher risk of the long-term unemployment and they are at higher risk of becoming economically inactive. Considering gender and skills level disaggregation, women and low-skilled workers were significantly more likely to lose their job in the aftermath of the COVID-19 pandemic. The Survey has also indicated disproportionate risks of having had postponed or cancelled medical appointments for

⁴⁴ Regulation (EU) 2021/1058 of the European Parliament and of the Council of 24 June 2021 on the European Regional Development Fund and on the Cohesion Fund. Available at: <https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:32021R1058>.

⁴⁵ European Commission. European Regional Development Fund. Available at: https://ec.europa.eu/regional_policy/en/funding/erdf/.

⁴⁶ European Commission. The Digital Europe Programme. Available at: <https://digital-strategy.ec.europa.eu/en/activities/digital-programme>.

⁴⁷ European Commission. European Globalisation Adjustment Fund for Displaced Workers. Available at: <https://ec.europa.eu/social/main.jsp?catId=326>.

⁴⁸ European Commission. Horizon Europe. Available at: https://ec.europa.eu/info/research-and-innovation/funding/funding-opportunities/funding-programmes-and-open-calls/horizon-europe_en.

⁴⁹ Eurostat. Employment and activity by sex and age – quarterly data, [lfsi_emp_q], 2021. Available at: http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=lfsi_emp_q&lang=EN.

⁵⁰ EU-27 except Austria and Ireland where data is not available.

women over the age of 50 (Jiskrova et al., 2021).

In addition, measures such as age limits on COVID-19 unemployment payments that are being implemented in several EU countries in various forms and to different extents affect the older population disproportionately and risk fuelling age discrimination. Considering that the older population has been identified as at-risk of COVID-19 complications, the need to adapt the working environment to the higher protection needs of the older population might mean prioritising the employment of younger candidates during the times of the pandemic and the exclusion of older groups (AGE 2020).

The analysis of the EU Member States' responses implemented at the national level shows that they all introduced measures protecting workers in the workplace, supporting jobs and incomes as well as supporting the economy. In terms of protection of employees in their workplace, the measures implemented were mainly related to the introduction and promotion of teleworking, the reduction of employee attendance time in the workplace to a necessary minimum, and the introduction of additional measures to secure the health and safety in the workplace.

While many supporting measures have been addressed to some selected groups of employees, like young people, or for families or households with kids, very few have been found as a support for older people, especially as regards their employability. Some examples of support measures introduced during the COVID-19 pandemic include the promotion of community engagement and the use of digital technology among older groups as support (Bousquet et al., 2020) as well as the prioritisation of older people in national vaccination rollouts (European Centre for Disease Prevention and Control, 2021) to reduce health risks and help older workers participate in and reintegrate into the labour market.

More broadly, a number of measures have been introduced throughout the EU to flatten unemployment growth during COVID-19, including the extension of existing and the introduction of new job retention schemes (OECD, 2020), furlough, and active labour market policies with a focus on vulnerable groups (e.g. retraining programmes) (Hogarth, 2021). While helping to support employment, job retention schemes, such as short time work and wage subsidies need to be applied with caution in order to minimise a potential age bias and the stigmatisation of some groups of workers.

3.2. Social participation

Social participation is an important pre-requisite to active ageing. It comprises social resources, that is, access to social networks and support, and, in some approaches, civic and socio-cultural participation as well (Walsh et al., 2021 and UNECE 2019). Social relations are vital here, as they increase the chances of being healthy and happy in old age. Social isolation and loneliness have been linked to depression and anxiety, as well as to other health problems. According to a survey held in 2004/2005 among European adults aged 65+, several factors affect feelings of loneliness. Women, those of an older age, those with lower socioeconomic status, people living without a partner, and those having no activity involvement were more likely to report feelings of loneliness. The proportion of older people feeling lonely is also higher among southern Europeans relative to northern Europeans (Vozikaki et al., 2018).

3.2.1. Level of social participation in the EU Member States

In the latest 2018 Active Ageing Index (AAI), countries with the highest social participation in Europe – measured by participation in voluntary activities, providing care to children and grandchildren or the infirm and disabled, as well as political participation – are Nordic countries (Denmark, Finland, Sweden,

and the Netherlands) as well as Austria, Belgium, Cyprus, France, Luxembourg and Malta. Lower social participation can be recorded in the majority of countries that joined the EU in 2004 or later (Bulgaria, Croatia, Czechia, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia, and Slovenia) plus in the Mediterranean region (Greece, Italy, Portugal, and Spain) and Germany. The AAI shows that recent evolutions in the social participation of older people suggest two diverging patterns: the AAI score for the domain "Social participation" for all countries grew at the same pace until 2012, then in some, growth continued in the following years (Austria, Belgium, Cyprus, France, Luxembourg, Malta, Denmark, Finland, the Netherlands, and Sweden), while in others it stagnated or decreased slightly (Bulgaria, Croatia, Greece, Hungary, Italy, Poland, Romania, Slovakia, Slovenia, Spain, Czechia, Estonia, Ireland, Germany, Latvia, Lithuania, and Portugal). Additionally, almost half of the EU Member States recorded higher growth in the social participation domain score for men than for women, although from lower levels, as in the social participation domain on average women outperform men in the majority of European countries (UNECE / European Commission, 2019).

According to 2020 SHARE data, over 20 % of those 50+ volunteer in the group of countries with the highest social participation. In other countries this share drops below 10 % and even below 5 % in southern and eastern Europe. Regional differences in volunteering rates have also been noticed in earlier studies, for example, by Mălina Voicu and Bogdan Voicu (2009). They show that the incidence of volunteering in all age groups in the 1990s and at the beginning of 21st century decreases from the north to south and also from the west to east of Europe. The lower incidence in the ex-communist Central and Eastern European countries is explained through cultural traditions, globalisation, and economic background. However, a slow increase over time can be noticed in these countries as younger generations usually volunteer more often than older ones.

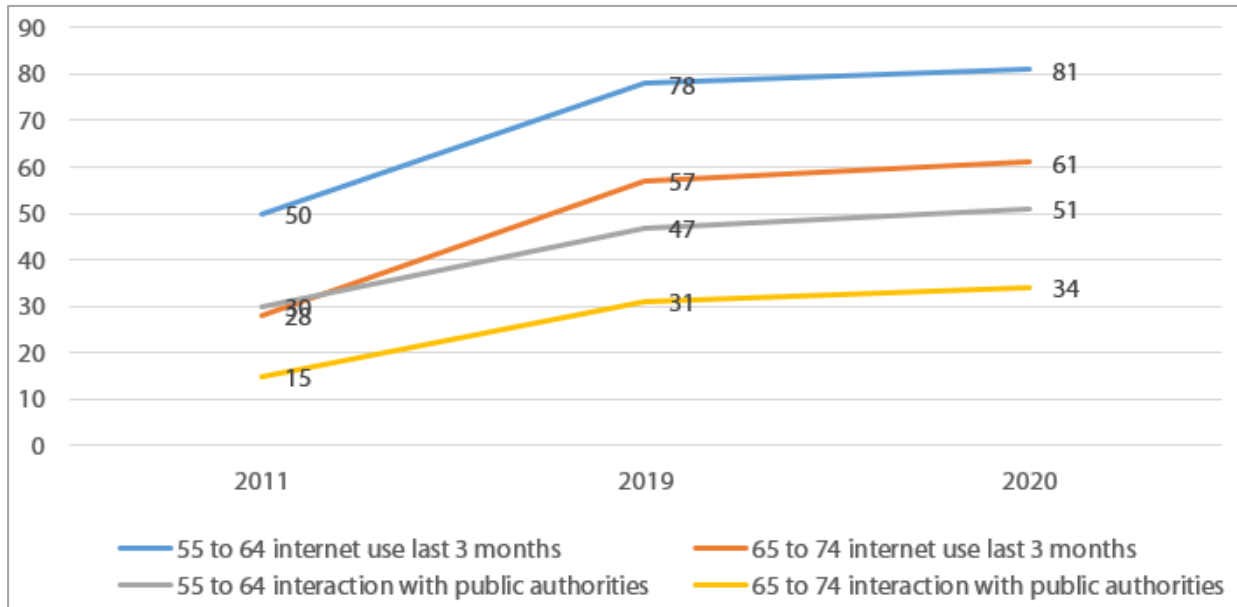
Analyses of Connolly et al. (2021), based on SHARE COVID-19 survey data collected between June and August 2020, show that older Europeans reduced their daily activities substantially in the first half of the year of the COVID-19 pandemic. The authors suggest that differences between countries can be to some extent explained by differences in restrictions and infections. Respondents reported changes in walking, shopping, and social activities (visiting family members and meeting more than five people), based on the question "Since the outbreak of Corona, how often have you done the following activities, as compared to before the outbreak?" It turns out that social activities have been reduced the most, from approximately 60 % of people aged 50+ in Bulgaria to 90 % in Spain and Luxembourg. Women have reduced their daily activities more than men and older seniors generally more than those aged 50-64. The participation of older people in social activities outside their own household has decreased additionally due to the lockdown of social centres and cultural activities, which closed for the longest periods in comparison with, for example, shops.

However, the COVID-19 pandemic limited some types of social participation but increased others. An example is volunteering. Among Europeans aged 50 to 64 considered within the above-mentioned SHARE COVID-19 survey, 20 % declared that they have reduced the amount of volunteering since the outbreak of the pandemic; conversely, 45 % have increased the amount of volunteering. In the age group 65-74 years, 30 % were less involved but 32 % increased the time devoted to volunteering. Even for people aged 75+ who volunteered before the pandemic, 24 % declared that they became involved in this activity more often. So, it seems that despite the considerable constraints on social activities imposed by lockdowns and other regulations, self-help and help for more vulnerable people naturally increased.

3.2.2. Internet access and types of digital services used in different age groups

Internet access is also a social and economic affordability issue which results in limitations in access and internet use. For example, according to Eurostat data, in 2020, 13 % of Europeans aged 55-64 and 32 % of those aged 65-74 have never used the internet. The best situation in this respect is in the Netherlands, Denmark, Finland, Sweden, and Luxembourg (less than 1 in 10 people aged 55-74 have never used internet) and worst in countries like Greece, Croatia, and Portugal where every third person aged 55-64 and two-thirds of those aged 65-74 have never used the internet. Fortunately, a positive trend in ICT use can be observed in all countries, also among older individuals.

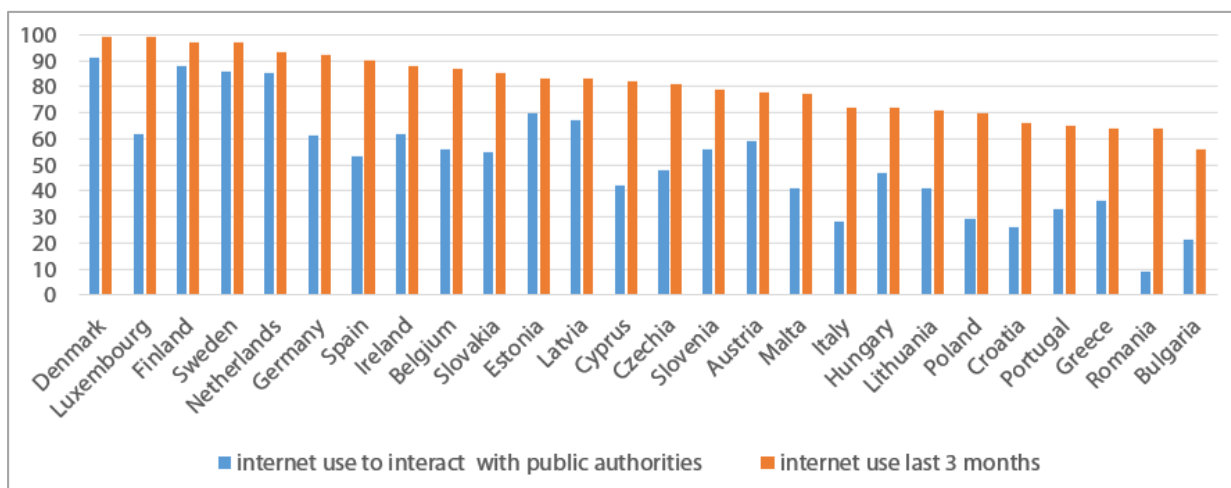
Figure 16: Internet use in the 55-64 and 65-74 age groups, in %, EU-27



Source: Eurostat 2011, 2019, 2020 (ISOC_CI_IFP_IU\$DV_631), downloaded 2021 (latest available).

There are significant differences between countries in terms of internet usage caused – among others - by lack of access to the IT infrastructure and the lack of knowledge on how to use it, mainly for older people. The lowest (or negligible) share of those using internet is in the 75+ age group, but it should be kept in mind that the majority of statistical surveys are not conducted among residents of residential care homes; therefore, in countries where the share of the older people in residential LTC is high, it does not show the full picture.

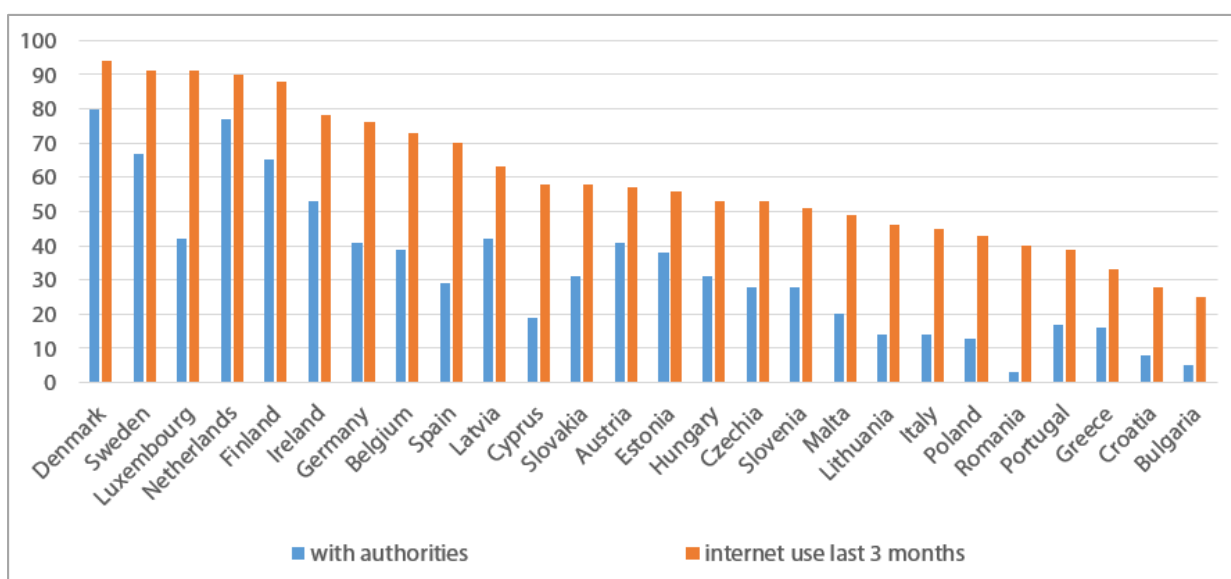
Figure 17: Internet use in the 55-64 age group, in %, 2020



Source: Eurostat 2021 [ISOC_BDE15EI\$DV_537], downloaded 2021 (latest available).

Note: data for France – not available.

Figure 18: Internet use in the 65-74 age group, in %, 2020



Source: Eurostat 2021 [ISOC_BDE15EI\$DV_537], downloaded 2021 (latest available).

Note: data for France – not available.

Interestingly, older people also use the internet for participating in social networks. This is a less frequent type of activity online but still between 20 % and 50 % of Europeans aged 55-74 (depending on the country) used the internet for social contacts in 2020.

Table 2: Internet use by males aged 55-74 by main type of activity, 2020

	E-mails	Telephoning or video calls	Participating in social networks	Finding information about goods and services	Internet banking	Seeking health information
Percentage of individuals using the internet						
EU-27	59	41	30	56	47	43
Belgium	75	49	57	69	67	39
Bulgaria	18	30	22	24	5	15
Czechia	60	25	22	56	47	45
Denmark	93	45	64	86	91	57
Germany	77	45	27	78	54	60
Estonia	54	29	25	55	52	30
Ireland	67	47	38	62	56	41
Greece	35	31	29	47	24	36
Spain	57	56	38	60	50	45
France*	66	28	19	48	53	37
Croatia	37	32	21	44	26	36
Italy	50	44	27	40	35	39
Cyprus	41	55	44	52	33	48
Latvia	48	36	33	49	51	29
Lithuania	34	30	23	44	35	33
Luxembourg	81	54	37	66	70	47
Hungary	49	40	41	54	31	45
Malta	48	42	44	50	41	44
Netherlands	90	70	48	87	87	67
Austria	65	35	31	56	48	41
Poland	34	25	18	38	28	29
Portugal	43	28	31	42	32	26
Romania	16	32	36	27	5	20
Slovenia	53	22	36	58	33	41
Slovakia	55	36	31	62	36	45
Finland	83	55	48	75	85	59
Sweden	82	52	47	80	85	48

Source: Eurostat 2021 [ISOC_CI_AC_I__custom_1099148].

* Data for France are for 2019.

Table 3: Internet use by females aged 55-74 by main type of activity, 2020

	E-mails	Telephoning or video calls	Participating in social networks	Finding information about goods and services	Internet banking	Seeking health information
Percentage of individuals using the internet						
EU-27	53	43	31	51	39	48
Belgium	69	51	58	64	62	43
Bulgaria	19	31	25	26	4	23
Czechia	59	30	23	56	43	55
Denmark	91	50	72	84	89	66
Germany	71	48	24	71	43	65
Estonia	60	43	42	60	61	48
Ireland	69	58	45	60	53	48
Greece	24	25	23	36	15	32
Spain	48	62	41	58	40	54
France*	65	30	20	49	52	44
Croatia	22	28	20	34	16	32
Italy	36	43	24	30	20	37
Cyprus	32	62	51	52	23	48
Latvia	57	43	46	49	58	42
Lithuania	42	45	36	50	41	48
Luxembourg	70	63	38	57	69	46
Hungary	50	48	50	53	28	51
Malta	33	39	42	46	23	45
Netherlands	87	73	55	82	82	73
Austria	53	38	27	42	35	40
Poland	33	29	22	34	26	35
Portugal	35	30	32	37	19	27
Romania	14	33	35	24	4	23
Slovenia	50	34	39	54	26	41
Slovakia	54	45	36	60	38	53
Finland	85	68	58	76	89	74
Sweden	83	60	61	82	83	56

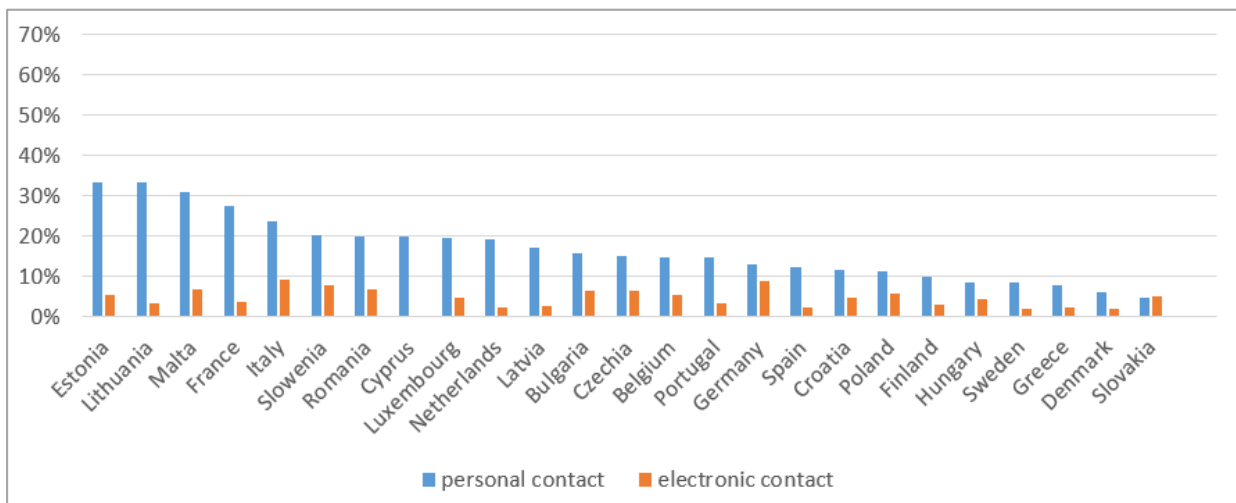
Source: Eurostat 2021 [ISOC_CI_AC_I__custom_1099148].

* Data for France are for 2019.

Meetings with relatives and friends can provide an individual with much needed support. Fiorillo (2020) found that the probability of unmet needs is lower for people who frequently have contact with friends or with relatives. The pandemic has forced the transfer of some activities to a remote form. This applies to social interaction as well. Since 2020, contacts through technology increased, also with ageing friends and relatives. This can have a positive impact on increasing levels of technology usage to increase social participation in future. Additionally, the importance of healthy lifestyles at all ages, self-help in the neighbourhood, and self-care have often been underlined in communication during the pandemic. If all these types of behaviour remain, they will facilitate active ageing policy in the future.

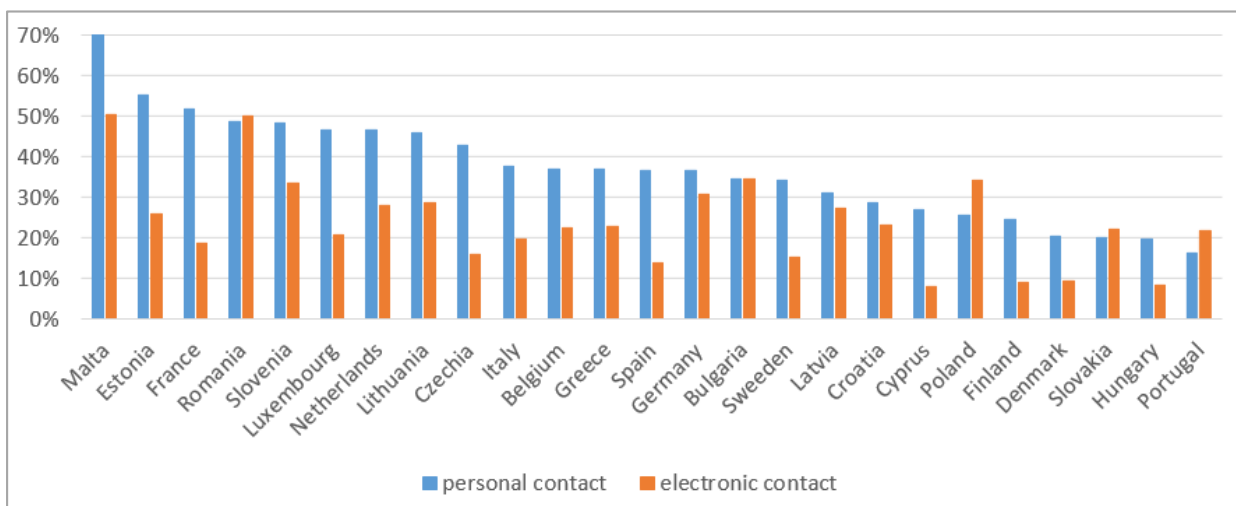
The share of people aged 50+ who reduced their contacts with relatives and non-relatives after the outbreak of the pandemic is presented below. The results are based on two questions asked in the SHARE COVID survey: having personal (face-to-face) contact with people outside ones' home and the frequency of contact via electronic means.

Figure 19: People (50+) who never contacted their children since the outbreak of the pandemic, in %, 2020



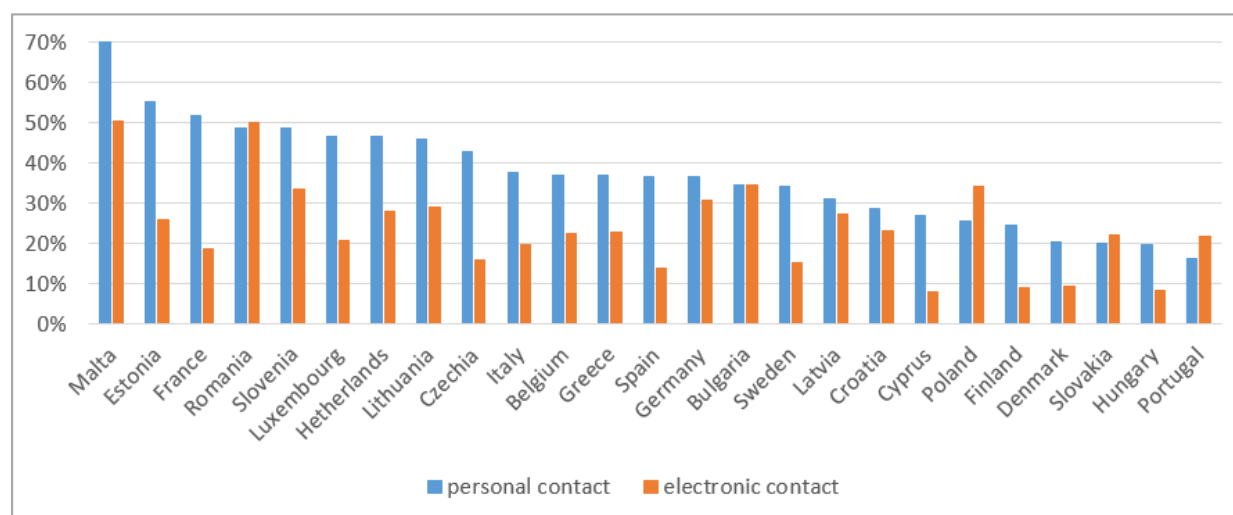
Source: Author's own elaboration based on SHARE wave 8 and SHARE COVID-19 survey 2020.

Figure 20: People (50+) who never contacted their parents since the outbreak of the pandemic, in %, 2020



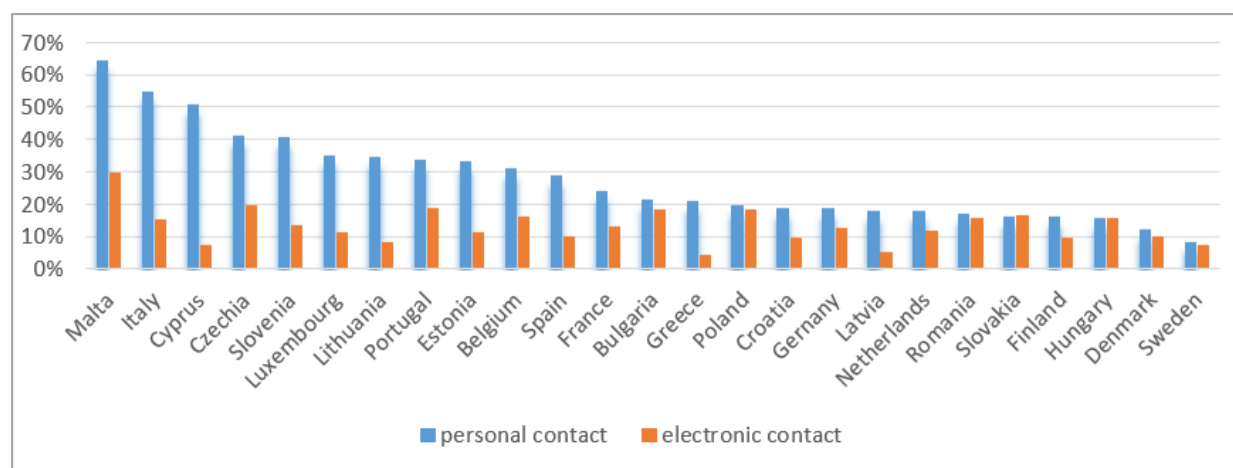
Source: Author's own elaboration based on SHARE wave 8 and SHARE COVID-19 survey 2020.

Figure 21: People (50+) who never contacted their relatives (other than children or parents) since the outbreak of the pandemic, in %, 2020



Source: Author's own elaboration based on SHARE wave 8 and SHARE COVID-19 survey 2020.

Figure 22: People (50+) who never contacted neighbours, friends, or colleagues since the outbreak of the pandemic, in %, 2020



Source: Author's own elaboration based on SHARE wave 8 and SHARE COVID-19 survey 2020.

Usually, persons aged 50+ met with their children in the first months of pandemic either personally or at least using electronic means. Only less than 10% of older people did not have remote contact with children. Contacts with parents were limited to a larger extent. Parents of respondents aged 50+ are persons in their 70s or older, so they belong to the most vulnerable group due to health reasons which explains the considerable limits in contacts. Between 20 % and 70 % of people did not meet their parents face-to-face in months since the start of the pandemic until June/August 2020⁵¹, but in the majority of countries, electronic contact replaced direct contact to some extent.

3.2.3. Challenges in social participation

In summary, social participation is an area where many Member States were already facing challenges before the pandemic. However, some (mainly Nordic cluster countries) were above average in this

⁵¹ Note that both start of the pandemic and the month of the COVID-19 survey might differ in countries participating in the survey, ranging from February/March (start of the pandemic) to June-August 2020 (time of the survey).

respect. Before 2020, a slow increase in some aspects of social participation could be observed, but COVID-19 hindered active ageing policy in this area because of lockdowns and health safety concerns. It seems that older adults who experienced a prolonged period of isolation may encounter negative health effects and it may have an unfavourable impact on physical and emotional well-being. Recent data on the effects of lower social participation on different groups are scarce and available mainly at the individual country level. Experience from 2020 suggests that improvements in the digital skills of the 50+ age group and better access to the internet can partially mitigate the loneliness of older people in the future.

3.3. Health and well-being

Being in good physical and mental health is a key prerequisite for economic and social activity in older age. This requires an accessible healthcare system and public health policies which effectively prevent health deterioration, disability, and dependency. Healthcare systems are under pressure due to increased demand for services. They are also facing problems with the assurance of adequate infrastructure, quality management, equal access to innovative medical technologies, and sufficient workforce, which was further amplified by the COVID-19 pandemic. Healthcare in many countries has been reorganised to provide treatment to COVID-19 patients, which might have limited access to other types of treatment, rehabilitation, and prevention.

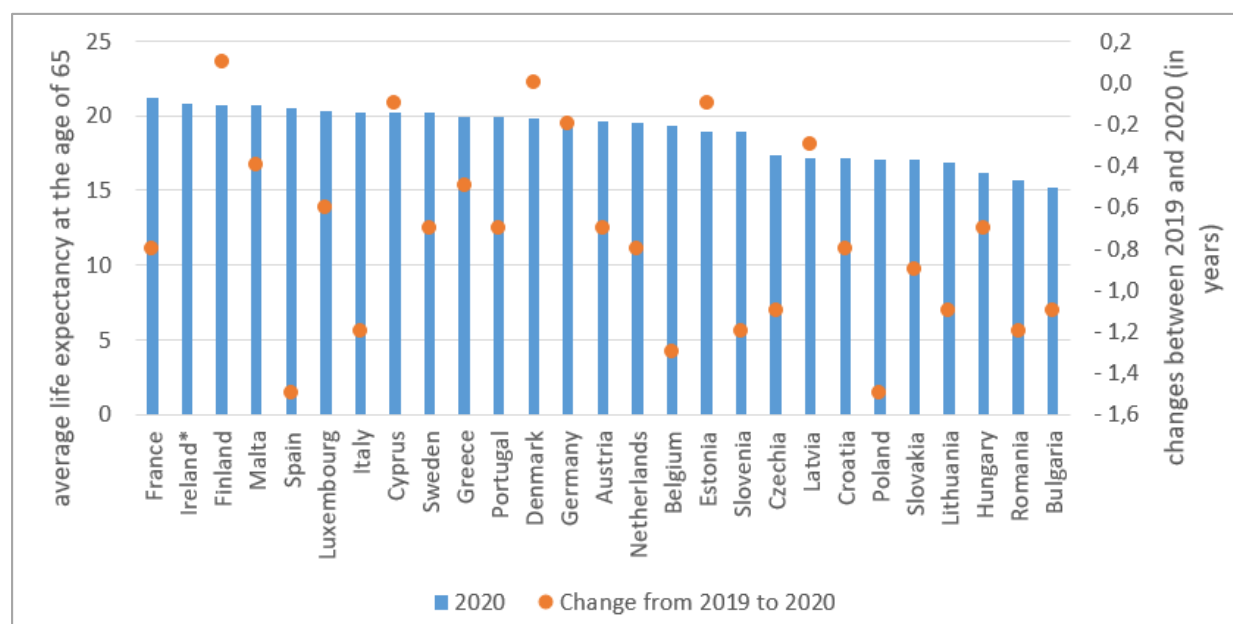
3.3.1. Health status of the older population

Over the past decade, life expectancy (LE) at the age of 65 has been slowly increasing, from 17.2 years for men and 20.9 for women in 2009 to 18.3 for men and 21.8 for women in 2019 in the EU-27. In 2019, the lowest life expectancy at the age of 65 was in Bulgaria (16.3 years) and the highest in France (21.9) and in Spain (21.3). Healthy life years (HLY)⁵², which tells us about the quality of life without disability and in good health, was estimated on average in the EU-27 as 10.4 years for women and 10.2 years for men in 2019. There is a gender gap in life expectancy as women are expected to live longer, but the gap in healthy life years is much smaller as their longer life is often related to disability and functional limitations. The difference in LE between men and women is particularly high in CEE countries: in the Baltic states (Lithuania, Latvia, Estonia) and Poland, it accounts for about five years.

The COVID-19 pandemic put a shadow on the longevity of older Europeans. The high death rate, which particularly affected the older population, resulted in a decrease in life expectancy at the age of 65 in most of the EU countries. Only in Finland and Denmark did the COVID-19 pandemic not have an adverse effect on life expectancy. The highest decreases in life expectancy were observed in Spain and Poland (decrease by 1.5 years compared to 2019) – countries with particularly high COVID-19 incidences and fatality rates.

⁵² The indicator measures the number of years that a person at the age of 65 is expected to live in a healthy condition and without disability.

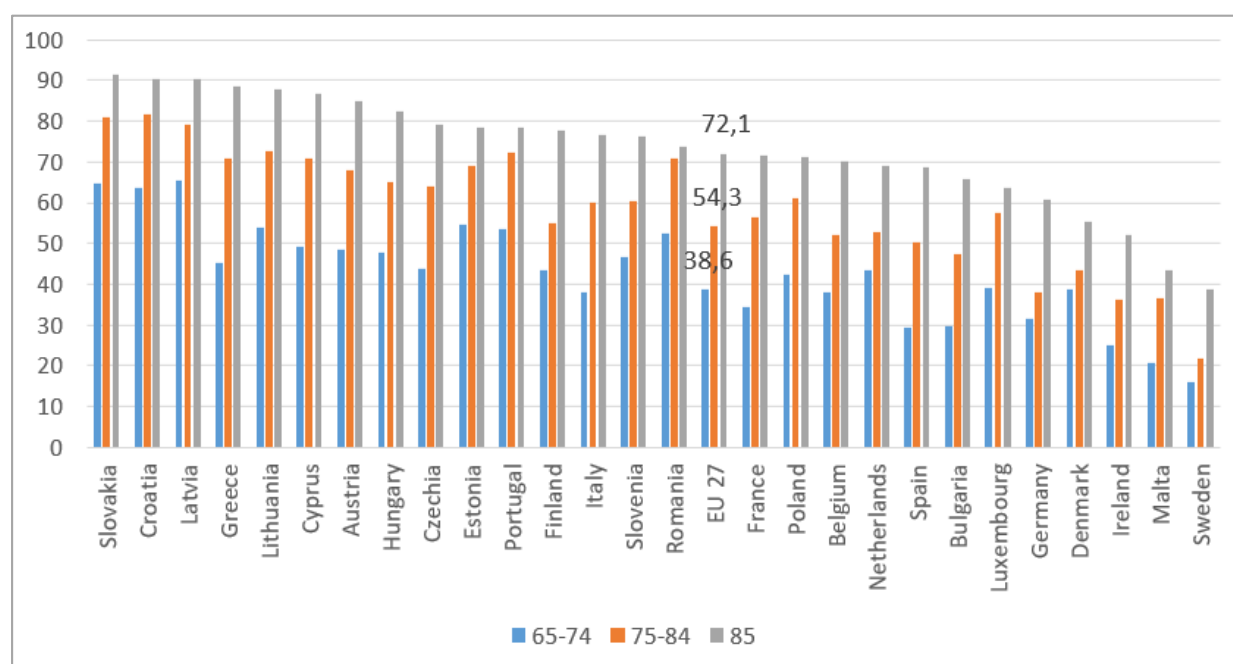
Figure 23: Average life expectancy at age 65, in years, 2020 compared to 2019



Source: Eurostat 2019-2020 [demo_mlexpec], downloaded 2021 (latest available).

The prevalence of long-standing health problems and disabilities strongly increases with age and is highly diversified between countries. Higher levels of limitations in everyday activities are reported in the countries of central and eastern Europe as well as some countries of southern Europe. Lower levels are reported in the countries of northern Europe. This is to some extent related to the institutionalisation of care for the most dependent older people in countries such as Sweden and Denmark and the lower levels of institutionalisation in Slovakia, Croatia, or Greece, for example. At the same time, lower levels of institutionalisation might have been beneficial during the COVID-19 pandemic as the risk of infection was higher in institutionalised care.

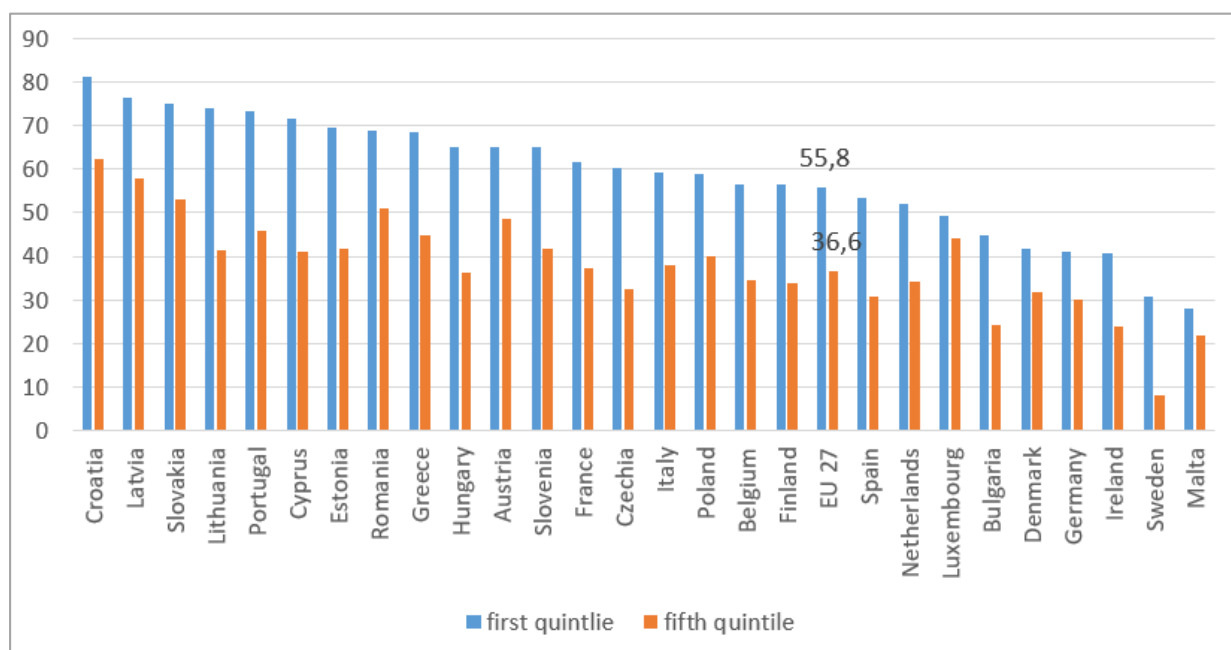
Figure 24: Limitations in usual activities due to health problems by age group, in %, 2020



Source: Eurostat 2020 [hlth_silc_12], downloaded 2021 (latest available).

There are strong income inequalities related to the functional abilities of older people. Individuals with lower income levels more frequently face limitations in everyday activities. This might be an effect of earlier experiences of relative poverty, poorer access to healthcare, or an unfavourable lifestyle earlier in life. Even in countries with a low level of income inequality (Czechia, the Netherlands, and Sweden), the gap between the first and the fifth income quintile is substantial, reaching a 20 pp difference. The largest inequalities are observed in Lithuania (32.8%), Cyprus (30.3%), and Hungary (28.9%).

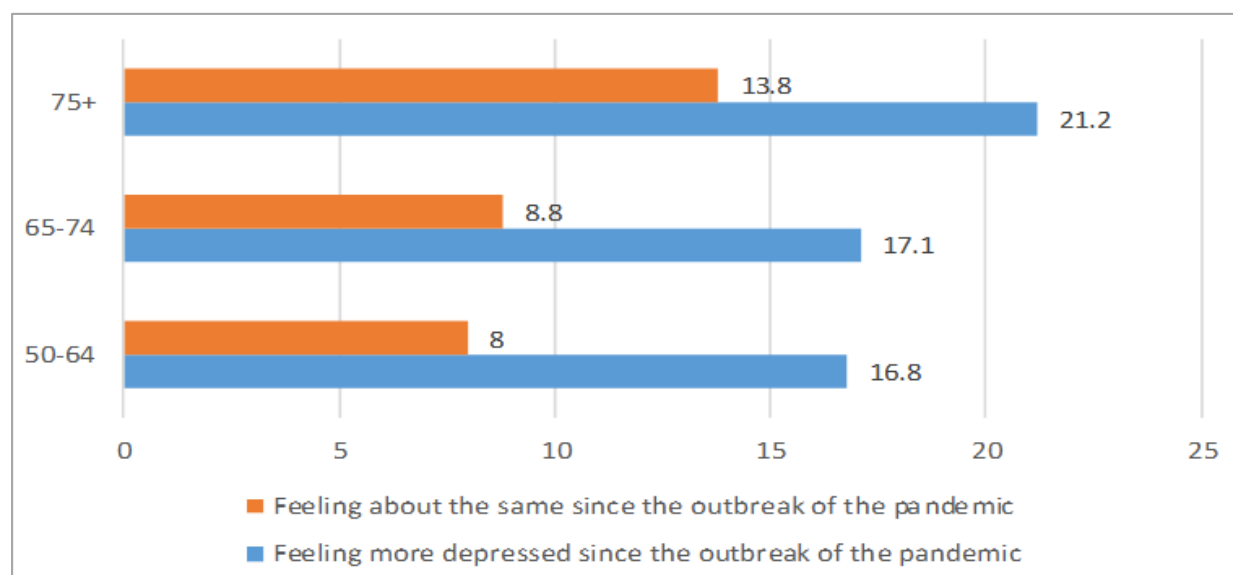
Figure 25: Income inequalities in long-standing limitations in usual activities (65+), in %



Source: Eurostat 2020 [hlth_silc_12], downloaded 2021 (latest available).

The COVID-19 pandemic had an impact not only on physical well-being, but it created a threat to mental well-being as well, increasing the risk of loneliness and depression of older Europeans. According to the SHARE survey conducted in 2020 and 2021 among the population aged 50 years and above, every fifth person aged 75+ felt more depressed than before the pandemic. Furthermore, 17.1 % of those aged 56 to 74 and 16.8 % of those aged 50 to 64 also experienced being more depressed during the pandemic. About every tenth older person felt the same as before the pandemic. The feeling of depression deepens with physical and social isolation, anxiety, and fear of infection.

Figure 26: Mental health during the COVID-19 pandemic by age group, in %



Source: Author's own elaboration based on SHARE wave 8 and SHARE COVID-19 survey 2020/2021.

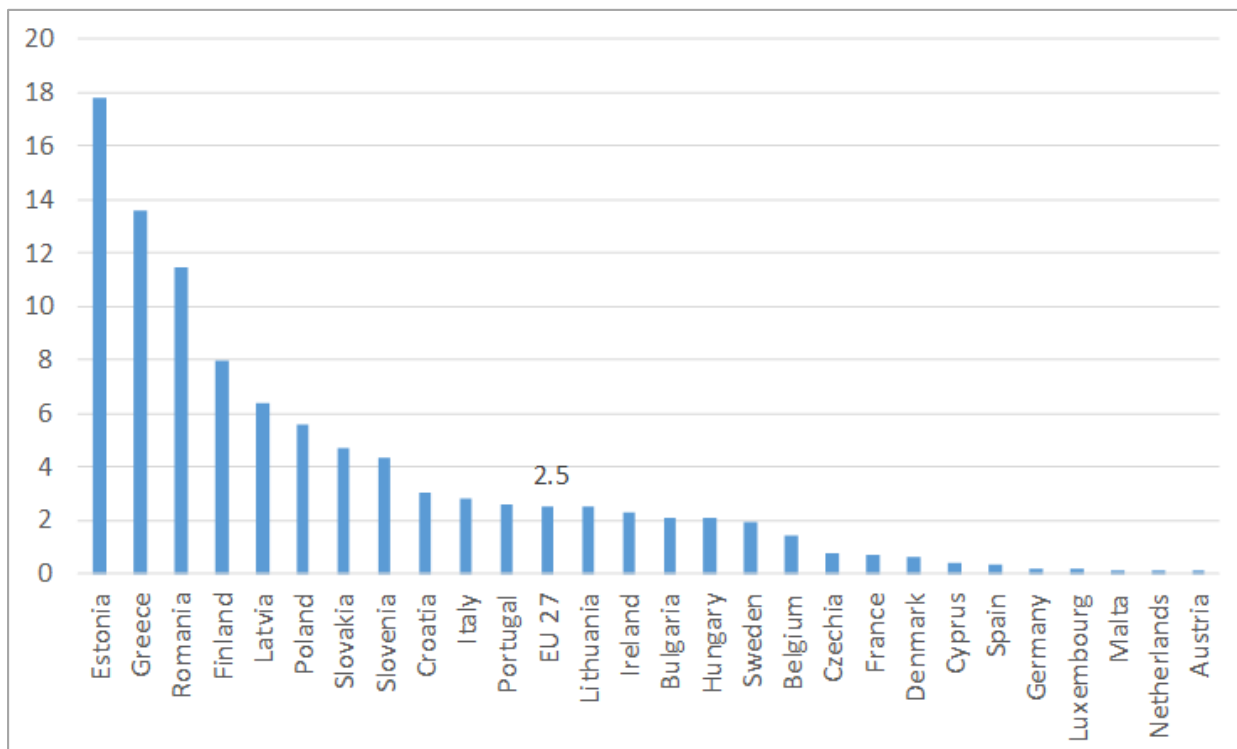
According to the Eurofound Living, Working and COVID-19 survey⁵³ conducted in February/March 2021, the feeling of loneliness of people aged 50+ was most frequently experienced in Greece (29.0%), France (27.1%), Poland (25.4%), and Germany (24.1%). The lowest levels of loneliness were in Slovenia (6.8%), Spain (9.7%), Hungary (10.8%), and Czechia (12.8%). In Greece, almost 32.5% of people above the age of 50 felt depressed all or most of the time. In Poland, the feeling of being downhearted or depressed was reported by 25.0% of older people, and in Cyprus, by 22.6%. Older people in Slovenia (8.5%), Ireland (8.7%), and Hungary (9.6%) less frequently experienced being depressed.

3.3.2. Access to healthcare services

Over the past decade, the access of older people (65+) to medical services has been slowly improving on average in the EU, though access to healthcare still strongly differs between European countries. Unmet healthcare needs due to distance, waiting times, or financial reasons declined in the EU-27 from 5.4% of the older population in 2011 to 2.5% in 2019. The level of unmet healthcare needs was the highest in Estonia (17.8%), Greece (13.6%), and Romania (11.5%). Almost no unmet needs for healthcare was reported in Austria, Malta, and the Netherlands in 2019. Access to healthcare services is better in countries with universal health coverage, higher healthcare expenditures in relation to GDP, and lower economic inequalities, such as the Netherlands, Germany, Sweden, and Malta.

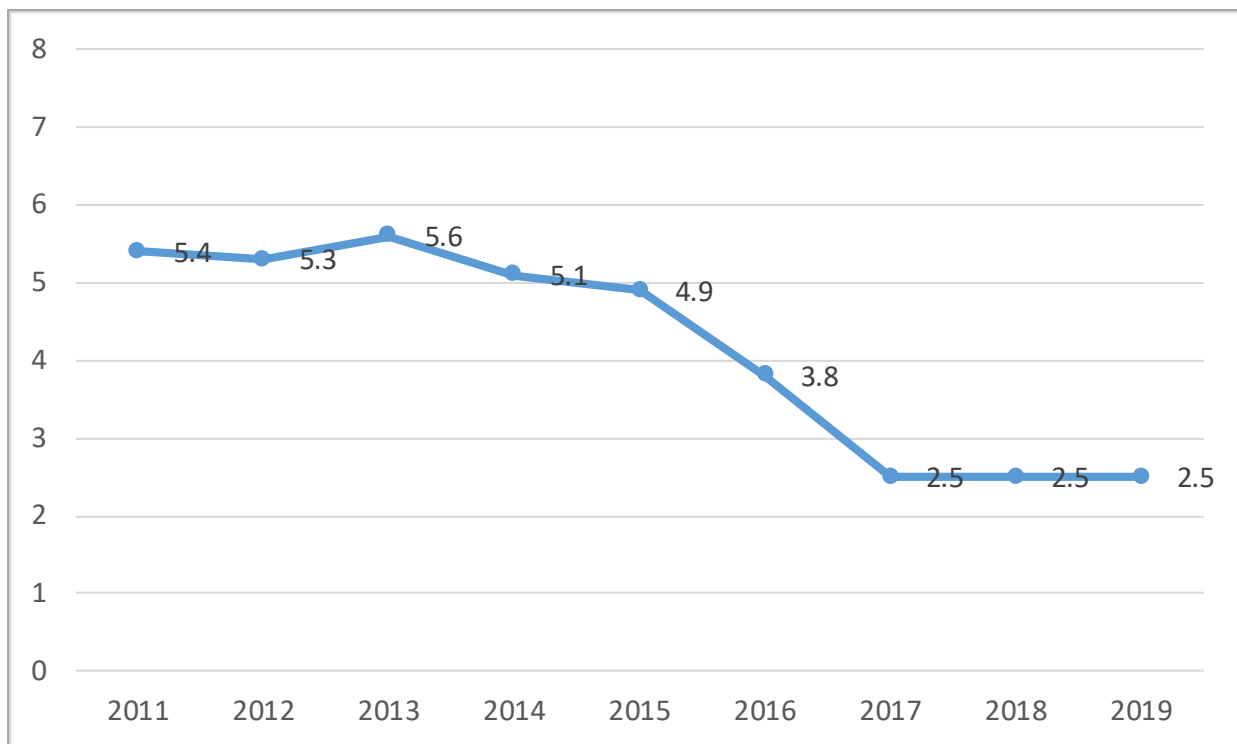
⁵³ Eurofound survey results available at: <https://www.eurofound.europa.eu/data/covid-19/quality-of-life>.

Figure 27: Unmet needs for medical care by country (65+), in %, 2019



Source: EU-SILC 2019 [hlth_silc_08], downloaded 2021 (latest available).

Figure 28: People (65+) with unmet needs for medical care, in %, EU-27, 2011-2019



Source: EU-SILC 2011-2019 [hlth_silc_08], downloaded 2021 (latest available).

Note: unmet needs for medical care due to transportation, cost, or waiting list are reported.

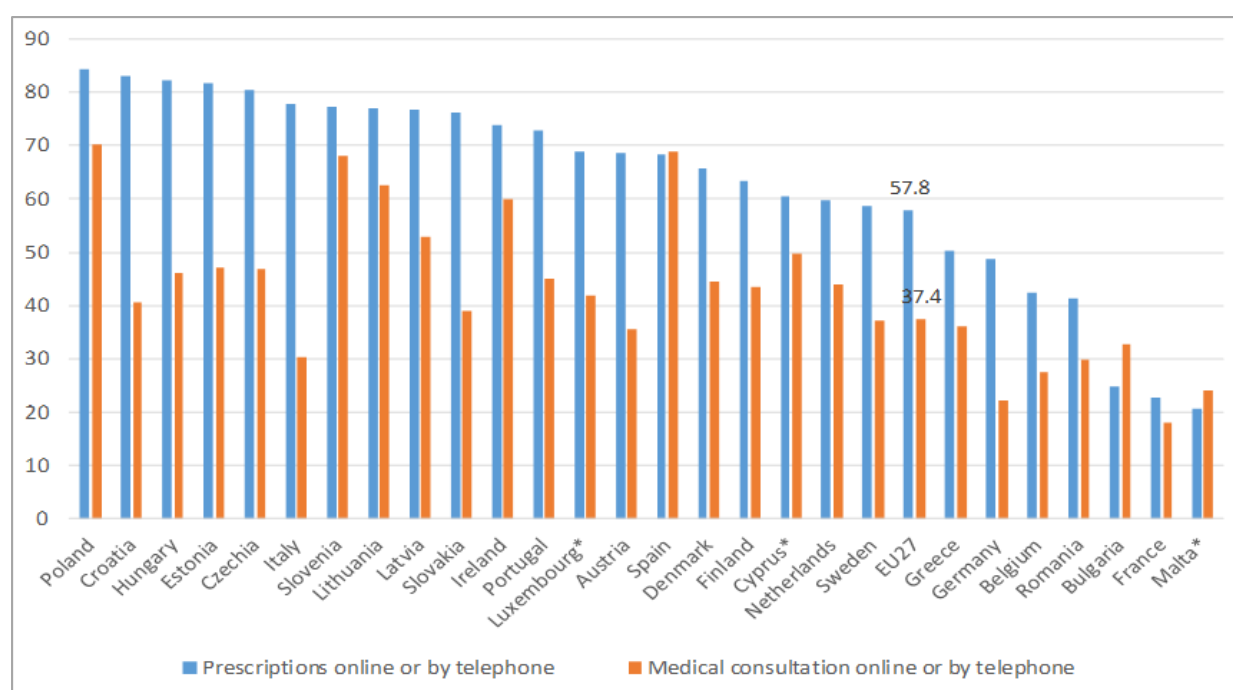
During the COVID-19 pandemic, the positive trend of improving access to medical treatment ceased. In most countries, healthcare systems were reorganised to provide acute care to persons with

COVID-19. It increased the risk of poorer access to hospital care and extended waiting times for medical procedures.

In most countries, primary healthcare services were transformed into online consultations. In February/March 2021, on average in the EU-27, 57.8 % of people aged 50+ used online or telephone medical prescriptions and 37.4 % used online or telephone medical consultations. It should be noted that, in some countries, e-prescriptions for reimbursed medicines were introduced well before the pandemic. For example, in Finland, e-prescriptions have been mandatory since 2014 and in Poland, since 2020. In Germany and Austria, e-prescriptions were introduced for the first time as pilot projects in 2018-2019 (Eurofound 2020). During the pandemic, e-prescriptions were commonly used by the population aged 50+ in most countries, with the exception of Malta, France, Bulgaria, Romania, and Germany.

The use of online or telephone consultations strongly varied between countries. In Spain, Slovenia, and Poland, about 68-70 % of people aged 50+ used online or telephone medical consultations. In France and Germany it was only about 20 %.

Figure 29: People (50+) receiving e-prescriptions/consultations, in %

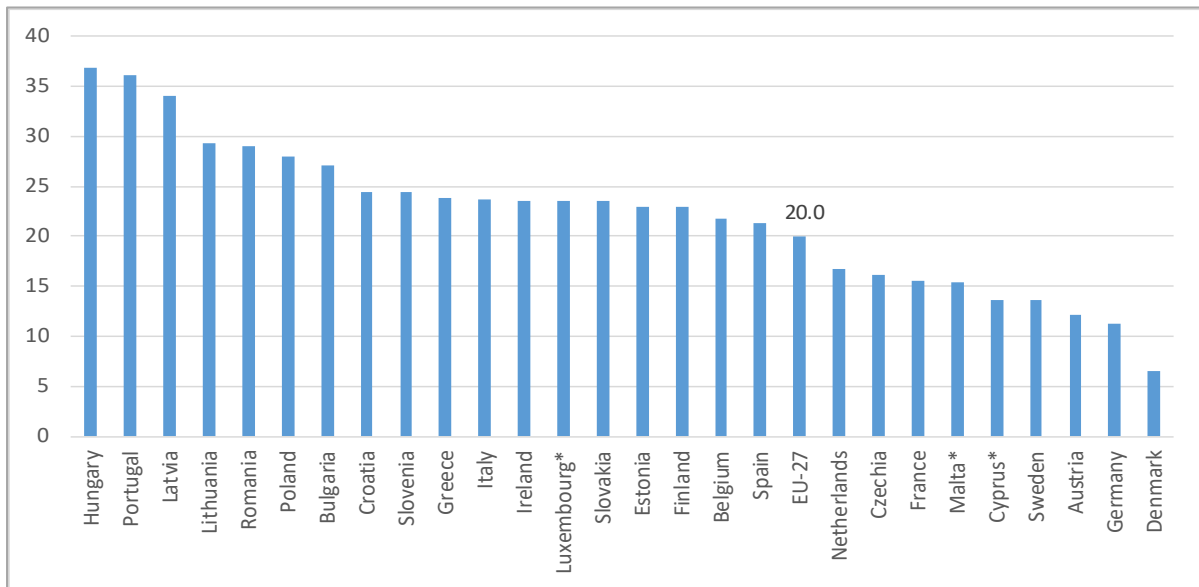


Source: Eurofound Living Working and COVID-19 dataset, February-March 2021.

* Data might not be sufficiently representative due to low response rate.

Overall, during the COVID-19 pandemic, access to medical consultations deteriorated in all EU-27 countries. On average, 20 % of the population aged 50+ in the EU-27 did not receive medical consultation when it was needed. The highest share was in Hungary (36.8 %), Portugal (36.2 %), and Latvia (34.0 %) and the lowest in Denmark (6.5 %), Germany (11.3 %), Austria (12.2 %), and Sweden (13.6 %). Overall, the countries where access to medical care for the older population was better in the years preceding the pandemic managed to sustain the trend, despite an increase in the unmet needs for medical care during the pandemic.

Figure 30: Unmet needs for medical treatment during the COVID-19 pandemic, in %

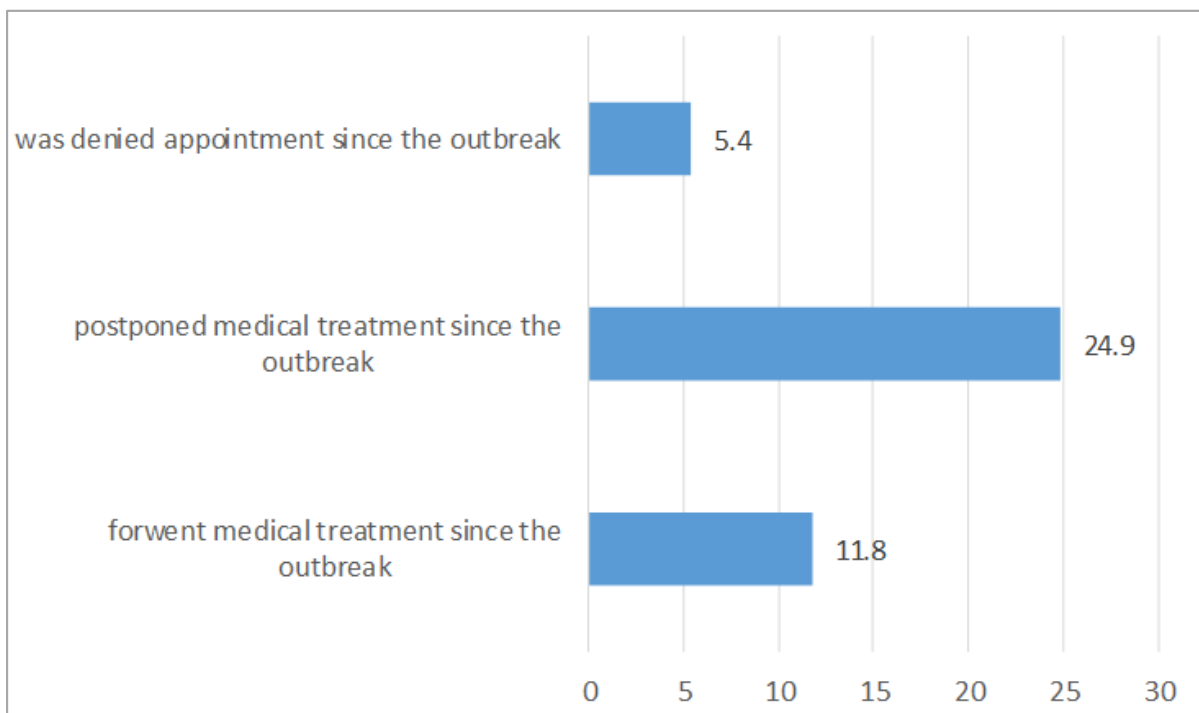


Source: Eurofound Living Working and COVID-19 dataset, February-March 2021.

*Data might not be sufficiently representative due to low response rate.

Unmet needs for medical treatment grew during the pandemic because of the postponement of medical visits either due to the introduced lockdown measures or due to fear of infection. About one-quarter of people aged 50+ had their medical treatment postponed and 5.4 % were denied an appointment with a medical doctor. More than every tenth person resigned from a medical consultation. These trends are similar across all age groups above the age of 50. Postponing or resigning from medical treatment, due to infection fears, quarantine, or the reorganisation of work at the medical facility, could have detrimental health effects in the future.

Figure 31: Reasons for unmet medical care in the population aged 50+, in %



Source: Author's own elaboration based on SHARE wave 8 and SHARE COVID-19 survey 2020/2021.

3.3.3. Health promotion and prevention

Health promotion and prevention have rarely been among the priorities of the healthcare system and were even less so during the pandemic. Adherence to medical plans, personalised health management, and the prevention and early detection of diseases and frailty are crucial for postponing dependency in the older population and increasing survival. Particularly important are cancer screenings, as next to cardiovascular system diseases, they are the dominating cause of death in the older population. Problems in access to cancer screenings and high variations are observed across countries and between urban and rural areas.

In the best performing countries, including the Netherlands, Finland, Denmark, Spain, and Slovenia, about 75 % of women aged 50 to 69 had breast cancer screenings within two years⁵⁴. By contrast, in Slovenia, Cyprus, and Hungary, about 40 %, and in Bulgaria, only about 20 % of women aged 50 to 69 had breast cancer screening in the period of two years. Between 2013 and 2018, the share of women who received screening decreased or remained stable in most EU countries. There are also noticeable differences between urban and rural areas. In rural areas, over 14 % of women have never had access to an X-ray breast cancer screening. In urban areas, the indicators decrease to 1 in 10 women having no access to screening. The largest gaps between urban and rural areas were in countries with overall lower access to breast cancer screening (Bulgaria, Romania, and Slovakia). Although there is no more recent data on breast cancer screening, access to screenings might have worsened during the COVID-19 pandemic.

There is a poor uptake of colorectal cancer screening for men aged 50 to 74, despite the existence of national screening programmes in some countries. In Bulgaria, Cyprus, and Romania, up to 90 % of the population have never undergone this procedure. In Slovenia, France, Germany, and Austria, up to 50 % of men aged 50 to 74 had colorectal cancer screening in the period of two years. There are also significant information gaps, as the latest Eurostat data are from 2014.

Another protective measure, particularly important for the older population, is vaccination against common seasonal diseases, such as influenza. There are large differences between countries in policies promoting vaccinations. In many countries, influenza vaccination for older people is neither obligatory nor covered within the healthcare services basket financed from public sources. The need for private purchase decreases the chances for vaccinations at the population level. Data for 2018 show that between 60 % and 70 % of older people (aged 65+) have been vaccinated in Ireland and the Netherlands, about 50 % in Sweden, Denmark, and Finland, and less than 10 % in Estonia, Latvia, Poland, and Bulgaria.

3.3.4. COVID-19 vaccinations

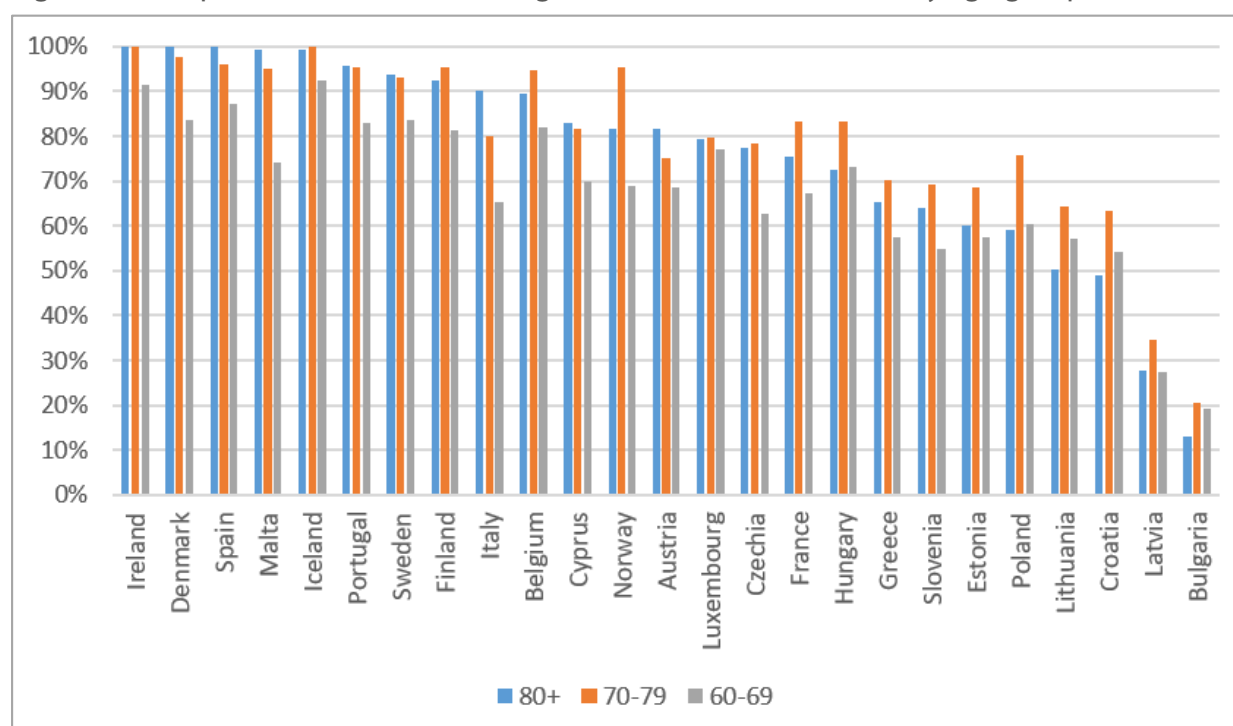
COVID-19 became the main public health concern in 2020, contributing to particularly high death rates in older people across the world. COVID-19 vaccinations in the EU began in late December 2020. Vaccinations are particularly important as they prevent the spread of the disease and are a precondition of social participation in the months and years to come. Countries adopted their vaccination strategies by prioritising groups according to high infection and mortality risks. Priority was given particularly to older people, residents of long-term care facilities, medical and care personnel, teachers, and groups facing the risk of severe development of the disease due to the existence of other health risks (e.g. diabetes, asthma). Vaccinations were planned in phases, starting with groups with the highest risk to

⁵⁴ Eurostat, Breast cancer screening, women aged 50 to 69, 2013 and 2018. Available at: [https://ec.europa.eu/eurostat/statistics-explained/index.php?title=File:Breast_cancer_screening,_women_aged_50_to_69_years,_2013_and_2018_\(%25\)_Health20.png](https://ec.europa.eu/eurostat/statistics-explained/index.php?title=File:Breast_cancer_screening,_women_aged_50_to_69_years,_2013_and_2018_(%25)_Health20.png).

those with the lowest risk. Typically, older people were in the first group of people offered vaccination. By mid-June 2021, over 51.2 % of the adult (18+) EU population received at least one dose of the vaccine and 26.8 %, the full vaccine course. In the EU, the highest uptake of the vaccination was in the oldest age group (80+), reaching a median vaccine uptake of 80.7 % for at least one dose and 71.6 % for the full vaccination course⁵⁵. In Ireland, Denmark, Malta, Norway, Portugal, and Spain, almost all people aged 80+ are vaccinated. In Austria, Denmark, Estonia, Finland, Malta, Portugal, Spain, and Sweden, all residents of long-term care facilities were vaccinated (ECDC, 2021).

In some EU countries, the oldest people hesitated to get a COVID-19 vaccine. In Belgium, Poland, France, Slovenia, and Hungary, a higher share of people aged 70-79 are vaccinated than those aged 80+. In Latvia and Bulgaria, only 28 % and 13 % respectively, of people aged 80+ received at least one dosage of COVID-19 vaccination.

Figure 32: People with at least one dosage of COVID-19 vaccination by age group, in %



Source: ECDC, data downloaded 13 June 2021.

3.3.5. Challenges in healthcare policy

The COVID-19 pandemic has had a negative impact on the health status and well-being of older people due to social distancing, emotional distress, and poorer access to medical treatment. The close monitoring of the pandemic effects, such as increases in morbidity, disability risk, and – potentially – dependency, is needed. Governments should envisage investments in prevention policies to identify the gaps that arose due to unmet needs for healthcare during the pandemic and improve access for those who faced particular difficulties in access to medical services over the past year. The closer monitoring of unmet health care needs, including data by age group, becomes necessary to identify gaps in the provision of medical services for older people.

Barriers in access to online or telephone medical services due to the lower digital literacy of older people should be tackled by investments in medical literacy programmes and improved access to

⁵⁵ Two doses of Pfizer, Moderna, Astra-Zeneca or one dose of Johnsons vaccine.

digital infrastructure.

While there is ample data on health status from epidemiological statistics and surveys, some limitations have been identified. Specifically, these are related to the definition and assessment of functional abilities and disability. Currently, Eurostat uses the notion of limitation due to health problems; however, other studies use different forms of functional limitation assessments. This grows in importance as changes in healthy life years, functional abilities, and disability would need to be carefully monitored in post-COVID-19 times.

There is also a need for more accurate and up-to-date measurements of preventive activities as well as vaccination monitoring as available data are outdated.

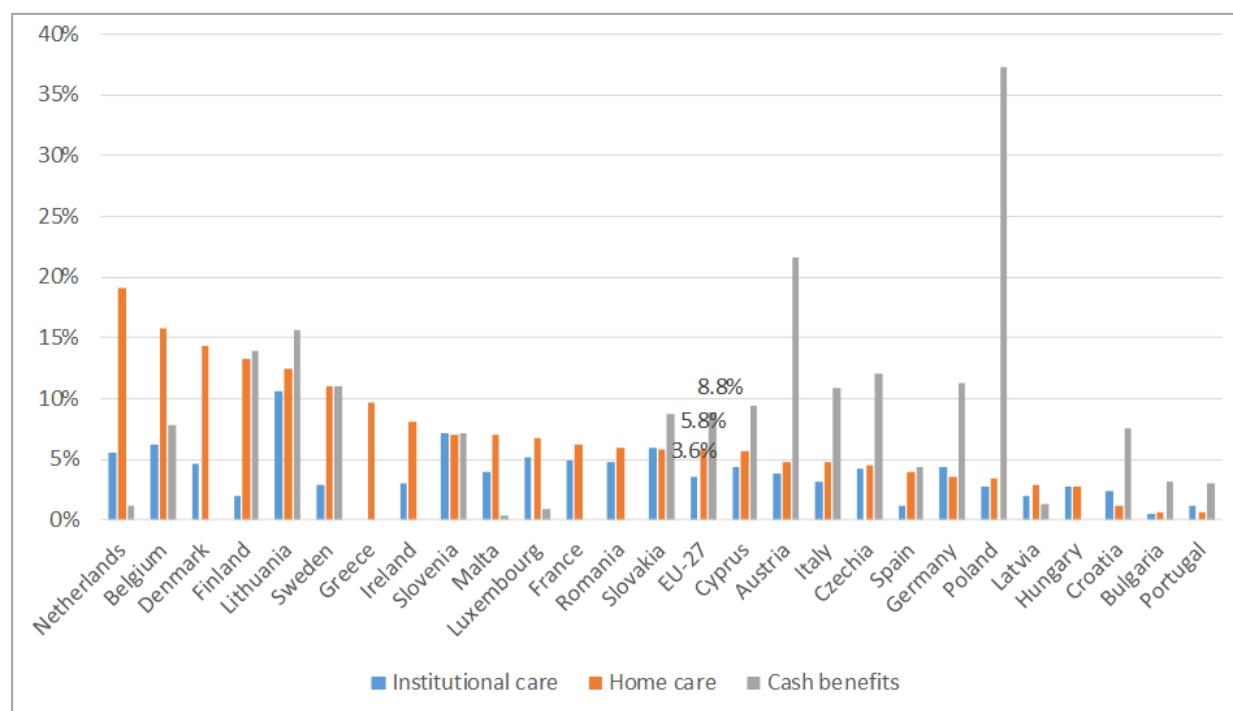
3.4. Long-term care

Long-term care (LTC) covers a broad range of services – home care, institutional care and nursing, and cash benefits – that are provided to people in need due to loss of functional capacity. The loss of capabilities related to the basic functions of daily living typically implies the need for residential care and nursing while the loss of capabilities related to the instrumental activities of daily living implies the need for home help and assistance (Colombo 2011). Though recipients of formal LTC services are of different ages, ageing and particularly functional limitations due to health problems and increasing frailty related to age are driving forces behind an increase in the demand for LTC (European Commission 2021d).

3.4.1. Use of long-term care in the EU Member States

In most European countries, care is predominantly the domain of the family. EU countries strongly differ with respect to the organisation and management of home care, access to and organisation of institutional care, in-kind and in-cash benefits and the support mechanisms introduced for family carers. Typically, there is a sectoral split between services provided in the health and social sectors, often accompanied by a division of responsibilities for the provision of benefits between national, regional, and local administrative levels (Spasova et al. 2018, European Commission and Social Protection Committee 2021d). The benefits packages and service coverage vary substantially, which is reflected in public spending on LTC. The level of LTC expenditures varies – from 0.3 % of GDP in Bulgaria and Cyprus to 3.5 % of GDP in Denmark and 3.7 % of GDP in the Netherlands in 2019 (European Commission, 2021d).

Figure 33: People (65+) receiving institutional, home care, and cash benefits, in %, 2019



Source: European Commission and Social Protection Committee (2021c).

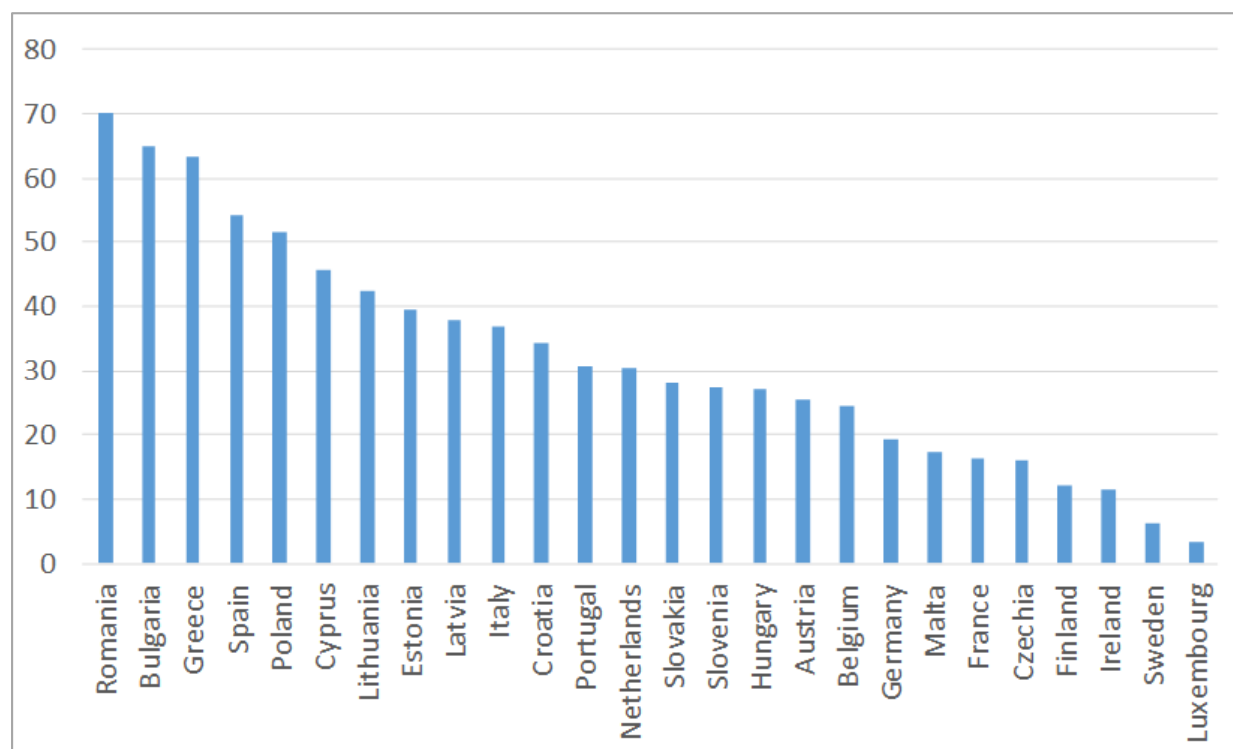
Nordic countries, such as the Netherlands, Denmark, Finland, Sweden, but also Lithuania, have the highest provision of care services for older people (65 years of age and above) (European Commission and Social Protection Committee, 2021a). The Netherlands, Estonia, Sweden, Belgium, Denmark, and Finland have the best coverage of the population with functional limitations due to health with home and institutional care (European Commission, 2021d). In recent years, in these countries policy priority is given to containing institutional care and expanding the provision of community home care services to support independent living, which is perceived as beneficial in terms of the well-being of seniors as well as the costs of care. In 2019, the highest share of older people in institutional care was noted in Lithuania, Slovenia, and Slovakia. A gender difference was noted in all but one of the EU Member States with regards to institutional care, the exception being Latvia (where the share of older men living in institutional households was marginally higher). The highest shares of older women living in institutional households are reached in Luxembourg (10.2%), Malta (9.2%), and France (around 7%). The lowest shares are in Greece, Romania, Bulgaria, and Poland (less than 2%) (Eurostat, 2020a).

Differences between countries in care provision and care use can be explained by institutional and cultural factors. Access to care is dependent upon the supply of home-based and institutional services and the ability to pay for them. For example, in Romania, access to residential institutions is limited for persons who do not have the financial resources to cover the monthly fee for institutional care (Spasova et al., 2018). On the other hand, the willingness to use care, particularly institutional, can be explained by the cultural reasons that determine the older-age people's attitude towards life in residential households. In southern and some eastern European countries, family relationships are closer than in western or northern countries and an expectation towards being cared for by family is expressed (Spasova et al., 2018). Thus, Italy and some Eastern European countries (Bulgaria, Romania, Poland) are typically characterised by the low provision of home care and institutional services in relation to the number of older people (65 years of age and above) as well as the dependent population in general (European Commission 2021d, European Commission and Social Protection Committee 2021a). In these countries, informal family care dominates.

In some countries with a lower provision of care services, cash benefits are granted to a larger share of older people (37.2% in Poland, 21.6% in Austria, 12% in Czechia). They are granted in order to support families in care provision and provide opportunities for buying services from the private market, though in some countries (e.g. Poland) benefits are low compared to the actual costs of care. Carers are also eligible for non-cash support. They are granted tax relief and pension rights (e.g. in Austria, France, Germany, Italy), information and counselling (e.g. in Austria, Bulgaria, France, Czechia, Finland, Germany, Spain and Sweden), medical check-ups (e.g. in Finland), access to trainings (e.g. in Austria, Czechia, France, Germany), and respite options (e.g. in Austria, Bulgaria, Czechia, Finland, France, Germany, Italy, Poland, Spain, Sweden) (Le Bihan et al., 2019).

The level of unmet care needs was estimated on average in the EU at 40%, meaning that this share of the 65+ population with functional limitations has not received adequate care (Eurofound 2019). In countries with well-developed care services (Netherlands, Finland, Denmark) levels of unmet care needs were substantially lower. In countries with a lower supply of services, the level of unmet care needs was higher (Bulgaria, Malta, Romania, Spain). In these countries, not only the poor supply of services becomes a problem, but also the ability to obtain services, which are often subjected to co-financing or provided by private sector institutions. In Romania, Bulgaria, Greece, Spain, and Poland over 50% of persons reported not using professional home care due to a lack of financial resources. The total costs of care are typically too high for persons with low incomes, amounting to 50% of disposable income, even if the care intensity is as low as 6.5 hours per week (European Commission and Social Protection Committee, 2021a). Thus, the main source of support for receiving care services are public social protection systems (e.g. in Netherlands, Sweden, Finland) or family. Public support in covering the costs of services is indispensable as, even with moderate care needs, older people would face the risk of poverty when purchasing long-term care at its full cost.

Figure 34: People not using professional home care services for financial reasons, in %, 2016



Source: Eurostat 2016 [ilc_at515], downloaded 2021 (latest available).

In many countries, the demand for care is higher than the supply, and provision of care is unequally distributed across the country, with care services being less accessible in rural areas (Spasova et al, 2018). The private sector plays a growing role in the provision of long-term care services. In countries with low access to publicly financed care, private providers, often paid fully out-of-pocket, fill in the gaps in the public provision of care (e.g. Poland, Czechia). In some countries, private providers are encouraged to operate in the long-term care sector in order to increase competition and develop markets for care services (Spasova, 2018). Often, private providers can obtain public funding or public authorities contract out beds with private facilities (e.g. in Germany, Ireland, Sweden). Also, non-profit organisations can be important care providers, assuring services frequently funded from public sources (e.g. in Germany, Ireland, and Poland).

3.4.2. Quality of services

The monitoring of the quality of long-term care services strongly differs across countries and types of services. In many countries, as the provision of long-term care is a regional, sub-regional, or community level obligation, quality definitions are formulated at the respective administrative level (Cès & Coster, 2019). Typically, input measures are adopted *ex-ante* via legislative regulation or financing mechanisms. These are more common for residential than for home care and include buildings and infrastructure, living standards, equipment, and a listing of the services provided. For home care, standards are set with respect to the requirements for services or the registration and accreditation process of the provider. In some countries, no universal standards for in-home care have been developed, though they might be implemented on an individual basis by the public authorities responsible for the services (e.g. in Poland, Cyprus). Standards are also more pronounced in the healthcare sector than in the social sector. Additionally, care providers use the International Organisation for Standardisation (ISO) or the European Quality in Social Services (EQUASS) to demonstrate the quality of their performance. In some countries (e.g. Poland), other external accreditation services are used to certify the performance of the service provider (e.g. by non-governmental organisations).

Client satisfaction questionnaires are output-oriented measures adopted mostly on a voluntary basis by the service providers. They allow for an assessment of general well-being, quality of life, satisfaction with services, and unmet needs and examine issues such as privacy and autonomy. In most countries, they are not standardised and local public authorities or providers themselves are responsible for their design and analysis. Overall, the measurement of the quality of services is very difficult given the complexity of the individual situations, needs, and expectations of the cared for as well as the subjectivity of the assessment, which results in poor comparability. Thus, interventions are undertaken mostly in cases of evident violations of older persons' rights or cases of negligence (Cès and Coster, 2019).

3.4.3. Innovations in LTC

There has been a discussion in recent years on adopting innovation in care in order to increase the well-being of older people, prevent loneliness and social isolation, improve coordination and quality, as well as contain the costs related to care. Evidence of the effectiveness of the selected measures is scarce and difficult to collect given the differences in individual care needs and the social and economic environment, but some hints into new care arrangements can be provided based on activities implemented in European countries in recent years.

Among the measures contributing to the prevention of social isolation and loneliness are technology-based interventions provided in the community as a supplement to typical home care. There is a high

variety of projects and solutions adopted in European countries focusing on improving the digital skills of older people in order to enable their contacts with peers or relatives. These were found to be particularly useful during the COVID-19 pandemic. In the Netherlands, video networks were used, allowing older immobile persons to have 24/7 contact with nurses or relatives and friends. Telephone befriending calls made by volunteers in order to provide emotional and psychological support were found to be successful in preventing the feeling of loneliness of older people in Germany. Telephone support was combined with an emergency care personal alarm provided to the older people living alone as a care support measure. Positive results were also observed in Spain, Finland, and Slovenia among older people who were provided digital training in using the internet and skype (Marczak et al., 2019). These types of digital services grew in importance during the COVID-19 pandemic.

Innovations are also related to the management of care. In recent years, personalisation (introduction of personal care budgets or vouchers) has been discussed. It is perceived as a tool empowering the cared for and their families by allowing them to choose the best care options, delivery pathways, and enabling choosing the best services to address individual needs. There are different forms of personalisation. In the United Kingdom, care vouchers were provided to people previously benefiting from in-kind care packages. In Germany, personalisation of care is incorporated in the care system, with cash benefits and care packages individually chosen by people covered with long-term care insurance. There is no evidence of cost efficiency, but an increase in the satisfaction of care recipients has been observed (Frisina-Doetter et al., 2019).

A new form of care is shared housing (*Wohngemeinschaft*) or intergenerational housing, where people with different care needs live in a common compound, use common outside environment, domestic support, care, and nursing. There is a growing number of shared housing groups, often as an alternative to residential care. With no evidence of cost efficiency, positive effects were observed for nutrition and the job satisfaction of carers (Frisina-Doetter et al., 2019).

3.4.4. Impact of COVID-19

COVID-19 has put additional pressure on the performance of LTC systems as older people faced a particularly high risk of dying and negative consequences from SARS-CoV-2 infection. When the pandemic hit, residents of long-term residential care were particularly at risk. Frequent close contact between residents and healthcare staff as well as numerous staff rotating between facilities, including hospitals, facilitated the spread of infection. Additionally, poor protective equipment, particularly in the first months of the pandemic, sped up the transmission of infections. In some European countries (e.g. Spain, France), as a first reaction to the COVID-19 outbreak, there was significant absenteeism among LTC residential care workers and a refusal to work in cases of an outbreak. LTC systems had to quickly adjust to the situation, reorganising care in order to increase safety of services' provision and support informal carers. Governments introduced various measures to support the supply of care in residential homes as well as in communities. Among those were⁵⁶:

1. Guidelines and regulatory measures:

- National guidelines on physical and social distancing, sanitary procedures, use of personal protective equipment, and management in case of infections were introduced in many countries (e.g. Germany, Poland, Denmark, Italy, Slovenia). Guidelines were published by governments in the form of national regulations (e.g. Denmark) or by other public bodies, such

⁵⁶ Author's own compilation based on information from country reports published by the London School of Economics and Political Sciences. Available at: <https://lccovid.org/country-reports-on-covid-19-and-long-term-care/>, Langins et al. (2020) and European Commission and Social Protection Committee (2021a, c).

as health funds or chambers of physicians as recommendations which should be followed by service providers (e.g. Poland).

- Centralised emergency management was introduced in terms of assuring access to personal protective equipment and crisis management (e.g. Austria, Greece, Hungary).

2. Financial measures:

- Additional funding for purchasing personal protective equipment (PPE) in residential, semi-residential, and home care (e.g. Poland, Germany, Netherlands). Funding was provided by the central government or regional authorities via ESF (Poland).
- Additional funding for families to provide intensive care at home or to purchase home care services in case of the inability to continue with up-to-date care provision due to COVID-19 (e.g. Austria).
- Temporary increase in wages of medical and care staff (e.g. Poland, Germany).
- Increase in sickness benefit of medical and care employees during quarantine and isolation in response to high infection risk they face in every-day work (e.g. Poland).

3. Reorganisation of work/employment in the face of staff shortages, particularly in institutional care:

- Introduction of an obligation to wear PPE, everyday temperature measurement while entering the facility, and PCR tests conducted in certain periods of time.
- Cessation of employment in multiple facilities in order to contain the spread of infection as well as the introduction of telework if feasible (e.g. online or telephone medical consultations) (e.g. Poland).
- Employment of undergraduates in medical professions (e.g. Netherlands) and decreasing the minimum requirements for the employment of residential care staff to encourage employment in long-term care (e.g. Austria).
- Creation of a platform to promote and encourage care work (e.g. Netherlands).
- Psychological support to care workers and the cared for (e.g. Slovenia).

4. Changes in service provision:

- Development of e-health applications and digital home care (e.g. Netherlands).
- Reorganisation of family visits and social contacts (in visiting zones, physical distancing, online meetings) in residential care (e.g. Poland, Netherlands).

5 Other measures:

- Promoting volunteering services in the community and neighbourhood to support older people with care needs in household activities or with groceries, among others (e.g. Poland).
- Opening a telephone helpline for family carers and migrant care workers (e.g. Austria).
- Regulations on migrant care work regarding number of hours worked and extending the period of care provision and introducing an obligatory minimum wage for live-in carers (e.g. Austria, Germany).

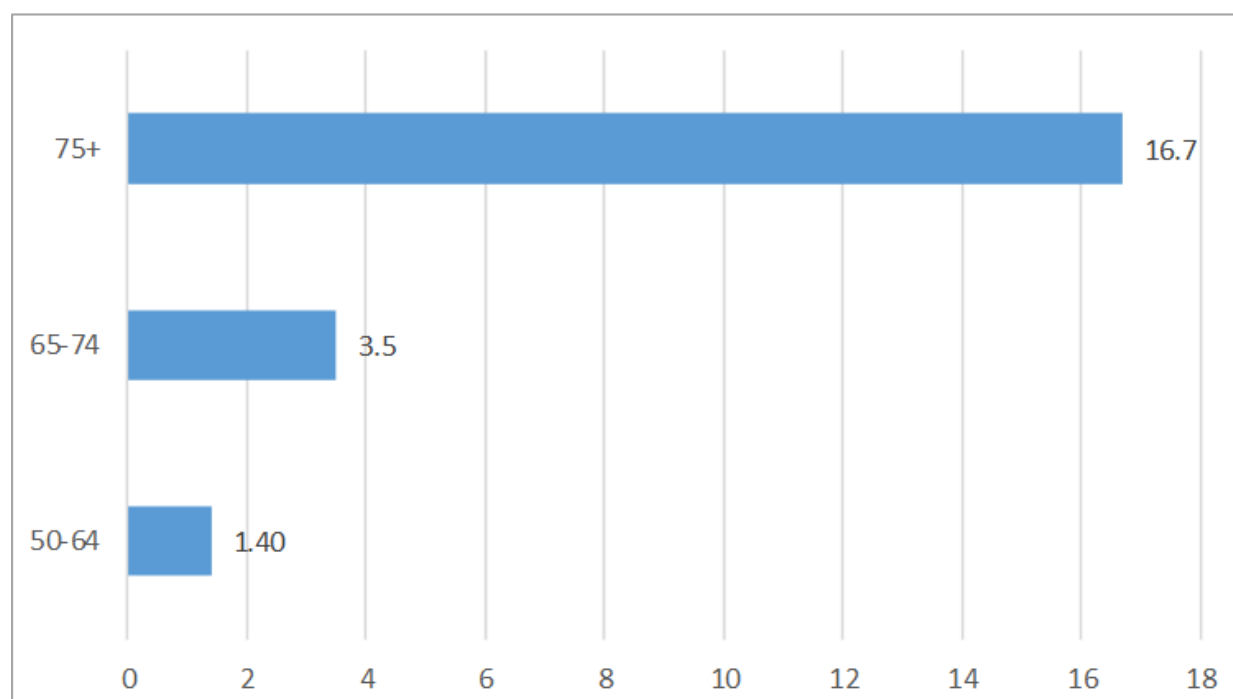
There is great differentiation among the measures introduced to respond to the specific problems that long-term care systems were facing. In Poland and the Netherlands, for example, attention was given to addressing staff shortages. In the Netherlands, financial measures supporting institutional care were

introduced to respond to the risk of the decreasing number of new residents and the outflow of care workers. Most countries introduced protective measures to prevent the spread of the infection, which were oriented particularly at physical and social distancing. Day care centres were largely closed and home care services in many countries were decreased to a necessary minimum.

In Austria and Germany, attention was given to measures supporting the provision of home care by family carers and migrants from neighbouring countries. The latter form of care is growing in importance as a substitution of publicly provided care in countries like Poland and Italy and a supplement to publicly provided care in Germany and Austria (Sowa-Kofta et al., 2019). In Austria, the federal government provided a financial bonus for live-in carers who decided to extend their shift by additional four weeks and provided assistance in travel arrangements. In Germany, migrant care work is organised by temporary work agencies and public employment services. They have been actively engaged in supporting the cross-border mobility of workers.

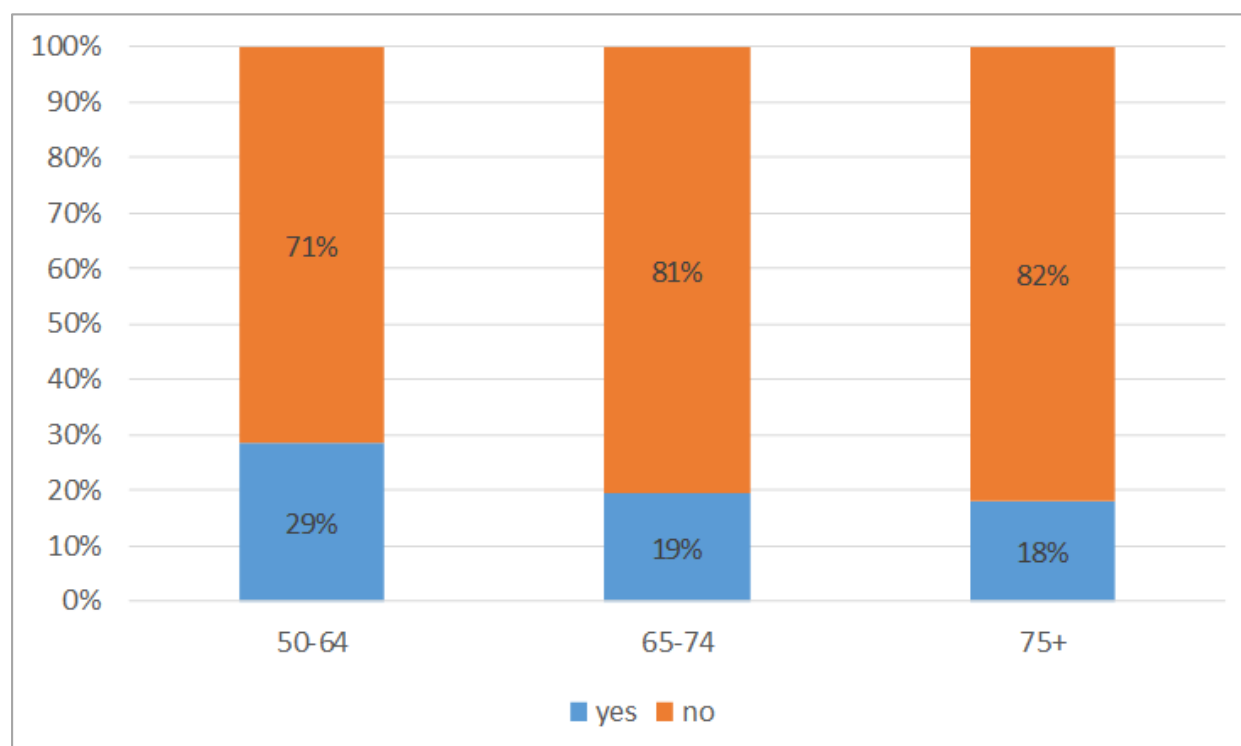
According to the SHARE survey, in European countries, 1.4 % of people aged 50-64, 3.5 % of people aged 65-74, and 16.7 % of people aged 75 years or more received home care before the pandemic. Out of home care recipients aged 50-64, about one-third experienced difficulties in obtaining care during the COVID-19 pandemic. Older people above the age of 65 less frequently reported problems with obtaining care, yet one-fifth of them experienced difficulties of some sort.

Figure 35: Recipients of home care (50+) before the COVID-19 pandemic by age group, in %



Source: Own calculations based on SHARE wave 8 and COVID-19 survey 2020/2021.

Figure 36: People reporting difficulties in obtaining home care during the COVID-19 pandemic



Source: Own calculations based on SHARE wave 8 and SHARE COVID-19 survey 2020/2021.

It should be noted that during the COVID-19 pandemic, the burden of care was shifted to families, while support options for family carers were often insufficient or lacking, particularly related to respite care options.

3.4.5. Challenges in long-term care

There are several challenges regarding long-term care, some are country specific, others are more universal. Countries in Nordic and Continental Europe have implemented policies replacing institutional care with home care provided in community settings. They work on coordination of services and introducing innovative solutions such as personalisation and new community living arrangements. In CEE countries (Bulgaria, Romania, Slovakia, Poland), there is a need to improve access to all types of care, particularly as some of them (Poland, Slovakia) are foreseen to age rapidly in the decades to come and families, which are traditionally the main care providers, will not be able to address the growing care needs (Spasova et al., 2018).

Adequacy and affordability of care are problems, as a significant share of the dependent population declares not receiving sufficient support and that financing is a dominating obstacle in obtaining care. According to the OECD estimates, even receiving low intensity care (6.5 hours a week) at full cost might result in a poverty risk for older people. Thus, social security is necessary to – at least partly – cover the costs of care, particularly for people with higher care needs (European Commission and Social Protection Committee, 2021a).

A common challenge for all European countries is insufficient nursing and care workforce. The number of care workers per 100 people aged 65 or more varies from 12.4 in Sweden and 8.0 in the Netherlands to 0.5 in Poland and 0.1 in Greece (European Commission and Social Protection Committee, 2021c). The population of nurses and carers is ageing and in many countries, inflow to the profession is not

sufficient to fill in gaps. The low prestige of care professions and low earnings when compared to other sectors of the economy create disincentives to undertake employment in the long-term care sector. The engagement of social entrepreneurship supports community care in some countries, though this is not a sustainable or sufficient measure. Migrant care work, often full-time/24-hour care, becomes more common, but the sector needs regulations regarding work time, quality monitoring, access to social protection, and prevention of abuse. Migrant care workers are typically employed by labour agencies and, as temporary workers, they are excluded from the labour regulations of the receiving country, including minimum wage, sick leave, maternity benefits, and pay for extra hours. In Germany in June 2021, the Federal Labour Court ruled that migrant care live-in workers providing services 24 hours/7 days a week are eligible for a minimum wage including while on standby⁵⁷. While the court decision will support the dignity and economic security of workers, who until now were not covered by German labour law, it might raise the costs of care to a level hardly bearable for many care recipients.

Finally, more research is needed regarding innovations in long-term care. These include care management and personalisation, the introduction of shared living arrangements, and the use of telecare and telemedicine. The COVID-19 pandemic has shown their importance, not as a substitution for the care in place, but as a supportive measure.

Despite efforts to monitor the performance of long-term care in European countries, data on coverage with different types of long-term care (residential, day care, home care) for the older population by age is still insufficient and poorly comparable. Difficulties in data collection arise from the fact that services are provided in the health and social sectors and cover a variety of in-kind and in-cash benefits targeted to different populations (older, disabled, poor with care needs). There is also a need for more statistical investigation on unpaid (family) care and domestic care, particularly care provided by migrants.

3.5. Supportive environments

The environment determines individual's opportunities to respond to disease, loss of function, and other forms of loss and adversity that they may experience in later years. Thus, the importance and the need for a supporting and age-friendly environment is growing in parallel with ageing. For instance, access to assisted living might prolong older-age individuals' living in a private household and postpone moving to a residential care institution. Similarly, access to safe and timely transportation is one of the necessary conditions for staying active in the labour market or for participation in community activities. This section focuses on the analysis of three aspects related to the supporting environment that are particularly relevant from the perspective of the ageing population: access to high quality and adjusted housing, access to high quality and necessary transportation, and the financial independence of the older-age population.

3.5.1. Housing

Housing in the context of active ageing is defined as access to affordable sufficient quality housing adjusted to the needs of older individuals (UN 2019). Older individuals' satisfaction with the quality of their life depends to a large extent on the conditions in which they live. Household composition, affordability, as well as the presence of amenities at home (i.e. hot water, toilet, and sewage system), cleanliness, and infrastructural adaptation of the residence (i.e. elevator, handrails) directly affect the physical and emotional well-being of older individuals.

⁵⁷ Commentary on the ruling, Deutsche Welle. Available at: <https://www.dw.com/en/germany-top-courts-order-on-foreign-nursing-home-workers-pay-triggers-debate/a-58045991>.

This sub-section will discuss the specifics of the older population's housing from three perspectives: housing composition, housing affordability, and housing quality. This sub-section mainly focuses on the situation concerning individuals living in private households while the section on long-term care (see above) pays more attention to the situation concerning living in residential care institutions. EU-SILC data is used as the main source of information in this sub-section.

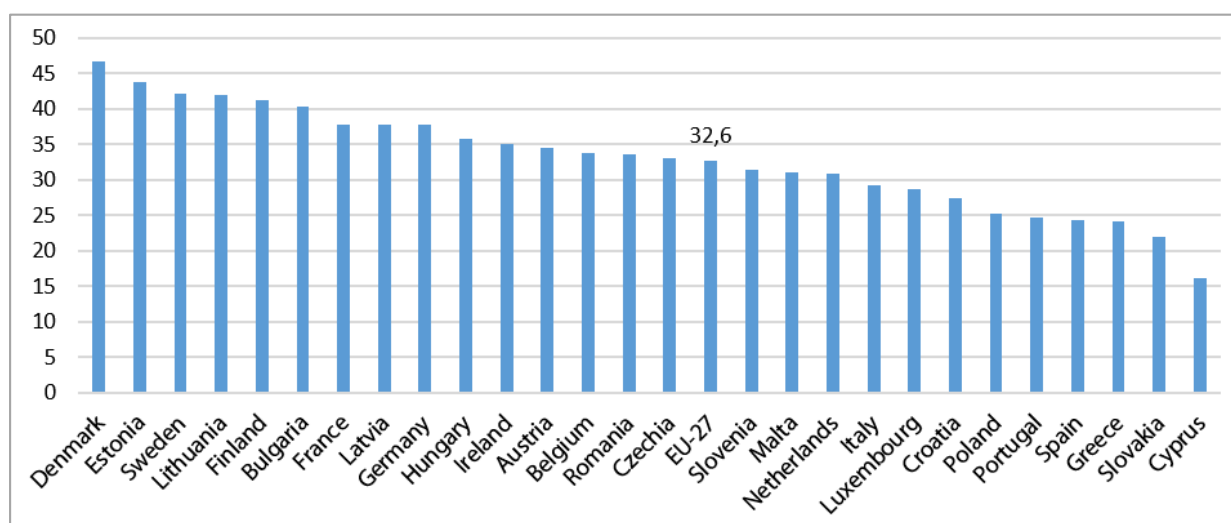
Household composition

A significant share of the older-age population in the EU live alone. Specifically, almost one-third (32.6 %) of individuals aged 65 years and over in the EU-27 lived alone in 2019, according to EU-SILC data. The share of the alone living older population varies across the EU countries and regions. Older-age individuals in Scandinavia and the Baltic states are the most likely to live alone, while the share of the alone living older population is relatively low in southern European countries. These differences are mostly determined by the family-oriented approach to work-family reconciliation that dominates in southern countries.

Additionally, some demographic groups of older individuals are more likely to live alone and thus face the challenges associated with this living situation. The share of older women living alone is much higher when compared to men. Based on EU-SILC data from 2019, slightly more than 40% of women aged 65 years old and over in the EU-27 lived alone, while this share among older men was only 23%. Moreover, older individuals living in cities and towns are more likely to live alone when compared to the population living in rural areas.

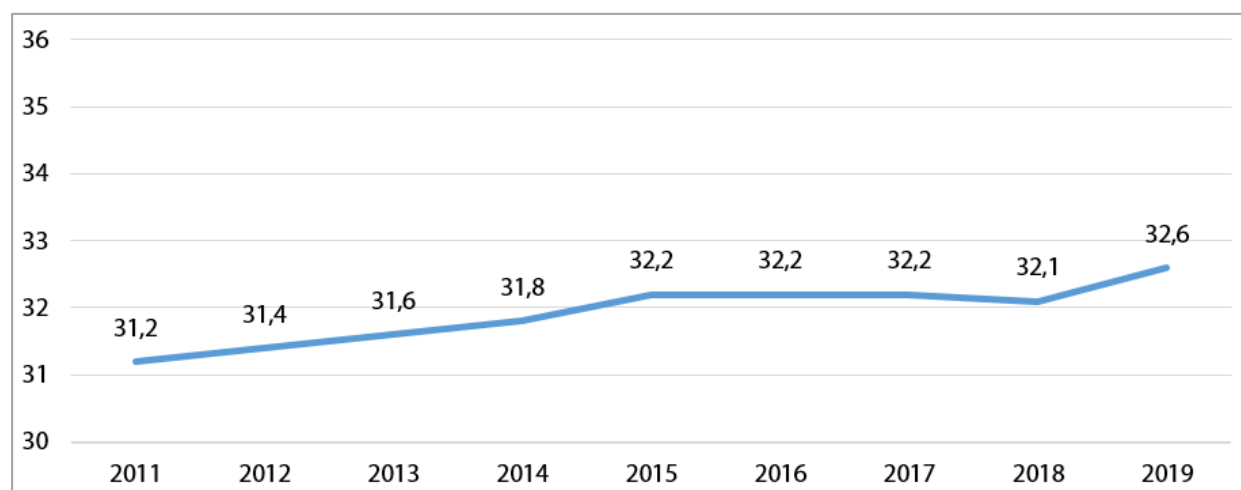
The share of individuals aged 65+ living alone has been slowly but steadily increasing over the last decade. The share of older persons living alone rose by 1.4% (out of the total population aged 65 and over) between 2011 and 2019 (Eurostat, 2019). This trend emerges due to a few reasons. First of all, an increasing life expectancy and improving living conditions and health status can help to maintain the independence of older people. Therefore, nowadays older-age citizens are more likely to be independent of daily assistance and, thus, live alone for longer. In addition, living alone can also be determined by weaker relationships with family members (Lim & Kua, 2011).

Figure 37: People (65+) living alone, in %, EU-27, 2019



Source: EU-SILC [ILC_LVPS30], downloaded 2021 (latest available).

Figure 38: People (65+) living alone, in %, EU-27, 2011-2019



Source: EU-SILC [ILC_LVPS30], downloaded 2021 (latest available).

The high share of older-age individuals living alone can be interpreted as both a positive and a challenging situation at the same time. On the one hand, living alone can be seen as a positive aspect, indicating older individuals' independence from the help of others, especially in the case of relatively healthy and strong older individuals. Moreover, many surveys indicate that the majority of older people prefer to live in their own homes even in the face of reduced capacity (Homes4life, 2020). Thus, living alone might have a beneficial effect on their self-esteem. On the other hand, in the case of relatively less healthy individuals who might need constant help with daily chores or individuals who live alone because they do not have any other alternative choice, living alone can become a significant barrier to their active ageing and decrease the quality of their life. Furthermore, the household composition determines not only the need for (external) physical help and care at home but also the psychological well-being of older-aged citizens. This is mostly because living alone can mean loneliness and weak relationships with other family members, which can negatively affect the mental health of older individuals.

There is not enough quantitative data to assess the effects of the pandemic on household composition. Moreover, there are no tendencies indicating any significant changes concerning household composition during the pandemic. It is likely that the majority of (older) people did not change their households during the pandemic. Nevertheless, the pandemic has not only significantly increased the challenges older individuals face from living alone, but it has also placed them under the spotlight. First, alone living older individuals were especially vulnerable and suffered from the lack of social contact and communication during the COVID-19 pandemic, when social interactions outside households were limited (Fingerman et al., 2021). Second, the opportunities for alone living older individuals to receive the needed help and care significantly decreased because of quarantine rules. For instance, children or family members were not able to visit and help older relatives with chores. For this reason, the pandemic has only increased the challenges associated with the limited availability of the formal home-based care services that had already been emphasised on the political level before the pandemic (Homes4life, 2020).

Affordability of housing

The majority of older citizens in the EU can afford their housing without a heavy financial burden. Moreover, there are no significant differences concerning the affordability of housing between the older and younger population. Nevertheless, it cannot be ignored that more than one-fifth of the older-age EU population need to allocate a significant part of their income to the rent, while more than

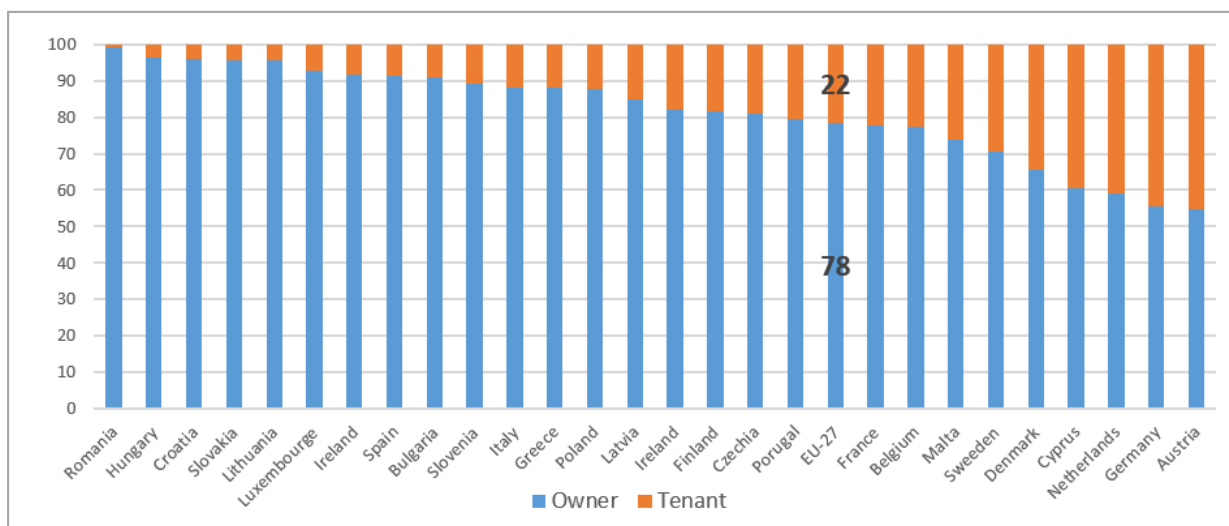
one-tenth of the population suffer from the housing cost overburden rate (i.e. live in households that spend more than 40% of their disposable income on housing costs). Moreover, real estate prices have been rapidly rising in Europe (especially in Western Europe) in recent years. It is also likely that older citizens will be one of the groups suffering the most significantly from this housing crisis because of their limited opportunities to earn additional income (Homes4life, 2020).

Affordability of housing for older citizens can be described through two key indicators: the share of the population with an ownership status as well as the housing cost overburden rate. Ownership status of the residential place shows whether an older-aged person lives in her/ his own house or whether she/ he needs to pay rent for it. Living in a rented house means that an older individual faces an additional financial burden. Meanwhile, people living in owned houses may spend these financial resources on securing other needs such as healthcare, food, clothing, housing, or entertainment. Thus, it is probable that people living in owned houses might be likely to be more active in their life as their financial capabilities are higher.

An absolute majority of the older-age population in the EU are owners of their homes. Moreover, older individuals (aged 65 years and over) are more likely to be homeowners when compared to the younger-aged population. In 2019, 78.4 % of older people (65+) were homeowners and only 22.6 % were tenants. In comparison, the share of homeowners drops to 70.5 % among people younger than 65 years old (18-64) (Eurostat, 2019). In addition, older people are more likely to be homeowners with no outstanding mortgage or housing loan rather than having not yet paid the mortgage (Eurostat, 2018). The share of older-aged tenants has been slightly decreasing in recent years. This positive trend can be explained by the improving financial situation of older people (see 2.2.5.3. Financial independence sub-chapter below), as well as due to a more flexible real estate purchasing policy (OECD, 2011). Nevertheless, real-estate prices in the EU (especially in Western European countries) have been rapidly rising in recent years. Therefore, it is likely that situation will start worsening soon because the share of (older) individuals who will be able to buy a dwelling is likely to decrease even more in the future (Homes4life, 2020).

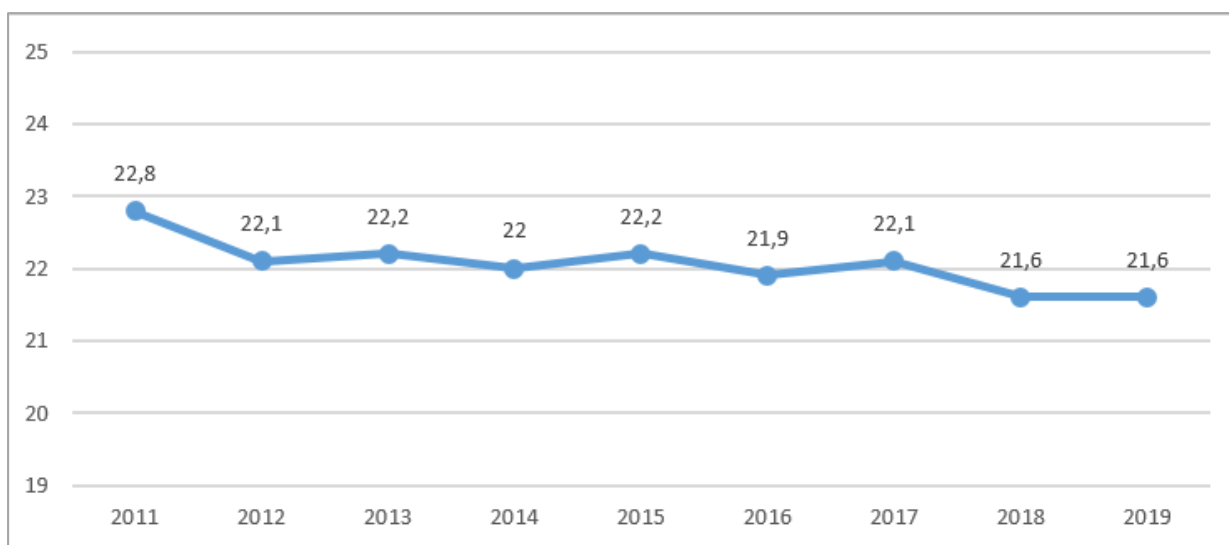
Moreover, the share of homeowners among the older population varies significantly across the EU. The highest share of older people with property status is in central and eastern Europe (e.g. Romania, Hungary, Croatia, Slovakia, Lithuania), where real estate prices are generally lower than in western or northern European countries (e.g. Austria, Denmark, Netherlands) (Statista, 2021). In addition, as it was pointed out above (see section on long-term care above), older persons in Northern and Western Europe more often choose to live in a residential household (i.e. institutional care institutions or older persons communities) when compared to eastern or southern European countries (Spasova, 2018).

Figure 39: People (65+) having tenant or owner status, in %, EU-27, 2019



Source: EU-SILC, [ilc_lvps15], downloaded 2021 (latest available).

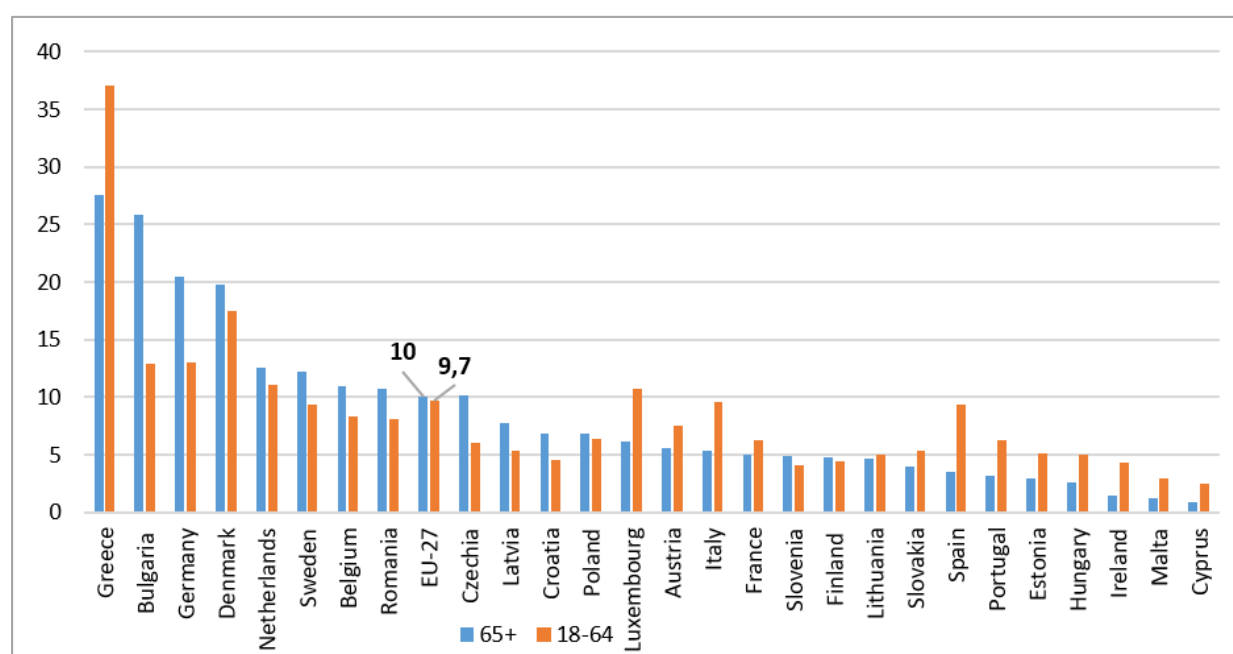
Figure 40: People (65+) having tenant status, in %, EU-27, 2011-2019



Source: EU-SILC, [ilc_lvps15], downloaded 2021 (latest available).

Housing costs include expenditures such as rent or mortgage payments, as well as property-related municipal taxes, utility costs (such as water, electricity, or gas), other fuel costs (such as solid or liquid fuels and bottled gas), and home repairs and maintenance (Eurostat, 2020a). One-tenth of the older-age EU citizens suffer from housing costs overburden. According to EU-SILC, in 2019, 10 % of older people (65 years and over) out of the total older population were living in a household where the total housing costs (net of housing allowances) represent more than 40 % of the total disposable household income. Almost identical rates were recorded for the EU population aged 16-84 years old (9.7 %). Older women are more likely to be overburdened by housing costs than men. In 2018, 11.3 % of women (aged 65 and over) out of the EU-27 older population (65+) were overburdened by housing costs. This was 3.4 % higher than the proportion for older men (7.9 %). This trend, in which a higher proportion of older women than older men is burdened by housing costs, was noticed in all but three EU Member States (Malta, Ireland, Cyprus) (Eurostat, 2020).

Figure 41: Housing cost overburden rate by age group, in %, EU-27, 2019



Source: EU-SILC, [TESSI161], downloaded 2021 (latest available).

There is no data indicating significant changes concerning the affordability of housing during the pandemic. Nevertheless, the lack of access to affordable housing is affecting not only low-income groups but also specific vulnerable and fragile groups in the population, such as older people. With COVID-19 and lockdown measures instructing people to stay at home, the failure of housing policies to provide affordable housing became even more obvious (Homes4life, 2020). Some groups, such as older individuals renting their housing or older-age single women (whose income is on average lower when compared to men), are especially vulnerable to high (or rising) housing costs.

Quality of households

Quality of the household is another aspect affecting older individuals' well-being. Quality of the household is determined by both the general (universal) quality of the housing (e.g. lack of household problems, safety of the neighbourhood, or the proper number of residents based on the household size) as well as by the features of the household adjusted to the specific needs of older individuals (e.g. existence of elevators, proximity of neighbours, among others). It is probable that persons who live in a favourable place and are satisfied with their housing quality will be more active and happier in their everyday life in comparison to persons who face housing issues.

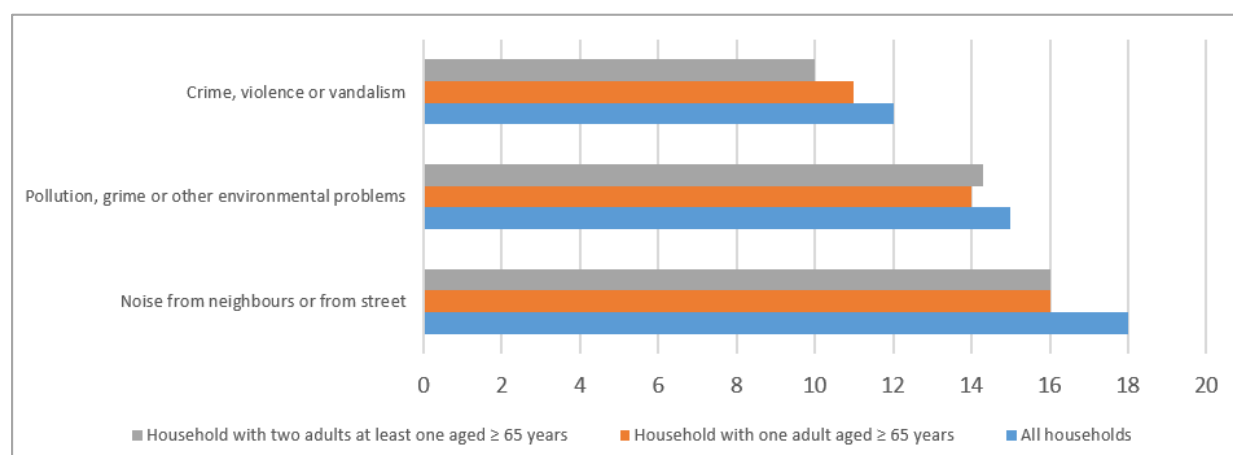
Older-age Europeans on average are less likely to face significant challenges related to overall household quality when compared to the younger or overall population. First of all, older individuals are less likely to live in a dwelling with a leak, damp, or rot in comparison to the total population. In 2019, the corresponding share of older people (those aged 65 and over) who resided in a home with housing problems was lower (10.5 %) when compared to the entire EU-27 population (12.7 %). This trend with a lower proportion of older-aged citizens suffering from poor dwelling conditions in comparison to the overall population was noticed in the majority of EU Member States, except for Slovenia, Italy, Luxembourg, Estonia, Greece, Croatia, Romania, and Malta (Eurostat, ilc_mdho01, 2021).

In contrast to the problem of overcrowding, which mainly affects younger people and those living in some of Europe's major cities, older individuals are more likely to live in under-occupied housing (Eurostat, 2020a). Nearly one-half (46.4 %) of older people (aged 65 and above) in the EU-27 lived in

under-occupied housing based on data from 2019. In comparison, only less than one-third (30.5 %) of working-age adults (aged 18-64 years) lived in under-occupied dwellings (Eurostat, ILC_LVHO50A, 2021). Living in under-occupied households often can be interpreted as a positive trend as it allows older people to have their private space, which in turn positively affects their everyday well-being. Nevertheless, living in an under-occupied household can also indicate a lack of other suitable housing options (see the sub-section below).

Moreover, older residents are slightly less likely to experience crime, violence, or vandalism in their local environment than the total population. In 2018, 12 % of all households in the EU-27 reported crime, violence, or vandalism in their neighbourhood, while the corresponding shares for households composed of older people were marginally lower irrespective of whether the household was composed of a single person aged 65 years or more or two adults, at least one of whom was aged 65 years or more. The highest shares of older people facing such problems were noticed in Bulgaria, Cyprus, Belgium, Luxembourg, Romania, and Austria (Eurostat, 2020a).

Figure 42: Households facing noise, environmental problems, or crime in their local areas, in %, EU-27, 2018



Source: Eurostat, [ilc_mddw01], [ilc_mddw02], [ilc_mddw03], 2020a.

All above mentioned general features (i.e. lack of significant household problems, lack of overcrowding, living in a safe neighbourhood) determine the overall household quality. Nevertheless, they indicate only if the basic (i.e. minimal) needs concerning the household quality are met. Households that can be perceived as favourable for active ageing should include a number of additional and more specific features. For instance, it is important whether the household is fully suitable for the individual living of older people, whether it has access to the internet and modern electronic devices, whether it is adjusted for people with movement or other disabilities, and whether there is close proximity of the neighbours, among others. There is the lack of quantitative data measuring these more advanced and specific attributes determining household quality from the perspective of older individuals. However, based on the expert opinions, few households meet the specific needs of older individuals (Homes4life 2020). According to experts at Housing Europe, 80 % of the housing stock is not suitable for independent living (Age Platform Europe, 2020).

During the pandemic, people needed to spend the absolute majority of their time at home. Therefore, older individuals living in households of an overall low quality (e.g. living in a dwelling with a leak, damp, or rot) as well as those living in households that are not adjusted to their specific needs (e.g. older-age individuals with a movement disability living in buildings without elevators) were especially negatively affected by the quarantine regime. It also had negative effects on their emotional well-being (Styvendaal et al., 2020). The pandemic only deepened and highlighted the already existing challenges

related to the lack of housing adjusted to the specific needs of older individuals. Experts emphasise that further policy efforts should mostly target the adaptation of the existing housing stock to the specific needs of (older) individuals because new construction only represents about 1 % of the total housing stock (Age Platform Europe, 2020). Moreover, the social housing sector is already trying to integrate all types of services and support in (or next to) households and help people to access these services, with the home seen as a hub (Homes4life, 2020).

Data limitations

When analysing housing issues among older people, some data gaps were noticed:

- Reliable data on the impact of COVID-19 housing issues among older people in the EU is not available yet. The latest available data is for 2019, and the data for 2020 and 2021 will not be published for 1-2 years. Therefore, assumptions about the housing situation in the context of the COVID-19 pandemic can only be made based on the estimated trends.
- The majority of the available quantitative data indicates the overall quality of the households (i.e. "minimal requirements"). Data that can be used to assess whether the households are adjusted to the specific needs of the older population (e.g. whether the building is adjusted to the needs of people with a movement disability) is currently not collected at the EU level.

3.5.2. Transportation

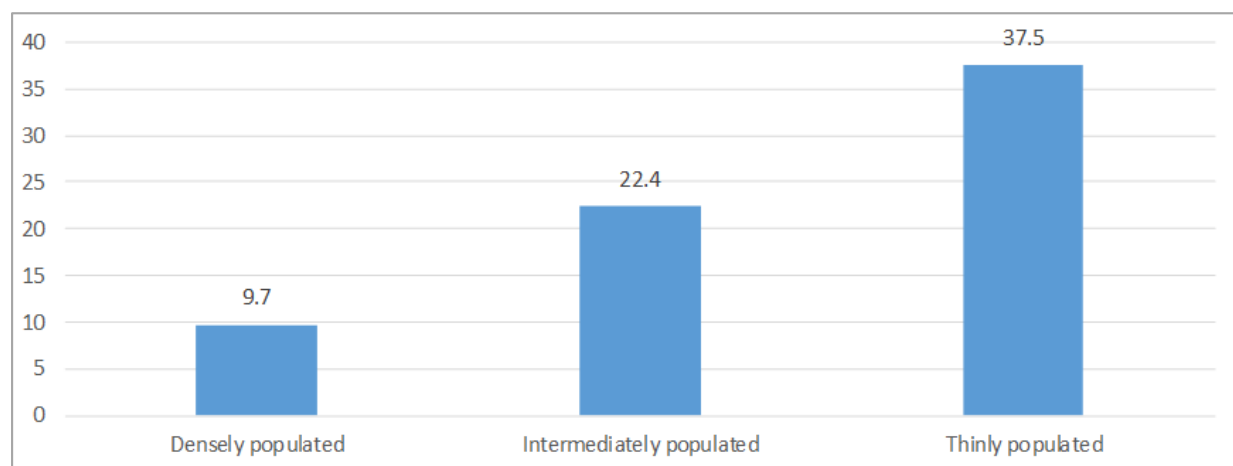
Transportation in the context of active ageing is defined as access to safe and timely transportation for older persons. The current generation of older people is more active than previous generations of equivalent age. In this context the public transportation plays a crucial role in maintaining their active lifestyle even when they are unable to drive. Sufficient accessibility to transportation is one of the necessary conditions for older people staying active in the labour market or participating in community activities, as well as travelling long distances to avail themselves of groceries, services, and other activities (Shrestha et al., 2017). Public transport plays a crucial role for older individuals because they are less likely to drive, to afford private transport services (i.e. taxis), or walk long distances when compared to the younger population. Accessibility of transportation for older individuals is determined by the three following aspects: availability of public transport, adjustability of the transportation to the specific needs of the older population, and affordability of the transport. These aspects are discussed further in this sub-section.

Availability of public transport

The likelihood of encountering difficulties in accessing public transport is determined by the place of residence. People living in thinly populated areas are more likely to face such difficulties than people living in densely or intermediately populated areas. In 2012, nearly 40 % of the EU-28 population living in thinly populated areas experienced some or great difficulties in accessing transportation services. This proportion varies from 13.4 % in Hungary to 71.2 % in Belgium (Eurostat 2012). Situation concerning the availability of public transport seems to be less problematic in densely and intermediately populated areas. For instance, the share of population who experienced some or great difficulties in accessing transportation services living in areas of intermediate density was 15.1 % lower than for thinly populated areas (22.4 %). In some countries the contrast between the availability of public transport in thinly and densely populated areas is especially significant. For instance, in Belgium, Germany, Ireland, and Finland differences between the population having some or great difficulty in accessing transport services in thinly and densely populated areas was larger than 40 % (Eurostat 2012). These statistics provide the general view of the availability of public transportation (i.e. without disaggregation by age). However, as older people are more dependent on public transport, they are

more vulnerable to its low accessibility than younger-aged or middle-aged people. This indicates that older-age individuals living in rural areas are among the most disadvantaged groups concerning the availability of transportation, which in turn might have a strong negative effect of their opportunities for active ageing.

Figure 43: People reporting difficulty accessing public transport by degree of urbanisation, in %, EU-28, 2012



Source: Eurostat 2012, downloaded 2021 (latest available).

Transportation adjusted to the specific needs of older individuals

Accessibility of transportation for older individuals is also challenged by the lack of transport vehicles adjusted to the specific needs of this age group. The bus that could be described as suitable for older people should have a number of different attributes such as step-less entrances, priority seats (usually in the front of the bus), handrails, priority seating facilities, real-time audible information, and wheelchair space (Shrestha et al., 2017). If such elements are absent, the use of public transportation becomes unattractive and uncomfortable for the older population (Shrestha et al., 2017).

The accessibility and design of public transport vehicles was significantly improved across the EU in recent years (Shrestha et al., 2017). Nevertheless, around 10-20 % of European population still does not have a sufficient access to public transportation adjusted to their needs. This share also includes older-age population and people with disabilities (Shrestha et al., 2017; Mobility4EU, 2017). In most of the cases improved accessibility and design of public transport vehicles for the older-age passengers would automatically lead to the improved quality of the transportation looking from the perspective of the general population. For example, high-quality audio system announcing the name of the next bus stop would be useful not only for passengers with sight or hearing related health issues, but also for people who simply do not know the route (Tracy, 2015). EU and Member States national level policies related to the accessibility of public transportation usually focus on three aspects: safety, affordability, and barrier-free access of transportation in particular (Tracy, 2015). Nevertheless, it is likely that more general attitude aiming to improve the quality of public transportation in general (not focusing on the specific aspects, or the needs of specific target group) could automatically lead to the increased accessibility of public transport for all individuals, including older-age population (Tracy, 2015).

Affordability of public transport

The low accessibility of transport among the older population can also be explained from a financial perspective. For example, older-age population is more likely to spend relatively large share of their income on healthcare services and medicaments. (Eurostat, 2015). As a result, a smaller share of their income can be spent on other facilities (including transportation). Because of the financial challenges some older-age people may be unable to access facilities and services that are essential for them such as healthcare institutions or shops that are not within their walking distance.

Affordability of public transportation looking from the perspective of older-age population can be increased by introducing discount systems for ticket prices, multiple use tickets, easily-understandable structure of fares (Shrestha et al., 2017). Member States frequently introduce various fare subsidies and discounts in order to increase affordability of public transport for older people (Shrestha et al., 2017). Fare subsidies are introduced and funded at both national and regional (e.g. municipalities) level. The compensation provided to older-age individuals might be funded from the national or regional budget, or from the income of the (private) transport providers themselves (Shrestha et al., 2017). The size of the compensation varies across and within the EU Member States. For instance, the bus ticket discount size for older age population varies across different municipalities and cities of Lithuania.

Impact of the COVID-19 pandemic

During the COVID-19 pandemic, the accessibility of public transport, especially for the older-aged population being in a risk group, has decreased. In general, national governments limited the amount of public transport during the lockdown. Moreover, national governments encouraged citizens not to leave their place of residence and not to use public transport during the lockdown without serious reasons. These encouragements were even more oriented to older people, who in particular are at a high risk of being infected with the COVID-19 virus. Thus, the older-aged population was more vulnerable to such a policy when compared to the younger population because older people may have no other transportation opportunities (i.e. not driving and cannot afford private transportation services, as well as cannot ask their relatives for help due to social distance restrictions). Furthermore, older persons often did not have officially justified reasons to leave their living places during the lockdown as they did not need to travel to work (because of retirement). In extreme cases, older people (similarly to other age groups) could receive fines for leaving their home and using public transport. Thus, the pandemic restrictions made the older people more vulnerable to the low accessibility of public transport.

Challenges related to the accessibility and affordability of public transport for older individuals

The relatively low availability and affordability of public transport for older persons pose physical and psychological challenges. First of all, older persons that are relatively frequently unable to drive or walk long distances compared to the younger population and use other than public transport travelling services may feel dependent and isolated from outdoor activities (i.e. if they are a long distance away). It limits their opportunities to remain in the community and enjoy social/cultural life. Second, in extreme cases, older persons without transportation opportunities may face serious challenges in accessing necessary facilities, such as hospitals, healthcare institutions, grocery shops, and pharmacies. In such a case, they may not meet their essential needs. Finally, the low accessibility of public transport may also be one of the reasons for early retirement. This is especially probable if an older person is unable to drive and her/ his working place is not accessible by walking. This indicates that low accessibility of the adjusted public transport can negatively affect the overall quality of life of the older population (Shrestha et al., 2017).

Data limitations

When analysing transportation accessibility for older people, some data gaps were noted:

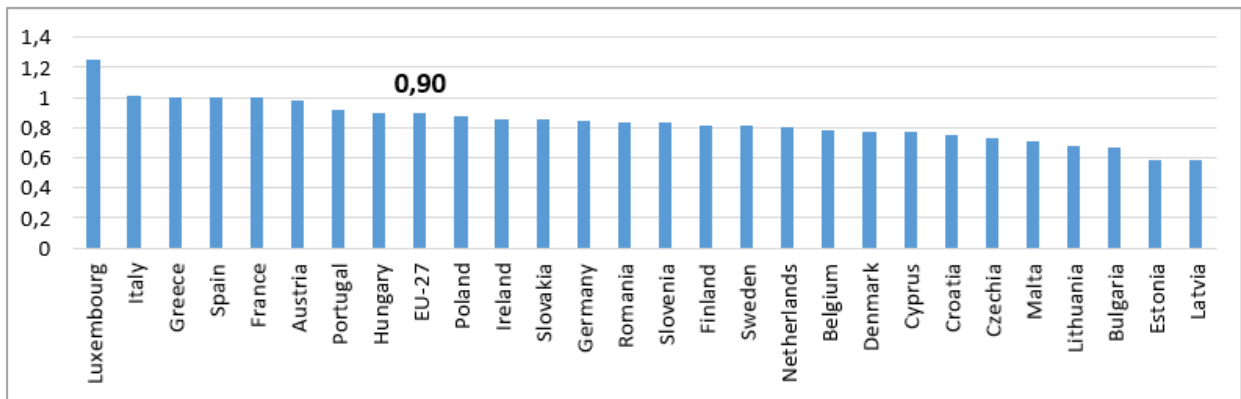
- Data on the accessibility of public transportation covers the EU-27 population without a breakdown for the older population. It allows for assumptions about low transport accessibility for older persons to be made; however, it does not provide clear evidence that older persons have lower accessibility of public transportation services.
- Data on the accessibility of transportation is outdated, with the last available data for 2015. However, the accessibility of public transport is likely to have increased between 2015 and 2020 due to changes in the public transport system (infrastructure and affordability) in many countries. Therefore, up-to-date data is needed to see more accurate trends.
- Information about the COVID-19 pandemic's impact on transportation accessibility is limited. The assessment is based on public government communications rather than on statistical data, which is not available yet.

3.5.3. Financial independence

Financial independence in the context of a supportive environment is defined as the financial situation of the older-age population, which allows them to live a full-fledged life. The income and median income of older individuals in the EU is slightly lower than the rest of the population. The median income of people aged 65 and above in the EU-27 was equal to 90 % of the median income for the population under the age of 65 in 2019. The differences concerning the relative median income of the older population are striking across the EU Member States. In five Member States (Luxembourg, Italy, Greece, Spain, France), the median income of the older population was equal to or higher than the median income of persons under 65. The Baltic States together with Bulgaria are considered to be in the worst position in terms of the relative median income ratio among the older population. The median income of people aged 65 and above in these countries was equal only to 60-70 % of the median income for the population under the age of 65 in 2019.

The average income of older individuals has been decreasing relative to the income of the younger population since 2015. This reflects the continued growth of working age incomes (European Commission and Social Protection Committee 2021b). In general, the relative average income ratio among older males was usually higher than among females. This difference remained quite stable (i.e. 0.2-0.3 points) throughout the observed period (i.e. 2011-2019). It can be partly explained by the lower pensions of women. The gender pension gap caused by the aggregated impact of labour market inequalities was equal to 29.5 % in 2019 (SPC and DG EMPL 2021). The situation concerning income inequality between genders seems even more problematic given the longer life expectancy of women compared to men. Given these factors, women are not only more economically vulnerable in old age, but also tend to live in a single household without additional external support (i.e. financial support from a spouse or family members) (Spasova et al., 2018).

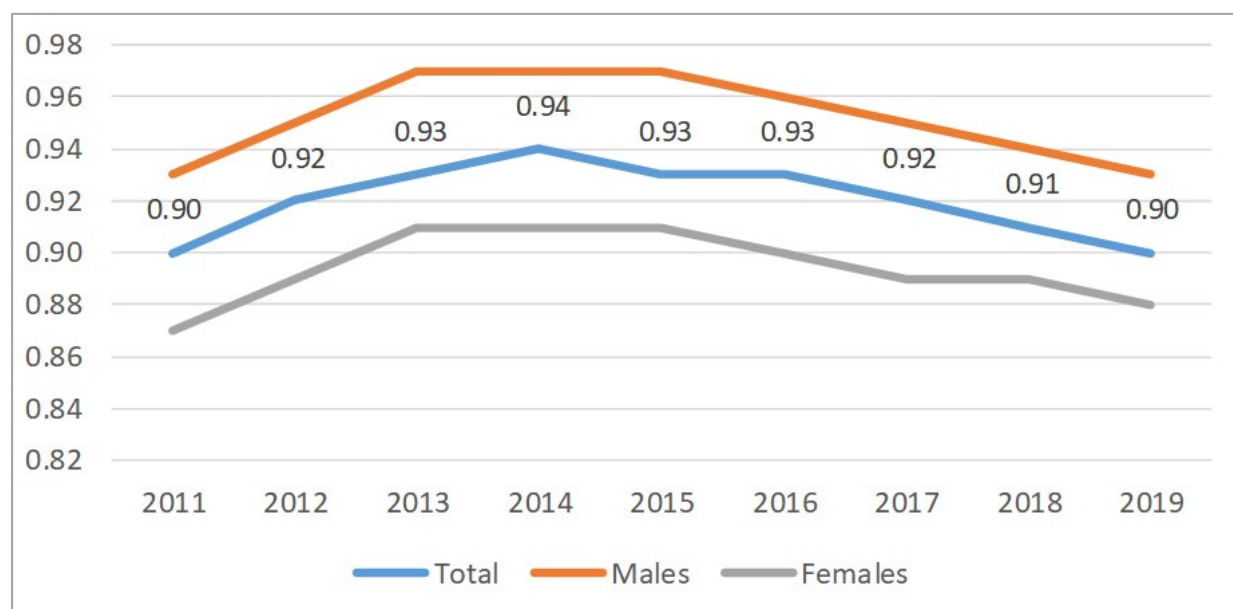
Figure 44: Relative median income ratio (65+), 2019



Source: EU-SILC, [ilc_pnp2], downloaded 2021 (latest available).

Note: Relative median income ratio (65+) is a ratio of the median equivalised disposable income of people aged 65 and above to the median equivalised disposable income of those aged below 65.

Figure 45: Relative median income ratio (65+) by gender, EU-27



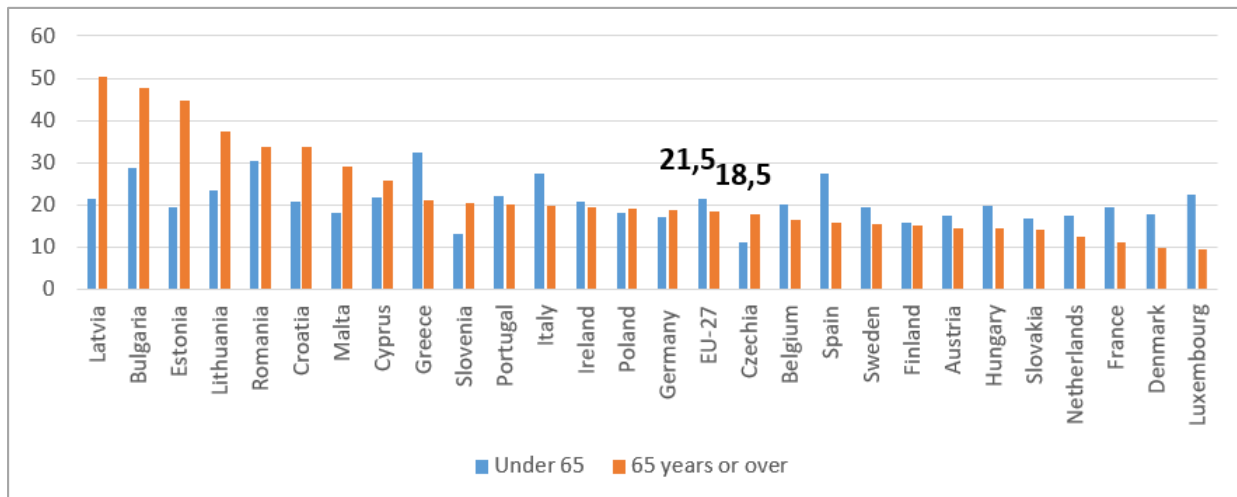
Source: Eurostat, [ilc_pnp2], downloaded 2021 (latest available).

Even though it could look like this at first sight, the lower income of older individuals in the EU does not indicate their worse financial situation compared to the younger population. Although pensions are lower than work incomes, in most Member States, pensions and taxation ensure more equal income and lower poverty in old age than in working age (SPC and DG EMPL 2021). On average, across the EU-27, the risk of poverty or social exclusion⁵⁸ is slightly lower among the older-age population. To illustrate, 18.5 % of the EU-27 population aged 65 years and over and 21.5 % of the population aged under 65 were at the risk of poverty in 2019. Despite this general positive trend, major differences are noticed between Member States. Eastern European countries (Latvia, Estonia, Bulgaria, Lithuania, Romania, and Croatia) account for the largest share of the older population at risk of poverty or social exclusion. Moreover, the gaps between the older and younger-aged population are higher in these countries. For example, in Latvia, the risk of poverty or social exclusion is higher by 29 % among the older population compared to younger people. Higher risk of poverty among older people compared to younger population in most of eastern European countries can be explained by low retirement pensions in these countries. Meanwhile, in a number of other countries (e.g. Luxembourg, Denmark, France, Netherlands, Slovakia, etc.) older-age population is less likely to be at the risk of poverty or social exclusion, also when compared to the younger citizens. In southern European countries this can be explained by the high unemployment rate among young people. Meanwhile, northern European countries have a strong public support system ensuring high retirement pensions for the older population (Salomon, 2012), while state support for younger individuals is usually lower.

The risk of poverty or social exclusion among the older population in the EU-27 has decreased by 1.3 % since 2011. However, the absolute number of older people at risk of poverty and poverty rate needs to be monitored in the future given the projected increase in the older population (European Commission and Social Protection Committee, 2021b).

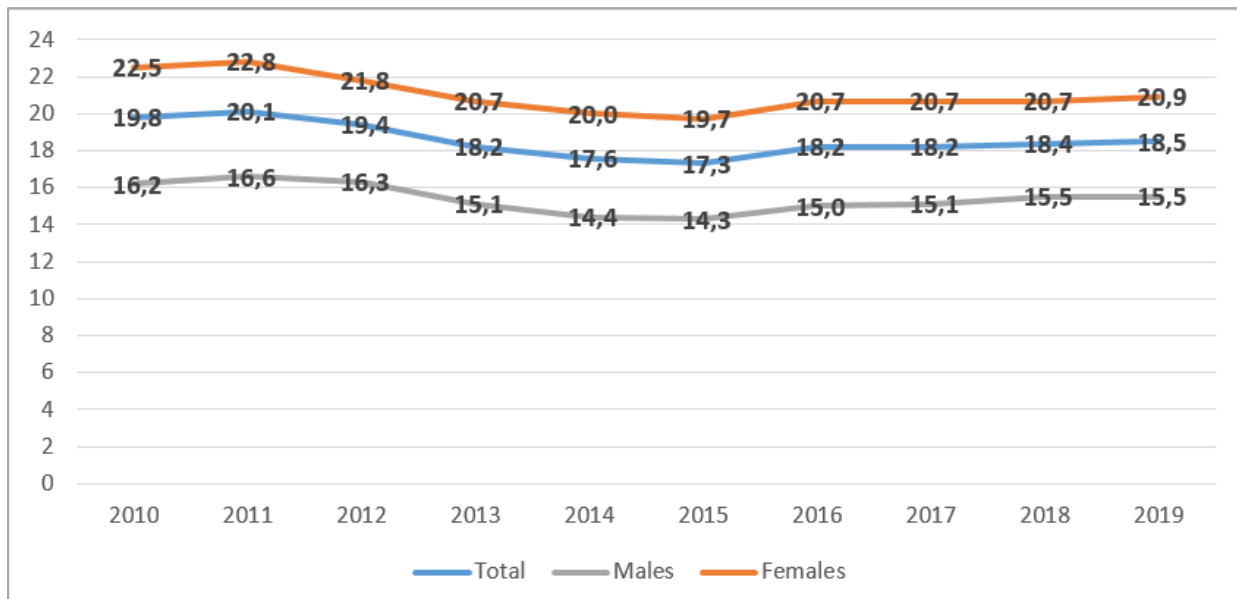
⁵⁸ People having a high risk of poverty are the ones whose equivalised disposable income (after social transfer) is below the at-risk-of-poverty threshold, which is set at 60 % of the national median equivalised disposable income after social transfers.

Figure 46: At-risk-of-poverty or social exclusion rate by age group, in %, EU-27, 2019



Source: Eurostat, [ilc_peps01], downloaded 2021 (latest available).

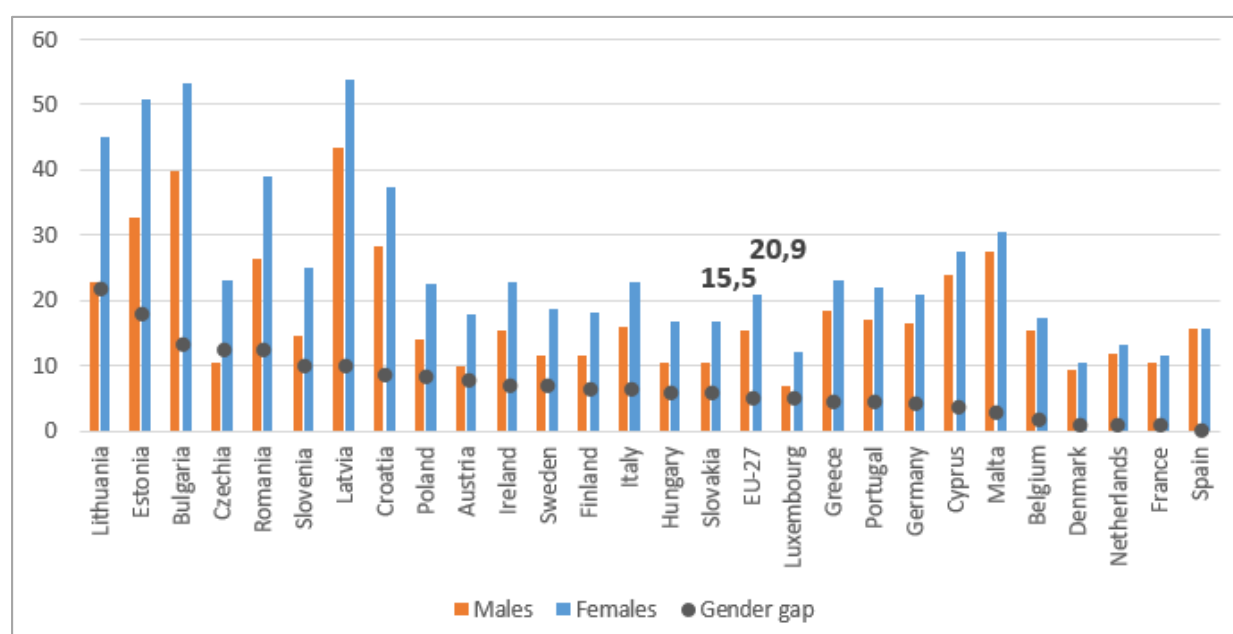
Figure 47: At-risk-of-poverty or social exclusion rate (65+), in %, EU-27



Source: Eurostat, [ilc_peps01], downloaded 2021 (latest available).

Financial gender inequality becomes more pronounced in old age. Older-age women are considerably more likely to be at risk of poverty than older-age men. In 2019, 15.5 % of older men in the EU-27 were at risk of poverty or social exclusion, while this share among older women was much higher – 20.9 %. The largest gender gaps are noted in Lithuania (22.1 %), Estonia (18.1 %), and Bulgaria (13.4 %). Meanwhile, the lowest gender gaps are in Spain (0,1 %), France (1 %), and the Netherlands (1.1 %). In general, the financial gaps between genders are higher in eastern European countries than in the rest of the EU.

Figure 48: At-risk-of-poverty or social exclusion rate (65+) by gender, in %, EU-27, 2019



Source: Eurostat, [ilc_peps01], downloaded 2021 (latest available). Note: Gender gap indicates the difference between the rates among females and males.

Impact of the COVID-19 pandemic

The impact of the COVID-19 pandemic varies across the cohorts of the older population. The financial situation of the older aged in most cases was not affected by the pandemic. Retired persons continued to receive stable state income despite the pandemic (i.e. pension benefits). However, it is likely that working older individuals are among the financially vulnerable population from the COVID-19 pandemic (Crawford & Karjalainen, 2020), mostly due to unemployment because of the cost-cutting policies implemented in their workplaces. This was more usual among low-educated older women (Jiskrova et al., 2020). Some (older) workers stayed officially employed because of furlough schemes but their salaries were "frozen" or decreased during the pandemic and lockdown. Nevertheless, because of the limitations of the data, it is too early to assess the impact of the furlough schemes on the financial situation of (older) workers from a longer-term perspective.

Financial uncertainty among the older population might affect their wish to purchase needed goods and services (Jaarsveld, 2020). The COVID-19 pandemic and the related likelihood of an ensuing financial crisis may encourage the older population to save money. Therefore, older people may not spend their money on purchasing items they need and instead save money. There is a risk that the financial turmoil of the crisis will have long-term consequences on the financial independence of the older population (Crawford & Karjalainen, 2020). For example, the economic crisis might likely lead to situations where older workers are forced to retire earlier because they cannot find the employment or they are unable to rebuild their pension funds due to poor investment performance. Policymakers will need to ensure that older people are supported in any change in employment and are well informed while deciding on pension savings.

Data limitations

When analysing financial independence among older people, some data gaps were noted:

- Although the data is well-updated and can be disaggregated based on country, gender, and age in many cases, limitations are noticed. For example, while clear trends are seen from the

perspective of the population aged 65 years and over, it is not possible to identify whether there are significant differences within this age group (i.e. 65-84, 85+).

- There is still insufficient data supporting the statements made by experts and policymakers about the COVID-19 pandemic's effects on the financial independence of the older-age population. The data needed to assess the impact of the furlough schemes will be available after some time.

3.6. Key features of Recovery and Resilience Facility with regards to ageing

A core instrument of the EU post-COVID-19 recovery plan – NextGenerationEU – Recovery and Resilience Facility (RRF) will provide about EUR 672.5 billion to support national reforms and investments in sustainable recovery through 2021-2026⁵⁹. The eligible investments included in the national recovery plans should focus on twin transition targets with at least 37 % and 20 % of the budget being dedicated to green and digital transitions, respectively. As of July 2021, 26 out of 27 Member States⁶⁰ have already submitted national recovery and resilience plans to the Commission. The assessments completed by the Commission so far show a rather positive evaluation of all national plans in terms of their alignment with the Country Specific Recommendations, European Pillar of Social Rights, as well as growth, jobs, economic, social, and institutional resilience priorities, in particular, with cost justification being the sole criteria marked as only partially met throughout the national plans.

Most of the plans have targeted the grant component of the RRF, with a marginal share of loans in the total funding⁶¹. As anticipated, most of the funding (up to 90 % of the total budget in the case of Germany, Luxembourg, and Austria) will be allocated to digital and environmental topics⁶². That being said, however, most of the measures carry a cross-thematic focus and a high multiplier potential with a significant funding overlap throughout the main pillars⁶³. Thus, while active ageing policies, and older people in general, have not been explicitly mentioned as a separate funding target, they are indirectly covered by investments within three out of six RRF pillars⁶⁴: (i) smart, sustainable, and inclusive growth (pillar 3); (ii) social and territorial cohesion (pillar 4); and (iii) health and economic, social, and institutional resilience (pillar 5).

3.6.1. Economic activity

Labour market participation and skills development have been mentioned in all national RRFs, albeit with a limited focus on the older groups and a rather varying scope of covered measures.

Thus, while most explicitly mention active labour market policies and trainings (e.g. Greece, Italy, Croatia, Austria, Cyprus), they underline youth employment and skills development among youth and

⁵⁹ This sub-section is based on the Commission assessment of the submitted national recovery plans and Commission Staff Working Documents for each of the Member States. European Commission. Recovery and Resilience Plans' assessments. Available at: https://ec.europa.eu/info/business-economy-euro/recovery-coronavirus/recovery-and-resilience-facility/recovery-and-resilience-plans-assessments_en.

⁶⁰ National recovery and resilience plan of the Netherlands has yet to be submitted.

⁶¹ Cyprus, Greece, Italy, Poland, Portugal, Romania, and Slovenia are the only Member States to have included loan requests in their national plans.

⁶² Darvas Z. et al., European Union countries' recovery and resilience plans, Bruegel, 14 July 2021. Available at: <https://www.bruegel.org/publications/datasets/european-union-countries-recovery-and-resilience-plans/>.

⁶³ Ibidem.

⁶⁴ Other RRF pillars include green transition (pillar 1), digital transformation (pillar 2), and policies for the next generation (pillar 6). <https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A32021R0241>.

vulnerable groups as key priorities. While older workers are likely to benefit from the upcoming labour market reforms and opportunities to reduce skills mismatch, the extent of their participation is yet to be seen.

At the same time, countries like Finland, Lithuania, France, Ireland, Czechia, Luxembourg, Portugal, and Belgium have explicitly included vocational education and lifelong learning measures in their recovery plans. Some, including Lithuania, Slovakia, and Slovenia in particular, have also underlined older people as a separate target group for digital skills development⁶⁵, while other Member States (e.g. Luxembourg) have clearly linked RRF allocation with investments in the employability of the older groups and increases in the employment rate of older workers as identified in the country-specific recommendations. The recovery plan of Portugal has further included a larger scale reform of the VET system with the aim to increase adult learning participation and improve section the delivery of digital skills trainings.

Other specific measures include the extension of the short-time work schemes and introduction of flexibility mechanisms (e.g. Spain) to limit labour market exit risks induced by the pandemic. Although these measures are aimed at supporting employment, their effects on the employability of the older groups have yet to be assessed against the risks of age discrimination, as they might disproportionately target older workers.

The majority of the measures that indirectly address the topics of the economic participation of older people include pension and welfare system reforms through the improvement of pension adequacy (e.g. Germany, Croatia), pension indexation mechanisms (e.g. Lithuania), simplification of the pension landscape (e.g. Ireland), and improvements in the availability of information on pension rights (e.g. Germany). The national plan of Austria further includes overarching pension reforms with a focus on increasing the effective retirement age and reducing the gender pension gap through pension splitting and increasing pensions of women.

3.6.2. Social participation

While Germany is the only country to explicitly include social participation as a separate action pillar, its national plan does not specifically address the situation of older people⁶⁶.

The topics of social inclusion, however, are mentioned throughout all national plans, with a primary focus on vulnerable (e.g. women, children, people with disabilities) and marginalised groups (e.g. Roma).

The digital inclusion of older people has also been explicitly mentioned in a number of national plans (e.g. France, Luxembourg, Slovakia). These include the development of basic digital skills outside the labour market to support the social participation of the older aged through technology (e.g. tablets for pensioners in Slovakia).

3.6.3. Health and well-being

Considering the development of national plans against the COVID-19 background, all plans include healthcare measures of varying degrees.

The majority of the measures are thus focused on improving healthcare sector resilience and

⁶⁵ European Commission, 2021, Commission staff working document, Analysis of the recovery and resilience plan of Lithuania. Available at <https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:52021SC0187>.

⁶⁶ European Commission, 2021, Commission staff working document, Analysis of the recovery and resilience plan of Germany. Available at <https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A52021SC0163&qid=1624627226552>.

digitalising health services. The older groups, though not explicitly targeted in the national plans, are likely to benefit from the investments into increasing the territorial coverage of healthcare services (e.g. Croatia, Italy, Latvia, Spain), modernising hospitals and healthcare facilities (e.g. Germany), and digitalising health services through telemedicine and developing e-health systems (e.g. Czechia, Lithuania, Italy, France, Ireland, Luxembourg, Slovenia, Belgium, Austria).

Some countries, e.g. Portugal or Slovakia, have also explicitly mentioned improving mental health services as one of the target areas of the healthcare-related investments. These measures are likely to provide less tangible yet valuable support to the well-being of older groups, especially those at risk of social exclusion as a result of the pandemic or job loss.

3.6.4. Long-term care

Alongside national healthcare reforms, more than half of the plans include explicit long-term care measures. These consist of improvements of the long-term care infrastructure, including increasing the capacity of the long-term care system (e.g. Croatia), developing long-term care day centres (e.g. Lithuania), modernising (e.g. France) and constructing long-term care facilities (e.g. Latvia).

Other relevant measures include mapping long-term care needs and developing new long-term care legislation in Czechia and a partial deinstitutionalization of the long-term care sector in Belgium. More comprehensive reforms of the long-term care sector are also expected in Portugal, Slovenia, and Slovakia through, among others, legislative changes and improvements in access to long-term care as well as strengthening and innovating the response of long-term care with a particular focus on older people.

The national plan of Lithuania, comprises a considerable number of systemic changes, including investments in vehicles and equipment for 90 mobile teams for outpatient services, the creation of temporary day centres across the country, increasing the capacity of long-term care facilities, and overarching reforms of the long-term care framework.

Once completed, these measures are likely to democratise and improve accessibility to long-term care, especially for older groups in more vulnerable situations, including those at risk of poverty and in remote regions.

3.6.5. Supportive environment

With infrastructure and the green transition being one of the key components of the national plans, most Member States have included transportation, housing, and energy investments in the proposed budgets. As with the components discussed above, older groups are likely to be indirect beneficiaries of the planned measures without being explicitly mentioned in the national plans.

Most measures include increased efficiency of transport networks through substantial investments in all modes of transport (e.g. Italy, Lithuania, Czechia and Croatia) as well as cross-border transport infrastructure (e.g. France). Besides progress towards the decarbonisation of transport system and decreasing emissions, these changes are expected to improve urban mobility and ensure better connectivity across different regions. Thus they are of particular benefit for the older population. The recovery plan of Latvia explicitly mentions the inclusion of easy access equipment for older groups and people with reduced mobility on updated public transportation vehicles.

Further, the living environment of older people could benefit from improved energy efficiency in buildings (e.g. Italy and Czechia) as well as building renovation (e.g. Austria). These changes are expected to reduce residential costs in the long term. More comprehensive measures include improvements in social infrastructure and housing (e.g. Spain, Austria), which are set to increase the

affordability and availability of adequate housing for vulnerable groups with the older population being one of the potential beneficiaries.

4. ACTIVE AGEING POLICIES AND SERVICES IN SELECTED EU MEMBER STATES

KEY FINDINGS

The eight country studies highlight a wealth of initiatives on good practices related to active ageing policies, including impact, challenges and policy responses in the context of the pandemic. However, there is a need for an exchange of good practices to increase know-how and lessons learnt in terms of success factors regarding access to services for older people.

Developing an active ageing policy in all countries followed a participatory process with councils of seniors, pensioners and other stakeholders being consulted at the national, regional, and local level.

Apart from the financial incentives offered to reduce early retirement, several Member States have introduced flexible contracts for older people, which allow a reduction in working hours without a significant decrease in income.

Good practices in improving working conditions for older people include: applying age management strategies, fostering intergenerational cooperation and exchange of knowledge, adjusting the workplace and duties of an employee to older workers' needs, mid-career reviews facilitating career reorientation, and projects focusing on new aspects of work-life balance.

To overcome financial barriers in social participation, some Member States offer discounts on cultural and sports activities for older people, as well as on public transportation tickets.

Some Member States established community day centres to provide seniors with infrastructure enabling them to spend their free time actively and to combat loneliness.

To minimise regional disparities in access to healthcare, Member States increasingly use telemedicine to provide specialised treatment in remote areas, introduce mobile care teams or incentives for medical studies' graduates to work in rural regions.

To ensure access to care, national governments have established digitalisation projects, including the use of e-health at home. Several Member States offer special financial support programmes for housing adaptation to give older people the opportunity to live independently for as long as possible.

Member States provide transportation aid for people with reduced physical mobility and discounted tickets for older people. Nationwide and local transport programmes with special door-to-door services have been introduced in some Member States.

To mitigate the impact of COVID-19 on older workers, some Member States implemented special measures including the suspension of dismissals from work and an increase in the additional income limit for persons working in retirement.

Telephone support lines for older people were shown to be a great help during the lockdown period caused by the COVID-19 pandemic.

This chapter builds on the eight country studies which provide insights into their national ageing policies and statistics on economic and social participation, health and well-being, long-term care, and supportive environments, giving particular attention to the impact of COVID-19 (Bergstra 2021a, 2021b, Mackevičiūtė 2021, Makindu 2021, Mukasa & Schoenmaekers 2021, Lamura et al. 2021, Ponz 2021, Ruzik-Sierdzińska 2021). The aim of each country study was to identify good practices as

well as gaps in service provision and to gather suggestions for action at the EU level. The studies refer to government reports and documents – such as policy programmes – as well as data provided by national statistics and research agencies. In addition to desk research, for each of the country studies, up to three semi-structured interviews were held with national level stakeholders.

The selection of countries reflects different welfare regime traditions (see: Esping-Andersen 1990 or other classifications described, e.g. by Isakjee 2017). The welfare regimes show various approaches to institutions, social policy problems, and solutions by defining undesirable social risks concerning certain groups and policy instruments. Austria, Germany, France, and the Netherlands all belong to the "continental" or conservative-corporatist welfare regime. Italy represents a group of Mediterranean countries with welfare regimes resembling the previous group but with a higher share of women involved in informal family care. The case study on Sweden examines its social democratic regime and the Nordic approach to active ageing policy. Finally, Poland and Lithuania represent countries that reformed their welfare regimes after the transition from the centrally planned to the free market economy in the 1990s. They faced a crisis on the labour market in the 1990s and introduced pension reforms in the following decade that have an impact on retirement decisions and economic participation. Table below presents the selection of country studies ranked by the Active Ageing Index (AAI) values for 2018, and includes information on healthcare and LTC expenditures and demographic structure. The AAI differs between countries, with the highest value found in the Nordic countries, moderate values in the continental welfare states, and lower values in southern and eastern Europe.

Table 4: Main performance indicators for selected Member States

Country	AAI 2018 – total score	Increase in the share of the population aged 65 years or over between 2009 and 2019 (in %)	Share of older (65+) people LTC recipients – home care (in %), 2016	LTC public expenditures as a share of GDP (in %), 2019	Total healthcare expenditures as a share of GDP (in %), 2019
Sweden	47.2	2.1	n.a.	3.3	10.9
Netherlands	42.7	4.2	11.2	3.7	10.2
Germany	39.6	1.1	n.a.	1.6	11.7
France	38.6	3.6	6.2	1.9	11.1
Austria	35.8	1.4	n.a.	1.8	10.4
Italy	33.8	2.5	4.5	1.7	8.7
Lithuania	33.4	2.6	8.6	1	7
Poland	31	4.2	1.5	0.8	6.5

Source: Own elaboration based on AAI, OECD Health data, Eurostat data, and The Ageing Working Group 2021 Report.

The table above presents several indicators for the selected countries ranked according to the value of the overall AAI which, as we can see, is correlated with the healthcare expenditures and groups of countries representing different welfare regimes.

Good practices are chosen to present the innovative approaches to services supporting active ageing in the selected countries. The good practices were identified based on the experience implementing services supporting active ageing in countries that are the best performers with respect to the AAI, but

also include outstanding and innovative approaches from countries with lower AAI that have developed their own innovative ways to stimulate activity of older people. Particularly, activities that improve policy responsiveness to the actual needs of older people, address the problem of territorial differences in service provision, and are oriented at improving the quality of services are presented. The focus is on more recent and innovative initiatives, though some earlier ones are noted if they are recognised as successful and are continuously implemented. Attention is also given to activities that are particularly important for dealing with the consequences of the COVID-19 pandemic and might be continued in the future.

4.1. Active ageing policies

4.1.1. Policies and programmes aimed at active ageing

In all countries studied, ageing has been an important element in policy discussions over the past several decades, streamlined by the Madrid International Plan of Action on Ageing, UNECE Regional Implementation Strategy *Challenges and Opportunities of Ageing Societies*⁶⁷, and the European Year for Active Ageing and Intergenerational Solidarity, although specific solutions in framing active ageing policies differ across Member States.

Several Member States have adopted active ageing policies under a single programme. Austria adopted its ageing programme in 2012 under the Federal Plan for Senior Citizens, entitled *Ageing and Future*. Poland, over the last decade, has adopted two documents: *Long-term Preconditions for Senior Policy for the period of 2014-2020* followed by *Social Policy Towards Older People 2030*. In Lithuania, active ageing was addressed by the *National Strategy for Addressing the Consequences of an Ageing Population 2005-2013*, although it has not been updated, and efforts towards pursuing active ageing have slowed in recent years. Currently, the integration of older people into society is one of the pillars of Lithuania's *National Strategy for Demography, Migration, and Integration 2018-2030*. The Italian government has undertaken efforts to establish an Italian Active Ageing Strategy within a three-year period, until 2022. However, some Italian regions have already designed and implemented systematic and comprehensive active ageing policies (e.g. Veneto, Friuli-Venezia Giulia, Emilia-Romagna, and Umbria) separately to what the central Italian government has planned. Sweden has, over the past two decades, been dealing with the topic of active ageing in a holistic way – in government reports and committees, such as the governmental report of 2003: *Ageing policies for the future – 100 steps towards security and development with an ageing population*. Germany developed a National Action Plan – *Challenges and Opportunities of Ageing Societies* – in 2007 with the aim of mainstreaming ageing policy. The latter was followed by demography strategy published in 2012 and updated in 2015: *Every Age Counts*.

Additionally, access to services important for active ageing is stimulated in respective policy domains, predominantly healthcare, social care, housing, and the labour market. For example, in Lithuania, the objective of stimulating labour market activity among older people is included in the *Lithuanian Employment programme for 2014-2020* and the *2021-2030 Programme for the Development of Social Solidarity*. However, Member States do vary in the degree to which active ageing is present in sectoral policies. Sweden and the Netherlands are the most pronounced examples when it comes to streamlining policies oriented at active ageing across sectoral policies and taking into account the lifetime perspective. In Sweden, public policies are oriented towards supporting independence and security throughout life: from being economically independent through work, being independent in terms of transport through accessible public transport, to living independently in one's own home,

⁶⁷ United Nations, What UNECE does for you. Available at: https://unece.org/DAM/highlights/what_ECE_does/English/0726054_UNECE_AGEING.pdf.

older Swedish people are supported in living independent lives through the provision of public services. Additionally, in Sweden, as in other Nordic countries, care for older people is generally seen as a public responsibility, with grown-up children carrying no legal responsibility for ageing parents (Bergstra, 2021a). Similarly, in the Netherlands, throughout all the recent policy initiatives, one can identify a focus on independence and self-reliance, although the self-reliance of older people has often been seen as a justification for cutting public services if not necessary (Bergstra, 2021b). Contrarily, in Italy and Poland, while the state is responsible for assuring security and services to older people, it is the family which is primarily responsible (Ruzik-Sierdzińska, 2021 and Socci et al., 2021).

The perception of active ageing in some of the Member States studied is closely linked to healthy ageing and the role of the healthcare sector. In Italy, the focus of ageing policies still largely lies in healthcare, with other areas receiving less attention. At the policy level, active ageing is often perceived as a public health domain, linking the concept to the WHO framework for active ageing. (Lamura et al., 2021). In France, the Law of December 28, 2015 is aimed at adapting society to population ageing; however, the main recommendations predominantly concern healthcare. Similarly, in the *Ageing and Autonomy Act*, the French government focused on home healthcare and the reorganisation of institutional care for dependant older people. In July 2021, the French president announced that the LTC and pension system will once again be the focus of discussions of the government starting in September and new policies can be expected in the future. In Germany, the federal ministry developed the *National Dementia Strategy*, which complements the holistic National Plan of Action of the Federal Government to Implement the Second United Nations Plan of Action on Ageing, Madrid 2002, and the UNECE-Regional Implementation Strategy, Berlin 2002.

It is important to mention, however, that even in Member States with higher adherence to active ageing principles, like Sweden and the Netherlands, national stakeholders expressed in interviews that the ageing policies of their respective Member States also show an overly large focus on ageing as seen from the perspective of healthcare and especially healthcare costs. This link between ageing and healthcare is connected to ideas about what it means to grow older and rising healthcare needs due to frailty and multimorbidity. In the Netherlands, programmes are in line with the concept of healthy ageing promoted mainly by the WHO (see details in 2.1 Healthy and active ageing in the international policy agenda). However, some national governments try to shift the focus from health to other policy areas, such as lifelong learning (e.g. Lithuania), which is in line with the Green Paper on Ageing of the European Commission, or to stimulating social activity and participation (e.g. Poland).

In Germany, activities have been undertaken to raise awareness of the need for policy focusing on ageing and older people via an educational event taking place every few years.

Box 1: German Senior's Day

The unique national event started in 1987 – German Seniors' Day – takes place every three years, each time in a different federal state with around 15,000 participants and many distinguished guests. The event attracts a wide range of diverse participants, among others, representatives of older people; NGOs; welfare organisations; church, social, consumer, and political associations; trade unions; and many more. High-level politicians, such as the federal authorities, are also active participants in discussions about current issues regarding older people. The event is a good example of how to disseminate knowledge about the programmes, projects, and activities directed to older people. It also ensures that the adaptation of policy guidelines and regulations concerning older people is a participatory process.

Source: Ponz 2021.

The pandemic is generally seen in the country studies as having had a negative effect on the ability of older people to lead active, independent lives. Older people had to self-isolate and often were more fearful of infection and adjusted their behaviour accordingly. New forms of age discrimination were seen during the pandemic in Lithuania, with older people being criticised by strangers for venturing outside of the home when spotted on the streets or in shops (Mackevičiūtė, 2021). The pandemic also reinforced the idea that older age is strongly tied to frailty, vulnerability, and dependence.

The pandemic also had positive effects regarding ageing policy. As highlighted in the Netherlands and Italy, in response to the pandemic, the governments have reallocated resources and increased the use of telemedicine, acknowledged the need for social contact and the prevalence of loneliness among older people, as well as focused on the impact of a healthy lifestyle on the risks of contracting diseases. Innovative interventions have been undertaken, particularly by the introduction of tele-meetings and the promotion of digitalisation among older people. In Germany, the government has worked on recommendations on enabling all older people to access digital technologies. In Poland, the promotion of digital technologies has become one of the priority areas of the *Activity+* programme, which was established in 2021 and is aimed at stimulating the social participation of older people. Still, in many Member States, efforts towards identifying all effects of the pandemic on the lives of older people are ongoing.

4.1.2. Participatory governance supporting the quality of active ageing policies

Establishing active ageing policies, programmes, and actions is a participatory process that reflects the adoption of a rights-based approach and quality management that aims to increase policy relevance and responsiveness. In many Member States, ensuring the participation of representatives of older people in the process of adopting active ageing policies is achieved through the creation of senior councils operating at the national, regional, and local level. In Poland, a Senior Policy Council established by the Ministry of Family and Social Policy operates at the national level. The Council members include experts in social policy and ageing and representatives of non-governmental organisations and senior associations. Since 2014, Senior Councils can be established at the lowest local level (municipality) and since 2019, at the county level. In Lithuania, the Pensioners' Affairs Council has been operating under the Ministry of Social Security and Labour since 2005, although recently its impact has been evaluated as symbolic. In Germany, policies and programmes, both at national and community level, are consulted upon with a nationwide umbrella organisation representing associations of older citizens (German National Association of Senior Citizens' Organisations – BAGSO). In France, the High Council for the Family, Childhood, and Age was established with the aim of enhancing the public debate and increasing expertise on topics related to ageing, the adaptation of

society to ageing, and support in relation to the loss of autonomy (among other things). The Council is responsible for sending opinions on any draft legislative measures concerning older and retired people, as well as the adaptation of society to ageing. In France, there are higher councils present at the local or national level, known as the Communal Council of the Elderly (CCA), whose mission is to encourage cross-cutting and intergenerational projects, to give the elderly a place in their city, to encourage mutual aid, and to strengthen social relationships. They make proposals to elected officials as well as provide a forum for debate. In Austria, the older citizens' organisations are active in shaping policies for older people at the national, federal, and community level. Senior representatives and particularly non-governmental organisations are active in the implementation of activities for older people at the community level, including organising meetings, trainings, physical activities, and health promotion (Austria, Poland, Lithuania, and Italy). It should be noted, however, that the actual impact of the advisory bodies depends on the willingness of authorities to incorporate their suggestions during the political process.

Box 2: Code of the Third Sector in Italy

In Italy, the law Code of the Third Sector was established in 2017 to regulate the functioning of non-governmental organisations. Among other things, it requires a more systematic participation of senior organisations in shaping policies that affect older people at the national, regional, and local administrative level. The control of the process is equally important alongside the participation therein.

Source: Lamura et al. 2021.

Monitoring the situation of older people in different spheres of life and regarding access to services is considered to be an element of quality management. In Poland, a requirement in the form of statistical reporting on the situation of older people has been introduced. Results of monitoring can feed the political decision process regarding ageing policy.

Box 3: The Law on Older Persons in Poland

The *Law on Older Persons*, introduced in 2015, requires that the Council of Ministers of the Republic of Poland must provide annual information on the situation of older people regarding their financial situation, living conditions, professional activity, health status, social participation, including volunteering and leisure activities, access to healthcare and long-term care services, and cases of age discrimination. The report also contains information about the implementation of the tasks of local governments in providing support for older people and the good practices which may be implemented in other places throughout the country. The law defined older persons as anyone over 60 years of age. The information is publicly available on the website of the Ministry of Family and Social Policy and the Central Statistical Office.

Source: Ruzik-Sierdzińska 2021.

4.2. Economic activity

4.2.1. Measures undertaken to support older workers

National policies on economic participation in all selected Member States are aimed at three policy goals: extending working lives and increasing employment through pension reforms, enhancing the employability of older workers through lifelong learning and continuous training, as well as investments to improve working conditions.

Regarding pension reforms, all but one of the selected Member States has decided upon a gradual increase in the pension age. In Poland, the pension age was set to rise gradually up to 67 years for both men and women; however, this decision was reversed in 2017, when the pension age was restored to 65 years for men and 60 years for women. Still, the existing defined contribution pension scheme creates incentives for older people to postpone the retirement decision, as with each year of economic activity the value of the retirement pension increases. A decrease in the statutory retirement age caused an inflow of new pensioners. The number of those who received their first old-age pension in 2017 was 82 % higher than in 2016. The pension system is particularly unfavourable for women, who tend to have a shorter contributory period due to maternity, lower earnings throughout life, and a lower retirement age, resulting ultimately in lower pensions (Ruzik-Sierdzińska, 2021).

Other Member States vary in the extent to which they have increased the pension age. In the Netherlands and Sweden, the pension age is dependent on life expectancy, representing the most far-reaching form of pension system regarding the pensionable age. In the Netherlands, estimates show that the current form of calculating the pension age will lead to a pension age of 69 years and three months in 2040. Another aspect of pension reform consists of reducing pathways to early retirement. In several of the selected Member States, most notably in the Netherlands, Austria, Germany, and Poland, routes to early retirement, such as tax-funded early retirement schemes, unemployment or disability benefits, and social aid, were abolished. In Germany, early retirees receive 0.3 % less pension for every month worked less, up to 14.4 % of a decrease in the pension amount. The country makes efforts to extend working lives beyond the retirement age by creating financial incentives in the form of an increase in the pension by 6 % for each year of postponement in claiming the pension.

In terms of increasing employment among older workers, it is notable that support for older workers starts at a relatively young age. Government programmes aimed at activating older workers start from 45 years of age in Lithuania, 50 in Poland, and 55 in the Netherlands. Most commonly, such policies are directed to the age group 55 and over, up to the retirement age. Sweden explicitly discusses methods to motivate people working past the retirement age. In a recent Swedish Government Official Report named *Never have the old been so young – more and more can and want to work longer* (Bergstra, 2021), the need for people to stay longer on the labour market is expressed due to budgetary reasons and labour market shortages. The presented research shows that more and more people in Sweden would like to work beyond retirement. Policy measures to motivate employers to hire older workers mostly entail offering workers above a certain age threshold a more flexible type of contract, thereby reducing the perceived burden of employers taking on such employees.

Box 4: Flexible types of contracts for older people

In France, several alternatives have been created to the permanent employment contract to counter the difficulties that older people face in the labour market. These include a *Senior CDD* (fixed-term contract) for people aged 57 and over, which allows for a temporary contract for up to 36 months instead of the customary 18 months. Another option is the *PEC*, a subsidised contract intended for people with difficulties accessing employment. It is a temporary contract that can be extended for up to five years or up to retirement age for those aged 58 and over.

In Austria, employees who are already entitled to the "corridor pension" – allowing for flexible entry into the public pension system between the ages of 62 and 68 – can reduce their working time by 40-60 % with partial wage compensation, such as the part-time scheme for older workers.

In Germany, the *Flexi Pension Act* enables people at retirement age to get a share of their pension, continue working (in agreement with the employer), and, owing to the continued contribution, the pension will increase.

Source: Makindu 2021, Mukasa & Schoenmaekers 2021, Ponz 2021.

Overall, pension reforms have been a more important mechanism for increasing the labour market participation of older workers than other policies. This is perceived as a weakness in current policies concerning economic participation (Lamura et al., 2021). In the Netherlands and Poland, many workers and labour unions indicate a preference for early retirement and oppose longer working lives, primarily because the work is seen as physically or mentally demanding (Bergstra, 2021b and Ruzik-Sierdzińska, 2021).

Regarding employability policies, governments are investing in the skills of older workers – either those already employed or the long-term unemployed. Lifelong learning policies are the main area of ageing policies in which European funding other than the Recovery and Resilience Facility was used (Sweden, the Netherlands, Lithuania, Poland). In Lithuania, the EU-funded project *Support to the older age unemployed* aimed at increasing the economic participation of older people. The project was successful, nearly doubling the initial target of the post-project employment rate. In Poland, challenges in terms of lifelong learning are less related to funding and more connected to the lack of willingness of the target population to engage in training activities, where over 50 % of people over 50 years of age do not see the need to improve their qualifications after completing formal education.

Improvement of working conditions for older people is oriented, among other things, at the introduction of age management strategies at the company level and the adaptation of workplaces. These initiatives are typically undertaken by middle-range or large companies. Examples of such projects are described, for example, in the case studies on France (Energetix) and Poland (PW Kampol).

Box 5: Age management strategy in Energetix, France

An example of a French company applying age management is Energetix, operating in the field of energy distribution. The company performed an analysis of its employees, which resulted in the implementation of new solutions to better manage employees of different ages. Among the solutions were the introduction of tutoring as an important practice enhancing the socialisation of the youngest employees and recognising the experience of the seniors and the reorientation of career paths for older employees to better meet their demands and capacities.

Source: Makindu 2021.

At the company level, efforts are being made to create an intergenerational work environment that enables older workers to pass on their experience to younger workers. The improvement of working conditions, with regard to employee capabilities and the suitability of the workplace, is also present in national policies and projects. In Austria, a legal framework has been established and certain initiatives have been undertaken and supported by social partners.

Box 6: Good practices in improving working conditions in Austria

The *fit2work* project started in Austria in 2010, funded by the General Accident Insurance Institution (AUVA), is an early-intervention programme aimed at preventing long-term sick leave and early withdrawal from working life for health-related reasons. The project supports the (re-)integration of older workers in gainful employment following withdrawal for physical or mental health reasons. *fit2work* works with both individuals and businesses. Between 2014 to 2020, consulting for business operations was co-funded by the ESF.

Another project was launched by the Chamber of Labour, the Federation of Austrian Industrialists, and Trade Unions. They prepared a *Toolbox* for creating an ageing-appropriate work environment. An *Information folder*, including checklists and proposals, for specific areas (e.g. production, office) was created, covering key issues such as management, organisation, qualification, and health for improving the working conditions of older workers. The target group were companies, mainly small and medium enterprises and members of works councils.

Source: Mukasa & Schoenmaekers 2021.

In France, a legislative act (French Labour Code Article L6312-1) began a national project on mid-career reviews, which entitled all workers to request a mid-career review from their employers.

Box 7: Mid-career reviews in France

The target group of this specific legislation is 45-year-old employees in companies with more than 50 employees. These employees are entitled to a mid-career review delivered by the line manager or the human resources department of the company. The mid-career review involves a structured process where employees review their career achievements critically, reflect on the years to come, focus on their strength and weaknesses, and try to find an optimal fit between their expectations and the needs of their employer. The main aim is to maintain workers in their jobs until a later age.

Source: Eurofound 2016.

Solutions enabling the reconciliation of work and care are particularly important for older workers in the pre-retirement age, since taking care of dependent adults peaks among workers aged 50-64⁶⁸. In addition to improving working conditions, the Italian government is planning to support projects focused on the work-life reconciliation.

⁶⁸ Eurofound (2018), *Striking a balance: Reconciling work and life in the EU*, Publications Office of the European Union, Luxembourg. Available at: <https://www.eurofound.europa.eu/publications/report/2018/striking-a-balance-reconciling-work-and-life-in-the-eu>.

Box 8: Supporting older workers in Italy

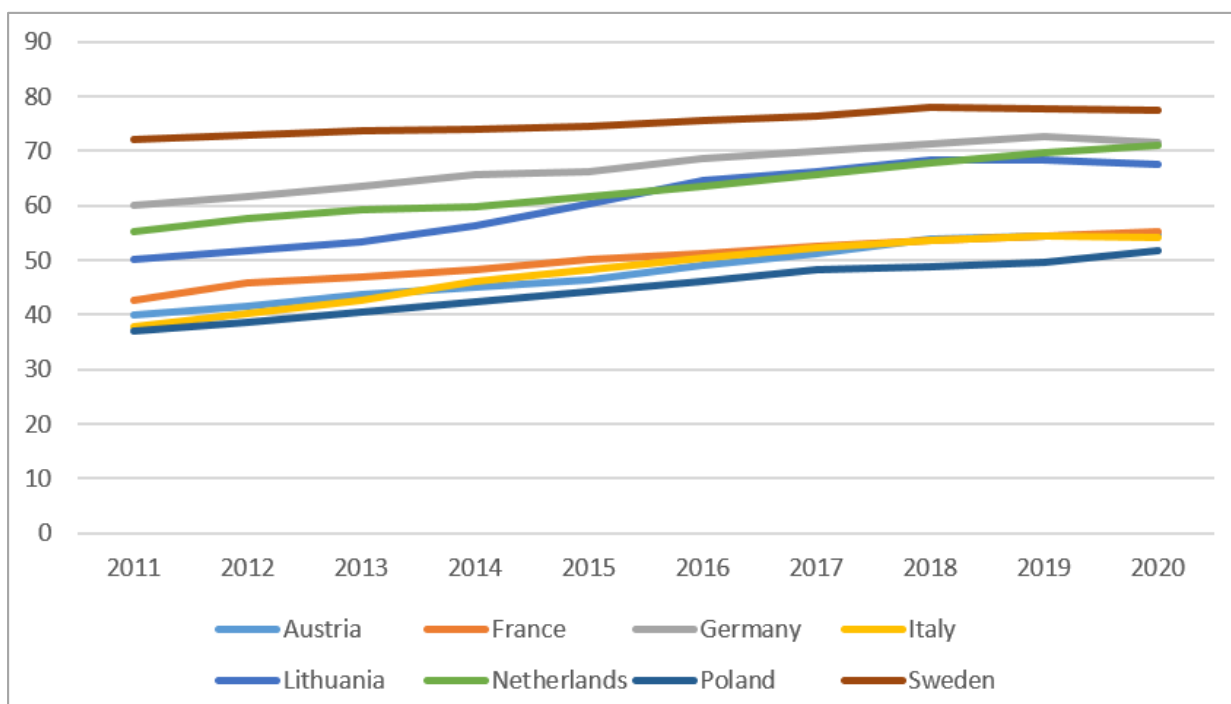
In Italy, the Ministry of Health is supporting new projects which promote employee welfare and a healthy lifestyle, including the training of company physicians, the application of ergonomics principles, and the creation of company gyms and services. These initiatives were introduced for the first time in 2008, and are ongoing since then, with adaptations and new initiatives being promoted and funded on a continuous basis. Also, the Department for Family Policies in 2019 launched a call for new initiatives for work-life reconciliation. However, due to the pandemic, the selection of projects is still ongoing.

Source: Lamura et al. 2021.

4.2.2. Impact of policies and activities supporting older workers

The impact of the policies implemented by Member States in the field of economic participation might be considered in light of the employment rate in pre-retirement age groups. The employment rate over the last decade in the 55-64 age group has significantly increased in all Member States studied, with a small upward convergence trend.

Figure 49: Employment rate of people aged 55-64 in selected EU Member States, 2011-2020



Source: Eurostat [LFSI_EMP_A__custom_1157946], downloaded 2021 (latest available).

Although on average in the EU the employment rate of older workers was not threatened by the COVID-19 pandemic, older employees have experienced some difficulties over the past year. In Sweden, statistics by the Swedish Public Employment Service showed that more people in absolute terms lost their jobs in the age group 50+ than those between 18-25. In Lithuania, the unemployment rate of older workers grew from 6.9 % in late 2019 to 9.6 % in the first quarter of 2021. Older unemployed people face difficulties in returning to employment due to low digital skills and lower labour market activation measures in place due to lockdown (Lithuania, Poland). On the other hand, data in France and Italy indicate that older workers are generally in contracts with higher labour protection as well as being under-represented in the sectors most affected by the pandemic, such as retail stores and restaurants; so older people fared relatively well during the pandemic. Also, in Poland

older workers (50+) were less affected by the pandemic than younger ones. The economic activity of older workers grew, and the pandemic did not result in pushing older people into retirement or unemployment in 2020 (Ruzik-Sierdzińska, 2021). In Germany and Italy, governments made efforts to introduce protection measures during the pandemic to prevent job loss by older people.

Box 9: Increase of income limit for working pensioners in Germany

The stimulus package to fight the impact of COVID-19 implemented by the German government in response to the risk of excluding older workers from employment included an increase of the additional income limit for persons working while on retirement in March 2020 from EUR 6,300 to EUR 44,590. It was aimed at facilitating continued work or the resumption of employment while retired. Annual income up to this amount, therefore, did not lead to a reduction in early retirement pensions, stimulating employability and supporting financial independence.

Source: Ponz 2021.

Box 10: Protection measures in Italy

In March 2020, the Italian government established a package of special measures for the labour market which included a temporary halting of dismissal procedures; it was later prolonged until the end of June 2021. The measure mainly protected older workers with permanent contracts. Additionally, special measures for the self-employed were introduced, among which older workers account for a huge percentage. From 1 July 2021, the general measures apply only to specific sectors that have been the most affected by the pandemic. The deadlines differ according to sector (e.g. 31 October 2021 for the textile and clothing sector and 31 December 2021 for tourism and trade)⁶⁹.

Source: Lamura et al. 2021.

4.3. Social participation

4.3.1. Policies and programmes encouraging social participation

There is wide variation between the selected Member States regarding the extent to which older people engage in social participation. Policies aimed at combating loneliness in the selected Member States generally focus on organising activities leading to a sense of community among older people, arranging meeting places for them and opportunities for intergenerational interactions. They also create friendly environments for more older people to be engaged in voluntary activities. In the Netherlands, 48.1 % of people aged 65 to 75 are involved in voluntary activities, while only 34.9 % of those 75 and older are involved in these activities (Bergstra, 2021). In Germany, the commitment rate was slightly lower, but shows a tendency to increase over the years. In 2019, 31 % of those 65 and older participated in voluntary work, the majority of which took place within the framework of clubs and associations or the church (Ponz, 2021). In Italy and Poland, where the availability of care services for dependent children, the disabled, and older people is poorer, volunteer work is less frequently undertaken by older women. Family care obligations prevent older people, and women particularly, from volunteering and other types of social participation.

In most Member States studied, nationwide programmes aimed at increasing the social participation of older people (60+) have been established. They intend to promote volunteering among older

⁶⁹ Francesco Rotondi, Blocco dei licenziamenti: quanto è stato efficace per salvare l'occupazione?. Available at: <https://www.ipsoa.it/documents/lavoro-e-previdenza/rapporto-di-lavoro/quotidiano/2021/07/17/blocco-licenzia-menti-stato-efficace-salvare-occupazione>.

people, increase their digital skills – which has grown in importance since the pandemic, and support intergenerational activities. The Austrian strategy for Lifelong Learning 2020, issued in 2011, seeks to achieve the goal of enriching quality of life via education in the post-employment phase. The French National Plan for *Ageing well* (2007-2009), with the aim of enabling the well-being of older people, was comprised of different activities regarding one's body, mind, and social relations. Polish programmes (*Government Programmes for Social Activation of Older Persons for years 2012-2013, 2014-2020, Multi-year programme for Older People – Active+ for years 2021-2025*) have provided funds for the implementation of projects and activities focusing on social activity, social participation, digital inclusion, and preparation for old age. Additionally, in Lithuania, several action plans developed by the Ministry of Social Security and Labour mention the challenges and actions relevant for the social participation of older people; however, these strategic documents describe the volunteering and social activities of older Lithuanians more as tools leading to employment or psychological well-being rather than social engagement *per se*.

A new federal model programme, which not only focuses on governmental actions for older people, but also supports NGOs operating in this sector, is being developed in Germany.

Box 11: Federal programme to combat loneliness and isolation in Germany

The federal programme *Strengthening the Participation of Older People – Ways out of Loneliness and Social Isolation in Old Age*, running from October 2020 to September 2022, aims to prevent and combat loneliness and social isolation and to strengthen financial security in older age. This model programme is also intended to initiate the development of specialist structures for social work with older, lonely, or socially isolated people on-site. Implementing agencies are non-profit organisations that belong to one of the six umbrella organisations of the independent welfare organisation in Germany as well as other non-profit organisations.

Source: Ponz 2021.

In Germany and Poland, community day care centres have been established to create opportunities for social engagement and prevent the social exclusion of older people.

Box 12: Community day centres in Poland and Germany

The Polish programme *Senior+* initiated in 2015 and modified in 2017 is addressed to local authorities and ensures financial support for establishing and running day care centres and clubs for economically inactive people aged 60+. The Programme provides seniors with infrastructure to actively spend their free time. Seniors are encouraged to participate in self-help activities and activities for the local environment. There are two types of centres, each with different hours of operation: a *Senior+ Day Care Centre*, which provides at least eight hours of services every day from Monday to Friday, and a *Senior+ Club*, which provides at least 20 hours of services per week. During the COVID-19 pandemic, activities in Day Care Centres and Clubs were organised on-line or outdoors.

In Germany, the Federal Programme *Multi-generational Centre*, introduced in 2007, with around 540 multi-generational centres, provides places for people of all ages to meet and engage in a wide range of activities in close cooperation with local stakeholders and the local administration.

Source: Ponz 2021, Ruzik-Sierdzińska 2021.

A unique activity – the Universities of the Third Age, which foster social participation, is present in Poland. The network of educational institutions for older people operates nationwide, promoting the idea of lifelong learning.

Box 13: The Universities of the Third Age in Poland

In Poland, the Universities of the Third Age network has been in operation since 1975 and is directed at older people. Currently, there are approximately 700 units. They support the activity of older people, mainly those with secondary or higher education and who are no longer formally active in the labour market. The Universities of the Third Age are often integrated into universities. The lecturers are either university lecturers, teachers of foreign languages, people running physical activity classes, or experts in various areas (e.g. dieticians).

Source: Ruzik-Sierdzińska 2021.

In all selected Member States, the increased vulnerability of older people regarding COVID-19, the social distancing measures, and the visitor ban in residential care facilities negatively affected social participation and increased loneliness among older people. In Sweden, all individuals above the age of 70 were expected to self-isolate to reduce the chance of infection, leading to a particularly large impact of the pandemic on the social lives of older people. The Swedish government did acknowledge that measures combating the coronavirus significantly affected loneliness and social isolation among older people and decided to attribute additional funds amounting to close to EUR 3 million to municipalities to implement measures combating the social isolation of older people in relation to the pandemic. While in pre-pandemic times, the non-governmental sector played an important role in stimulating and organising participatory activities for older people in all selected Member States, its activity was exceptionally important during the pandemic, for example in providing assistance to older people and establishing telephone support lines, which very often operated before, but the forced isolation contributed to a significant increase in the number of people calling.

Box 14: Telephone support lines

In Germany, the project *Silver Net*, established in 2017 and first available only in Berlin, is reachable for older people throughout the country. People can call the line for free and talk regularly with their *Silver Net* friends to find their way out of isolation and loneliness. *Silver Net* is a non-profit association that is financed through donation funds.

The Lithuanian *Silver Line*, established in 2016, covers two areas: friendship conversations, which enable older people to build friendships with volunteers during regular weekly calls, and emotional help conversations, which provide professional help from psychologists. In the first quarter of 2021, more than 10,000 calls were made. The project was initiated by a non-profit association; however, it receives some public funds, which were increased during the pandemic as a consequence of the increased need for emotional support among older people.

France is the only country in which such a support line is entirely funded by the government. It was established as part of a national plan to limit the negative consequences of the pandemic. It began operating in 2020 and is free of charge for all older people.

Source: Mackevičiūtė 2021, Makindu 2021, Ponz 2021.

Different institutions have different roles in organising activities aimed at increasing the social engagement of older people, i.e. ministries or relevant committees create programme outlines and plan funding for specific programmes and activities. Regional and local authorities typically administrate these funds and organise calls for projects under the governmental programmes. Finally, the NGOs design and implement particular projects with financial support from the government and regional or local authorities. There are numerous examples of such projects. In Italy, the nationwide

NGO Anteas launched the project *Care laboratories (Laboratori di cura)*, which provides a series of activities based on drama therapy, music therapy, creative labs, memory training sessions, and narrative experiences in schools, all aimed at recognising and stimulating residual skills in older people and volunteers through social and emotional interaction with school-age children. The Lithuanian Red Cross organisation has created the *Warm Visits* programme, which targets lonely people who have no close relatives or friends and rarely leave their homes due to health and other barriers. These people are regularly visited by Red Cross volunteers who walk outside with them and help older people with shopping, doctor's visits, and seeing friends.

4.3.2. Access and affordability of social activities

Programmes and activities aimed at increasing the social participation of older people are rarely assessed from the effectiveness perspective. An evaluation of the *Government Programme for Social Activation of Older Persons* in Poland for the period 2016-2019 points to a strong differentiation in the number of implemented projects between regions. More projects are implemented by entities operating in areas with high social capital, assessed by a number of NGOs in relation to the number of inhabitants and the higher activity of older people than in communities with lower social capital. The overall costs of the programme were moderate in terms of general government expenditures, and even low when recalculated per senior participant. Though the programme reached only 1-2% of the senior population in Poland, it was highly valued by the participants, who otherwise often would not have the ability to be active in the local community (Ruzik-Sierdzińska, 2021). In Lithuania, the social participation of older people receives relatively less funding and attention at the policy level compared to policies aimed at economic participation, health, or financial situation (Mackevičiūtė, 2021).

Despite the implementation of national strategies and numerous activities undertaken by local authorities and non-profit organisations, many barriers to the social participation of older people are ever-present. As an example of these barriers, we can look to Sweden, where the following obstacles to social participation were identified: (i) a lack of financial means, significant because many activities require some form of contribution; (ii) a lack of digital skills, which especially since the onset of the pandemic are a prerequisite for maintaining social contact; (iii) a lack of activities and transport services in rural areas; and (iv) the types of neighbourhoods and houses with certain forms of living – for example, small-scale housing projects with shared courtyards as opposed to tall buildings – supporting social contact more than others (Bergstra, 2021a). Those barriers are also present in other Member States.

Affordability of social participation is considered a problem in Sweden, Poland, and Lithuania. Even though some activities are funded from the public budget, additional individual financial contributions might be needed for certain social activities. Even a relatively low cost could become a barrier for participation. To avoid similar problems in Germany, the state pension insurance automatically provides all pensioners with a pension ID card, which entitles pensioners to a discount on sports clubs, theatre tickets, museum tickets, and train tickets, among others. In Italy, to combat people's fear or reluctance to participate in social activities, health and social care is now often offered to participants at social and cultural centres as an additional incentive to participate.

Regional differentiation in access to social activities and cultural events occurs in Poland, Lithuania, and Italy. In Lithuania, even though branches of associations act and organise social activities in different regions, the availability of activities is much lower in rural areas than in the larger cities. In Italy, social participation in voluntary activities is much easier in small and medium communities, while it is much more difficult in larger cities, for instance Rome. This is due to the difficulty of movement in bigger cities for older people.

4.3.3. Digitalisation and social participation

During the COVID-19 pandemic, most typical social activities were limited due to temporary lockdowns and requirements regarding physical isolation and social distancing. In response to the pandemic, some social activities were conducted online, and assistance was provided via social media to people under quarantine and those feeling isolated and depressed. However, there were obstacles to participation because of older people being less competent in the digital world. Thus, various projects have been undertaken with the aim of increasing the digital literacy of older people.

Box 15: Increasing digital literacy in older people in Germany

Two projects established in 2019 by the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth in Germany: *Digital Angel – secure, useful, helpful* and *Digitalisation and Education for Senior Citizens* aim at fostering the active participation of older people in society and enabling them to lead self-determined lives in an increasingly digitalised society.

The regional project *Train the Trainer – Qualification of Digital Topic Champions for Older People in North Rhine-Westphalia*, initiated in 2020, aims at helping older people use the internet, social networks, and smartphones safely. As part of the project, older people are trained and then help other older people to be digitally literate and able to participate. This is to ensure that all age groups in our society participate in the digital transformation and that no one is left behind.

Source: Ponz 2021.

4.4. Health and well-being

4.4.1. Access and affordability of healthcare

While significant variations exist in the practical availability of healthcare in terms of, for example, waiting times and the availability of specialists in rural areas, all selected Member States have ensured that universal, publicly funded healthcare is offered to all its citizens, including older people. In theory, this means that the accessibility of healthcare in all reviewed Member States is safeguarded regardless of one's financial means. In practice, however, public healthcare shows substantial shortcomings in several Member States (Italy, Lithuania, and Poland). Increasingly long waiting times have created a parallel mechanism of out-of-pocket services to meet the needs of the population. In Lithuania and Poland, citizens rate the public healthcare system as poorly accessible, and public expenditures in relation to GDP are below the EU-27 average (4.6 % of GDP and 4.3 % of GDP, respectively, compared to 6.1 % of GDP in 2019) (OECD 2021).

All selected Member States offer full coverage for older people. Medical services are provided by public and private entities. Although most healthcare providers in the Netherlands are privately run, as well as a growing share in Sweden, a system of reimbursements by insurers tied to government regulation ensures that healthcare users are not met with additional healthcare costs. German and Polish health insurance plans do not include full coverage for certain aids, such as glasses, hearing aids, and artificial teeth; however, in Germany, the co-payments made by patients are tax deductible and in Poland, the cost may be reimbursed by the employer. In France, the public healthcare system is combined with user fees, which are symbolic amounts of money that must be paid for the delivery of healthcare services. These fees, even if relatively low, are seen by French seniors as too high given individual incomes. Older people more often suffer from complicated and co-existing health conditions; thus, they more frequently require medical attention. Ageing populations therefore mean rising healthcare costs (European Commission, 2021). In Italy, Lithuania, and Poland, the share of private expenditures is

significant (for example over 23 % in Italy, 29 % in Poland), with most people who have the financial means buying additional healthcare services on the private market due to long waiting times for publicly provided healthcare services. Since older people commonly lack the financial means to pay for private healthcare, especially in Lithuania and Poland, this situation contributes to unequal access to healthcare.

Apart from financial barriers, a shortage of medical professionals in rural areas as well as a lack of transport services to reach medical facilities contribute to disparities in access to healthcare in France, Germany, Poland, and Lithuania. Several innovative solutions were introduced in Germany to improve accessibility and minimise regional differences.

Box 16: Projects to minimise regional differences in access to medical services in rural areas of Germany

Project aimed at minimising regional differentiation is the "rural doctor quota" was introduced along with the *Master Plan for Medical Studies 2020* by the German government in 2017. Federal states will be able to award up to 10 % of medical school places in advance to applicants who plan to undertake to work for up to ten years after completing their studies in family doctor care in rural regions that are underserved or threatened by undersupply.

The project *Innovative Health Models* of the Institute for General Practice of the Goethe University Frankfurt, introduced in 2003, also focuses on regional differentiation. Here, the idea was to create a database to support rural districts and municipalities who are looking for ways to secure health care in their region, doctors looking for successors in specific regions, and other actors from the health sector. The database became a meeting place for all stakeholders and a platform for innovation, where good practices can be exchanged.

The third solution, which combines telemedicine and regional differentiation, is the TEMPiS project (Telemedical Project for Integrative Stroke Care) in South-Eastern Bavaria, launched in 2003. Regional hospitals without expertise in strokes are connected with stroke units in larger cities via 2-way video conferencing to obtain specialised treatment in hospitals without dedicated medical wards. More than 10 thousand patients are treated every year in the TEMPiS network.

Source: Ponz 2021.

The pandemic had a substantial effect on access to healthcare services for all age groups, including older people. During 2020, there was a decrease in the number of operations, visits to medical facilities, and specialised medical care. Especially during the first wave of the pandemic (March-May, 2020), the number of visits and treatments decreased sharply. The pandemic also led to a decrease in the provision of home nursing care in all selected Member States. In Sweden, the number of people waiting longer than 90 days to see a specialist, the period in which access to specialised care is generally guaranteed in Sweden, increased substantially from 22,000 people in 2017 to 158,000 in 2020 (Bergstra, 2021a).

4.4.2. Health promotion

A strategy to reduce healthcare costs or to stop the costs from increasing beyond a sustainable level is focusing on health prevention measures. In the Netherlands, for example, general practitioners are trained to refer patients to lifestyle improving interventions, such as dietary and fitness advice. Additionally, the central government assists municipalities and local healthcare providers by collecting and sharing good practices and offering financial assistance.

Still, the selected Member States share a common lack of focus on preventative care. In Italy, for example, there is a cultural orientation to disease rather than health. The prevailing approach is based on a passive medicalisation of care instead of an active investment in prevention (Lamura et al., 2021). In Austria, health promotion was recognised by the government to have an important role in ensuring healthy ageing. In Lithuania, public activities and events are organised to inform the population about prevention measures. A good practice can be found in Poland, where a preventive check-up for people aged 40 and over will be introduced from July 2021.

Box 17: The pilot programme Prevention 40+ in Poland

In July 2021, the government introduced a pilot programme: Prevention 40+. All persons aged 40+ can register for a preventive medical check-up financed by the National Health Insurance. If risk factors are identified or test results are alarming, more detailed tests will be performed or the individual will be referred for a consultation with a specialist. The programme is planned to run until the end of 2021.

Source: Ruzik-Sierdzińska 2021.

4.4.3. Digitalisation in healthcare

The pandemic resulted in substantial increase in digital healthcare (telemedicine) and increased data sharing and cooperation among healthcare providers. In the Netherlands, financial mechanisms that used to discourage digital care, for example because physical visits were reimbursed at a different rate, were changed to maintain the availability of care. The shift to digital care did place large demands on older people to adapt to the new situation. They had to learn and use new digital skills – something which a number of older people struggled with. In Poland, a survey conducted in 2020-2021 among people aged 60 and over by the Institute of Policies for Seniors (*Instytut Polityki Senioralnej*) showed that 60% of respondents declared that they have difficulties in using medical or rehabilitation services, with almost two out of three indicating problems with access to a GP or a specialist. Difficulties reported by older patients in Poland emerging from presentations at the 15th Patient Organisation Forum that took place online in February 2021 involved mainly the denial of in-person visits, the need to make telemedical appointments, concerns about the effectiveness of telemedical (remote) diagnostics, and refusals to provide home visits (Ruzik-Sierdzińska, 2021). In the Netherlands, representatives of senior organisations highlighted that older people struggled with the sudden shift to consultations with doctors online and ordering medicine online. In the view of stakeholders, attention should be given to training and support to older patients as well as maintaining the possibility to conduct medical treatment in-person.

However, although technology initially requires investments, it does eventually help to reduce the costs of healthcare and support quality, as shown in the examples from the Netherlands and Sweden.

Box 18: Using new technology to support independent life and healthcare in the Netherlands and Sweden

To guarantee a safe and independent life for older people at home, smart technology solutions are used in the Netherlands. Among other things, this involves the use of medicine dispensers and devices for video-communication with caregivers. Special devices are provided for people suffering from dementia. A network of sensors is installed in the house of the older person in question, ensuring a higher level of security and control.

In Sweden, the most common solution for home care in the house is security alarms for older people. Passive alarms not activated by the resident of the house, such as alarm doormats and camera supervision with GPS-alarms, are also being introduced by local authorities. In some municipalities, people can rent the device, while in others they can apply for a complete exemption from the device fee on the basis of income. Similarly, as in the Netherlands, devices reminding people to take their medicine are in place.

Source: Bergstra 2021a, Bergstra 2021b.

The introduction of telemedicine helps to address barriers in access to services in rural or remote areas. In France, teleconsultations, telediagnosis, and remote monitoring are being developed, enabling older people in isolated areas to use healthcare services. The Lithuanian e-health infrastructure is still underdeveloped; however, currently registration for healthcare services via e-health solutions is possible. Also, in Poland e-prescriptions were introduced in 2020 and the development of patient-friendly information systems in healthcare sped up.

4.5. Long-term care

4.5.1. Differentiation of LTC

The healthcare systems in all selected Member States offer long-term care services provided by health professionals, both inpatient and outpatient. Residential and care services are also provided within social assistance or social services. In Germany, a separate long-term care system is in place. Long-term care units are also operated by private owners. In Member States such as Germany, Austria, Italy, Poland, and Lithuania, many older people receive informal care from family members, relatives, and other non-professional care givers, mainly migrants.

In various Member States (Sweden, the Netherlands, France, Italy), there has been a shift from residential care to home care. In the Netherlands, this shift is reflected in a separate policy – the *Long-term Care Act* introduced in 2015. The legislation is based on several assumptions that are shared in the long-term care policies of all studied Member States, namely: (i) older people want to live independently for as long as possible; (ii) older people want to and can pay more for support and care; (iii) informal care and volunteers can largely replace professional care; and (iv) the use of technology can help older people to live independently for longer. The statistics show that in the Netherlands, from 1995 to 2019, the share of people living in care institutions decreased from 16 % to 5.6 % (European Commission and Social Protection Committee 2021c, Bergstra 2021b). Similarly, in Sweden, a key feature of Sweden's provision of long-term care to its population over 65 is that a large majority, namely 96 % in 2019, up from 94.7 % in 2010, live in their own house as opposed to a specialised housing arrangement (Bergstra, 2021a). There has been a steep decline in the number of older people in care homes in Sweden, down from 20% of the population in 2000, to 2.9% in 2021 (European Commission and Social Protection Committee, 2021c). This shift has been accompanied by a changing population of care home residents, being increasingly frailer and older (Bergstra, 2021a). Informal care plays an

important role, and everywhere one can identify a growing lack of informal care suppliers due to ageing populations, people living away from their older parents due to work, and smaller families. Changes in the socio-professional structure of the population living in rural areas result in a reduction in the number of multi-generational families. At the same time, the average number of household and family members is decreasing. As a result, the potential capacity of the family to perform the care function for older people is reduced.

Some Member States, like Germany, offer policy measures that support informal caregivers. *The Caregiver Leave Act* and *the Family Caregiver Leave Act* allow employees to take care of close relatives in need of long-term care. *The Caregiver Leave Act* provides for the option to take paid leave of up to ten working days, while under *the Family Caregiver Leave Act*, employees can take full or partial leave for up to six months to provide long-term care for a close relative at home. A similar leave scheme for employees to take care of older relatives is offered in Austria. In Italy, most older people with long-term care needs still rely mainly on the family as the main source of regular help, which is supported from the government with cash benefits. The national care allowance of EUR 500-800 per month is received by every person who is dependent on others in performing daily activities. To improve the quality and availability of home care nursing services, the Dutch government funds the training and hiring of medical specialists, who will provide their services outside residential care institutions. In Sweden, to meet older people's expectations, intergenerational houses are being established, where students are offered reduced rents in exchange for living in the same building as older people and for undertaking activities with older residents. Also, to help people age at home, public institutions are providing home-delivered meals, home care to take care of personal hygiene and household duties, and medical services at home. Similar practices are present in Italy: a nursing home in the Piedmont region offers preventative domiciliary services to older people who would otherwise not be eligible to benefit from local home care services, thus promoting their ageing at home.

However, in Member States where informal care is predominant and cash benefits are offered to support dependant people, privately hired care givers and live-in migrant care workers have become an indispensable source of support for families. In Austria, migrant carers come from neighbouring Member States, such as Bulgaria, Czechia, Romania, Hungary, and Slovakia. In Italy, they come from Romania, Poland, and recently from Ukraine. In Poland, migrant care workers are mostly from Ukraine. They usually provide round-the-clock care and work in a shift system, spending a certain period at the patient's house (e.g. half of the month) and returning home for a period of the same duration. To regulate this sector, the Austrian government introduced in 2007 regulations on working conditions, social security, and training competences as well as some quality criteria for migrant care workers and the related brokering agencies. What is more, during the pandemic, the government took some steps to address expected shortages in home care provided by migrants.

Box 19: Emergency management in Austrian home care during the pandemic

Starting from March 2020, the Austrian government has allocated EUR 100 million to support long-term care services provided by migrants. The aid is for securing the provision of care at a regional level (organising trains, flights to Austria), paying one-off sums of EUR 500 to all migrant workers who decide to stay in Austria to continue working, and lastly subsidising those personal carers who were in their home country during this period. This support came from the hardship fund.

Source: Schmidt et al. 2020.

Commonly in the studied Member States, COVID-19 has made long-term care a priority for the first time. The pandemic exposed weaknesses that were present long before the start of the pandemic but had thus far failed to gain sufficient attention. In Sweden and the Netherlands, among these

weaknesses are the following: (i) a lack of person-based care and a focus on individual diseases as opposed to holistic care; (ii) the great number of different people representing different organisations, bringing with it a lack of coordination; and (iii) a lack of personal attention and a lack of qualified staff, both nurses and medical staff. Care homes have been heavily criticised since the start of the pandemic in all studied Member States for not doing enough to prevent the virus, especially in France, Italy, Austria, Sweden, and the Netherlands. Care homes have struggled to deal with the virus, reporting a lack of protective gear as well as high levels of stress among care workers. Regarding home care, COVID-19 led to a big decrease in formal home care services and day care provision, with an estimated 31 % of formal home care and 87 % of day care services for older people halted during the first wave in 2020 in the Netherlands (Bergstra, 2021b). In Austria, the pandemic has exposed other weaknesses, such as: (i) the reliance on low-cost alternative employees from Eastern Europe and (ii) a limited number of health and social workers. This has led to increased pressure on informal care provided by friends, family, and acquaintances.

The good practices seen in Germany and the Netherlands regarding quality control for these services could be considered in other Member States.

Box 20: Quality management in Germany and the Netherlands

In Germany, the quality of care services, excluding private households with live-in carers, as well as nursing homes is well regulated through the Sozialgesetzbuch XI (books of the Social Code) and monitored annually by the Medical Services of the Health Insurance or the auditing service of the Association of Private Health Insurance through unannounced visits.

In the Netherlands, the Health and Youth Care Inspectorate supervises care for vulnerable people, especially older people. Similarly to Germany, the main tool of supervision are unannounced visits, but also mystery guests – mainly Inspectorate employees posing as family members of patients.

Source: Ponz 2021, Rijksoverheid 2021.

4.5.2. Access and affordability of LTC

In Germany and several other countries, moving to a long-term care facility seems to be the last option for most older people and the most expensive (Ponz, 2021). Policies aimed at supporting people ageing at home are largely motivated by cost effectiveness. By providing more ways to stay at home for longer, either through digital means or through supporting informal caretakers, governments aim to contain the rising costs associated with a growing demand for institutional care.

Most of the selected Member States offer some form of financial support for their citizens. In Austria, a long-term care benefit is granted without testing one's income or assets. The cost of staying in French residential institutions is split between the health insurance system, the regional councils, and the patients, who cover only the cost of housing and food. Furthermore, additional financial aid is available for the residents of long-term care units based on the degree of loss of autonomy or limited financial resources. In Germany, children who are liable to pay the cost of their parents' care in residential institutions are supported by the social welfare office if their gross income meets the eligibility criterion. Additionally, relatives who take leave from their jobs to take care of older relatives have the right to apply for an interest-free loan to cushion the effect of losing their income. In Lithuania, to render long-term care services affordable, policies regulate the prices of services based on the income of the individual instead of having fixed prices for everyone. In Poland, local authorities cover the costs of residence in social welfare homes for people whose individual incomes are insufficient to cover it and for families who are unable to support them financially.

With regard to access, the undersupply of long-term care services is a problem in Lithuania and Poland, where the increasing demand for residential care exceeds the number of available places at the institutions. There are waiting lists of several months for a place, while in Sweden the waiting time between application and move-in date is on average 67 days. The rate of long-term care beds in Poland is low and their geographical distribution is uneven. In 2019, nearly one-fifth of counties had no access to long-term residential care. About 2.7 % of older people are in institutional care settings and 3.4 % use home care services. To improve the situation of the long-term care sector in Poland, the public programme *Care 75+* was introduced.

Box 21: Polish project Care 75+

The project *Care 75+*, launched in 2018, aims at improving access to care, quality of care, and the quality of life of older people by helping local communities provide community-based care services to people aged 75+. The programme is targeted at communities with fewer than 60 thousand inhabitants, including rural and remote areas. A subsidy from the governmental budget can be used to increase the number of services provided to already existing services or to launch new ones. The national government co-funds up to 50% of the total cost of services while the remaining funds come from the local government's budget.

Source: Ruzik-Sierdzińska 2021.

4.5.3. Digitalisation in long-term care

Regarding the use of technology, domotics can assist people living at home for longer, and this is especially common in the Netherlands and Sweden. Examples of digital technology for home care include security alarms; passive alarms not activated by the individual, such as alarm doormats and movement alarms, camera supervision, and GPS alarms; and medicine robots that can remind people to take their medicine and dispense medicine according to a pre-programmed schedule. Additional tools include electronic locks at the homes of people receiving home care and electronic planning tools which help to schedule home visits, register visits, and register notes about visits. The use of digital technology in care homes includes, most commonly, passive alarms, such as sensory alarms and GPS alarms, digital planning tools for employees, video consultations used for consulting with medical staff, digital locks on apartments of residents as well as other, less often used digital means, including robotic cats to keep people company, virtual games for stimulation and training for people with dementia, musical dolls, shower robots, and incontinence sensors. Also, it is worth noting that some of these early technological attempts at home care have been undertaken in Poland. Wristbands monitoring the user's vital functions and up to 15 parameters are available to purchase by individual customers. The wristband has a connection to a telecentre which monitors the condition of the patient. This solution proved to be particularly helpful during the COVID-19 pandemic, monitoring isolated patients.

Box 22: The project Living at home for longer in the Netherlands

Along the lines of *the Long-term Care Act*, in 2018, the Dutch Ministry of Health, Well-being and Sport launched the programme *Living at home for longer*, which supports older people with home care. The programme aims at enabling older people to live independently for as long as possible by using home digitalisation. It funds use of e-health at home, such as providing medical care via videocalls, medicine robots, and sensors to prevent falls. It will run until the end of 2021.

Source: Bergstra 2021b.

4.6. Supportive environments

4.6.1. Housing

With governments sharing common priorities, and strengthened by the EU which supports independent living, it becomes highly important that older people can find suitable housing adjusted to their needs. The accessibility of housing does not appear to pose a great problem in the studied Member States. Rather it is the suitability of that housing that shows deficiencies in some Member States. For example, in Lithuania, despite the generally low incomes of the older population, 95.5 % were owners of real estate (Mackevičiūtė, 2021). To compensate for the high cost of living in one's own house, some Lithuanians can get partial compensation for heating, drinking, and hot water costs. The eligibility criteria are income and the value of the property. In Italy, in 2018, the proportion of older people (aged 65 or more) living in under-occupied dwellings, meaning having at their disposal more than the number of rooms considered adequate, was 26 % – a level more than double than that reported for working-age adults living in the same kind of dwelling (Lamura et al., 2021). In Sweden, older people report generally living well and being happy with their housing situation; however, the government offers support for pensioners with lower incomes to guarantee rent payments in rental apartments.

In terms of the suitability of housing, there is generally a need throughout the studied Member States to adjust conditions to the needs of older people. In Italy, architectural barriers represent the main cause affecting the quality of housing for older people. This is related to three main factors: the interior of the buildings, the buildings themselves, and their immediate surroundings/neighbourhood. The interior mainly refers to the bathroom (accessibility of the bathtub), the stairs, and narrow environments which prevent the use of aids for mobility, such as wheelchairs. Within buildings, stairs are the main issue, while external mobility immediately outside the building is mainly compromised by irregular or broken pavements lacking proper maintenance.

Various steps are being taken to improve the suitability of the housing stock in the studied Member States. In Poland, an important step to improve accessibility was the development and implementation of the Governmental programme *Accessibility Plus 2018-2025 (Dostępność plus 2018-2025)*, which supports eight areas: architecture, transport, education, health, digitalisation, services, competitiveness, and coordination. The Accessibility Fund has been established to provide financial support for, among other things, the adaptation of municipal buildings and multi-family housing. In other Member States, housing adaptations are also realised with the support of the government.

Box 23: Housing adaptation programmes in Germany, Lithuania, Sweden, and Italy

In Germany, the modification of homes to make age-appropriate living possible, such as stairs, lifts, barrier-free kitchens, and bathrooms, among others, can be financed with *Kreditanstalt für Wiederaufbau* (the state-owned investment and development bank) grants or low-interest loans as part of the *Age-appropriate renovation* under The Federal Ministry for Family Affairs, Senior Citizens, Women and Youth.

In Lithuania, older people with recognised disabilities are eligible for housing adaptation from governmental funds. The responsible specialists in the municipalities assess the need for housing adaptation, i.e. how much and what kind of work needs to be done. Each year, around 400 dwellings are adjusted under this policy measure.

In Sweden, an act (2018:222) ensures that people with a disability can apply for a housing adaptation grant. The purpose of the grant is to give people with disabilities the opportunity to live independently in their own homes. Apart from cash grants, it is possible to receive grants in two other forms: a commitment from the municipality or in the form of a used product. The adaptations eligible for a grant include the installation of showers, lifts, removing thresholds, or moving walls to make the space age appropriate.

In Italy, in the regions of Emilia-Romagna and Tuscany, older people can receive counselling services regarding the adaptation of their homes to specific needs. Similar actions are also taken in France. As a result of a national consultation conducted from October 2018 to January 2019, the government plans to invest EUR 550 million towards home support to make it possible for older people to stay at own home for as long as possible.

Source: Act (2018:222), Mackevičiūtė 2021, Ponz 2021, Lamura et al. 2021.

The adaptation of houses is particularly important since the majority of older people are reluctant to live in an institutional setting. However, some older people need partial assistance, and therefore Member States are developing different programmes to help them in their daily activities and to avoid having to move house. For example, in France, there are non-medical retirement homes for older people – singles or couples. In Germany, Lithuania, the Netherlands, and Italy, multi-generation houses and communal living houses have been developed. These are apartment buildings in which the different generations have their own apartments. People living in group dwelling houses are more independent and do not receive constant social or health care services.

In terms of accessibility of housing, there is no indication that the situation has been affected by COVID-19.

4.6.2. Transportation

The accessibility of transport for older people consists of two elements: affordability and accessibility of adequate transportation.

The affordability of public transportation is related to ticket prices. All studied Member States offer some form of discounted tickets to older people or people with a lower socio-economic status. Lithuania is the only country from the selected group which has applied public policies at the national level determining age-based discounts for tickets. In other Member States, such policies are implemented at the regional and local level or depend on specific transport operators. In Italy, transportation related to healthcare needs is covered by the health system in the case of low incomes. Similarly, in Germany, a general practitioner can issue a transport voucher for transportation to a medical service point; costs are paid by the health insurance company.

The second element relates to the accessibility of public transport for people with reduced physical mobility. In various Member States, municipalities offer additional transportation services to people who are unable to use public transport, although the accessibility of this service is regionally differentiated.

Box 24: Special transport services in the Netherlands, Sweden, France, Lithuania, Germany, and Italy

In the Netherlands, the *Social Support Act*, which entered into force on 1 January 2015, guarantees special forms of transport both at the national and municipal level. Within municipal borders, a shared taxi service is offered at a reduced rate. For longer trips, a nationally organised service is available.

In Sweden, there is a nationwide service for citizens with physical limitations who are unable to use public transport. At the municipal level, there are on-demand and door-to-door flexible minibuses.

In France, since February 2005, some local governments offer individual transport on request and shuttles to markets. Also, in Lithuania, municipalities provide special public shuttle services for older people, giving priority to people travelling to medical or social institutions.

In German Saarland, the *Mobisaar* project financed by the Federal Ministry of Education and Research and introduced in 2015 provides a door-to-door service helping patients get on and off buses and trains, and also provides assistance at ticket machines.

In Italy, such services go even further. For example, the project *Giuseppina*, introduced in 2007 in Ferrara, offers social taxis which, apart from basic transportation services, try to establish meaningful relationships between drivers and passengers.

Source: Bergstra 2021a, Bergstra 2021b, Mackevičiūtė 2021, Makindu 2021, Ponz 2021, Lamura et al. 2021.

The COVID-19 pandemic has strongly limited the use of transportation by older people. Due to the fear of infection, many older people have refrained from using public transport, resorting to private means offered by relatives, neighbours, and friends. In Sweden, some municipalities have offered individual shuttle services to all people over 70 as well as people under 70 with illnesses. This was especially needed since people above 70 were advised by the government not to use public transport at all. In many Polish municipalities, a free transportation service to vaccination points was arranged for people who could not get there by themselves or with the help of caregivers.

4.6.3. Financial independence

The financial situation of people above 65 and the distribution of poverty among the different age groups in all studied Member States varies. For example, in Germany in 2019, the percentage of men above 65 at risk of poverty was lower than for the total population, while for women it was higher (Ponz, 2021). In the Netherlands, for those over 90, the poverty rate increases to 11 %, compared to 6 % for the general population, due to the increase in the costs of healthcare (Bergstra, 2021b). This has two main reasons: increased medical costs and low pensions. As for low pensions, a commonality across the selected Member States is that women and people with a migrant background run a higher risk for poverty in old age. Older people above pension age with a migration background have often lived part of their lives in another country and during that time have not contributed to contribution-based pension schemes or schemes (regarding the statutory pension) based on residency, such as in the Netherlands. Additionally, women often lack years of pension contributions due to having left the labour force to raise children. In Poland, the risk of low pensions is particularly high for women because

they are more likely to have breaks in employment related to childcare, they earn on average less than men, and they can retire earlier and live longer. All this together means gendered risks for old-age poverty in Poland, and this applies in other Member States as well.

To prevent poverty among older people, the Member States have undertaken several actions, including the introduction of a minimum pension and a special allowance. In France, a "solidarity" allowance is paid to older people, regardless of the pensioner's nationality. In Italy, the introduction of a basic income has resulted in the introduction of a basic pension, which contributes to the reduction of the risk of poverty. Relatively low pensions and the large amount of older people at risk of poverty in Lithuania has resulted in pension reform, the aim of which is to introduce a new pension accumulation scheme. The interim solution proposed by the Lithuanian government consists of a special allowance for single persons, which is expected to reduce the at-risk-of-poverty rate for single older people. In Poland, the right to a minimum pension was given to women who gave up employment to raise at least four children. The Dutch government supports the financial independence of older people in different forms, offering financial assistance for housing and health care. Also, Swedish pensioners are eligible for housing benefits, and additional financial support is offered for the frailest groups, including migrants without any pension or people with a very low pension incapable of maintaining a decent living standard.

As for the financial situation of older people, there has not been strong evidence in any of the studied Member States that COVID-19 has led to an increase in poverty among older people, especially since pension payments were not affected.

5. CONCLUSIONS AND RECOMMENDATIONS

The above analysis provides a comprehensive picture of active ageing policies and access to services supporting active ageing in the EU-27. It discusses the latest trends, shows the impact of the COVID-19 pandemic on the provision of services for older people, and presents examples of policies and activities undertaken in recent years in selected Member States to foster labour market activity, increase social participation and well-being, improve long-term care provision, and support financial independence among older people. The conclusions point to the main challenges identified throughout the analysis, particularly with respect to barriers in access to services due to economic situation, place of living, and distance from service providers; gender; and other causes of exclusion.

It should be noted, however, that the scope of this report is very broad considering supportive services that are located in policy fields, such as employment and pension systems, healthcare, poverty prevention and social safety nets, long-term care, and social services. While the European Parliament and the EC establish the general principles, priority areas, and framework for achieving the targets set by the EPSR and respective strategies, specific policy solutions are the primary responsibility of the EU Member States.

The policy pointers formulated below arise from analysis of access to services supporting active ageing across EU Member States (Chapter 3) and analysis of the policies and activities including good practices supporting the provision of services to older people in eight Member States (Chapter 4).

Active ageing policies are a useful tool for streamlining and monitoring progress towards an ageing-friendly society and access to services for older people in line with the EPSR principles. Setting up integrated policies oriented at the well-being of older people and active ageing by national, regional, or local authorities is a long process. Dignified ageing is supported by including social partners and older people in decision making processes, in what is an expression of a rights-based approach.

Table 5: Policy pointers for encouraging healthy and active ageing in national policy

Challenge	Policy pointer
Further streamlining of healthy and active ageing in national policy.	<ul style="list-style-type: none"> • Formulate a coordinated healthy and active ageing policy framework at the national, regional, and local policy level. • Improve responsiveness of healthy and active ageing policies and programmes by adopting a formal consultation process on programmes and activities with bodies representing older people at the national, regional, and local policy level.
More effectively execute a rights-based approach to active ageing.	<ul style="list-style-type: none"> • Further improve participation and consultation of senior councils and other organisations representing older citizens in political processes regarding healthy and active ageing and implementation of the EPSR regarding services for older people.
Improvement in monitoring of progress towards active ageing.	<ul style="list-style-type: none"> • Improve monitoring of progress towards active ageing via the regular (annual) publishing of national indicators on access to services important for older people and social participation at the national, regional, and local level. • Continue work towards adopting the AAI at the subnational level (regional, local).
Increase awareness of benefits of healthy and active ageing for individuals, society, and the economy.	<ul style="list-style-type: none"> • Promote knowledge on the benefits of healthy and active ageing via social campaigns (e.g. via media, social media, social networks) as well as promote specific activities (e.g. volunteering). • Facilitate further discussion and research on how active ageing should be reflected in professional and academic training, education, and particularly in training gerontology-related professions.

Source: Author's own elaboration based on analysis in Chapter 3 and Chapter 4.

Table 6: Policy pointers for encouraging the economic participation of older people

Challenge	Policy pointer
Frequent early retirement, despite an increase in the pensionable age in most countries and policies stimulating the employment of older workers.	<ul style="list-style-type: none"> • Further reform pension systems to reduce economic incentives for early retirement, while considering the non-financial factors that influence retirement decisions (e.g. health, social, and psychological well-being; quality of work; and preference for leisure). • Introduce measures for creating an ageing-appropriate work environment, promote good practices in improving working conditions, provide consulting to individuals and entrepreneurs on implementing an ageing-friendly work environment, and introduce ageing-friendly management and work organisation.
Although there are no significant changes in the activity rate among people aged 55-64, it is still too early to assess the real impact of COVID-19 pandemic on older people's labour market participation.	<ul style="list-style-type: none"> • Monitor closely statistics on the economic activity of people in their pre-retirement and retirement age (including reduced working hours and the use of flexible forms of employment); • Ensure that the reduced working hours imposed by pandemic restrictions do not push older workers out of the labour market.
The Work-Life Balance Directive is an important milestone for the implementation of flexible working arrangements; however, it does not address issues related to the preferences of older people to transition smoothly from full-time employment to more flexible forms of work.	<ul style="list-style-type: none"> • Combine retirement age reforms with policy measures that aim to extend working lives through the introduction of measures allowing for more flexible forms of employment, such as creating the conditions for combining part-time work with retirement. This would prevent poverty, promote the well-being of older people, and create financial incentives to continue employment.
Recent Eurostat data underline a higher relative old-age income poverty for women, caused by gender asymmetry in caring responsibilities and their higher usage of flexible working arrangements and part-time work.	<ul style="list-style-type: none"> • Ensure that the introduction of incentives to extend the duration of working life through flexible working arrangements does not affect the gender old-age income gap.
Older people may be unwilling to participate in lifelong learning due to, among other things, uncertainty over the future payoff of investment in learning.	<ul style="list-style-type: none"> • Modernise Continuous Vocational Education and Training systems by increasing the volume and quality of self-paced, job-related, and work-integrated, opening access to CVET services, or introducing new investment packages to support adult participation in learning and enhancing employability.

<p>The risk of the labour market exclusion of older people due to the rapid digitalisation of the labour market.</p>	<ul style="list-style-type: none">• Ensure a focus on the most disfavoured groups of older workers when developing national strategies for digitalisation.
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Source: Author's own elaboration based on analysis in Chapter 3 and Chapter 4.

Table 7: Policy pointers for encouraging the social participation of older people

Challenge	Policy pointer
The pandemic has hindered social activity. People experiencing a prolonged period of isolation may encounter negative health effects. It may also have an unfavourable impact on physical and emotional well-being.	<ul style="list-style-type: none"> • Support activities identified as good practices that can also be introduced in other countries, e.g. (i) opportunities for older and younger people to meet and jointly engage in voluntary activities and (ii) special funds devoted to activities for older people.
Living in remote areas and lacking financial resources are common barriers to social participation.	<ul style="list-style-type: none"> • Support the development of community day centres as a tool to stimulate the integration and participation of older people in more remote (rural) areas, where other social engagement options are less available. • Monitor the adequacy of old-age income for different age groups of older people, men and women, and those living in families or single households.
Considerable differences exist in the availability and knowledge of how to use ICT between countries, especially for people aged 65+. This can be an obstacle to using ICT as a means to increase social participation.	<ul style="list-style-type: none"> • Promote lifelong learning in the field of ICT for older people and their carers: launch new projects and continue effective projects aimed at facilitating the participation of older people in digital education and the digital world; feed results into improved policy-making. • Support internet access in remote areas and for people with lower incomes.

Source: Authors' own elaboration based on analysis in Chapter 3 and Chapter 4.

Table 8: Policy pointers to strengthen access to healthcare services for older people

Challenge	Policy pointer
<p>The COVID-19 pandemic has contributed to a decrease in the well-being and health status of older people, particularly those with multimorbidity.</p>	<ul style="list-style-type: none"> • Review up-to-date methods for measuring functional limitations and healthy life-years, taking into account the detrimental effects of COVID-19 on mental health and physical well-being. • Further monitor trends in functional abilities and healthy life-years for different age groups of older people in order to measure the impact of COVID-19.
<p>The reorganisation of healthcare systems during the COVID-19 pandemic, the fear of infection, and long waiting times for healthcare may lead to detrimental health effects and high morbidity in the years to come.</p>	<ul style="list-style-type: none"> • Identify the factors underlying the inadequate provision of healthcare services and the unmet needs for care among different age cohorts and in each EU Member State and propose a plan for tackling them by increasing the capacity of healthcare service providers, funding, and investment in adequate professional staff using RRP and ESF+. • Implement national screening programmes for adults (the 40+ or 50+ population) oriented at prevention and the early detection of non-communicable diseases, taking into account gender-related and age-related health risks, so as to prevent potential health loss from postponed, foregone, or poor access to medical services during the COVID-19 pandemic.
<p>Problems with access to online and telephone medical services were reported, which could have contributed to foregoing medical care.</p>	<ul style="list-style-type: none"> • Undertake educational projects and intergenerational activities oriented at the improvement of digital literacy and access to digital infrastructure by older people that would allow them to use telemedicine and fully benefit from information systems in healthcare. • Establish telephone helplines for people facing difficulties in using online medical services or having no access to healthcare information systems.

<p>Territorial differences in access to healthcare are observed, with poorer access to health services in rural and depopulated areas.</p>	<ul style="list-style-type: none"> • Support the provision of healthcare in rural and depopulated areas by introducing measures such as: (i) mobile healthcare services provided at regular intervals; (ii) a system of financial and in-kind (e.g. accommodation) incentives for medical graduates to undertake employment in rural areas; (iii) the introduction of a quota for graduating medical students to undertake employment in rural areas; and (iv) the use of telecare for consultations with specialised medical units in the region regarding the diagnosis and treatment of non-communicable diseases.
<p>Economic inequalities in health status and loss of functional abilities are significant.</p>	<ul style="list-style-type: none"> • Promote national policies, programmes, and activities oriented at health education and a decreasing economic, social, and geographical disparities in health status and access to healthcare across life (from childhood, through adulthood to older age). • Include tools for the measurement of socio-economic (income) gradients in the physical health, mental health, and functional abilities of different age cohorts in the new tools for measurement of the barriers and gaps in healthcare or European Health Data Space proposed by the EPSR Action Plan.

Source: Authors' own elaboration based on analysis in Chapter 3 and Chapter 4.

Table 9: Policy pointers to strengthen long-term care for older people

Challenge	Policy pointer
<p>Wide disparities in access to long-term care services result in unmet needs for care, particularly in southern and eastern Europe.</p>	<ul style="list-style-type: none"> • Encourage and streamline national activities at the European level for the development of responsive long-term care systems, particularly in countries where family care dominates and services are separated between the health and social sectors. Recommendations should take into account different levels of service provision and the characteristics of LTC across the EU-27, pointing to the need for deinstitutionalization in countries with high levels of residential care, the development of services addressing unmet needs, the need to increase the affordability of care, and the use of new technologies.
<p>Despite recent efforts by the EC and SPC, the data for monitoring the provision and use of LTC by specific age groups are still limited.</p>	<ul style="list-style-type: none"> • Strengthen data collection and reporting on LTC at the national and European level by including basic LTC indicators regarding the use of LTC by older-age groups and people with care needs on the Social Scoreboard and in the Eurostat database.
<p>The financial burden of care results in unmet needs for care, particularly among people with lower incomes and those at risk of higher functional limitations.</p>	<ul style="list-style-type: none"> • Close the gap in unmet care needs to provide public support to cover (at least partly) the costs of care for people with high care needs and low incomes via national social protection systems (e.g. care vouchers). • Promote low-cost solutions such as volunteer work and neighbourhood support groups in providing people with low care needs assistance in performing instrumental tasks of daily living (groceries, household help, gardening).
<p>A shrinking care workforce prevents the long-term care system from developing.</p>	<ul style="list-style-type: none"> • Promote national policy solutions oriented at increasing the number of nursing care professionals such as education in care-related professions, vocational training enabling reskilling for care professions, investing in gender diversity in the LTC workforce, establishing e-platforms to encourage entrance into the care profession, and using social entrepreneurship structures to educate in care professions and provide care. • Increase the attractiveness of work in care-related professions by providing adequate wages and improving working conditions for care workers (e.g. introducing or improving quality standards or equipping carers with digital tools which are helpful in organising daily

	<p>care work such as applications on mobile devices).</p> <ul style="list-style-type: none"> • Establish mobile care teams consisting of medical doctors, care personnel, and nurses to monitor the care needs of older people and provide care in early-palliative cases. • Support informal carers with training, work-life balance measures (e.g. care leave), and respite options in order to increase their capacity to provide care and support independent living among older people.
<p>Migrant and in particular live-in care has been developing in several EU countries (Italy, Germany, Austria, Poland), but still receives little recognition within national LTC and inadequate social protection.</p>	<ul style="list-style-type: none"> • Improve the monitoring of migrant care work in LTC in the formal and informal sectors of care in EU Member States via the national administrations. • Formulate EU-level or national guidance on migrant LTC work regarding the minimum wage, social protection provision, and national guidance on professional requirements. • Consider the provision of additional support for the cared-for to increase their ability to pay for care services (e.g. cash benefits for covering costs of care, care vouchers).
<p>Adequate use of new technologies and innovative care solutions in order to support older people living alone and preventing loneliness and social isolation.</p>	<ul style="list-style-type: none"> • Improve access to new technologies by providing digital devices to people with low to moderate care needs (e.g. wristbands, telemonitoring) and provide training in using digital devices to persons being cared for and informal (family) carers. • Promote alternative care management measures (e.g. shared housing, communal living houses, neighbourhood and volunteer care work) to improve the well-being and security of older people and prevent loneliness and social isolation.

Source: Authors' own elaboration based on analysis in Chapter 3 and Chapter 4.

Table 10: Policy pointers to address housing-related challenges for older people

Challenge	Policy pointer
<p>Almost one-third of older people (65+) within the EU-27 live alone. Older people living alone might require care assistance (e.g. taking care of the household, some everyday tasks). In addition, living alone can lead to loneliness and hence mental health problems.</p>	<ul style="list-style-type: none"> • Stimulate the further development and accessibility of home-based care services. The needs of older people who require only minor help (e.g. help with cleaning the house once per week) should not be ignored or put below the needs of individuals requiring more extensive care. • Stimulate national or regional investment in shared living or communal living houses adjusted to the needs of older citizens.
<p>More than one-fifth of older people in the EU need to allocate a significant part of their income to rent, while more than one-tenth of the population suffer from the housing cost overburden rate. Older women are more likely to be overburdened by housing costs than men.</p>	<ul style="list-style-type: none"> • Encourage the provision of subsidies fully or partially covering housing costs for the older people with the lowest incomes (including rent or utilities' costs).
<p>Older Europeans on average are less likely to face significant challenges related to overall housing quality when compared to the younger population. However, few households meet the specific needs of older people.</p>	<ul style="list-style-type: none"> • Focus further policy efforts on the adaptation of the existing housing stock to the specific needs of (older) people (instead of focusing on the construction of new buildings). Provide EU benefits or encourage the use of national and regional budgets for the adaptation of older peoples' homes to increase their safety and adjust the environment to their functional abilities (e.g. adaptation of toilets and bathrooms, installation of lifts and ramps). In some countries, governments ensure that older citizens can get low interest loans for the adaptation of housing, while in other countries, these services are fully funded by the public budget. • Engage older people in decision-making processes regarding the adaptation and rearrangement of their accommodation. • Stimulate investment from local authorities (communities) with a high share of older people in easily accessible green areas and parks, supporting the integration of local communities.

Source: Authors' own elaboration based on analysis in Chapter 3 and Chapter 4.

Table 11: Policy pointers to address transportation-related challenges for older people

Challenge	Policy pointers
Older people are more dependent on public transportation services. They typically do not drive and cannot afford private transportation services.	<ul style="list-style-type: none"> • Encourage the provision of subsidies partially or fully covering private transportation costs in case of necessary travel (i.e. to the hospital, pharmacy, or grocery store, among others). • Encourage the development of public shuttle services for older people (e.g. in some countries, a shared taxi service is offered to older people at a reduced rate, in other countries, there are on-demand and door-to-door flexible minibus lines).
People living in thinly populated areas are more likely to encounter low availability of public transport.	<ul style="list-style-type: none"> • Promote the implementation of additional trajectories of public transportation needed for older people, e.g. to the places they usually visit such as healthcare institutions and day centres, among others.
The public transport system infrastructure is not well adapted for older people, which reduces the attractiveness of these services for them.	<ul style="list-style-type: none"> • Promote the further development of public transport infrastructure to meet the needs of older people. For example, this includes the installation of step-less entrances (low floor, kneeling facility), handrails, priority seating facilities (in the front sections), real-time audible information, and wheelchair spaces, among others. EU funds (RRF, ESF+) might be well used for this development.

Source: Authors' own elaboration based on analysis in Chapter 3 and Chapter 4.

Table 12: Policy pointers to address financial vulnerability in older people

Challenge	Policy pointer
<p>Older citizens of Central and Eastern European countries face the most significant financial challenges because of the limitations related to pension systems in these countries.</p>	<ul style="list-style-type: none"> • Further strengthen and promote EU level monitoring and the EU Semester's Country Specific Recommendations on pensions.
<p>Particular demographic groups are more financially vulnerable, for example, older women or older people living alone. These groups tend to receive lower income which leads to higher material deprivation and the high risk-of-poverty.</p>	<ul style="list-style-type: none"> • Ensure that the pension system contributes to the financial well-being of the most financially disadvantaged people. For example, in some countries, pension systems include special allowances for single older people receiving a minimum or lower monthly income (pensions), while other countries have set a minimum pension level. • Provide benefits that partly or fully compensate for the gender wage gap and the lower pensions women receive. Survivor pensions help redistribute income to older women but are not sufficient to offset career inequalities.

Source: Authors' own elaboration based on analysis in Chapter 3 and Chapter 4.

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The study focuses on active ageing policies and access to services for the ageing population in the EU-27 in five areas: economic activity, social participation, health and well-being, long-term care, and supportive environments including housing, transportation, and securing financial independence. It presents the challenges and trends in achieving active ageing policy goals in those areas, as well as the impact of the COVID-19 pandemic. Eight country studies for selected Member States provide a comparative assessment as well as examples of policies and good practices undertaken in recent years.

This document was provided by the Policy Department for Economic, Scientific and Quality of Life Policies at the request of the committee on Employment and Social Affairs of the European Parliament (EMPL).

PE 662.940
IP/A/EMPL/2020-14

Print ISBN 978-92-846-8421-2 | doi:10.2861/93717 | QA-02-21-952-EN-C
PDF ISBN 978-92-846-8422-9 | doi:10.2861/568600 | QA-02-21-952-EN-N