Global Future Council on Longevity

WORLD ECONOMIC FORUM

COVID and Longer Lives: Combating ageism and creating solutions

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Contents

Foreword

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Remarkable gains in life expectancy, declines in fertility and the progression of relatively large-sized cohorts to the older ages have led to an ageing global population. Life expectancy has increased to 70 years or more in many countries, while the total fertility rate has dropped from 5 to 2.5 in the past seven decades and, for the first time, individuals aged 60 or more have outnumbered children under the age of five.

On 11 March 2020, Tedros Adhanom Ghebreyesus, the Director-General of the World Health Organization (WHO) declared COVID-19 a pandemic. Older adults with existing co-morbidities are recognized as a vulnerable group, at high risk of severe outcomes and mortality. At the same time, concerns are intensifying about the further detrimental impacts on older adults' well-being caused by measures taken to mitigate the transmission of the virus. These developments underscore the critical importance of action to enable individuals to age in good health.

The purpose of the COVID and Ageing Society Virtual Dialogue Series was to bring together key voices to address the challenges of the coronavirus disease (COVID-19) pandemic and provide an enabling platform for stakeholders to discuss the short- and potentially longer-term effects of COVID-19 on older adults and their wider implications; to share examples of promising efforts to respond, support and protect older adults within the context of COVID-19; to explore opportunities for and challenges to the acceleration, scaling up or transfer of such responses; and offer a platform where all key stakeholders can learn from and help strengthen the response for older adults.

In seeking a Great Reset, however, we need to acknowledge that population ageing brings with it opportunities and challenges that must be understood and harnessed. Global populations are benefiting from increased longevity, presenting new opportunities to capture unique skill sets, social capital, knowledge and experiences that older adults can offer to restart economies. Governments and industries are urged to better understand the opportunities and challenges of older adults in this pandemic and harness their potential to contribute as we restart economies.

As the COVID-19 pandemic has shown us, much needs to be done to promote healthy ageing and improve our response to the opportunities and challenges of ageing in today's world. As the International Organization for Public-Private Cooperation, the World Economic Forum is putting its full weight behind the topic of healthy ageing and longevity to create a world in which everyone can live a longer and healthier life. The Forum, together with its Global Future Council on Longevity, will continue to accelerate progress and drive collective action towards promoting healthy ageing, combating ageism and developing communities that promote the abilities of older people.

Preface

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Soon after the first meeting of the Global Future Council on Longevity (GFC on Longevity) in Dubai, the world changed. As we all know, a new threat, SARS-CoV-2, emerged and rapidly spread around the world, causing a global pandemic.

Early on, it was clear that older people, particularly those with certain chronic conditions, were dying at alarming rates. However, the priorities of governments, health systems and global institutions did not always focus on those who were in greatest danger.

And so, the Council rose to the challenge, quickly pivoting its work and yet staying precisely on course. Recognizing the urgent need to direct attention to the unique issues faced by older adults during the COVID-19 pandemic, the Council organized a five-part dialogue series about COVID-19 and ageing societies.

We are pleased to present this summary report of the COVID and Ageing Society Virtual Dialogue Series, co-sponsored by the World Economic Forum, AARP and the National Academy of Medicine, USA. It has been our honour to serve as co-chairs. We thank the GFC members for their commitment to achieving our mandate to "drive action and impact on healthy longevity". We would also like to thank everyone who contributed to the success of the dialogue series and the development of this report, especially Sofiat Akinola and her colleagues at the World Economic Forum.

COVID-19 has upended how we work, learn, connect socially, receive care and participate in the marketplace. COVID-19 has affected everyone, yet this great disruption has been particularly devastating for older people, who have suffered economic hardship, become socially isolated and faced the sting of ageism – a sting that, like the virus itself, can be deadly. Older people belonging to certain racial and ethnic minority groups remain especially at risk as a result of unaddressed systemic inequities.

As countries start to reopen and rebuild, older people must not be forgotten. They must be at the centre of governments' economic and social policy responses. Older people must also be part of the ongoing development of vaccines as well as prominent in plans for vaccine distribution.

It is hoped that the insights contained in this report will spark ideas that lead to meaningful action. The human rights, dignity and worth of older people must underpin all efforts to reset and "re-normalize" the global community. Despite the unforeseen COVID-19 pandemic, our work, at its core, remains the same as it did at the beginning of 2020. Standing together, we can ensure that no one is left behind and that every individual has the chance for a better tomorrow.

1 Executive summary

The coronavirus (COVID-19) pandemic has exposed long-standing challenges and inequalities in the way we define and protect the rights of older people around the world. The COVID and Ageing Society Virtual Dialogue Series focused on five thematic areas in which older people have been most significantly affected by the pandemic and where there is potential to do more to improve their lives and well-being. What follows is a look at those themes.

1. Ageism in the time of coronavirus
Ageist stereotypes that older people are frail, helpless and a burden on society have led to prejudice and discrimination in the way policies and responses to COVID-19 have been designed and operationalized. Meanwhile, COVID-19 has exacerbated perennial issues confronting older people. Undervaluing the economic and social contributions of the older population is a form of ageism and does a disservice to struggling economies that can benefit from gains in health and longevity. Employers can play a role by making workplaces more age-friendly and offering older employees upskilling and training opportunities, job redesign and fair work practices.

As a result of COVID-19 lockdowns and physical distancing regulations, older people, especially in lower- and middle-income countries, are facing a loss of financial security and limited opportunities to earn an income. Chronic disease care and health screening services have been interrupted due to safe-distancing measures, so are not reaching the older people who most need them.

Future actions must preserve the fundamental human rights and dignity of people regardless of age, and properly recognize and value older people as essential members of society. The pandemic underscores that it is now time to focus on the intersectionality of ageism with gender, culture, ethnicity and sexual orientation; strengthen intergenerational solidarity in workplaces and wider society; and challenge our everyday biases and assumptions about older adults.

2. Converging pandemics: isolation and loneliness
COVID-19 is not the only pandemic plaguing older people: isolation and loneliness are distinct phenomena. While social isolation refers to the frequency of interactions, loneliness arises from a lack of meaningful and satisfying relationships. Loneliness affects people of all ages and has a significant negative impact on a person's physical and cognitive health, increasing the risk of anxiety, depression and suicide. Discrimination and exclusion, for example, whether because of one's age, ethnicity, gender or sexual orientation, can exacerbate loneliness and the impact of COVID-19.

The best solutions to loneliness and isolation discard ageist narratives, instead encouraging intergenerational solidarity, social participation, connectedness and a sense of belonging. Innovative and inclusive virtual solutions that repurpose "old" technologies such as the telephone, television and radio, in addition to enabling internet access for all, can also promote social participation and connectedness. Technological advancements are proving to be critical tools in preventing isolation from turning into loneliness. However, tapping into those tools to realize their full potential will mean addressing inequalities in accessing such technologies as well as the need to train older people so they feel familiar with them.

3. Home and community-based care
The coronavirus pandemic has turned a spotlight on homes and communities as being among the safest places to receive care. Family caregivers must therefore be better valued and supported. Strengthening the social capital of older adults is also necessary to shift the narrative away from their victimhood and towards their ability to contribute – that is, to play a role within their communities in

helping to develop greater community resilience, both with respect to the current pandemic and against future crises. Well-designed home and community spaces can further promote the health and well-being of older adults. Yet, for most older people even in developed countries, such indoor and outdoor spaces are still a distant prospect.

Telemedicine and digital technology have burgeoned as solutions in caring for older people at home and as a means of allowing seniors to remain socially engaged, protecting them against loneliness and isolation. However, the growth and potential of these technologies has raised concerns about the digital divide, and virtual solutions must be accessible to those who need them most.

Focusing on the needs of the individuals receiving care and their caregivers is the key to unifying multiple stakeholders in home and community care settings. While models of home and community care will differ across geographies and cultures, there are opportunities for local solutions to be shared globally.

4. Long-term care facilities

COVID-19 has exposed serious challenges in long-term care facilities that existed before the pandemic. Increased collaboration across the public, private and social sectors is needed to improve such facilities. To advance transparency and the best interventions within long-term care, there must also be integration between long-term care and healthcare systems, as well as consistent reporting requirements throughout the industry and across countries. Regulations should focus, too, on quality improvement over quality assurance to yield higher compliance and greater collaboration among government and long-term care providers.

A critical component of improving long-term care facilities and care delivery is to better empower, support and protect the long-term care workforce. Providing better compensation and training, implementing safety protocols and promoting better behaviour-change communication (e.g. on regular hand-washing and the wearing of masks) will create a safer and more stable workforce.

Facilities with long-standing commitments to integrating technology within their care approach have been able to effectively deliver care throughout the global pandemic. Technology can also play a vital role in enabling residents to maintain valuable social connections.

5. Impact of COVID-19 on older adults in low- and middle-income countries (LMICs)

Almost 70% of the global older population live in LMICs. Many are unable to avoid exposure to COVID-19 because they live in overcrowded, multigenerational households or have little choice but to continue working, often putting them at higher risk of infection (e.g. through contact with customers and co-workers, use of public transport systems, etc.). Poorer communities are also susceptible to premature ageing and related health risks that are further exacerbated by ethnicity, gender and migration status. COVID-19 has not forged the appalling levels of inequalities that prevail in many LMICs – rather, it has simply brought them into the open. Countries that have fared better in responding to the pandemic are precisely those that are more egalitarian, with free access to universal health care.

Healthcare coverage is insufficient in most LMICs, with widespread barriers for older people accessing health and social care. There is a long way to go in terms of mainstreaming ageing and older people into care planning and delivery. However, the most effective pandemic-related actions in LMICs have been local. The LMICs that have quickly mobilized community health workers have seen the greatest successes. These measures need to be supported, reinforced and scaled up in all countries.

Older people must be fully integrated into all social, economic and humanitarian responses – both nationally and internationally. While they are more vulnerable, it is apparent that, after any crisis, older people play a critical role in reconstruction.

2 Introduction

The year 2020 will be a defining one for the rights of older people around the world – not least because of the COVID-19 pandemic that has infected millions globally and continues to see rising infection rates. The crisis has also exposed the systemic age-based discrimination and disparities in social protection and healthcare that plague societies, both in the discourse on and responses to the pandemic. Older people have been subjected to increased stigma, isolation and loneliness, as well as violations of their basic rights to health and life. This alarming phenomenon has prompted strong reactions from the highest levels of global governance. The United Nations Secretary-General, António Guterres, has emphasized that responses to COVID-19 must respect the rights and dignity of older people, a sentiment echoed by the UN Independent Expert on the enjoyment of all human rights by older people.

It is significant then, that 2020 is also a year of concerted global collaboration and calls to protect and promote the rights of older people, not only in response to the pandemic, but in light of the unprecedented rise in the proportion of older people in the world population. This is the year the World Health Organization launches the Decade of Healthy Ageing. In addition, 2020 marks the 30th Anniversary of the United Nations International Day of Older Persons and sees numerous programmes and activities around the world on the rights of older people.

The World Economic Forum Global Future Council on Longevity (GFC on Longevity), in collaboration with AARP and the National Academy of Medicine, USA, is proud to be a part of this global momentum and call to action. Through the COVID and Ageing Society Virtual Dialogue Series, the GFC on Longevity convened experts from around the world to share ideas and propose solutions to capture the opportunities and manage the challenges facing older adults during and after the pandemic. This five-part dialogue series addressed ageism in pandemic-related responses, the converging pandemics of loneliness and isolation, the challenges for long-term care facilities as well as home and community-based care, and the impact of the coronavirus on older adults in low- and middle-income countries.

This document summarizes the key discussion points and takeaways from the dialogue series and identifies actions that stakeholders – including governments, businesses and non-governmental and civil society organizations – can take to influence change. The GFC on Longevity hopes that the insights from the discussions will spur innovative and collaborative ways of thinking about, and effective responses to, the needs of older adults arising as a result of the pandemic and beyond.

3 COVID and Ageing Society Virtual Dialogue Series

3.1 Ageism in the time of coronavirus

Unlike COVID-19, ageism is not new. Ageism is stereotyping, prejudice and acts of discrimination towards people based on age. Stereotypes of ageing are manifest in the belief that young people are invincible while older people are frail, helpless and a burden on society. These myths lead to prejudice – how we feel about a person or group of people based on age – and during the pandemic specifically have translated to a commonly held view that older people are expendable. In turn, that viewpoint has led to ill-informed policies on how and to what degree resources should be spent on older adults and has further exacerbated the toll of the pandemic on older adults' lives.

In short, the coronavirus pandemic has exposed in the most brutal way the impact of ageism on older people in terms of their ability to access healthcare, where they work, the financial security they build and the way they are viewed by healthcare professionals and society as a whole.

Ageism in action

In confronting COVID-19, the World Health Organization (WHO) calls for resources to be allocated to those with the greatest medical need, regardless of age. However, there have been instances of health systems implementing COVID-19 triage policies that are based solely on a person's age while ignoring other risk factors such as underlying chronic conditions. Discrimination may have also affected the degree to which data has been collected and reported from residential settings and how "lockdown" policies were written and implemented.

COVID-19 has had more indirect effects on the challenges older adults face as well. Increasingly, older adults are struggling to access healthcare that falls outside services responding to the acute needs of those related to COVID-19 diagnoses. Chronic disease care, time-sensitive treatments for eye diseases, and health screening are just three critical services that have fallen by the wayside during the pandemic. Healthcare professionals and older people alike fear unnecessarily exposing themselves to the virus, causing cancellation of routine appointments. Health systems are rightly focused on testing and treating people suspected of having the COVID-19 virus. However, this leaves older adults, many of whom may be isolated in their homes, feeling all the more vulnerable, isolated and fearful, which in turn may precipitate mental health disturbances. Social (or physical) distancing has led to information, resources, policy updates and health messaging not reaching the people who may need it most.

Longevity has forced people to rethink how they work, plan for and live in retirement, and the COVID-19 era has had implications in this area, too. People continue to work past the so-called "traditional" retirement age in high-income countries, both for personal reasons related to staying active physically and mentally, and also for financial security. In the decade preceding the COVID-19 pandemic, 100% of employment growth in the G7 countries came from people over the age of 55 years.[1] As employees extend their working years, "smart" workplace environments are adapting to become more age-friendly. Changes in workplace culture have accelerated dramatically under COVID-19 as flexible work arrangements are no longer just a perk of the job but rather an important and sometimes essential measure for employees' safety.

Survey results from *The New Social Contract: Age-Friendly Employers* showed that 57% of workers do not see retirement as a binary event but rather a transition period from full-time to part-time work, flexible work arrangements or new careers.[2] Nevertheless, 33% of workers in the same survey felt that their employers are not facilitating a multigenerational workforce, despite evidence that age-friendly workplaces are more productive and innovative, and also benefit younger employees who are looking for a work environment that accommodates various life stages.

The degree to which people are affected by COVID-19 is vastly different based on a person's gender, race and sexual orientation. Marginalized groups are more likely to be employed in essential services and risk exposure to the coronavirus. Women appear to have shouldered a greater burden of caregiving responsibilities during lockdowns, compounded by loss of income and social isolation. Around the world, such disparities – as well as related disparities[3] in access to healthcare services, quality housing and economic opportunities – are laid bare, as people who are racially discriminated against are more likely to be exposed to and diagnosed with COVID-19 and suffer the financial shocks of lockdowns.

Older people have undoubtedly faced a loss of financial security during COVID-19 lockdown periods, in trying to balance protecting their own health with earning an income, sometimes for the survival of themselves and their family. Amid forced retirement due to a loss of employment, lay-offs and a diminished labour market, many older people must still earn money, yet the opportunities to do so are limited in this time of shutdowns and social distancing.

As older adults represent most COVID-19 deaths around the world,[4] policy debates have presented a false trade-off between saving the lives of older adults and preserving the livelihoods of other generations.

The common view of ageing is that older adults place a burden on society by, for instance, overloading healthcare systems, national pension funds and employer budgets. Yet the paid and unpaid (e.g. childcare) contributions of older people equal or surpass the costs of caring for

older adults. Older people drive economies and, as one example, they are responsible for over half of consumer dollars spent in the United States.[5] Furthermore, people over the age of 50 contribute more than $745 billion to the US economy in the form of volunteering, caregiving and childcare.

Undervaluing the economic and social contributions of older adults is itself a form of ageism and does a disservice to struggling economies that can benefit from gains in health and longevity.

Key takeaways

- Prejudices have led to clear and routine acts of discrimination. Myths about older adults are at the root of policies and decisions that violate their human rights and threaten their livelihood and well-being.
- Places of work, living environments and healthcare systems must all be reoriented to reflect the diversity of older adults' individual needs and life circumstances.
- Ageism is multidimensional and intersectional. It is impossible to address ageism without taking on the discrimination and inequities that older adults face based on race, gender or sexual orientation.
- Contrary to ageist myths, older adults have a vital role to play now more than ever. They bring experience, knowledge and social capital to present-day challenges and are therefore vital to the reopening of economies as well as in redesigning and reimagining the future of work, and in educating children and supporting families.

A dose of optimism: looking to the future

The global community has a role and a responsibility to combat ageism, which is the single most impenetrable barrier to the pursuit of healthy ageing. We believe actions must include the following:

1. Revise the narrative and discourse on ageism towards human rights and dignity. Older people are not a homogenous group; they are a diverse group in terms of health, functioning and the resources available to them. Their rights should not diminish with age.
2. Recognize older people as essential members of society; they bring experience and expertise invaluable to future generations. Their role is a core component of family, community and national economies, particularly as the world continues to live with COVID-19.
3. Acknowledge and confront ageism's intersectionality with gender, culture, race and sexual orientation.
4. Urge a UN Convention on the Rights of Older People that addresses structural barriers and lays the groundwork for improved national, legal, economic and social frameworks and protections for older adults.
5. Strengthen intergenerational solidarity in workplaces and in society, bridging the technological divide and working with community organizations.
6. Challenge our own biases towards ageing, including the language we use and the assumptions we make about older adults.

While ageism is at the root of many challenges that accompany COVID-19 policies for older adults, it existed long before the pandemic. There is, however, also cause for optimism in the longer term. This global pandemic has forced health systems and individuals to focus on prevention, while creating new-found understanding of the critical importance of investing in public health. Companies and societies have demonstrated innovation in enabling human connection, conducting business and supporting and strengthening care systems. Mental health has risen to the forefront of public consciousness and emerged as a health priority, while digital inclusion is recognized as a necessary tool for reducing social isolation.

At the centre of all the promise of solutions, however, is the need to address ageism as older individuals are, in many instances, most vulnerable to the related challenges. If ageism is not tackled as a priority, meaningful progress in these areas will be stymied. There is an opportunity for health systems, workplaces, civil service organizations and the private sector to collaborate and innovate, ensuring that the diverse needs and perspectives of older adults are central to informing and crafting policy that influences societal change.

3.2 Converging pandemics: isolation and loneliness

Social isolation and loneliness are separate concepts. Social isolation is the lack of social interaction. Loneliness, by contrast, is a subjective pain due to a lack of meaningful and satisfying relationships – including the absence of a close confidant, satisfying relationships and connections with family and friends, a valued connection to meaning and purpose in society and a contribution to the public good. Loneliness has a significant negative impact on a person's physical and cognitive health, increasing the risk of anxiety, depression and suicide acutely, and increasing the risk of cardiovascular disease. Importantly, loneliness doesn't discriminate. It can affect any age group, with young people in many countries reporting high levels of feeling lonely. Loneliness has obvious implications as communities around the world navigate the challenges of COVID-19.

A pandemic within the pandemic

The COVID-19 pandemic has heightened loneliness in virtually every adult age group. For older adults, loneliness combines and overlaps with the pandemic's other threats, including "precariousness" (threats to jobs, income, food, housing and the necessities of life); enforced isolation from quarantine and other coronavirus-related measures; ageist assertions that devalue older adults and suggest they are to blame for others' precariousness; and the moral distress of not being able to be with loved ones who are ill with COVID-19 or in quarantine. Specific COVID-related impacts on older adults in lockdown include higher rates of forgetfulness and functional decline.

Moreover, ageist discrimination and exclusion can exacerbate loneliness and the threat of COVID. This is worsened in the case of marginalized groups. For example, the rates of pre-existing chronic diseases are higher in older adults who have been discriminated against or who have fewer resources and access to healthcare. In addition, as participants in the COVID and Ageing Society Virtual Dialogue Series symposium discussed, there is evidence that older LGBT adults are more likely to be estranged from their families of origin, as well as community institutions such as churches, meaning that they have fewer sources of social support. This can place them at higher risk of loneliness and isolation in the context of COVID-19.

There are also greater risks of material deprivation due to higher rates of poverty and homelessness. Furthermore, this community faces increased levels of underlying conditions such as HIV/AIDS and diabetes. As a result, it is unsurprising that older LGBT people – especially LGBT people of colour – have been hospitalized and are dying at higher rates. The SAGE programme in the US is using digital programming to combat such isolation but is also aware that many older adults may struggle with accessing technology.[6]

Technology, in fact, can be a significant part of the solution in addressing loneliness more generally. Solutions for both isolation and loneliness need to involve increasing access to technology for all older adults, combined with training so that people gain confidence in their technical skills. In addition, the onus shouldn't simply be on the individual to learn digital skills; rather, it should be the responsibility of service providers to offer a variety of different options that do not exclude older adults.

Technology is not the only way to keep older adults engaged. In Zimbabwe (where older people often live with extended family and offer advice to younger generations) and other low- and middle-income countries, traditional cultural practices can provide more affirming narratives and roles that have a positive impact on mental health. Even in areas that do not have a lot of economic resources, culture and community are powerful tools in fostering a sense of social connection. Symposium participants also emphasized that older adults are typically the most active volunteers in their local communities, so creating safe ways for them to continue their engagement will enable a critical form of social participation that both serves the community and allays loneliness and strengthens connections.

Key takeaways

- Social isolation and loneliness are two distinct phenomena. Someone who is socially isolated may not necessarily feel lonely.
- Loneliness is an experience stemming from the absence of meaningful interaction, while social isolation is about frequency of interaction. An individual can be socially connected but feel lonely due to lack of meaningful and satisfying social interactions and/or relationships.
- Loneliness doesn't discriminate and is highly prevalent. Loneliness is experienced by people of all ages. It is a myth that everyone who is lonely is old, and that everyone who is old is lonely.
- COVID-19 has exacerbated the rising experience of loneliness and precariousness in adults.
- Social connections between generations are vital.
- Ageism limits our ability to value the older members of the population and their important contributions. Viewing older adults only in terms of support and dependency needs devalues them and worsens exclusion and loneliness.
- Universal digital connection is essential and it needs to be truly universal – that is, available to all, analogous to public transport.
- The best solutions to loneliness and isolation encourage social participation, connectedness and a sense of belonging. Solutions that create the sustained infrastructure to bring people together with shared purpose and values will be the ones that strengthen resilience and combat loneliness and isolation – as well as precariousness – in future pandemics.
- Virtual doesn't mean it has to be on screen. There is a need for innovative virtual solutions that help and encourage social participation. We should explore repurposing and reviving the use of simple and existing tools such as telephones, radio, TV programming and volunteering opportunities. Assuring internet access for all should be a public good, like other public utilities. These tools can address issues of digital access and ensure older adults have multiple options for maintaining social connections and participation.

Complex challenge = multipronged approach

Given that the pandemic has exacerbated pre-existing risks for loneliness and isolation, numerous actions need to be deployed to address the increased threat. Proposed solutions include resolving ageist narratives that are inaccurate, devaluing and isolating for older adults; finding ways to create universal access to technology and digital education; creating local approaches to identify at-risk and precarious older adults and provide support, even in isolation; developing methods to strengthen the essential bonds in communities that create social capital and intergenerational solidarity; and creating new roles for older adults that tap into their enormous desire, as well as that of people of all ages, to contribute to solutions, even if they are physically isolated due to COVID-19 risks.

Importantly, although internet access and digital literacy are very important, there are also other ways to address loneliness and isolation – including using

older technologies, such as traditional telephones – that combine both low- and high-tech approaches. Moreover, while older adults often require support, programmes should not fall into the trap of reinforcing ageist stereotypes of dependency. We need to develop new ways to protect vulnerable groups, including older adults, without isolating them for long periods. Furthermore, solutions should focus on participants' sense of agency and their capabilities to contribute. Meeting the universal and deep-seated need for meaning and purpose is an important way to solve loneliness and meet generative goals.

3.3 Home and community-based care

With COVID-19 putting limitations on healthcare services delivered in hospital settings and continuing to ravage nursing homes, the pandemic has turned a spotlight on homes and communities as being among the safest places to receive care in many cases. Home and community care comprises care delivered at home and in settings such as day care and activity centres. These care models, in fact, have always been an important and preferred way of supporting people as they age because they allow people to remain in familiar environments, surrounded by their loved ones, and allow elderly people to continue to engage with a wider variety of people as well as participate in a broader spectrum of activities. Now, during the pandemic, such care models have shown another benefit: They have seen fewer elderly mortalities compared to institutional environments that have proven vulnerable to runaway infection rates.

Particularly with advancing technologies, home and community care has the potential to play an even greater role in services and support for older individuals globally, both during and after the pandemic, in achieving better health outcomes and national resilience.

Crucial role: past, present, future

During the pandemic, there has been greater appreciation of family caregivers as crucial members of the home care workforce. Family caregivers must receive the appropriate support if they are to continue to be part of the solution as care is provided to ageing populations, particularly during the current crisis. Notably, in lower- and middle-income countries such as Jamaica, where multigenerational family structures are the norm, strong family structures allowed an early preventative approach to COVID-19.

Community care also plays an important role in harnessing the strengths of older adults and ensuring the resilience of a population against future disasters. Community care models, such as Ibasho in Japan (*ibasho* means "a place where you can feel like yourself"), that enable elders to participate in organizing and providing care, help to shift the narrative away from the victimhood of older people towards recognizing them as valuable resources for their communities.[7] Strengthening the social capital of older adults is essential for them to thrive in their homes and communities.

The emergence of new uses of technology has also created positive developments. Telemedicine allows the provision of the right care, at the right time, in the right place. With COVID-19, we have seen the rapid acceleration of virtual solutions to protect older adults and manage chronic diseases at home, as well as allowing older people to remain socially engaged and guard against loneliness.

Tapping the potential of such technology requires consideration of several issues. Integration and interoperability between electronic medical record systems of different providers are essential to providing healthcare workers with the relevant information to care for older adults at home. Technologies must also be designed to address the needs of older adults, families and front-line care workers. Adequate training must be provided to all users in order to ensure adoption.

With the acceleration of technology also comes the issue of the digital divide – be it between countries and communities with varying levels of resources, or older people with different economic backgrounds, or with different physical and mental capabilities. We must be aware of the challenges presented by virtual solutions, especially the implications for access to health and healthcare for people who need it the most.

The built environment is another critical factor that affects health and well-being at home. It can promote and encourage healthy habits and lifestyles and plays a critical role in shaping how and where people interact and decisions on whether to age in place (i.e. in their own homes and communities). Well-designed home and community spaces can enable older adults to maintain their independence, reduce trips to the hospital, have easy access to transport and integrated age-related services, remain socially engaged and feel safe and secure.

As home and community-based care evolves, what it looks like will differ across geographies. This will be shaped by local cultures, norms and assets. In countries with no formal systems of community care, an adaptive shift is happening. For example, in some parts of the Caribbean, people are working to develop practical training to educate family members to deliver care to their loved ones. There is, indeed, an opportunity here for local solutions to be shared globally.

Overall, what is important is that as older adults choose to age in place, we must ensure that they have access and options to choose spaces that enable them to live longer, happier and more fulfilled lives.

Key takeaways

1. Home and community care will look different across different geographies and cultures. There is much that we can learn from other countries, as the world seeks more people-centred options for eldercare.

2. Focusing on the needs of the individuals receiving care and their caregivers is the key to unifying multiple stakeholders in home and community care settings.

3. Multidisciplinary approaches towards determining a person's care needs and package of services, undergirded by joint financing mechanisms that integrate both health and social care providers, can provide more comprehensive, scalable, cost-effective and higher-quality care to older people.

4. In designing home and community care for older people, we also need to mitigate the risk of social isolation and loneliness, and guard against over-medicalizing their needs.

5. Technology (both high-tech and low-tech) can play a big role in delivering healthcare and connecting people. However, we need to be careful about issues such as privacy, data security, the digital divide, and the interoperability and usability of systems by older people and care staff.

6. We also need to pay greater attention to the needs of the home and community care workforce, such as training needs and the need for protection, to better enable them to fulfil their roles as important contributors to the healthcare system.

An investment need and opportunity

Despite its importance, home and community care has hitherto not received enough attention from governments and health systems. While home and community care has long been crucial to the broader system, the COVID-19 period has shown that these settings have the potential to significantly buttress healthcare delivery, even during crises, by ensuring that care can continue while institutional health facilities threaten to be overwhelmed. For many people with less acute care needs, this should be the preferred model because it brings better outcomes at lower costs. As countries learn lessons from COVID-19, more attention should be paid to designing national health systems with a strong, integrated home and community care element, and more resources should be devoted to building and enhancing this model of care.

3.4 Long-term care facilities

Tragically, COVID-19 has disproportionately harmed older adults around the globe, especially those residing in long-term care facilities. Many deaths in our senior populations caused by this global pandemic have occurred in such facilities. In connection with that vulnerability, social isolation has increased for facility residents.

Yet challenges within long-term care structures existed prior to this global pandemic. COVID-19 has only amplified and accelerated the urgent need to revamp and improve the care provided to our ageing populations by these facilities.

Key takeaways

To improve long-term care delivered by facilities in the future, we must take the following steps around the globe:

- Increased collaboration is vital. A consistent theme, throughout not only this discussion but all of the conversations held in the COVID and Ageing Society Virtual Dialogue Series, is the need for collaboration globally – across countries and sectors. Our dialogue series spotlighted facilities that are effectively protecting their residents and empowering their workforce, and countries that are evolving regulations for long-term care facilities in impactful ways. As more of these best practices emerge, we need to develop better methods for sharing these successes with leadership across the public, private and social sectors. This summary report is one method of advancing that collaboration.

- Consistent data reporting is crucial. As with so many challenges in healthcare and social care systems, the need for accurate and transparent data reporting emerged in relation to long-term care facilities during this global pandemic. Specifically, the lack of consistent reporting across facilities and across countries has hindered our ability to fully understand the impact of COVID-19 on residents. To advance transparency and the best interventions within long-term care, we must develop consistent reporting requirements throughout the industry and across countries. Harmonization of reporting would include implementation of surveillance systems to ensure proper reporting of new infections, "hotspot" identification, better monitoring and effective mechanisms to reduce transmission of infectious diseases, including COVID-19.

- A key factor is workforce empowerment. A critical component of improving long-term care facilities and their care delivery is to better empower, support and protect the long-term care workforce. We must effectively train and adequately compensate carers. By advancing both better compensation and training in this field, we will create a more stable workforce. Additionally, it is imperative that long-term care facility workers can remain in a consistent setting with one employer rather than having to work for multiple employers, reducing the risk of transmission across facilities. Taking all such actions will not only improve the lives of care workers but also improve the quality of care delivered to older populations living in these facilities. This outcome has been demonstrated in facilities in Canada and Australia, where the focus has been on improving career pathways, advancement opportunities, comparable pay and other benefits to carers in long-term care facilities.

- Implementing safety protocols for the long-term care residents and the workforce is needed. The safety of long-term care residents and the workforce is paramount. Facilities must have access to adequate personal protective equipment (PPE) and make it readily available to staff. Carers must be provided with proper and ongoing training to ensure they have up-to-date knowledge on how to wear PPE and how to reduce infections for themselves and the residents they are supporting. Additionally, facilities should implement mandatory testing for their workforce and residents, along with ensuring basic infection control protocols are in place. Quarantining those who are sick is also a critical step that a facility must take. Regulations that advance these safety measures will improve the care provided to residents of long-term care facilities along with the safety of their workforce. Lastly, governments need to help provide financial support for, and emergency distribution of, safety equipment earlier on for these facilities – as many governments did in acute care settings. Adhering to unfunded mandates of this magnitude is not feasible for many long-term care facilities.

- We must improve the integration of long-term care and healthcare systems. A consistent theme across our dialogue series was the need for better integration of long-term care providers, including facilities, with healthcare systems. By acknowledging that long-term care providers are an essential part of the healthcare ecosystem, we can provide more holistic care to ageing populations and better monitor the quality of care provided within these facilities. Additionally, with better integration comes better data reporting and increased communication across all providers. This will ultimately yield better care and improved outcomes.

- We need to make use of technology solutions. COVID-19 has increased the advancement of virtual care as a viable solution for supporting the healthcare and long-term care needs of our ageing populations. Facilities with long-standing commitments to integrating technology within their care approach have been able to effectively deliver both care and critical social and recreational programming to residents throughout the global pandemic. We must acknowledge and advance the essential role that technology plays in the delivery of care, including its use within facilities of reporting data, supporting ongoing training, measuring and tracking vitals, offering engagement to residents and empowering social connections for our ageing populations and their loved ones.

- Improving social connectedness is crucial. One of the biggest challenges facing residents of long-term care facilities is a lack of social engagement. Sadly, due to COVID-19, social isolation among older populations has increased, especially for those in facilities, as

their ability to interact with loved ones has been limited through quarantines and other facility policies. Within facilities, we must strike a balance of keeping residents safe while ensuring they can maintain valuable social connections. One way to do this is through technology. By enabling residents to have access to technology resources, they are better able to connect with their loved ones. Workers should be trained to support residents' use of technology, so carers can help strengthen those social connections that are so critical to mental and physical health.

– We need to develop effective regulation. Regulation repeatedly arose as a crucial way to ensure that long-term care facilities take the necessary steps to protect and support their residents and workforce. One key aspect to this regulation, however, is that it should focus on rewarding and incentivizing continual quality improvement rather than be positioned as a vehicle to punish for lack of compliance. There is a belief that developing an incentive-based regulatory framework that advances best practices, such as those being shared here, will yield higher compliance and greater collaboration among government and long-term care providers.

Coming out stronger

COVID-19 has shone a light on the significant challenges existing within long-term care facilities, as it has done with so many aspects of our world. There is hope that, through the tragedy of this pandemic and by integrating the recommendations herein, we will improve our global approach to long-term care and the way we care for our ageing populations will emerge stronger and better than before.

3.5 Impact of COVID-19 on older adults in low- and middle-income countries (LMICs)

As the UN Secretary-General, António Guterres, has stated, “We have been brought to our knees by a microscopic virus.” Something that started as a global health crisis has morphed into an economic crisis, then a social crisis and it is now moving into a security crisis. Hardest hit by the economic impact of COVID-19 will be poorer countries. For many of them, the repercussions from the virus are “worse than the financial crisis of 2008” and, for Latin America, “worse than the debt crisis of the 1980s”, according to the President of the World Bank, David Malpass. The prospect of people going hungry, he said, is “gravely concerning”.

By September, eight out of the 10 countries registering the highest number of new coronavirus infections were lower- and middle-income countries (LMICs) that are home to 6.5 billion people – 80% of humanity. South and Central America have become global epicentres of the pandemic and expert predictions are that Africa may be next in line. Decades-long progress towards eradicating poverty in many LMICs has been undermined in a matter of months. Worse is likely to be still ahead.

Inequalities, higher health risks exposed

Although far from a heterogeneous grouping, populations of many LMICs share low confidence in their public and political institutions and poor scientific and health literacy. Some nations, such as 12 out of the 22 Arab countries, were in some sort of emergency or chronic humanitarian crisis prior to the pandemic. According to the International Monetary Fund, over half of LMICs entered the COVID-19 crisis with high public debt levels.

As in all regions of the world, COVID-19 is feeding on inequality, yet it is the widespread and often extreme inequalities in many LMICs that have presented the coronavirus with greater opportunity to cause harm. There have been enormous differences in the responses to COVID-19 across the LMICs, however, that have produced very different outcomes – ranging from impressive containment and few deaths in countries such as Malaysia, Thailand, Uruguay and Vietnam, to runaway contagion and very high levels of mortality in countries such as Brazil, Mexico and Peru.

COVID-19 has exposed the falsehood that we are all in this together – or at least, that we are in this together on the same terms. Age is the single most powerful predictor of negative outcomes from the coronavirus. Globally, the mortality rate for older people is around 12% compared to 1% for younger people. Clearly, biology plays a part, but the coronavirus has also laid bare the fault lines that have been ignored for decades – inadequate healthcare systems, major gaps in social protection and the structural inequalities that create differentiated outcomes. Almost 70% of the global older population live in LMICs. Many of them cannot easily avoid daily exposure to the virus because they often live in overcrowded, multigenerational households and have no choice but to continue to work (often in the precarious informal sector) well beyond “retirement age”.

Chronological age, however, is only part of the story. Health risks endemic to poor communities such as cardiovascular disease (CVD), diabetes, chronic obstructive pulmonary disease (COPD) and hypertension mean larger numbers of younger people in LMICs have greater susceptibility to COVID-19 in comparison to high-income countries. In Brazil, for example, up to one in three coronavirus deaths are younger adults from poor communities. In all parts of the world, poor people age prematurely. In most LMICs, the pool of poor people and therefore the pool of the prematurely aged, is much larger. Social determinants produce a much wider range of outcomes within LMICs. The variables of race, gender, migration status and Indigenous identification make them even more pronounced.

Healthcare coverage is insufficient in most LMICs in normal times and the surge capacity is limited. Access barriers to health and social care for older individuals are widespread. There is a long way to go in terms of mainstreaming ageing and older people into planning and delivery. Historically, both the prevention and management of non-communicable diseases (NCDs) have not been prioritised, leading to greater vulnerabilities to COVID-19. The even-further reduced focus on NCDs brought about by the coronavirus pandemic is creating enormous collateral damage. Unsurprisingly, the rates of people living with disability are higher in LMICs than in high-income countries. Social care, when available, often exists as a separate and under-resourced resource, while quality mental health and palliative care are poorly integrated into the public health system. Recurrent ageism fuels the neglect and is reinforced in the dismissive messaging from some prominent political leaders. Mounting evidence suggests an increased incidence of elder abuse (including financial abuse) across most LMICs during the pandemic.

Key takeaways

1. Eight out of the 10 countries currently registering the highest number of COVID-19 cases are LMICs.

2. Age is the single most powerful predictor of negative outcomes from the coronavirus. Almost 70% of the global older population reside in LMICs. Many of them cannot easily avoid daily environmental exposure to the virus because they often live in overcrowded, multigenerational households and have no choice but to work (often in the precarious informal sector) well beyond "retirement age".

3. In all regions of the world, COVID-19 is feeding on inequalities, but the widespread and extreme inequalities in many LMICs have presented the coronavirus with even greater opportunity to cause harm.

4. COVID-19 has provided a stark reminder of the indivisibility of the health, social and economic silos common in LMICs.

5. There is a need for both short- and long-term strategies that build health literacy and community trust, explicitly address equity and create lasting mechanisms to share good practice and amplify key messages.

6. There must be much greater consideration of the wide range of life-course trajectories and cumulative inequalities that lead to very different susceptibilities in older age. This means taking robust action on environmental and educational fronts across all life courses and strengthening public infrastructures.

7. While older people are more vulnerable, it is well established that after any crisis they can and must play a critical role in reconstruction. They are vulnerable yet resilient.

8. The pandemic will be defeated only when it is defeated everywhere.

People and communities first

COVID-19 has produced a stark reminder of the connectedness of both groups and nations, and demonstrated the actual indivisibility of otherwise separate health, social and economic systems. It has highlighted the links between food production, environmental degradation, housing, sanitation, and racial, gender, income and occupational disparity. It is also a likely harbinger of future pandemics. Climate change, incursions into uninhabited regions sheltering potentially threatening microorganisms, and abusive use of antibiotics in animal farming near densely populated areas are all cause for great concern.

The pandemic has alerted us to the need to put people and their communities at the very centre of any crisis response efforts. In the absence of rapid and effective national responses, the best actions in LMICs have been local. The LMICs that have quickly mobilized community health workers have seen the greatest successes. These measures need to be supported, reinforced and scaled up in all countries. Many LMICs have been able to reactivate systems established after previous infectious disease outbreaks and build on a strong citizen mobilization. There is a need for both short- and long-term strategies that consolidate health literacy and community trust, explicitly address equity and create lasting mechanisms to share good practice and amplify key messages. Where there is no trust, there is fear – and misbehaviour.

We need inclusive systems that do not marginalize others. Older people must be fully integrated into all social, economic and humanitarian responses – both nationally and internationally. While they are more vulnerable, it is well-established that after any crisis, older people play a critical role in reconstruction. They are vulnerable yet resilient. Thus, we need a vision for *all* ages. We cannot frame this as a conflict between younger and older generations. The intersectionality of generations is more important now than ever. We must consider the wide range of life-course trajectories and the cumulative inequalities that lead to the very different susceptibilities in older age. This means taking robust action on environmental and educational fronts across all life courses and strengthening public infrastructures.

We need the strong collaboration of intergovernmental and civil society organizations and more imagination in our public-private partnerships. We also need to strengthen a rights-based approach to policies on ageing at all levels. Renewed focus must be given to the UN 2030 Sustainable Development Goals. There must be more collective action in all areas of research, development and implementation. The World Bank, the IMF and others have aptly called for more ambitious debt relief plans and more transparent borrowing arrangements for poorer countries.

As observed by Albert Camus in his 1947 novel, *The Plague*, "It may seem like a ridiculous idea, but the only way to fight a plague is with decency." The time is now for a large dose of decency.

Conclusion: themes define actions

Across all five sessions of the COVID and Ageing Society Virtual Dialogue Series, certain themes remained constant. Through those themes emerged crucial next steps needed in ongoing efforts to better protect older people from COVID-19 and ensure their health and well-being in the future.

First, ageism in all its forms must be eradicated both in COVID-19 responses and in broader health and social systems. Not only does ageism lead to highly discriminatory practices towards older people, thereby worsening their health outcomes, its harm can also be exacerbated by other identifiers such as ethnicity, gender, sexual orientation and socioeconomic status. In fact, as the proportion of older adults in the world population grows, ageing should be mainstreamed into care planning and delivery.

Second, older people themselves must be at the centre of collective action and change. When older individuals are valued and included in creating solutions, the entire community grows more resilient against future disasters. Age-inclusive spaces are also an excellent way to guard against social isolation and loneliness and keep people physically and mentally engaged as they age.

Third, those at the front lines of health and social care must be better valued and supported. From family caregivers in the home and community to healthcare workers in long-term care facilities, the care workforce must receive adequate training and compensation and be protected through sound safety regulations and protocols. A safe and stable care workforce is critical to ensuring the well-being of older people.

Fourth, there needs to be greater collaboration among stakeholders across the public, private and social sectors for sustainable solutions in aged care during and post-COVID. This dialogue series and its recommendations, having been informed and enriched by the perspectives of experts from multiple sectors, represents this kind of collaboration.

These commitments will go a long way to ensuring that responses to COVID-19 are informed, inclusive and targeted, and that action is taken at all levels to protect the rights and dignity of older people.

> **Now is the time for global leaders to decide: Will we succumb to chaos, division and inequality? Or will we right the wrongs of the past and move forward together, for the good of all?**
>
> Antonio Guterres, Secretary-General of the United Nations

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