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Delivering prevention in an ageing world

Democratising access to prevention

Health and care
Prevention
Immunisation
Inequalities
Diseases and conditions
Life expectancy
International

Consultation paper

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We want to hear from you

The International Longevity Centre UK (ILC) is running *Delivering prevention in an ageing world*, an international programme of work supported by Home Instead Senior Care, GSK, Pfizer, Seqirus, MSD, and Gilead. Our aim is to discover how G20 countries can deliver preventative healthcare throughout people's lives.

Following *Prevention in an ageing world,* a year-long programme that sparked conversations from Abu Dhabi, Taipei, Austin, Geneva, Sydney and London, all the way to the G20 Health Ministers, the message is clear: It's never too late to prevent. And the health and economic costs of failing to invest in preventative interventions across the life course are simply too high to ignore.

Over the coming year, we will conduct research and engage with stakeholders around the globe to understand not only **why** we should prioritise prevention, but **how** we can deliver it.

The *Delivering prevention in an ageing world* programme reflects the urgent need for G20 governments to match commitment with action, by:

- **Democratising access to prevention** to reduce health inequalities
- **Inspiring and engaging policymakers, healthcare professionals and individuals** to invest, promote and take action on prevention
- **Using technology effectively** to improve access to preventative healthcare, improve uptake rates, reduce barriers and empower patients.

This consultation paper sets out the key criteria we've identified that will allow governments and healthcare systems to democratise access and deliver prevention. Our upcoming expert roundtable will be an opportunity for health and policy experts to respond.

But the conversation mustn't end there. We're eager to engage with as many experts as possible during our consultation process. We want to know what else can be done to democratise access. We want to find more examples of good practice from G20 countries. And we want to know how we can better connect people to preventative services.

We welcome your thoughts and feedback. You can respond to the consultation **here** until Monday, 31 May 2021.

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Delivering prevention in an ageing world

Across the G20, people are living longer, but not necessarily healthier, lives. We know that left unchecked, the situation will get worse. Investing in prevention is central to addressing this challenge. We know that:

- Prevention works: it can substantially improve society's health and wellbeing by reducing morbidity and increasing the number of years spent in good health:
    - The global disease burden could be reduced by 40% over the next 20 years with preventative health interventions[1]
    - There's a positive relationship between investing more in public health spending and increases in healthy life expectancy[2]
- Prevention is cost-effective: it provides value for money and returns on investment in both the short- and long-term, and contributes to the sustainability of our healthcare systems:[3]
    - Immunisation, screening programmes and health checks are known to be both cost-effective and cost-saving[4]
    - Access to, and proper use of, medications not only improves population health but also reduces unnecessary economic burdens on healthcare systems[5]
- The benefits of prevention can extend beyond healthcare systems: it can benefit economies by helping people continue to work and consume in later life:
    - In Europe, people who report being in good rather than poor health are over four times more likely to be in work between the ages of 50-65 and over 10 times more likely between the ages of 65-74. Moreover, increasing preventative health spend by just 0.1 percentage points can unlock a 9% increase in annual spending by people aged 60 and over, and an additional 10 hours of volunteering.[6]
    - By investing in preventative services for cardiovascular disease, type 2 diabetes and lung cancer, better-off countries can reverse productivity loss of USD 649 billion each year. in those aged 50-64.[7]

That said, for preventative services to fully deliver these benefits, we must ensure democracy of access. As it stands, we know that many preventative services don't reach everyone equally. In the UK for example, older black adults are 40% less likely to be vaccinated against the flu than their white counterparts and the most socioeconomically deprived adults are 26% less likely to be vaccinated.[8a] In Finland, only 64% of Kurd migrants participated in cervical cancer screening in 2011, compared to 94% of the general Finnish population.[9b] In China, adults living in rural areas are 22% less likely to be screened for hypertension than those living in urban areas.[10c]

Lack of access to vital preventative services contributes to a widening of health inequalities. This has become even more apparent during the COVID-19 pandemic, which has served to further expose and amplify these inequalities. If we want to deliver prevention, we need to democratise access. This means:

Ensuring that no one is excluded from the health services they need due to where they live. Equally, it's about actively engaging communities and delivering prevention in such a way that responds to their diverse needs. For example, we know that, because of where they live, many indigenous communities can't access vital preventative interventions and medicines[11]; we know that cultural barriers prevent the black community in the UK and US from accessing flu and pneumococcal vaccines. Democratising access is about breaking down barriers and ensuring that prevention works for all members of society.

If we fail to act, we risk leaving behind those most in need.

[a]UK figures are based on *Seasonal influenza vaccination uptake between 2011-2016.*
[b]Data from the *Finnish Migrant Health and Well-being Study 2010–2012* and the *National Health 2011 Survey*.
[c]Data from the *China Health and Nutrition Survey* between 1993-2011.

Democratising access to prevention

Never too late: Prevention in an ageing world, our flagship report from 2020[12], argued that if preventative interventions are to be effective, healthcare systems must overcome the cultural, economic, and geographical barriers that may stop people accessing and benefitting from them.

Based on conversations with health and policy stakeholders over the last two years, we've identified five key criteria for democratising access to preventative healthcare:

- Make prevention convenient
- Ensure that cost is no barrier
- Tailor prevention
- Improve health literacy through co-production
- Address ageism

This consultation paper offers examples of good practice by healthcare systems, private companies and third-sector organisations that have democratised access to prevention by using each of these criteria. We have specific questions for you regarding each criterion, through which we hope to better understand the challenges and opportunities for democratising access to prevention.

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Making prevention convenient

Stakeholders have told us that a lack of access to preventative health services remains a widespread barrier. Access barriers can range from geographic distance, to mobility issues, poor transport links or costs, preventing too many from accessing the preventative services they need. This means it's crucial to bring prevention to where people are. From mobile health clinics, to drone deliveries, we've identified examples of how health systems can connect underserved populations to prevention by making it more convenient to access.

Case study

Mobile health clinics: Brazil, India, Indonesia and USA

- Mobile health clinics (MHCs) are vans that operate at the heart of communities which can reach groups who have not previously accessed preventative treatment
- They offer screening and vaccinations, and help manage chronic diseases such as hypertension, asthma, cancer and heart problems
- They are treating millions of people per year around the world

MHCs are most widely used in the US and India. They are deployed in familiar community areas such as shopping malls, churches, parks, and community and recreational centres. They're particularly successful at reaching populations who are traditionally at higher risk of ill-health, who have little or no contact with the wider healthcare system. This includes older adults, those in deprived and rural areas, and minority groups.[13]

The US has 2000 MHCs serving 7 million people per year. In India, Asia's largest mobile healthcare network for older adults is run by HelpAge. It operates 174 MHCs serving over 2,586 community locations providing 2.5 million treatments each year.[14] They offer free health checks and medication and keep records to monitor individual progress.

MHCs in the US and India have helped patients to reduce high blood pressure, encouraged healthier behaviour and better disease management through education.[15] Indonesia and Brazil have adapted this intervention by deploying floating health clinics to reach remote coastal indigenous communities.[16]

Case study

Delivering HIV prevention to at-risk groups: US and UK

- PrEp@Home delivers pre-exposure prophylaxis (PrEP) test kits to people's homes in the US
- Test@Work used texting to increase HIV prevention awareness for targeted workers in the UK
- Both interventions have successfully targeted individuals at greater risk of HIV to overcome some of the access barriers they face

PrEp@Home[17] addresses transportation barriers and the stigma associated with attending PrEP locations, which often prevent minority populations at greater risk of HIV from accessing and adhering to PrEP.

The intervention has reduced the number of mandatory annual in-person PrEP prescription renewal visits by delivering test kits to people's homes. 93% of participants renewed their prescriptions, with 75% reporting no missed PrEP doses within the last week. 77% found the kits easy to use and more than 85% indicated they preferred it to the standard in-clinic visit.

Test@Work[18] used text messages to improve awareness of HIV and HIV testing in the UK during the COVID-19 pandemic. It targeted the construction industry, where workers are at greater risk of HIV because they are more likely to engage in behaviour linked to greater HIV exposure.

291 employees across 21 worksites received a series of messages over a 10-week period. Messages contained web links to evidence-based resources to promote HIV awareness and reduce barriers to testing and HIV prevention, and discourage high-risk behaviours.

Almost 70% of those invited to take part agreed to receive texts and only 12% decided to opt-out during the study. A quarter of recipients clicked on links for sexual health services and a fifth clicked on links to seek more information. The highest number of clicks per message were for messages offering HIV home testing and free condom services.

Case study

Drone delivery of vaccines and other life-saving health interventions: international

- A number of drone programmes are delivering vaccines and other life-saving health interventions to remote and underserved communities
- They are cost-effective and can easily overcome geographical barriers, delivering healthcare much more quickly[19]
- They are delivering prevention to millions of individuals around the world

Drone healthcare delivery services are in place around the world. Drones are a faster, more cost-effective way of widening access to health than land-based transport. Across many lower income countries, they have the potential to improve vaccine uptake by at least 36% and reduce the cost of every dose administered by a fifth.[20]

In 2019, the Ghanaian government partnered with private and third-sector organisations to launch the world's largest drone delivery service. This delivers routine vaccines to 2,000 health facilities, serving 12 million people across the country.[21] In Rwanda, drones make 2,000 deliveries of medical supplies per day,[22] and during the COVID-19 pandemic, drones have been used in China to deliver medical testing supplies from hospitals to the Chinese Centre of Disease Control and Prevention, reducing unnecessary human contact to make delivery safer.

Case study

Community diabetes and cardiovascular screening programmes: Germany and Portugal

- Bavaria ran a diabetes prevention programme in 2019 and Portugal ran a cardiovascular disease programme in 2016, both delivered by community pharmacists
- Both interventions employed widely-used screening tools to identify those who were at risk or undiagnosed

- Both successfully screened and referred at-risk or undiagnosed individuals to appropriate prevention treatment

In 2014, the Bavarian State Ministry of Public Health and Care Services in Germany launched the *Diabetes moves us!* programme. This trained community pharmacists to talk about diabetes, and launched a diabetes prevention network to promote pharmacy-led events that included diabetes screening tests and educational talks.

215 pharmacies signed up to the network, registering 103 events. 2,502 individuals had their blood sugar checked and 1,765 completed the Finnish Diabetes Risk Score (FINDRISC) questionnaire. 195 individuals were advised to immediately visit their physician because of very high glucose levels and 80.2% were advised to change their lifestyle to prevent type 2 diabetes.[23]

In 2016, 120 Portuguese community pharmacists led a campaign to prevent cardiovascular disease by identifying those with undiagnosed conditions and those at risk, and educating them on risk factors for the disease. Pharmacists checked patients' lifestyle and family history, and administered a Systematic Coronary Risk Evaluation (SCORE).

They assessed 1,268 individuals and referred 129 individuals to the Nutritional Service or the Pharmaceutical Consultation Service, depending on their level of risk. [24]

Consultation discussion

We know that lack of access is an ongoing barrier for many individuals and communities. Our case studies suggest several ways to bring preventative services to where people are.

MHCs offer a unique way to reach underserved communities, both in rural and urban areas, and appear to be adaptable to different countries.

1. What is needed to get MHCs out to more locations where individuals are unable to access preventative health? What are the potential barriers to implementation?

Delivering prevention to people's homes or workplaces by post or digital mechanisms appears to be highly effective in improving uptake of preventative services among at-risk groups.

2. Are they a cost-effective way to make prevention more convenient?
3. What might prevent healthcare systems from partnering with businesses to deliver prevention to their employees?

Drone delivery presents new cost-effective opportunities to deliver preventative health supplies to individuals and communities.

4. What are the barriers to implementing drone-facilitated health delivery?
5. Do drones present a sustainable method for delivering health supplies?

Greater involvement of pharmacists in the prevention agenda also offers new opportunities. Not only are community pharmacists highly accessible, but they are trusted actors who understand the needs of the community. In addition, delivering prevention through pharmacies can help alleviate the economic burden on healthcare systems. Even though the interventions outlined above were implemented for a short period of time, they demonstrate how community pharmacies can play an important role in prevention.

6. How can we make community pharmacy-led interventions more sustainable? How can community pharmacies play a greater role in prevention?

While we've suggested some potential ways to make prevention more convenient for patients, they have limitations.

7. How else can we make prevention more convenient; do you have examples of this?
8. What barriers do healthcare systems face in making prevention more convenient and how might they be overcome?

Ensuring cost is no barrier

Out-of-pocket charges can be a barrier to accessing preventative services, particularly for those living in poverty or with multiple health problems. Despite world leaders having pledged to try to achieve universal health coverage by 2030 many countries still require individuals to pay high out-of-pocket charges. For example, some EU countries' out-of-pocket payments account for almost half of all health spending per household.[25] Other indirect economic factors such as reluctance or inability to take time off work may also affect access. We've identified some interventions that seek to overcome both direct and indirect economic barriers to accessing preventative services.

Case study

Addressing co-payment policies: International

- Several countries have minimised co-payment charges for outpatient prescribed medicines to improve access to essential preventative treatment
- These policies either exempt vulnerable populations from payment or reduce their costs
- Countries with minimal out-of-pocket charges have populations with low unmet health needs

Outpatient medicine charges account for the largest proportion of out-of-pocket charges, forming a significant barrier to accessing essential preventative treatment. Austria, the Czech Republic, Slovenia, and the UK are leading the way in Europe with exemptions for those from vulnerable groups, including people on low incomes, older people, and regular users of health services.

Other countries offer low fixed co-payments or an annual cap linked to household income; they also ensure that publicly financed benefit packages cover a wide range of essential medicines.[26]

Studies have demonstrated that co-payments have a negative impact on vulnerable populations, especially on people living with chronic illness.[27] In countries with high out-of-pocket payments there are high levels of unmet health needs, especially among people on low incomes, making them more likely to experience further financial hardship.[28] Recent ILC research also finds G20 countries with a larger proportion of public healthcare expenditure also have healthier populations.[29]

Case study

Breast cancer screening programme: China

- This is a programme, delivered in the workplace, to improve breast cancer screening among Chinese women
- The programme reduced cost barriers that prevent women from accessing mammograms
- Participants who had never previously undergone mammography reported having had one after the intervention

China has low uptake for breast cancer screening, due to lack of knowledge and misperceptions about breast cancer risks and screenings, as well as direct and indirect screening costs.

Four worksites in Nanjing offered a support programme for 232 women aged 40 or over. The programme consisted of motivational interactive educational discussions on the causes of, and risk factors for, breast cancer, and on the benefits of early prevention interventions. Participants also received patient navigation support and financial assistance. This included support booking appointments and arranging transportation to screenings, payment for their mammograms, and allowing employees to attend screening appointments during work without affecting their pay.

73% of those who had never previously had a screening reported having had a mammogram. The study also found that knowledge about breast cancer risk factors and screening guidelines increased significantly between the start and end of the study.[30]

Consultation discussion

Paying for preventative health services remains a significant barrier for many vulnerable groups around the world. Our examples suggest ways in which healthcare systems might be able to alleviate the economic burden for individuals.

Protecting those at greater risk of economic vulnerability by reducing or eliminating co-payments for outpatient prescription medicines could be effective but is challenging at a national level.

9. What prevents countries from eliminating or reducing outpatient medicinal co-payments for economically vulnerable people and what is the long-term health and economic impact of not reducing these costs?

Workplaces can help reduce the indirect economic factors that prevent people from using preventative services.

10. How might we encourage more employers to help reduce out-of- pocket charges and how could this be facilitated by healthcare systems or governments?

Reducing the cost of prevention is likely to improve inequalities in health.

11. How else can we reduce out-of-pocket charges; do you have examples of this?

Tailoring prevention

Our stakeholders have stressed that failure to tailor preventative services to individual needs is an ongoing barrier that prevents individuals and communities from engaging with prevention. As our societies become more diverse, and with a greater proportion of older people, healthcare systems will need to address both medical and non-medical needs to ensure equal uptake of their services. We've identified examples of both large population-level interventions and small pilot studies which have found unique ways to tailor prevention to the needs of the population.

Case study

CANImmunize: an app to help people manage immunisations: Canada

- CANImmunize is a free app that helps people to manage and track their vaccinations and educate themselves on the importance of immunisation
- It offers tailored educational information for different groups, including at-risk groups, and a personalised immunisation tracker and forecaster to better manage and keep up-to-date with vaccinations
- The app has been downloaded over 175,000 times, and might be used to facilitate the next stages of the COVID-19 vaccine rollout.[31]

Launched in 2014, CANImmunize lets individuals record when they receive a vaccination, and creates a schedule which suggests nearby locations and available vaccination dates, along with appointment reminders.

The app also offers easy-to-read articles on communicable disease prevention, along with videos, games and a comic book to help people learn about immunisation, pain reduction strategies and recommendations. It has been translated into different languages, and offers tailored information and recommendations for at-risk populations and refugees (who typically have low uptake for vaccination).[32]

Already downloaded over 175,000 times, the app might be used to help facilitate the next stages of the COVID-19 vaccine rollout

by helping individuals and healthcare professionals keep track of their vaccinations, and in particular to help better track the safety of different vaccines.[33]

Case study

Accessible technologies to improve adherence: Australia and Finland

- These two interventions use accessible technologies to help improve adherence to medicines and preventative treatment for those with chronic conditions
- They're specifically tailored to meet the needs of older adults with low digital literacy and those with physical disabilities, by limiting the need to interact with the technology
- Participants have kept up with their medications and preventative treatment requirements

Peninsula Health in Victoria, Australia has implemented ITEC-CHF, an innovative telemonitoring programme for older adults with chronic heart failure to improve compliance with daily weight management and help prevent their illness from progressing.

ITEC-CHF uses a 'zero touch' design to make monitoring weight much easier. Participants are not required to interact with the technology other than stepping onto a weight scale. If there is abnormal weight fluctuation, they are contacted by a nurse to identify the appropriate preventative action.

Initial findings suggest the approach has effectively improved patient outcomes and experience.[34]

A Finnish pilot study has implemented an in-home advanced robotic system to help older adults with medication adherence by administering medication at scheduled intervals. The system notification combines sound, an on-screen message, and light. Patients simply press a dispenser button to access their medications.

The device was used for 727 days by 27 patients. The study found that 99% of the alerts resulted in on-time medicine sachet retrievals by patients and all patients found the device easy to use.[35]

Case study

The SeaFit programme: health services for fishermen: UK

- The SeaFit programme established permanent health clinics near ports and quaysides to help connect fishermen with health services and preventative treatment
- They offer preventative and other health services tailored to meet the needs of fishermen whose occupation puts them at greater risk of ill-health
- In its first year, health advisors engaged with almost 700 individuals and many have engaged with health services more frequently as a result

Strenuous working conditions, coupled with occupational barriers that prevent fishermen from visiting healthcare services, puts them at increased risk of developing a number of conditions.

The SeaFit programme was set up in 2018. It established permanent health clinics and now organises ad hoc health check events at a number of ports and quaysides throughout the UK.[36] A wide range of services are available, including health checks, dental treatment, counselling, health screening and self-management for chronic diseases, alcohol and smoking cessation services, physiotherapy, cancer prevention information, and eye tests.

Its main successes have been offering health services that respond to the specific needs of fishermen, and its ability to build trust quickly within the fishing community. This has been achieved through the support of the service by charities dedicated to improving the lives of fishermen.

The programme has shown promising results. In its first year, health advisors engaged in some way with just under 700 individuals. Patients reported having seen their doctor more often as a result of a health check.[37] Three-quarters made changes to their diet, and over a quarter of those who received a dental check had done so for the first time in at least five years.[38]

Consultation discussion

One of the reasons preventative services fail to engage individuals and communities is because they're not tailored to meet their needs. Our case studies highlight how healthcare systems can address both the medical and non-medical factors that might hinder participation.

CANImmunize illustrates how interventions can be delivered to a large population, while still meeting the needs of individuals and communities.

12. How can we use data and technological interventions to tailor preventative services to the needs of individuals, particularly older adults?
13. What barriers might prevent people, including older adults, from using tech-based services (including apps) and how might these be overcome?
14. How can apps be used to help facilitate the rollout of the COVID-19 vaccine?

Accessible technologies can help older adults with low digital literacy and those with chronic conditions manage their health conditions more easily.

15. Are these interventions, and other similar accessible technologies, feasible for wider implementation?
16. Do accessible technologies help reduce inequalities in health?

The SeaFit programme was led by charities who understand the barriers fishermen face to accessing healthcare; they have been able to reach individuals with little to no contact with preventative health services.

17. Is this a sustainable model of healthcare delivery? Could similar programmes be used for other higher-risk groups?
18. How can healthcare systems better facilitate partnerships with charities and community organisations to deliver tailored services?

Tailoring services is essential if we want to widen our reach and engage all individuals and communities equally.

19. Do you have any examples of interventions that are tailored and successful?
20. What are the current gaps in our understanding of the health (and wider) needs of older adults and how is this limiting our ability to reach this cohort?

Improving health literacy through co-production

Our stakeholders listed poor health literacy as a barrier that prevents some individuals or communities from engaging with preventative health services. One way to overcome this is to actively engage those communities by co-producing health messaging with them, but this approach is rarely implemented. Engaging those who are likely to benefit from the service, or who might face barriers in using the service, can help to improve their health literacy and allow better self-management of diseases. We've found two examples that demonstrate how co-production can improve health literacy and uptake of prevention among marginalised groups.

Case study

Increasing pneumococcal vaccine uptake among older black Americans: USA

- This was an educational intervention delivered by pharmacists to improve pneumococcal vaccine uptake among black Americans in a care home
- The care home residents developed and delivered the intervention using a variety of educational tools
- Participants' knowledge about the pneumococcal vaccine increased by 54%; all unvaccinated individuals reported receiving the vaccine after the intervention

In the US, pneumococcal vaccine uptake rates are particularly low for black Americans. A lack of knowledge about pneumococcal disease and the vaccination contributes to poor uptake.

In 2014, pharmacists delivered an innovative educational intervention to 190 individuals in a care home where 80% of residents were black Americans.

The intervention had three components: a 30-minute educational presentation delivered by a pharmacist, a 10-minute live skit by a health education theatre group, and action planning via small group breakout sessions. The design and delivery were co-produced with the participants: the skit was performed by members of the care home community, who incorporated

examples of how they might overcome vaccination barriers related to real-life social influences.[39] The benefit of employing co-production to improve health literacy is clearly demonstrated as both vaccine knowledge and uptake increased significantly because of the intervention.

Case study

DELFGOUD: preventing frailty among deprived older adults: Netherlands

- The DELFGOUD project aimed to prevent frailty among deprived older adults
- The programme delivered sessions to improve physical, mental and social capabilities through education messages and training programmes that were co-produced by those using the service
- The project successfully reached 30% of its target population, with 80% of participants completing the 12-month programme

Older adults from groups with lower economic status are at greater risk of becoming frail due to a sedentary lifestyle, lack of resilience, loneliness and depression.

Launched in 2010, this three-year project was led by regional counsellors; it supported 20,000 older adults from deprived neighbourhoods. It aimed to enhance healthy active ageing and independence, and improve their quality of life. The programme consisted of physical activity sessions, diet counselling, social skills training, and a training programme to cope with depression, held in the local neighbourhood. It focussed on offering sustainable change using co-production. Participants developed an educational kit called *what's in it for you*, for their peers; they organised and led a range of sessions such as cooking classes, diet circles, physical activity classes, and social participation projects.

The project reached 30% of its target population. 80% of the participants completed the 12-month programme. 80% reported feeling fitter, an increase of social contacts and being able to better manage activities of daily living. Due to its success, the programme has been adopted in other municipalities.[40]

Consultation discussion

Individuals or communities with poor health literacy are less likely to engage with preventative services. Using co-production to design health messaging is one way to improve the health literacy of those taking part.

Using co-production to improve health literacy appeared to be effective in improving pneumococcal vaccine uptake among African Americans.

21. Is it a cost-effective solution for improving health literacy and vaccination uptake?

The DELFGOUD project appeared not only to be effective in improving health outcomes, but also sustainable, having been adopted elsewhere.

22. Are there any barriers to implementation that might prevent it and other interventions that use co-production to improve health literacy, from being used more widely?

In some countries co-production is now widely accepted and seen as good practice.

23. Do you have any other examples of interventions that have used co-production to improve health literacy?

Addressing ageism

There is a tendency for healthcare systems to focus on the needs of younger rather than older populations, especially when it comes to prevention. But in a rapidly ageing world, we must move away from this damaging culture and focus our efforts on implementing prevention across everyone's lives. Just as it's never too early, it's never too late to prevent ill health. Healthcare systems must also recognise that many individuals hold ageist perceptions and attitudes themselves that can act as a barrier to engaging with preventative services. Therefore, we must also help older adults recognise the value of preventative interventions and see healthy ageing as the norm.

Case study

Community pharmacists empower older adults to reduce inappropriate prescriptions: Sweden

- This programme was delivered by community pharmacists to help older adults reduce the number of inappropriate medicines being prescribed to them
- The intervention educated older people about their current and future health needs, helping them become better advocates for their own health
- In just a few years the use of inappropriate prescriptions for adults aged 80 or over was halved; it is estimated that between 700,000 and 800,000 older adults aged 65 or over now have fewer inappropriate medicines prescribed as a result of the intervention

Sweden's state-owned community pharmacies, along with two charities for older people, implemented the *Check my Medicines* campaign in 2009.

The programme empowered older adults to take charge of their own medicines (and health) to reduce medicine misuse. Community pharmacists identified inappropriate medicines by developing a dialogue with older people, to help them develop a better understanding of their current conditions and the health conditions they might face, as well as how their lifestyles might affect their health. The pharmacists also supported them by

ensuring they were prepared for consultations with health professionals, to better engage in discussions regarding their ongoing health needs.

In just a few years, the programme has halved inappropriate prescriptions for older adults aged 80 or over (from 33% to 16%) and 700,000-800,000 older adults, aged 65 or over, now have fewer inappropriate medicines prescribed.[41]

Consultation discussion

Ageism is a widespread barrier that prevents many people from using preventative services throughout their lives. Yet we know that it's never too late to prevent ill-health.

Our case study demonstrates how we can empower adults to remain healthier for longer by taking control of their health. It also demonstrates that this approach is sustainable and can effectively reach a large number of people.

24. What can be done to encourage widespread adoption of this intervention? What are the potential barrier to implementation?

Addressing ageism requires a change of culture within healthcare systems and a focus on delivering prevention across the life course.

25. Do you have any examples of healthcare systems successfully implementing a life course approach to preventative health; how have they achieved this?
26. How can we tackle ageism in the healthcare system? What can we do to address ageism on the part of healthcare professionals?
27. What other preventative intervention case studies exist that have successfully tackled ageism?

What else have we missed?

We want to hear from you if there's anything we've missed from our consultation paper.

- What other mechanisms and levers are important in democratising access to prevention in an ageing world?
- Can you share other examples of interventions that successfully democratise access to prevention?

We welcome your thoughts and feedback. You can respond to the consultation **here** until Friday 9 April 2021.

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About the ILC

The International Longevity Centre UK (ILC) is the UK's specialist think tank on the impact of longevity on society. The ILC was established in 1997, as one of the founder members of the International Longevity Centre Global Alliance, an international network on longevity.

We have unrivalled expertise in demographic change, ageing and longevity. We use this expertise to highlight the impact of ageing on society, working with experts, policy makers and practitioners to provoke conversations and pioneer solutions for a society where everyone can thrive, regardless of age.

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