AgeFLAG Project

Joint report on national needs and priorities to improve health and well-being of the ageing population in the Baltic Sea Region

Collected through national needs assessments held in Estonia, Finland, Latvia, Lithuania, Poland, Russia and Sweden

Conducted between
11 March and 10 December 2020

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1. Background

It has become evident to the Expert Groups of the Northern Dimension Partnership in Public Health and Social Well-being (NDPHS) and other NDPHS actors that active and healthy ageing is a cross-cutting theme that touches upon all of the Partnership's focus areas. Considering this wide relevance to the work of nearly all of the Expert Groups, there has been a call for horizontal action that tackles the challenges of the ageing population. In 2018, several planning workshops were carried out using the logic framework approach for the development of project ideas for this horizontal action. The current project, namely "Roadmap to improve the health and well-being of the ageing population in the Baltic Sea Region (AgeFLAG)", is the outcome of these workshops. It seeks to identify the most important issues in relation to active and healthy ageing that countries in the region are facing. For this purpose, the project partners in Estonia, Finland, Latvia, Lithuania, Poland, Russia and Sweden organised national needs assessments in 2020. The consortium of partners was formed from regional stakeholders with a mandate to work with policies surrounding the topic of ageing. They expressed strong interest as well as demonstrated capacity in contributing to the development of the Roadmap for a Flagship project on active and healthy ageing. The list of our partners and their roles in the partner countries can be found from Annex I. The workshops and other methods of needs assessments that were held in the aforementioned countries have fed into this joint report, which will guide the partners' efforts to develop common solutions through cross-border cooperation.

1.1 Note on terminology

The AgeFLAG project focuses on healthy ageing and the current challenges and needs for supporting this process in the Northern Dimension area. Considering the breadth of the concept and its central role in the project, some conceptual clarifications and definitions are in order. The WHO defines Healthy Ageing "as the process of developing and maintaining the **functional ability** that enables **wellbeing** in older age"[1]. Functional ability refers to the capabilities that allow people to be and do the things they value, for example, meeting the basic needs, to learn, grow and make decisions, to be mobile, to build and maintain relationships, and to contribute to society.

According to the WHO, "functional ability is made up of the intrinsic capacity of the individual, relevant environmental characteristics and the interaction between them"[2]. Intrinsic capacity refers to mental and physical capacities that are essential for basic functions, such as walking, talking, seeing and remembering. The presence of diseases, injuries and age-related changes may compromise the level of intrinsic capacity. In addition to the intrinsic capacity, the surrounding environments, including home, community and broader society, and all factors within them, such as the physical aspects of space, people and their relationships,

[1] The World Health Organisation. "Ageing: Healthy Ageing and Functional Ability". WHO.int. https://www.who.int/news-room/q-a-detail/ageing-healthy-ageing-and-functional-ability (accessed January 8, 2021)
[2] Ibid.

attitudes and values, health and social policies, the systems that support them and the services implemented, influence functional capacity. An environment that supports intrinsic capacity and functional ability is essential for healthy ageing. Wellbeing is considered in the broadest sense to include domains such as happiness, satisfaction and fulfilment in life.

2. Aim of the national needs assessments

The aim of the national needs assessments was to bring together the most relevant national stakeholders to identify the *top five* national needs of each country that should be addressed to improve active and healthy ageing. Initially, the needs assessments were planned in a workshop format. However, due to COVID-19 restrictions, other methods of online meetings or alternative methods of collecting the required information and input were developed and implemented.

The needs assessments were conducted between March and December 2020. The majority of them (Estonia, Finland, Latvia, Lithuania, Poland and Sweden) were conducted online due to the restrictions of physical meetings related to the COVID-19 pandemic. The only workshop that could be carried out in person was held in Russia on 11 March 2020 before the COVID-19 restrictions were enforced.

The participants were suggested to approach healthy ageing through either preventive, supportive or integrative approach of both preventive and supportive aspects. While the preventive approach focuses on preventing the deterioration of health and wellbeing among older adults, the supportive approach stresses support for those who have already experienced deteriorating health and wellbeing. Poland, Latvia, Lithuania, Russia and Sweden focused on both prevention and support primarily among the post-retirement age group. While Finland also focused on both aspects, it also considered the preparedness for ageing and crises, such as the COVID-19 pandemic, among older adults. Estonia opted to focus on prevention among the pre-retirement age group (50-65 -year-olds) specifically.

Germany and Norway were consulted online about their national needs for improving active and healthy ageing after the synthesis and analysis of results from the workshops conducted in Estonia, Finland, Latvia, Lithuania, Poland, Russia and Sweden.

3. Facts and figures about health, wellbeing and ageing in the Baltic Sea Region

The topic of active and healthy ageing is more relevant in the 2020s than ever before. The life expectancy rate is increasing throughout the world, also in the Northern Dimension area. According to the World Bank data[3], the life expectancy rate at birth, which estimates the number of years a new-born would be expected to live if the mortality patterns at the time of birth would remain constant throughout the life, was

[3] The World Bank. *Life expectancy at birth, total (years).* Distributed by World Development Indicators. https://databank.worldbank.org/reports.aspx?source=2&series=SP.DYN.LE00.IN&country= (accessed January 12, 2021).

72,6 years on average in the region (including Germany and Norway) in 1990. As of 2018, the life expectancy at birth has increased by six years, standing at 78,6 years, indicating that people are generally living significantly longer than only 30 years ago. As presented in Figure 1, this trend is present in all project countries with the biggest change having occurred in Estonia with nearly a nine-year increase in life expectancy and the smallest in Russia with a change of just under four years.

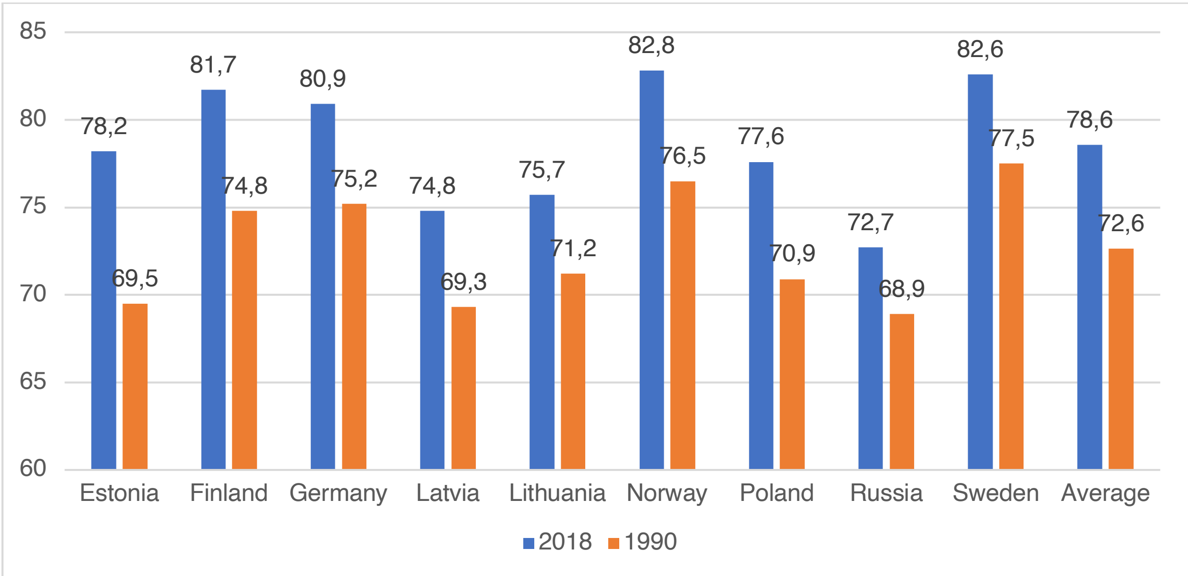

Figure 1. The life expectancy in years in 2018 compared to 1990 per project country.

Simultaneously, the share of older adults in the population and the older age dependency ratio is increasing, indicating an ageing population. According to the World Bank data[4] from 2019, on average almost a fifth (19,4%) of the population in each country of the Northern Dimension area was aged 65 and above. This share has rapidly increased since 1990 when old adults made up 13,0% of the population in the region. With the old age dependency ratio standing at 30,3%, for every two working-aged people, there currently is roughly one dependent older adult. The population has, thus, aged in the past 30 years. This trend is also expected to continue in the near future. It is prospected that, in 2030, 27,4% of the population in the region are aged 65 or older and that, with the old age dependency ratio at 51,5%, for every one working-aged person there is one dependent older adult[5]. Therefore, the region is currently experiencing a significant societal and demographic transformation. The rapid increase in the share of older adults aged 65 and above is demonstrated in Figure 2.

[4] The World Bank. *Population ages 65 and above (% of total population).* Distributed by World Development Indicators.
https://databank.worldbank.org/reports.aspx?source=2&series=SP.POP.65UP.TO.ZS&country= (accessed January 12, 2021).
[5] United Nations Department of Economic and Social Affairs. *World Population Ageing 2019.* New York: United Nations, 2020.

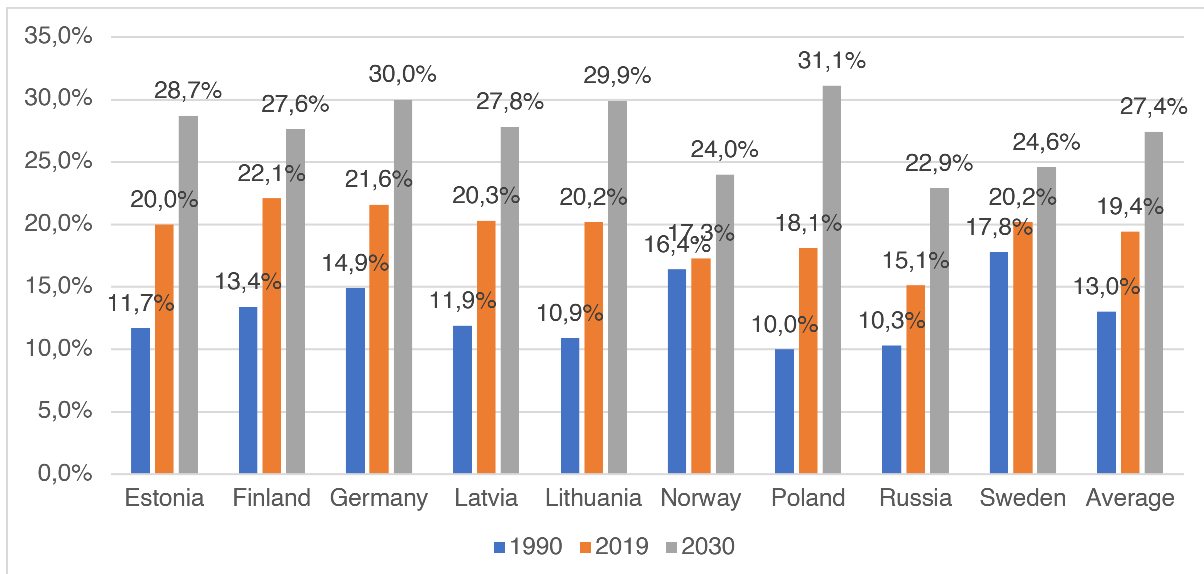

Figure 2. The share of older adults aged 65 and above in the population in 2019, 1990 and 2030.

Currently, a 60-year-old in the region can expect to live longer than ever before. According to the most recent data retrieved from the Global Health Observatory[6], currently people aged 60 still have 22,6 years ahead of them with 17,2 of them in "full health" on average. This corresponds to 5,4 years lived with some form of morbidity or disability at an old age[7]. A well-functioning health care and social system that is prepared for meeting the complex needs of older adults is a cornerstone for an appropriate response to the ageing society. With this demographic change in mind, this project seeks to identify the most acute regional needs regarding healthy ageing and to prepare for joint future activity for improving the health and wellbeing of older adults in the Northern Dimension area.

4. Participants

The partners were free to choose the participants in their workshops, which resulted in a wide variety of sectors and institutions being represented. More information about the participants in each workshop can be found from the table below:

[6] The World Health Organisation. *Life expectancy and healthy life expectancy*. Distributed by the Global Health Observatory. https://www.who.int/data/gho/data/themes/topics/indicator-groups/indicator-group-details/GHO/life-expectancy-and-healthy-life-expectancy (accessed January 14, 2021).

[7] Despite small country differences, the years lived with morbidities at an older age are closely dispersed around the average with the highest at 6,2 years and the lowest at 4,9.

Country	Number of participants	Institutions and sectors represented
Estonia	21	• Government institutions, such as the Ministry of Social Affairs and the Government's Office; • Local day centres and nursing homes; • Education and activity providers, such as libraries, veteran sports associations and the Association of Non-Formal Education; • Non-governmental dementia competence centre; • Universities and research organisations.
Finland	28	• Older people's service providers from the public and private sectors; • Non-profit organisations representing older adults and pensioners; • Retirement insurance companies and national insurance institutes; • Working groups of the Northern Dimension; • Universities and research organisations.
Latvia	26	• Government institutions, such as the Ministry of Health and the Ministry of Welfare, including institutions subordinate to these ministries; • Local government structural units in charge of public health and welfare issues; • Organisations for senior citizens and pensioners; • NGOs responsible for the provision of health and social services; • Private sector organisations responsible for providing healthcare and social services to the senior citizens; • Universities and research organisations in the fields of health, well-being and technological innovation.
Lithuania	43	• National and local level policymakers, responsible for health and social care, from the Ministry of Health and municipalities; • Social and public health care providers, such as social service centres, hospitals and public health bureaus; • Universities and research organisations; • Umbrella organisations working with older adults, such as the University of Third Age; • NGOs and civil society organisations.
Poland	20	• Government institutions, namely the Ministry of Health and the Ministry of Family, Labour and Social Policy; • The National Institute of Public Health;

		• National, regional and local level actors, such as the Commissioner for Human Rights; • Representatives from the regional government of Mazovia and City Mayors.
Russia	27	• Government institutions, such as the Ministry of Foreign Affairs and the Ministry of Health; • Regional and municipal level policymakers; • The NDPHS Expert Groups; • Medical organisations on the level of top management and GP; • NGOs; • Universities and research organisations.
Sweden	n/a	The exact number of participants in not known, but multiple representatives were consulted from each of the following institutions: • Government agencies, such as the National Board for Health and Welfare, the Public Health Agency and the Swedish Work Environment Authority; • Regional and municipal level policy makers; • Research organisations; • The Council for Elderly Affairs, consisting of representatives from the five largest Pensioners' Organisations in Sweden.

5. Methodology and reflections on the workshops

The workshops were initially designed for physical meetings where the national needs for improving active and healthy ageing could be identified and then prioritised. The following four-step methodology was envisioned for the offline workshops:

1. The participants are presented with the most recent national data and other relevant facts and figures on ageing[8]. The presentations are designed to build a common knowledge basis on the topic.
2. The participants are invited to map all possible needs arising from the topic in the national context.
3. Smaller groups are formed where the participants together seek to identify the needs they consider the most important.
4. In a joint discussion with all the groups present, the top five national priorities are identified.

[8] The general situation in the region is presented in Chapter 3 and Annex II of this report.

Due to the outbreak of the COVID-19 pandemic, all workshops apart from the one conducted in Russia, held before nation-wide restrictions took force, had to be transferred to an online format. The project partners, thus, had to adapt the methodology to meet the needs of online discussion. In the following, each partner's adapted methodology is presented along with some reflections on implementation.

5.1 Estonia

The proposed methodology was transformed into an online format, following the four proposed steps, namely:

1. The participants were presented with the most recent national data and other relevant facts and figures, which provided a common knowledge basis on the topic.
2. The participants were invited to map all possible needs arising from the topic in the national context.
3. Smaller groups were formed where the participants identified the needs they consider the most important.
4. In a joint discussion with all the groups present, the top five national priorities were identified.

Despite some limitations due to technical difficulties and the barriers of online discussion, the workshop was successful and reached its goal of identifying the top five national needs.

5.2 Finland

The workshop was successfully held online. To meet the needs of the Finnish context and the online discussion, the following methodology was used:

1. Together with the invitation to participate in the workshop, the participants received a questionnaire on the most important national challenges/development needs and possibilities for collaboration within the Northern Dimension area before the workshop. In the questionnaire, the invitees were asked to elaborate on the following three thematic needs:
    1. Preparedness for unexpected situations (e.g. pandemics) from the perspective of older adults;
    2. The social and health care services for older adults, and;
    3. The promotion of welfare and health among older adults.
2. Before the workshop, the participants received the most recent national data and other information for review. In addition, a general picture of the challenges and services were presented with the focus on ageing and substance and alcohol use during the workshop.
3. The participants were split into three working groups of 7-8 participants with each group focusing on a specific thematic issue during the workshop. The groups identified relevant needs surrounding the issue and then prioritised three of the

needs they considered the most important. The group work was followed by joint discussion where the chairs of the groups presented in total 11 identified needs. All participants voted on the top five national priorities, using the Mentimeter -application at menti.com.

The participants jointly agreed that the chosen priorities were important. These macro-level topics included a multitude of ways to plan and implement projects based, for example, on the current good practices and projects. The discussion focused on the situation in Finland, although suggestions for improved collaboration in the Northern Dimension area were also discussed during the workshop and presented in the questionnaire circulated before the event.

5.3 Latvia

Instead of organising an online or face-to-face workshop, the four-step methodology was adapted to a single expert survey based on the Delphi method. The following method was used:

1. The most relevant national data and other facts and figures were presented in the cover letter that was sent to the experts prior to the survey.
2. In the survey, the experts were asked to prioritise the needs and constraints that, according to the expert's knowledge and experience, are essential for promoting health and wellbeing of the older adults in Latvia.
3. The data obtained in the survey were translated into a spreadsheet format, and the contents of the replies were analysed by identifying keywords that were inserted into a matrix. Taking also into account the priority level indicated in the responses, the top five national priorities could be identified.

Despite the fact that the survey was conducted in a single round, the results are reasonable and credible, as almost all relevant stakeholders were represented among the participants apart from commercial organisations responsible for health and social services for senior citizens.

5.4 Lithuania

The workshop assumed an online format. The data collection followed a four-step process:

1. Participants were chosen from a wide range of stakeholders, who were divided into five focus groups, consisting of 8-10 participants each, based on their backgrounds and expertise.
2. The participants were presented the most recent information and data on the ageing society and healthy ageing to provide a common understanding of the topic for discussion.

3. Each focus group, with the help of professional facilitators, identified the five most important needs in their focus areas.
4. The facilitators identified the recurring priorities across the groups and compiled a list of 10 priorities selected from the group discussions. All participants jointly voted on the top five priorities as well as on whether prevention or support should be given priority.

The participants were engaged in the discussion and willingly shared their thoughts, ideas and experiences from the practice. After the final polling on the priorities, the participants voiced their disappointment with the outcome of one of the needs, which initially was not selected as one of the five priorities. In further discussion it became evident that this need was considered as a prerequisite for the successful implementation of the five initially prioritised needs.

5.5 Poland

The original workshop that was set to take place on March 19 was cancelled due to a national lockdown imposed a few days before the set date. The methodology was adapted to the following format that allowed remote participation:

1. A letter requesting information on the current needs was sent to as many institutions and stakeholders as possible. The participants were asked to identify needs and to suggest potential solutions for them with particular focus on needs. In addition, they were requested to distinguish between prevention and support in their responses and to prioritise either one of the aspects or both.
2. Based on the replies received, opinion makers that could potentially contribute to fruitful discussion were identified and invited to participate in a series of online meetings.

The information collection via letters was valuable and informative but did not yield any kind of discussion on priorities. To overcome this obstacle, online meetings were held with the opinion makers. However, due to the barriers of online communication, the meetings proved somewhat ineffective, as free and easy exchange of opinions turned out challenging. Thus, the priorities identified remain somewhat inconclusive.

5.6 Russia

The workshop was held physically, following the proposed methodology.

The discussion among the participants was fruitful, leading to more than five proposed priority needs. The participants found it useful to discuss the problems and needs in the field of health and wellbeing among the older population together, as they all represented stakeholders from different sectors and different viewpoints on the issue.

5.7 Sweden

Due to the pandemic, conducting a workshop with the AgeFLAG stakeholders was not possible. Therefore, other ways to reach out to stakeholders in a situation where many of them are burdened with heavy and often stressful workloads and/or work with risk group members were explored. The following method was used:

1. Online meetings were held where information was shared and collected;
2. Stakeholders were asked to contribute in writing, and;
3. The National Board for Health and Welfare assessed the information and identified the priorities.

While this method was the second-best option for the proposed workshops, it enabled identifying the most acute needs in Sweden and, thus, served its purpose.

6. Outcomes: the priorities for action on healthy ageing identified by projects' partners

Based on the national needs assessments, the following priority areas for further action to improve health and wellbeing of the ageing population can be distinguished:

1. Healthy ageing, wellbeing, social environment and social connections;
2. Health, social and integrated care;
3. Education, knowledge and life-long learning; and
4. Labour participation

The top five national needs identified in the partner countries in relation to these four priority areas can be found from Annex III.

6.1 Healthy ageing, wellbeing, social environment and social connections

Considering the ageing population and the subsequent increase in people living with chronic diseases, all the partner countries prioritised the prevention of the deterioration of health and functional ability among older adults. Of particular concern for many participants was the availability of activities that support older adults' physical and mental health. Physical activity is essential, for example, for maintaining the ability to live independently and preventing the development or worsening of many lifestyle-related health conditions. Staying socially active, in turn, helps maintain many cognitive functions and improves mental health. Municipalities and communities should ensure the availability of physical spaces and services for positive social and physical activity. Special attention should be paid to the proximity and accessibility of green areas in residential and rural areas, the presence of interest groups for senior citizens, and the availability of quality active recreational and cultural events.

There is also a need for national policies that support the financial and social security of the older adults in some of the participating countries. Often older adults have

limited and insufficient income to cover their expenses related to subsistence, housing, medicine, social activities and/or medical services. This is problematic both in terms of physical health, as, for example, serious health issues may be neglected due to insufficient funding, and mental wellbeing, since social activities may become inaccessible. Thus, the state should ensure that all older adults have access to sufficient and sustainable financial support for covering their basic needs and encouraging participation in society.

Participants in multiple countries also called for the increased use of supportive technology and the exhaustion of digital solutions in everyday life. Currently, the frequency of the use of technology varies widely among older adults. Many of them struggle with the new technology and, thus, underutilise digital solutions in healthcare and social life. Yet increasing and fostering digital literacy is necessary in a society that is becoming increasingly digital. The use of technology can significantly increase the independence of older adults and support their daily lives, as health and other services become readily available. Furthermore, digital solutions may help tackle loneliness that many older adults struggle with, as connecting with friends and family through digital means can help older adults feel socially connected.

One of the issues hindering active and healthy ageing in many participating countries seems to be ageism – the negative image of ageing in the society. The common attitude that "active lifestyle is meant for youngsters and certain types of people, not me" is destructive for mental health and healthy ageing. Consequently, promoting intergenerational conversation, reducing stigmas around ageing, strengthening social inclusion, generating age-friendly environments and creating a safe space for self-realisation and development are pivotal for encouraging a positive image of self and one's place in society. The provision of affordable socialisation opportunities and improving employment opportunities for older adults are some of the means suggested for fostering the sense of self-worth and preventing ageism. Simultaneously, there is a need for a system that supports the transition from working life to retirement and the social adaptation to the new status as a pensioner.

6.2 Health, social and integrated care

All participating countries also stressed the importance of the availability of and the access to affordable, comprehensive and integrated social and health care services. Of particular concern were the treatment of and care for older adults with multimorbidity and complex care needs, the continuity of care, and personalised care. To improve the existing health and home care services for the older population and to provide targeted and comprehensive care, identifying and analysing care and competence deficits as well as service needs are needed. Moreover, it is necessary to develop and strengthen collaboration among health and care providers. Closer collaboration between healthcare workers can ensure the continuity of care and the availability of specialised services to the clients with complex care needs.

The participants in, for example, Estonia and Russia also voiced out the need for more professional human resources and enhanced training for medical staff who work in a variety of relevant fields, such as mental health, geriatrics, nutrition and rehabilitation. Training is needed for effectively tailoring care for the needs of older adults and for improving guidance for making healthy adjustments to lifestyle. Qualified health care workers and better tailored, supportive care may help develop a social environment supportive of active and healthy ageing at the community level.

6.3 Education, knowledge and life-long learning

Nearly all participating countries called for enhanced education and knowledge-building among older adults. Conceptual development of lifelong learning is needed to encourage continued learning at an older age. More training opportunities, for example, for increasing digital competences, health awareness and communication skills could be beneficial for encouraging active ageing. These opportunities should be provided with the target audience of older adults kept in mind, recognising the special needs of this age group, for example, in terms of reciprocal learning.

Improving health literacy was also prioritised in, for example, Russia and Poland. As older adults are fundamentally responsible for their lifestyles and ageing process, guidance and support for making informed lifestyle choices are needed. Age-friendly resources where older people can easily access evidence-based advice could help them make informed choices about which measures to take to preserve health and advance their wellbeing. Improving digital literacy is an important aspect of increasing health literacy, as it is pivotal for accessing information online and assessing its reliability.

6.4. Labour participation

Many of the participating countries also highlighted the importance of labour participation among the older people. Continued work among the older people even past the retirement age is beneficial for the seniors themselves as well as for the employers, who benefit from the experience and knowledge of the older workers. It also benefits the society as a whole, as the work of the senior citizens contributes to increase in GDP. Moreover, working and, thus, contributing to a community, allows the older adults to maintain social contacts and feel useful while enhancing intergenerational ties. In many cases, it makes life more meaningful and motivates to leave home and take care of oneself. Considering these positives, there is a need for implementing initiatives aimed at encouraging older adults to continue their employment whenever possible.

Simultaneously, the employers' perceptions of older adults and working environments need to be adjusted. Flexibility should be encouraged with opportunities for part-time work and adjusting working conditions to suit the older

workers' needs. The exchange of knowledge and experiences may help the employers explore how to support the health of their workers into their retirement. The workplace-based adjustments should be accompanied by legal protection for working pensioners to ensure their health and safety at work.

7. Further steps

The partners, together with representatives of the NDPHS Expert Groups and other relevant actors in the region, will participate in a Policy Lab where the outcomes are discussed and possible solutions explored. Based on the identified priority areas within the AgeFLAG project, the Roadmap to improve health and wellbeing in the Baltic Sea Region will be developed. Moreover, a Taskforce will be formed to contribute to and later implement the Roadmap.

Annexes:

Annex I: The list of the partners and their roles in the national systems.

Estonia

The Estonian Institute of Population Studies is a research and training institute in the Tallinn University. Ageing is one of the key areas of the Institute's demography research. The mission of the Institute is to monitor, analyse and project the existing and emerging trends that shape the ageing society. Since 2010, the Institute has been conducting the Survey of Health, Ageing and Retirement (SHARE) among people aged 50 or older in Estonia. The Estonian Institute for Population Studies also contributes to the ongoing project *The development of advocacy capacity among institutions and organisations targeted to older people* commissioned by the Estonian Ministry of Social Affairs. The Institute is the only academic institution in Estonia that has developed a training course for Educational Gerontology. Ageism and active ageing are one of the focus points of this course.

Finland

The Finnish Institute for Health and Welfare (THL) is an independent expert agency working under the Ministry of Social Affairs and Health of Finland. The Institute studies, monitors and develops measures to promote the wellbeing and health of the population in Finland as well as gathers and produces information based on research and registered data. It also provides expertise and solutions to support decision-making and serves various parties: the government, municipal and provincial level decisionmakers, actors in in the social welfare and health sector, organisations, the research community and the public. One of the tasks of the THL is to support the development of older people's services and to assess, follow and study the implementation of these services.

Latvia

The Rīga Stradiņš University is a leading academic research institution in the fields of medicine, pharmacy, dentistry, rehabilitation and nursing sciences. It is among the largest education institutions in the Baltic States in medicine and health sciences. The basis of the RSU research activity is the concentration of resources for the purpose of conducting outstanding, up-to-date, comprehensive and implementable scientific research that is consistent with the contemporary public needs. In its operations, RSU devotes particular attention to the integration of framework, pre-clinical and clinical research and linkages thereof to public health indicators.

Research at RSU is organised in three platforms of which one is dedicated to public health. The Public Health Platform provides qualitative research to facilitate health promotion, health care organisation and the improvement of the occupational health and safety in Latvia. Population ageing is an aspect that is often encountered in this research.

Lithuania

The Lithuanian University of Health Sciences (LSMU, Lietuvos sveikatos mokslų universitetas) is the largest institution of higher education for biomedical sciences in Lithuania with almost 100 years of academic experience and great potential for development. It is one of the leading universities in the region in the fields of training health professionals and postgraduate education. LSMU is a member of the World Health Organisation, where it fulfils the role of a collaboration centre for research and training in epidemiology as well as for prevention of cardiovascular and other chronic non-communicable diseases.

The Faculty of Public Health at LSMU is actively involved in public health research. The Faculty has worked on healthy and active ageing in numerous research activities and is well established in this field.

Poland

The National Institute of Geriatrics, Rheumatology and Rehabilitation, based in Warsaw, is a science and research institute as well as a medical service provider in Poland. It trains physicians and physiotherapists to become specialists in geriatrics, develops national standards of care and conducts research projects. The Institute also cooperates with NGOs and organises events and seminars to teach about healthy ageing. It is specialised in researching ageing processes as a part of the interdisciplinary science gerontology. The conducted studies focus on different fields, such as sociology, demography, psychology and medicine. Gerontological research at the Institute is conducted through the Gerontology and Public Health Department.

Russia

The Federal Research Institute for Health Organisation and Informatics of the Ministry of Health of the Russian Federation carries out a wide range of activities from scientific research and training to health informatisation and international cooperation. The main objective of the Institute is to conduct scientific research to support policymaking in the field of health system development and the implementation of the national health policy. The Institute carries out medical, demographic and socio-hygienic research on the health and reproduction of the population. Furthermore, it cooperates with local and international organisations to conduct joint research and experience exchange in the field of public health, and implements initiatives in the field of innovative patient-centred health and social care technologies for older adults with non-communicable diseases.

Sweden

The National Board of Health and Welfare is a government agency under the Ministry of Health and Social Affairs in Sweden that works to ensure good health, social welfare and social care on equal terms for the whole Swedish population. The activities

concern social services, health and medical care, and communicable disease prevention. The Board produces and develops statistics, regulations and knowledge in a number of different areas, such as oncology, patient safety and eHealth. Moreover, it develops health and social care support for different groups in society, such as children, older adults and people with mental illnesses or disabilities. Based on the governing laws, the Board produces regulations and general advice on how to comply with the requirements of the regulations.

Annex II: Facts and figures about ageing in the Baltic Sea Region.

This annex expands on the facts and figures presented in section 3 of this report and presents some country-specific information on labour participation and retirement, the health of older adults as well as health, social and elderly care organisation in the region. Most of the data presented in this annex is gathered from open source databases. This enables the use of similar indicators across the countries and, with that, effective regional comparison. For full disclosure, these sources are referenced in footnotes. The rest of the information provided in this Annex comes from our partners, as presented in the national needs assessment reports.

Demographic change

As introduced in Chapter 3 of this report, the Northern Dimension area is going through a social and demographic transformation, as people are living longer and population is ageing. Despite a general trend towards longer life and healthy life expectancies, there are large variations between the countries in the region. There is a ten-year difference between the highest life expectancy rate[9] in Norway (82,8 years) and the lowest in Russia (72,7 years). Even when excluding premature deaths from the calculations by considering the life expectancies at age 60[10], Russians are still expected to live just under five years less than Norwegians. Despite these differences in expected life lengths, the health prognoses for older adults are somewhat similar throughout the region, including in Russia and Norway. In all the countries, the difference between the life and the healthy life expectancy at 60[11] is closely around 5 years. This indicates the years spent in suboptimal health. Consequently, people spend around equally long suffering from disabilities and morbidities at an older age throughout the region regardless of their place of residence.

Just as there are differences in life and healthy life expectancies in the region, there are also differences between the health and life prognoses for men and women[12]. Generally, women live longer than men with on average 4,5 more expected life years at the age of 60 in the region. The sex-related differences are the smallest in Norway and Sweden with women living around 2,3 years longer than men and the largest in the three Baltic countries with a nearly 6-year gap between the two sexes. The life expectancies at age 60 for each sex in the region are presented in Figure 3.

[9] The World Bank. *Life expectancy at birth, total (years).* Distributed by World Development Indicators. https://databank.worldbank.org/reports.aspx?source=2&series=SP.DYN.LE00.IN&country= (accessed January 12, 2021).

[10] The World Health Organisation. *Life expectancy and healthy life expectancy.* Distributed by the Global Health Observatory. https://www.who.int/data/gho/data/themes/topics/indicator-groups/indicator-group-details/GHO/life-expectancy-and-healthy-life-expectancy (accessed January 14, 2021).

[11] The World Health Organisation. *Life expectancy and healthy life expectancy.* Distributed by the Global Health Observatory. https://www.who.int/data/gho/data/themes/topics/indicator-groups/indicator-group-details/GHO/life-expectancy-and-healthy-life-expectancy (accessed January 14, 2021).

[12] Ibid.

While women in all the countries in the region are more likely to live longer, they are also more likely to suffer from disabilities and morbidities longer than their male counterparts[13]. With on average 24,7 years still ahead at the age of 60 of which 18,6 in "full health", women generally live just over 6 years in suboptimal health. In contrast, men, who live on average 20,2 more years after turning 60, 15,5 of which in optimal health conditions, suffer from disabilities and morbidities on average just under 5 years at old age. This implies that women generally live with disabilities and morbidities at an older age over a year longer than men in the Region. The healthy life expectancies at age 60 for each country and sex are presented in Figure 4.

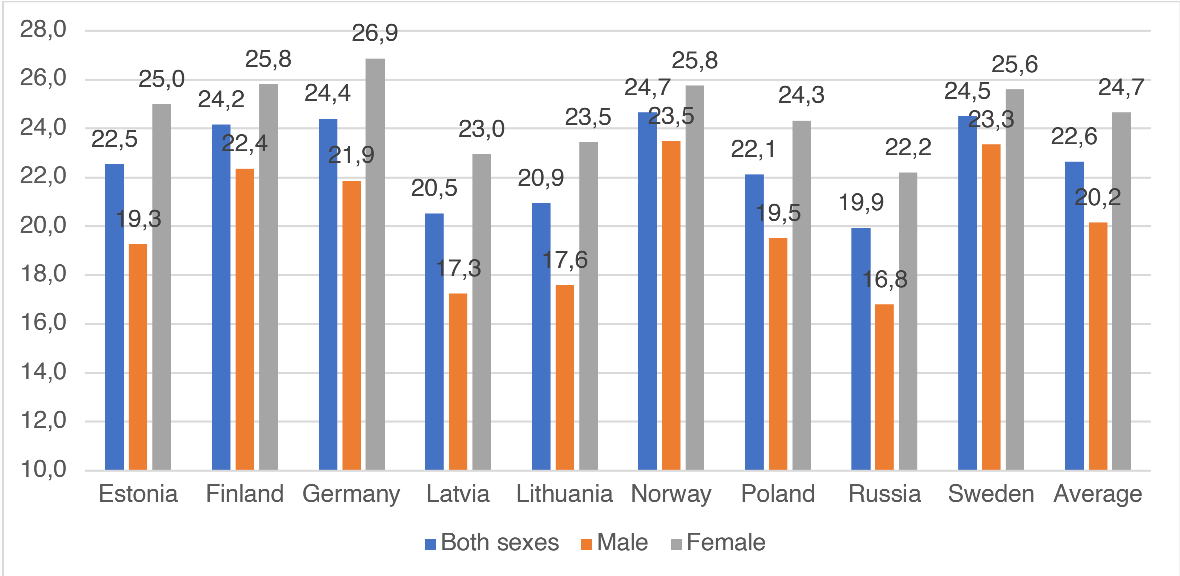

Figure 3. The life expectancies at age 60 in years per sex and country.

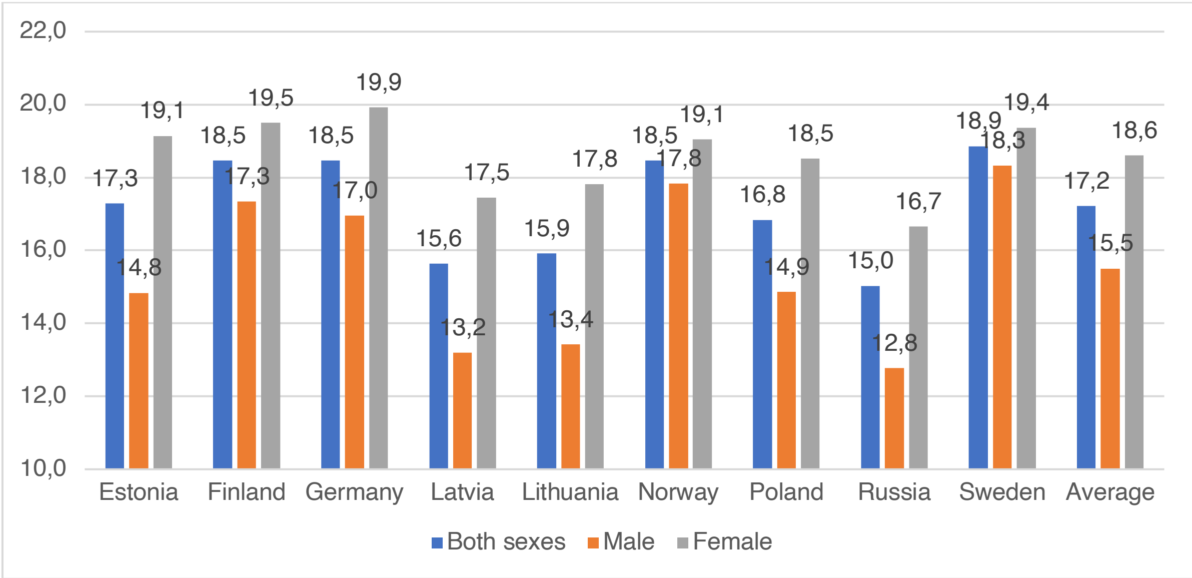

Figure 4. The healthy life expectancies at age 60 in years per sex and country.

[13] Ibid.

Retirement and labour participation

The statutory retirement ages for men[14] range from 60 to 67 years of age in the region with 65 being the most common age[15]. All countries apart from Poland and Norway have recently increased or are planning to increase the retirement age thresholds as a response to the changing demographic and the growing life expectancies. In some countries, such as Estonia, Finland and Sweden, the retirement age depends on the prevailing life expectancies. Moreover, in some countries there is an option for flexible retirement with the earliest possible time defined in law. In Sweden, for example, the earliest possible retirement age is currently 62, but the right to remain in the labour market continues until 68 (69 from 2023 onwards). The pension systems in the Northern Dimension area are diverse, and they reflect each country's economic structures, labour markets and culture, which makes comparison between the countries difficult.

On average around 12% of the people older than 64 years continue to participate in working life in the Northern Dimension countries, often past the statutory retirement age. However, there are vast differences between the countries - the lowest labour participation rate is at 5,5% in Poland, whereas the highest one stands at 28,1% in Estonia. The latest labour participation rates for those aged 65 and more in the countries at study, gathered from the OECD data[16], are presented in Figure 5.

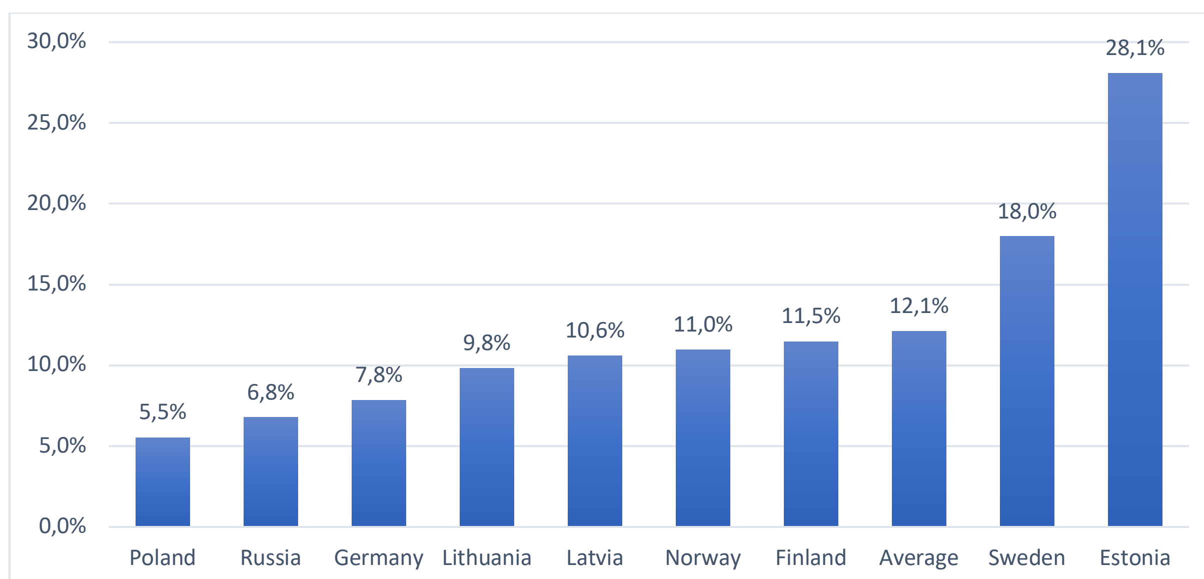

Figure 5. The labour participation rate for those aged 65 and more in the countries at study.

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[14] While some countries have identified different retirement ages for men and women, this is not the case for all. Generally, the retirement age for men is higher than that for women in cases where distinction between sexes is made. For the comparison, the retirement age for men is used.

[15] Finnish Centre for Pensions. *Retirement Ages.* ETK.fi. https://www.etk.fi/en/work-and-pensions-abroad/international-comparisons/retirement-ages/ (accessed January 15, 2021).

[16] OECD. *Labour force participation rate.* Distributed by OECD Data. https://data.oecd.org/emp/labour-force-participation-rate.htm (accessed January 13, 2021).

Health of older adults

According to the Eurostat data on the self-perception of health status[17], 35% of those aged 65 and over in the region (excluding Russia[18]) consider themselves to be in a very good or good health, 42% in a fair health, and 23% in a bad or very bad health. Older adults in the three Nordic countries, namely Finland, Norway and Sweden, are most optimistic about their health than others. In Norway and Sweden 63% and in Finland 48% of them believe that they are in a very good or good health. Only between 8 and 12 per cent of the older adults view their health being bad or very bad. In contrast, older adults in Estonia, Latvia and Lithuania tend to view their own health more negatively. While only between 9 and 19 per cent of them consider their health "good" or "very good", between 31 and 38 per cent think they are in a bad or very bad health. In general, people tend to have a worsening image of their well-being until they turn 75 in the post-Soviet countries of the Northern Dimension area. After this, this image turns more positive again. Nevertheless, the overall perception of one's well-being has become more positive during the last decade in these countries, as shown in Figure 6.

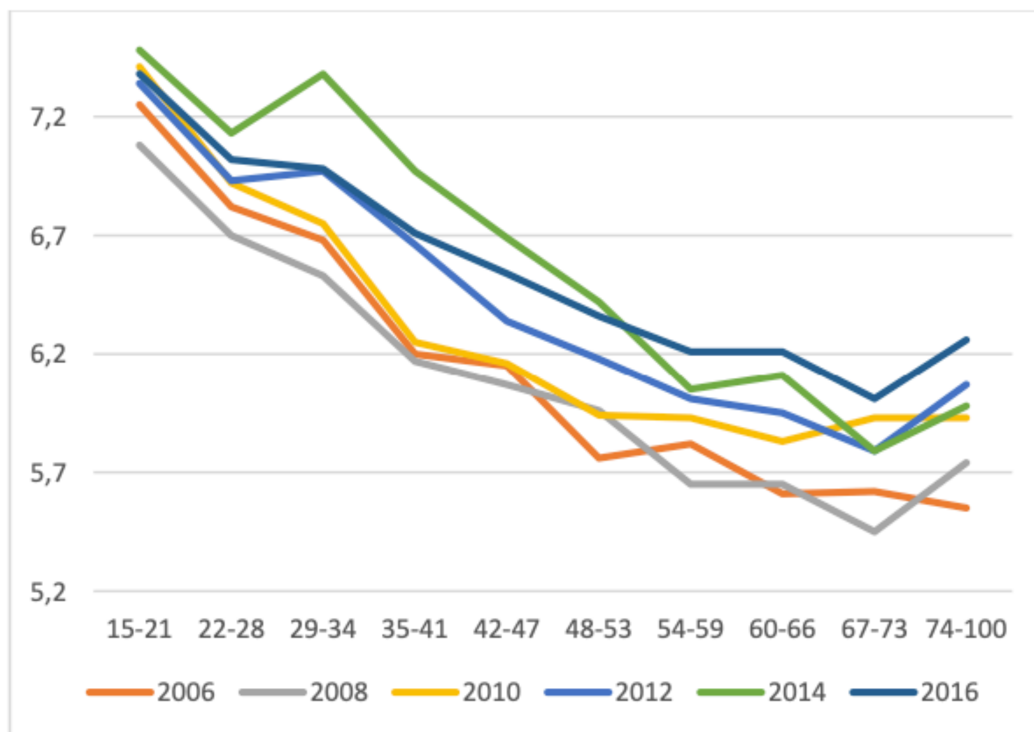

Figure 6. The evolution of subjective wellbeing throughout one's life cycle in Estonia, Latvia, Lithuania, Poland and Russia between 2006 and 2016.[19]

Among those aged 65 and older, cancers and the diseases of circulatory system are by far the biggest causes of mortality. According to the 2017 Eurostat data on the

[17] Eurostat. *Self-perceived health by sex, age quintile.* Distributed by Eurostat. https://ec.europa.eu/eurostat/databrowser/view/hlth_silc_10/default/table?lang=en (accessed January 18, 2021).

[18] No data available from Russia.

[19] Vainiomäki, Paula. *Koettu hyvinvointi Latviassa, Liettuassa, Puolassa, Venäjän Federaatiossa ja Virossa vuosina 2006-2016.* MSc thesis in Social Politics. University of Turku, 2020, https://www.utupub.fi/handle/10024/149941.

causes of death[20] in the project countries, including Germany and Norway but excluding Russia[21], 42% of all deaths among those aged 65 and older were caused by diseases of circulatory system, being the leading cause of death. This was followed by cancers, causing 22% of the deaths. Diseases of respiratory system, such as influenza and pneumonia, as well as mental and behavioural disorders, including dementia, Parkinson disease and Alzheimer disease, caused 8% and 5% of the deaths respectively. The causes of death are demonstrated in Figure 7.

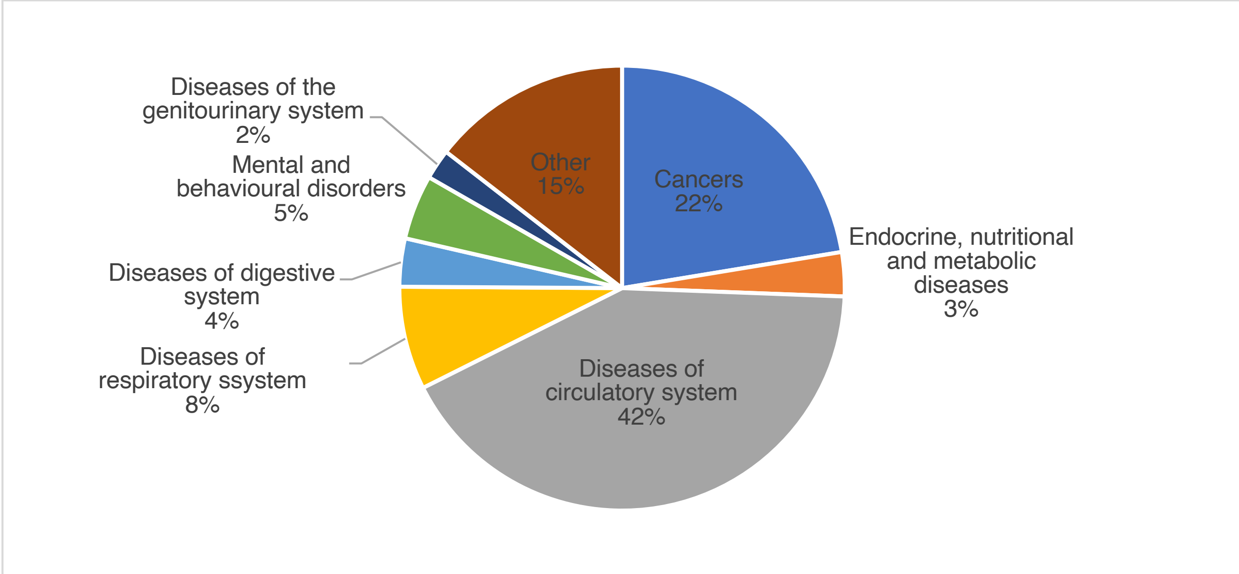

Figure 7. The main causes of death among those aged 65 and over.

The national needs assessments identified many negative behavioural trends that are common among older adults in the Northern Dimension area. In particular, poor lifestyle choices, such as unhealthy diet and poor nutrition, obesity, sedentary lifestyle, and excess alcohol and tobacco consumption, are of concern in multiple partner countries. Furthermore, older adults are often lonely and struggle with finances. Both of these function as discouraging factors for making healthy lifestyle choices.

Health, social and long-term care

The organisation of health, social and elderly care is characterised by cooperation between the government and the regional and municipal level actors in all the partner countries. The management and the supervision of the healthcare system, and the establishment of guiding rules and principles often fall under the responsibilities of the Ministries of Health and/or Social Affairs. The regional, local and municipal level actors, in contrast, are often responsible for the provision of health, social and elderly care services. However, the degrees of decentralisation of the decision-making power vary

[20] Eurostat. *Causes of death – deaths by country of residence and occurrence.* Distributed by Eurostat. https://appsso.eurostat.ec.europa.eu/nui/submitViewTableAction.do (accessed January 18, 2021).
[21] No data available from Russia.

between the partner countries. In Sweden[22] and Finland[23], for example, the healthcare systems are highly decentralised, meaning that regional councils and municipalities manage, run and to a large part finance the system. In contrast, in Latvia[24] and Lithuania[25] the main decision-making power remains in the hands of the Ministries of Health with regions and municipalities primarily implementing central decisions and organising the provision of health, social and elderly care services.

Healthcare costs in all the partner countries are partially covered either by the national health system or a compulsory health insurance scheme. In Sweden and Finland, the public coverage of the health expenditure[26] is the highest among the partner countries at 85% and 79% respectively, leaving less than 20% of the total costs for the patients to cover themselves[27]. In contrast, the national health systems and health insurance schemes cover only 60% of the health expenditure in Latvia and Russia, leaving nearly 40% of the costs for out-of-pocket payments.

The public expenditure on healthcare is also unevenly distributed between different services. Inpatient care is the most heavily supported service in all the countries. On average, 90% of the total expenditure for these services are publicly covered. In Sweden, this share is as high as 99%, practically indicating free inpatient care for the citizens. Only in Russia and Latvia the publicly covered inpatient costs make up less than the average of 90% of the total expenditure, 69% and 82% respectively. Outpatient care is significantly less heavily supported than inpatient care. Only 64% of the total outpatient care expenditure is covered by the national health system or a health insurance scheme with the share ranging from 53% in Russia to 81% in Sweden[28]. Long-term health care falls between the two services with on average 83% of the service expenditure covered by the health system or an insurance scheme. The largest coverage is in Poland with 95% of the expenditure being publicly paid, whereas only 55% of the costs are covered in Estonia.

According to the national needs assessments, there are some systematic factors that influence older adults' willingness and likelihood of seeking care. Growing costs, poor health literacy, long queues for treatment and long travel distances to healthcare

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[22] OECD and the World Health Organisation. *The State of health in the EU: Sweden – Country health profile 2017.* Brussels: European Commission. 2017.
[23] OECD and the World Health Organisation. *The State of health in the EU: Finland – Country health profile 2017.* Brussels: European Commission. 2017.
[24] OECD and the World Health Organisation. *The State of health in the EU: Latvia – Country health profile 2017.* Brussels: European Commission. 2017.
[25] OECD and the World Health Organisation. *The State of health in the EU: Lithuania – Country health profile 2017.* Brussels: European Commission. 2017.
[26] The World Bank. *Domestic general government health expenditure (% of current health expenditure.* Distributed by World Development Indicators.
https://databank.worldbank.org/reports.aspx?source=2&series=SH.XPD.GHED.CH.ZS&country= (accessed January 18, 2021).
[27] The World Bank. *Out-of-pocket expenditure (% of current health expenditure).* Distributed by World Development Indicators.
https://databank.worldbank.org/reports.aspx?source=2&series=SH.XPD.OOPC.CH.ZS&country= (accessed January 18, 2021).
[28] OECD. *OECD health statistics 2020.* Distributed by OECD.Stat.
https://stats.oecd.org/Index.aspx?ThemeTreeId=9 (accessed January 18, 2021).

centres are common reasons for pushing back a visit to the doctor’s office. Moreover, many tend to adopt a “wait and see” mentality, which often results to worsening of the condition and delayed diagnosis.

Annex III: The top five needs of the partner countries in relation to the four priority themes.

	Estonia	Finland	Latvia	Lithuania	Poland	Russia	Sweden
Healthy ageing, wellbeing, social environment and social connections	Accessibility and existence of common places and mutual activities, including the development of the community as an environment for active ageing.	Enhancing and maintaining active and healthy ageing.	Financial and social security.	Shaping healthy lifestyle habits and motivation for change.	Introducing and implementing an integrated, comprehensive, long-term national policy that addresses challenges related to healthy ageing and demography.	Physical and mental health.	Healthy ageing.
	Development of social environment supportive for mental health.	Strengthening social inclusion.	Sense of security and independence.	Increasing and maintaining physical capacity.		Social adaptation to the new status as a pensioner, creation of an environment for self-realisation and development.	Digitalisation.
			Physical and social activities.	Establishment of positive public attitudes towards older adults and ageing.			

				Age-friendly environment and virtual assistive technologies.			
Health, social and integrated care	Training of professionals.	Identifying and assessing service needs and service integration both on client and population levels.	Provision and availability of health and social care.	Person-centred care (domiciliary care, residential care and nursing, social activities depending on the needs and wishes of the older person).	Access to comprehensive and integrated healthcare services.	Personnel (intergenerational communication, respect, training of geriatricians and specialists).	Primary health care.
		Ensuring the continuity of care.		Intersectoral collaboration and integration of social and health services.			
		Analysing care and competence deficits.					

Education, knowledge and lifelong learning	Conceptual development of lifelong learning to meet the real needs of the ageing society.		Health promotion.	Age-friendly environment and virtual assistive technologies.[29]	Education aimed at increasing health literacy in society.	Knowledge-building: health literacy, health status, social privileges and rights, computer and financial literacy.	
					Increasing digital literacy among seniors.		
Labour participation	Making the work environment much more flexible.				Increasing employment rate among 60+.	Creation of environment for social and labour activities (formal and informal) of elderly population.	Older people at work and after retirement.

[29] This priority is applicable to two priority themes, “Healthy ageing, wellbeing, social environment and social connections” as well as “Education, knowledge and lifelong learning”. Virtual assistive technologies are important for communication and socialization, but require training for their use is needed before the benefits can be reaped.