ECONOMICS & Sociology

Iga Rudawska, Active Ageing and its Impact on Labour Market, *Economics & Sociology*, Vol. 3, No 1, 2010, pp. 9-24.

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ACTIVE AGEING AND ITS IMPACT ON LABOUR MARKET

Received: February, 2010
1st Revision: March, 2010
Accepted: April, 2010

ABSTRACT. This paper focuses primary on the recently emerged notion of "active ageing" and the strategies aiming at turning it into a crucial mechanism in societal and economic adjustment to population ageing. It begins by highlighting the demographic revolution described by population ageing, more and more longer human life expectancy at birth, old age dependency ratio and their consequences on workforce. It goes on to discuss the concept and rationale of active ageing and its relationships to labor force. Then it outlines the basic principles on which policies on active ageing at work setting should be based and key elements of a strategy to implement it. The core of the active ageing policies is to enable people to continue to work according to their capacities and preferences, and to prevent or delay disabilities and chronic diseases that are costly to individuals, families and the health care system. This would also help to offset the rising costs in pensions and income security schemes as well as those related to medical and social costs.
Next, the focus of the paper moves to the organizational level and the elements of an age management approach are discussed. It is stressed that a strategy of active ageing will enable ageing workers to have a stronger impact on their later life careers as well as on their health. At the macro level, if increased numbers of healthy older people were to extend their participation in the work force (through either full or part-time employment), their contribution to public revenues would continuously increase. The main reference point for this paper is Europe.

JEL Classification: J1, P2

Keywords: labour force, ageing society, active ageing concept, demographic transformation, organisational initiative.

Introduction

An ageing population provides many advantages to the overall economy. Nations with declining working-age populations will be able to draw on older experienced workers and industries will be able to grow as they serve the needs of older consumers. Global ageing requires governments and the private sector to address the challenges to social security as well as pension systems. A balanced approach to the provision of social protection and economic

goals suggests that societies who are willing to plan can afford to grow old. Labour market policies have a more dramatic impact on a nation's ability to provide social protection in old age than demographic ageing per se. The goal must be to ensure adequate living standards for people as they grow older, while recognizing and harnessing their skills and experience and encouraging harmonious intergenerational transfers.

The term "active ageing" was adopted by the World Health Organization in the late 1990s. It is meant to convey a more inclusive message than "healthy ageing" and to recognize the factors in addition to health care that affect how individuals and populations age (Kalachea and Kickbusch, 1997). The active ageing approach is based on the recognition of the human rights of older people and the United Nations Principles of independence, participation, dignity, care and self-fulfilment. It shifts strategic planning away from a "needs-based" approach (which assumes that older people are passive targets) to a "rights- based" approach that recognizes the rights of people to equality of opportunity and treatment in all aspects of their life. It supports their responsibility to exercise their participation in the political process and other aspects of community life.

The ageing workforce - demographic and epidemiological transforamtion

Demographic changes are expressed mainly in progressing ageing of societies. Worldwide, the proportion of people age 60 and over is growing faster than any other age group. Between 1970 and 2025, a growth in older persons of some 694 million or 223 percent is expected. In 2025, there will be a total of about 1.2 billion people over the age of 60. By 2050 there will be 2 billion with 80 percent of them living in developing countries. Until now, population ageing has been mostly associated with the more developed regions of the world. For example, currently nine of the ten countries with more than ten million inhabitants and the largest proportion of older people are in Europe (see Table 1). Little change in the ranking is expected by 2025 when people age 60 and over will make up about one-third of the population in countries like Japan, Germany and Italy, closely followed by other European countries (see Table 1).

In both developed and developing countries, the ageing of the population raises concerns about whether or not a shrinking labour force will be able to support that part of the population who are commonly believed to be dependent on others (i.e., children and older people).

Table 1. Countries with more than 10 million inhabitants (in 2002) with the highest proportion of persons above age 60

Country	002	025
Italy	4,5%	4%
Germany	4%	3,2%
Greece	3,9	1,6
Belgium	2,3	1,2
Spain	21,	1,4
United		

Kingdom	0,8	9,4
France	0,5	8,7

Source: United Nations; 2001.

The old-age dependency ratio (i.e., the total population age 60 and over divided by the population age 15 to 60 – see Table 2) is primarily used by economists in order to forecasting the financial implications of pension policies. However, it is also useful for those concerned with the management and planning of caring services.

Table 2. Old age dependency ratio for selected countries/regions

Country/ region	002	025
Japan	,39	,66
North America	,26	,44
European Union	,36	,56

Source: United Nations; 2001.

The percentage of people over 65 years old in 1970-2000 increased the most in Spain and Italy – from 10-12% to 16018%. According to forecasts, this index is to exceed 20% by 2010 (United Nations, 1998), which means an almost two times larger change in relation to 1970. Average coefficient of old age rate (percentage of people 65 years old and more in overall population) in the EU countries (before expansion) in 2001 amounted to 16.5% (United Nations, 1998, p. 146). In Central and Eastern European countries, this process is slightly slower. In Poland, for example, citizens aged 65 years and more constituted in 2000 approximately 12% of population. In 2050, their percentage is to increase to 28.4% (Figure 1). It should be emphasised that so called second demographic transition process is being accomplished in respective societies at a non-uniform rate. In the classification proposed by a Dutch demographer, D. J. Van de Kaa, according to demographic revolution advancement degree, Poland has been placed in the third group, next to Bulgaria, the Czech Republic, Hungary, Byelorussia, Russia and Yugoslavia.

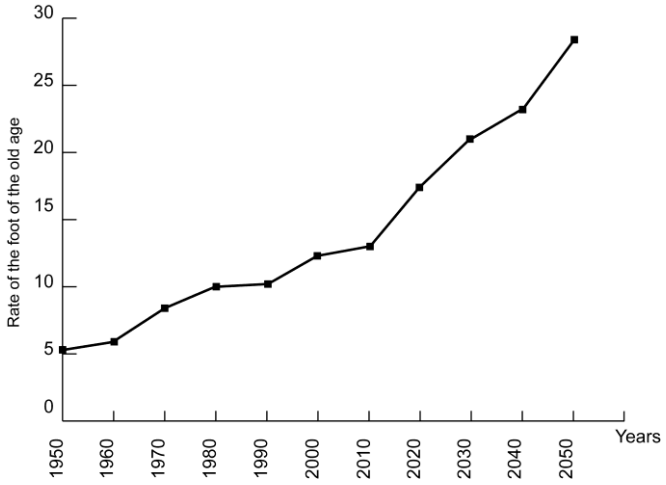

Figure 1. Coefficient of old age rate (65+) and its prognosis up to 2050 – example of Poland
Source: own elaboration based on: Rocznik Demograficzny; 2001.

A basic consequence of the aging process of European societies, is changes in the volume of indispensable healthcare services as well in the intensity and structure of their consumption. Empirical evidence show that the intensity of using healthcare services of the public sector grows together with age as well as changes the proportion between acute diseases and chronic illnesses. The main problem are chronic illnesses, in particular locomotor system ailments that limit physical fitness, and cardiovascular diseases, tumours, senile dementia and other diseases which handicap psychosomatic functions. Finally, the prolonged duration of life favours the appearance of diseases, with individual genetic predispositions being at the bottom of them (Leowski, 2000).

The main implication of chronic illnesses, which prevail in contemporary aging societies, is limitation of physical fitness. The research work of McKinlays on American statistical data showed that the number of days of limited activity due to chronic illness, adopted as an indicator of that state, grows together with the age of individuals (Sokolowska, 1980). Therefore, acquisition of the next years of life and increase in average further duration of life ensues mainly due to increase of disabled years. Epidemiologists who have nicknamed longevity the "paradoxical", due to its frequently questionable attributes, are pretty much right (Omran, 1998). As a matter of fact, it means more years of life but frequently of a low quality, being a derivative of chronic illnesses, physical and psychical weakness, alienation and isolation, depression, loss of independence as well as of lowering of social and economic status.

Limitation of the aforesaid negative phenomena is connected with provision of appropriate care to people affected by civilisation diseases, which in turn requires adequately high financial expenditures and an advanced, in respect of organisation and technology, system of health care. Higher percentage of people advanced in years means not only the necessity of bearing larger expenses on health care and different forms of financial cover connected with the occurrence of diseases (pensions, sickness and care allowances) but also larger burdening of the pension system. In particular, this refers to women for whom the index of life expectancy, and in this connection the time on pension, considerably exceeds the analogous value for men. However, the life expectancy at birth in Central and Eastern European countries, still differs from the values recorded in the developed countries of Western Europe (Figure 2).

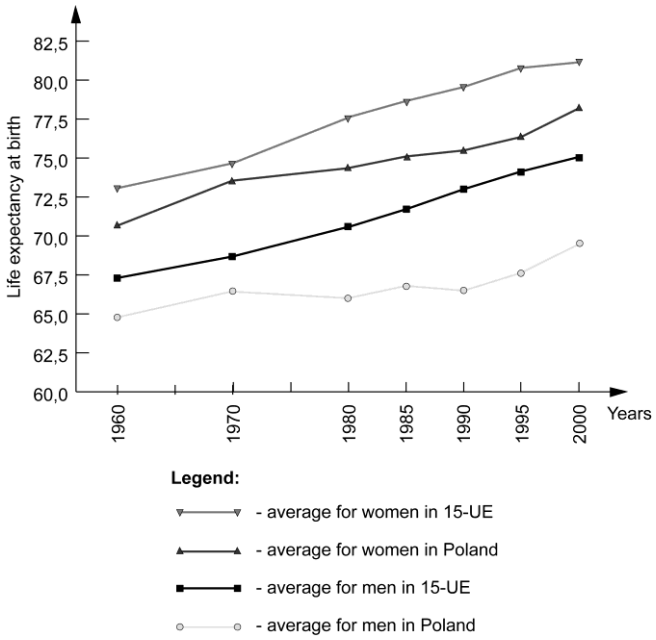

Figure 2. Life expectancy at birth for women and men (1960-2000)
Source: own elaboration based on: The world health report 2004; 2004 and OECD; 2004

The differences illustrated above are a resultant of differently formed epidemiological trends, which in turn are connected with the social and economic development (Table 3).

Table 3. Factors contributing to the gap in life expectancy between the Eastern European and Western European countries

Age groups / Cause of death	< 1 year	1-34 years	35-64 years	> 65 years	All ages
	Additional life expectancy in western Europe by age groups (years)				
Infectious and parasitic diseases	0,3	0,1	0,08	-0,01	0,47
Cancer	0	0,05	0,25	-0,35	-0,05
Cardiovascular diseases	0	0,07	1,36	1,85	3,28
Respiratory diseases	0,68	0,2	0,15	-0,5	0,97
Digestive diseases	0,02	0,03	0,08	-0,04	0,09
External causes	0,04	0,64	0,04	0,18	0,12
Other diseases	0	0	-0,02	-0,2	-0,22
Undefined conditions	-0,1	0,01	0,04	0,18	0,12
All causes	0,93	1,09	2,63	1,4	6,06

Source: Saltman et. al. (ed.); 1998.

The increase of demand for medical services in the field of geriatrics will be accompanied by diminishing funds of insurance systems caused by a reduction of the participation of productive-age population. This trend corresponds to negative population growth, which in further perspective will mean a contraction of the population part that is economically active and being able to support the growing number of people advanced in age.

The demographic dependency ratio (number of people at the post-productive age, i.e. men 65 years old and more and women 60 years old and more per 100 persons professionally active, i.e. men 18-64 years old and women 18-59 years old) in Western European countries has already exceeded the value of 20 (largest value is recorded in Sweden – 27.1; as of 2000), while it is to exceed considerably the value of 30 by 2020 (Jacobzone et. al., 1998).

Perhaps more than anything else, policy makers fear that rapid population ageing will lead to an unmanageable explosion in health care and social security costs. While there is no doubt that ageing populations will increase demands in these areas, there is also evidence that innovation, cooperation from all sectors, planning ahead and making evidence-based, culturally-appropriate policy choices will enable countries to successfully manage the economics of an ageing population. Research in countries with aged populations has shown that ageing per se is not likely to lead to "health care costs that are spiralling out of control", for two reasons. First, according to OECD data, the major causes of escalating health care costs are related to circumstances that are unrelated to the demographic ageing of a given population. Inefficiencies in care delivery, building too many hospitals, payment systems that encourage long hospital stays, excessive numbers of medical interventions and the inappropriate use of high cost technologies are the key factors in escalations in health care costs. For example, in the United States and other OECD countries, new technologies were sometimes rapidly introduced and used where alternative and less expensive procedures already existed, and for which the marginal effectiveness was relatively low (Jacobzone and Oxley, 2002).

There appears to be considerable scope for policy makers to address these issues and improve the effectiveness of health care. Second, the costs of long-term care can be managed if policies and programmes address prevention and the role of informal care. Policies and health promotion programmes that prevent chronic diseases and lessen the degree of disability among older citizens enable them to live independently longer. Another major factor is the capacity and willingness of families to provide care and support for older family members. This will depend to a large extent on the rates of female participation in the labour force and on workplace and public policies that recognize and support the care giving role.

In many countries, the bulk of spending is on curative medicine. Care for chronic conditions leads to an improved quality of life. However, it is always preferable if those conditions could be prevented or delayed until very late in life. Decision makers need to evaluate whether such outcomes can be achieved through policies that address the broad determinants of active ageing, such as interventions to prevent injuries, improve diets and physical activity, increase literacy or increase employment. Ultimately, the level of funding allocated to the health system is a social and political choice with no universally applicable answer.

However, the WHO suggests that it is better to make pre-payments on health care as much as possible, whether in the form of insurance, taxes or social security. The principle of "fair financing" ensures equity of access regardless of age, sex or ethnicity and that the financial burden is shared in a fair way (WHO, 2000). A second major concern to policy-makers is the demand that an ageing population may put on social security systems. Alarmists point to the growing proportion of the "dependent" population that has retired from the formal labour force. The idea that everyone over age 60 is dependent is, however, a false assumption.

Many people continue to work in the formal labour market in later life or would choose to do so if the opportunity existed. Many others continue to contribute to the economy through informal work and voluntary activities, as well as intergenerational exchanges of cash and family support. For example, older people who look after grandchildren allow younger adults to participate in the labour market.

The process of society aging induces not only an increase in the demand for long-term care and rehabilitation but also for services that are building the system of emotional, psychological and even economical support. In extreme cases, longevity can mean a prolongation of agony, which in turn contributes to an increase in the interest in euthanasia as well as to explosion of suicides in the segment of old and disabled people. Societies will be forced to struggle with moral, religious and legal implications of these phenomena.

The role of age on the labour market

Changes to the European population will affect economy in general and particularly employment. The size of the workforce and population have an effect on the overall magnitude of the economy. GDP in EU is projected to rise at an average annual rate of 2.8 percent over 2006-16, reflecting increasing demand for goods and services. Although this tendency, which will continue to boost overall employment, a slowdown in both labour force and productivity growth will constrain employment growth.

Over the 2006-16 projection period, growth in the labour force is projected to slow significantly, for two reasons: the baby-boom generation is aging and retiring, and the labour force participation rates of women have peaked. The labour force is expected to grow at an annual rate of 0.8 percent during 2006-16, compared with a rate of 1.2 percent in 1996-2006 (Dohm and Shniper, 2007). Although the labour force participation rate for those aged 55 years and older is anticipated to jump from 38.0 percent to 42.8 percent during the coming decade, a large number of persons aged 55 years and older are expected to retire and leave the workforce.

In all the UE countries, employment rates reach their peak in mid-life, whereas they turn out to be low for youths, on the one hand, and for seniors, on the other. The average employment rate for the 25-54-year age group was 77.6% in 2004, compared with 40% and 42,5% for the 15-24s and the 54-65s (Table 4). The lower participation of youths is explained by education and by an increasingly long process of insertion on the labour market, while for the seniors it is the result of a relatively low average age of retirement (61.3 years in Europe in 2003, see Table 5).

Table 4. Employment rates by age group in some EU countries (2004)

Country	15-24	25-54	55-65
EU-15	40	77,6	42,5
Austria	51,9	82,6	28,8
Belgium	27,8	77,3	30
Denmark	62,3	83,7	60,3
Finland	39,4	81	50,9
France	30,4	79,6	37,3
Germany	41,9	78,1	41,8
Greece	26,8	73,5	39,4
Ireland	47,7	78,8	49,5
Italy	27,6	72,2	30,5
Luxembourg	21,4	78,7	30,8
Netherlands	65,9	82,5	45,2
Portugal	37,1	81,1	50,3
Spain	35,2	72,7	41,3
Sweden	39,2	82,9	69,1
United Kingdom	55,4	80,8	56,2

Source: European Commission; 2006

Table 5. Average exit age from the labour force in the EU (2003)

EU-15	61,3	Italy	61
Belgium	58,7	Luxembourg	58,2
Denmark	62,2	Netherlands	60,5
Germany	61,6	Austria	58,8
Greece	62,7	Portugal	62,1
Spain	61,5	Finland	60,4
France	59,6	Sweden	63,1
Ireland	62,9	UK	63

Source: European Commission; 2006

The similar situation is found again in the transitions by age group in 2000-2001 observable in certain European countries (Table 6). Flows to inactivity are highest for the 55-64s, whereas the younger age group turns out to have the highest probability of experiencing transitions of any kind and, in addition, the greatest likelihood of experiencing a transition to employment.

Table 6. Transitions by age group in some European countries, 2000-2001

		EU	Denmark	UK	France	Germany	Italy	Spain
15-24								
U=>	N	42%	12%	54%	40%	54%	25%	53%
	I	15%	88%	6%	6%	28%	18%	12%
I=>	N	17%	33%	31%	9%	17%	8%	15%
	U	6%	4%	8%	4%	4%	11%	5%
N=>	U	6%	4%	3%	10%	6%	6%	13%
	I	7%	26%	6%	4%	10%	7%	6%
25-54								
U=>	N	34%	47%	44%	27%	37%	25%	43%
	I	14%	10%	21%	6%	11%	13%	17%
I=>	N	13%	25%	28%	0%	3%	8%	1%
	U	4%	4%	2%	1%	2%	4%	1%
N=>	U	2%	2%	1%	2%	3%	2%	4%
	I	2%	2%	5%	1%	4%	2%	2%
55-65								
U=>	N	8%	20%	27%	3%	4%	28%	9%
	I	30%	48%	27%	20%	36%	11%	25%
I=>	N	2%	1%	4%	0%	0%	2%	0%
	U	1%	1%	0%	0%	0%	0%	0%
N=>	U	3%	4%	1%	2%	9%	1%	3%
	I	11%	9%	12%	15%	8%	15%	12%

Observed probability of transition from one status to another between 2000 and 2001

U - Unemployment, I - Inactivity, N - Employment
Source: Anxo and Erhel; 2006

During the median period (25-54), transitions between employment, unemployment and inactivity remain relatively high, but lower than for youths, indicating stabilisation as regards employment. There is therefore a tendency towards compression of careers, with employment concentrated on the years between 25 and 54. This general observation masks substantial divergences between countries, however. Ever since increasing the employment rate of seniors became an objective of the European Employment Strategy (50% in 2010), these differences have become familiar for ageing workers in the European Union (Courtioux, Erhel, 2005). This research reveals a contrast between two groups of country. In the Nordic countries, as well as in Portugal and United Kingdom, employment rates are above the EES target (even exceeding 60% in Sweden and Denmark). By contrast, another group of countries is very far from attaining the objective: these are Belgium, Luxembourg, Austria, France and Italy. In these countries the average age of exit from the labour market is below 60, as a reminder of the substantial recourse to arrangements for early retirement or equivalent measures (unemployment benefit without the requirement to look for a job, incapacity benefits, etc.).

It must be stressed, however, that the differences do not concern only the seniors. If this comparison of the role played by age on the labour market is generalised, one obtains an initial picture of the heterogeneity of life course structures between European countries. Table 4 reveals the existence of four groups of country. In the United Kingdom, Ireland, and Denmark, employment rates are high for all age groups. In Belgium, Greece, France, Italy, Germany and Luxembourg, employment is heavily concentrated on the middle of the life cycle, with low employment rates for both youths and seniors. Observations available for two further country groups show asymmetric situations: Austria and the Netherlands have relatively high employment rates for youths but low rates for seniors. By contrast, in Sweden, Finland, and Portugal, they are relatively low for youths and high for seniors.

These life course structures tend to coincide with the usual typologies of social protection models (Esping-Andersen, 1990) or capitalism models (Amable, 2003). In the so-called "liberal" countries, the relatively low level of social protection and the more limited role of education and training create incentives to work throughout a lifetime, while the Nordic countries favour better equilibrium between training (education and in-career training) and employment. Note that the case of Denmark is special in his respect: youth employment rates are high in the country but this mainly reflects the employment of students, compatible with continuing education. In the "continental" and Southern countries, the concentration of employment between the ages of 25 and 54 is the result of the lengthening of the period of education and the highly selective nature of the labour market (both as regards youths in the insertion phase and seniors). This situation therefore aggravates the financial constraints on social protection systems, since the burden of financing, which is provided mainly by social contributions, is concentrated on a more restricted group, with careers that are briefer on average.

A projected slowdown in workforce growth is expected to generate fewer new jobs during 2006-16 than in 1996-2006. The retirements of baby boomers will have a substantial impact on job openings over the coming decade. Net replacement needs are defined as job openings generated due to the necessity of replacing workers who permanently leave an occupation (Dohm and Shniper, 2007). Except in occupations that employ large number of young workers, such as waiters and waitresses, a large number of the job openings due to net replacement needs are expected to come from occupations that will lose workers to retirement.

Workforce ageing by itself is not a sufficient issue to reach the top of the policy agenda, apart, that is, from a few enlightened organisations and countries. However, the combination of workforce ageing, on the one hand, with the development of early exit on the other, has created an imperative for policy action. Thus it is the age/employment paradox that is the main spur to action: the combination of increased longevity with falling retirement ages. In the EU there is a culture of early exit: only just over one-third of 55–64 year olds are economically active. The trend in most developed countries towards early exit from the labour market, particularly among older men, has added substantially to the pressure on social protection systems. This age/employment paradox has the effects of raising the cost of pensions and reducing the revenues available to fund them. This situation is clearly unsustainable in the developed countries where early exit is well entrenched.

Explanations for the growth of early exit among older male workers focus on the interaction between "push" factors reducing their job opportunities and "pull" factors such as affluence and the provision of early exit pathways, which reduce their incentives to remain in or to seek employment (Walker, 1985; Funk, 2004). The dominant factors in Europe have been on the demand-related "push" side and, specifically, low demand and unemployment (Kohli, Rein, Guillemard and Van Gunteren, 1991). When a high risk of unemployment is coupled with a labour market characterised by age discrimination the result can be a very powerful push indeed. On the "pull" side the growth and proliferation of financial incentives for early retirement has enabled many older workers to afford to stop working. In Western Europe early exit became a goal of public policy from the 1970s to the mid-1990s. Measures such as pre-retirement in Denmark and Germany, disability compensation in the Netherlands and Sweden and the Job Release Scheme in the UK actively encouraged the trend towards early labour force exit, sometimes as a means of substituting younger for older workers.

The concept of active ageing and its determiants

The concept of active ageing is a relative new-comer to Europe, achieving widespread currency only in the past five years. Its pedigree in the US is much longer and can be traced back to the early 1960s when it was argued that the key to "successful ageing" (Pfeiffer, 1974; Rowe and Kahn, 1987) was the maintenance in old age of the activity patterns and values typical of middle age (Havighurst, 1963). Successful ageing was to be achieved by denying the onset of old age and by replacing those relationships, activities and roles of middle age that are lost with new ones in order to maintain activities and life satisfaction. This theory of ageing was seen partly as a response to the then influential theory of "disengagement" which viewed old age as an inevitable period of withdrawal from roles and relationships (Cumming and Henry, 1961).

Active ageing is the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age (WHO, 2001). Active ageing applies to both individuals and population groups. It allows people to realize their potential for physical, social, and mental well being throughout the life course and to participate in society according to their needs, desires and capacities, while providing them with adequate protection, security and care when they require assistance. The word "active" refers to continuing participation in social, economic, cultural, spiritual and civic affairs, not just the ability to be physically active or to participate in the labour force. Older people who retire from work and those who are ill or live with disabilities can remain active contributors to their families, peers, communities and nations. Active ageing aims to extend healthy life expectancy and quality of life for all people as they age, including those who are frail, disabled and in need of care.

A new concept of active ageing began to emerge in the 1990s under the influence of the WHO, which, not surprisingly, emphasised the vital connection between activity and health (Butler, Oberlink and Schecter, 1990, p. 201) and the importance of healthy ageing (WHO, 2002).

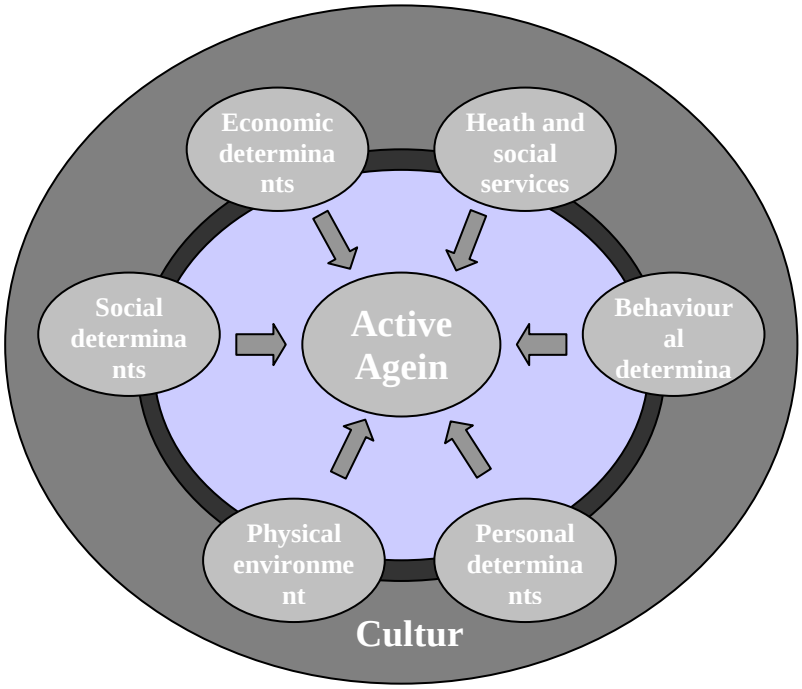

Figure 3. The Determinants of Active Ageing
Source: WHO; 2002

Given the link with health and the European context in which it was developed, this approach to active ageing has focussed on a broader range of activities than those normally associated with production and the labour market and has emphasised health and the participation and inclusion of older people as full citizens. The thinking behind this new approach is expressed perfectly in the WHO dictum "years have been added to life now we must add life to years." (WHO, 2002). This suggests a general lifestyle strategy for the preservation of physical and mental health as people age rather than just trying to make them work longer. Thus the essence of the emerging modern concept of active ageing is a combination of the core element of productive ageing with a strong emphasis on quality of life and mental and physical well-being (European Commission, 1999; Cabinet Office, 2000).

Active ageing depends on a variety of influences or determinants that surround individuals, families and nations. These determinants apply to the health of all age groups, although the emphasis here is on the health and quality of life of older persons. At this point, it is not possible to attribute direct causation to any one determinant; however, the substantial body of evidence on what determines health suggests that all of these factors are good predictors of how well both individuals and populations age. More research is needed to clarify and specify the role of each determinant, as well as the interaction between determinants, in the active ageing process. We also need to better understand the pathways that explain how these broad determinants actually affect health and well being. Moreover, it is helpful to consider the influence of various determinants over the life course so as to take advantage of transitions in order to enhance health, participation and security at different stages. For example, there is evidence that stimulation and secure attachments in infancy influence an individual's ability to learn and get along with others throughout all of the later stages of life. Employment, which is a determinant throughout adult life greatly influences

one's financial readiness for old age. Access to high quality, dignified long-term care is particularly important in later life. Often, as is the case with exposure to pollution, the young and the old are the most vulnerable population groups.

Three aspects of the economic environment have a particularly significant effect on active ageing: income, work and social protection. Throughout the world, if more people would enjoy opportunities for dignified work earlier in life, people would reach old age able to participate in the workforce. Thus, the whole society would benefit. In all parts of the world, there is an increasing recognition of the need to support the active and productive contribution that older people can and do make in formal work, informal work, unpaid activities in the home and in voluntary occupations. In developed countries, the potential gain of encouraging older people to work longer is not being fully realized. But when unemployment is high, there is often a tendency to see reducing the number of older workers as a way to create jobs for younger people. However, experience has shown that the use of early retirement to free up new jobs for the unemployed has not been an effective solution (OECD, 1998).

In less developed countries, older people are by necessity more likely to remain economically active into old age. However, industrialization, adoption of new technologies and labour market mobility is threatening much of the traditional work of older people, particularly in rural areas. Development projects need to ensure that older people are eligible for credit schemes and full participation in income- generating opportunities.

Active ageing policies

An active ageing approach to policy and programme development has the potential to address many of the challenges of both individual and population ageing. Active ageing policies and programmes recognize the need to encourage and balance personal responsibility, age-friendly environments and intergenerational solidarity. Individuals and families need to plan and prepare for older age, and make personal efforts to adopt positive personal health practices at all stages of life. There are good economic reasons for enacting policies and programmes that promote active ageing in terms of increased participation and reduced costs in care. People who remain healthy as they age face fewer impediments to continued work. The current trend toward early retirement in industrialised countries is largely the result of public policies that have encouraged early withdrawal from the labour force. As populations age, there will be increasing pressures for such policies to change – particularly if more and more individuals reach old age in good health, i.e. are "fit for work." This would help to offset the rising costs in pensions and income security schemes as well as those related to medical and social care costs. With regard to rising public expenditures for medical care, available data increasingly indicate that old age itself is not associated with increased medical spending. Rather, it is disability and poor health – often associated with old age – that are costly. As people age in better health, medical spending may not increase as rapidly.

The policy framework for active ageing shown below is guided by the United Nations Principles for Older People (WHO, 2002). These are independence, participation, care, self-fulfilment and dignity. Decisions are based on an understanding of how the determinants of active ageing influence the way that individuals and populations age.

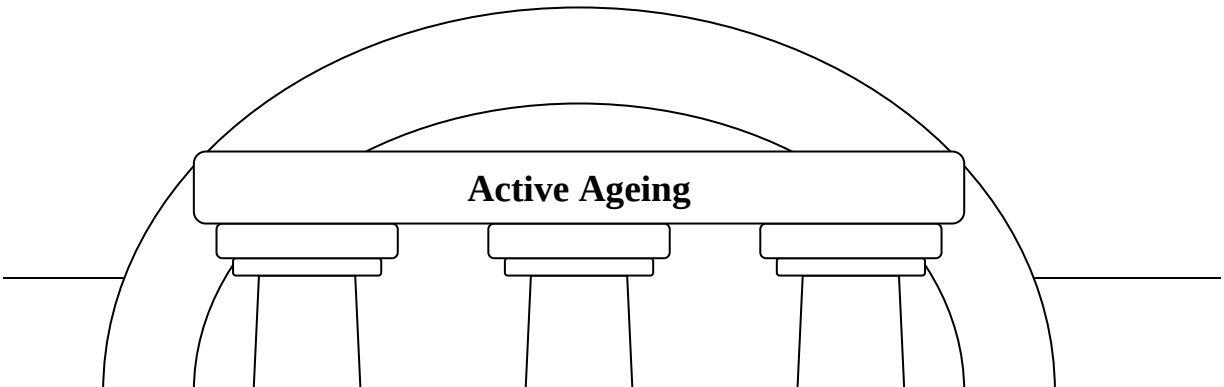

Figure 4. The pillars of a policy framework for active ageing
Source: WHO; 2002

The policy framework requires action on three basic pillars:

Participation. When labour market, employment, education, health and social policies and programmes support their full participation in socioeconomic, cultural and spiritual activities, according to their basic human rights, capacities, needs and preferences, people will continue to make a productive contribution to society in both paid and unpaid activities as they age.

Health. When the risk factors for chronic diseases and functional decline are kept low while the protective factors are kept high, people will enjoy both a longer quantity and quality of life; they will remain healthy and able to manage their own lives as they grow older; fewer older adults will need costly medical treatment and care services. For those who do need care, they should have access to the entire range of health and social services that address the needs and rights of women and men as they age.

Security. When policies and programmes address the social, financial and physical security needs and rights of people as they age, older people are ensured of protection, dignity and care in the event that they are no longer able to support and protect themselves. Families and communities are supported in efforts to care for their older members.

The following policy proposals are designed to address the three pillars of active ageing: health, participation and security. Some are broad and encompass all age groups while others are targeted specifically to those approaching old age and/or older people themselves.

Formal work. Enact labour market and employment policies and programmes that enable the participation of people in meaningful work as they grow older, according to their individual needs, preferences and capacities (e.g., the elimination of age discrimination in the hiring and retention of older workers). Support pension reforms that encourage productivity, a diverse system of pension schemes and more flexible retirement options (e.g., gradual or partial retirement).

Informal work. Enact policies and programmes that recognize and support the contribution that older women and men make in unpaid work in the informal sector and in care giving in the home.

Voluntary activities. Recognize the value of volunteering and expand opportunities to participate in meaningful volunteer activities as people age, especially those who want to volunteer but cannot because of health, income, or transportation restrictions.

Active ageing at the organisational level

Regardless of what policy makers do, the focal point for age management and adjustment to workforce ageing must be the individual organisation. Recent European research has revealed significant shifts in the attitudes of employers towards older workers. Some employers are reassessing the consequences of early exit (Walker, 1997). It is being seen by some as a waste of experience and human resources and of the investment they have made in the workforce. Others see roles for older workers in training younger people or in preventing skill shortages. In the pan-European research supported by the European Foundation one can find 160 examples of good practice in the employment of older workers, ranging from small changes in job recruitment advertisements through to comprehensive age awareness programmes. In the UK some employers have even constructed a positive "business case" for employing this group. This "business case" is built upon five points: the return on investment in human capital; the prevention of skill shortages; maximising recruitment potential; responding to demographic change; and promoting diversity in the workforce (Walker, 1997). Despite the clear and present signs of change, good practice in the employment of older workers remains a minority pursuit. Progress is slow and often relies on the existence of a human resources director within organisations to doggedly promote the issue or a specific initiative. Thus the answer to the critical question posed earlier as to how successfully firms are adjusting to workforce ageing is that in the EU, a few have done so highly successfully but the majority have yet to face up squarely to the issue.

At the organisational level, in both the public and private sectors, a new age management perspective is required, ideally as part of a general diversity strategy. The term "age management" may refer specifically to the various dimensions by which human resources are managed within organisations with an explicit focus on ageing but, also, more generally, to the overall management of work-force ageing via public policy or collective bargaining (Walker, 1997). Within organizations there are five main dimensions of age management: job recruitment (and exit); training, development and promotion; flexible working practices; ergonomics and job design; and changing attitudes towards ageing workers (Casey, Metcalf and Lakey, 1993). It is essential to adopt a life course perspective because the skills and potential of a person vary at different ages. Therefore the aim must be to design work places and work biographies so that people of all ages can develop optimally and exploit their potential to the full. A key focus of age management, therefore, is the quality of work: this must be improved if work ability and, therefore, employability are to be maintained. In Europe the labour market withdrawal rate of older workers in low quality jobs is up to four times higher than that for those in high quality jobs (Leowski, 2000). To rectify this disparity means better educational qualifications, ensuring access to continuous vocational training, improvements in health and safety, making work organisation and working time more flexible, promoting diversity and making career progress possible. European research has collected numerous examples of good practices in age management (Walker, 1997; 1999) and the following summarises the key elements:

- Developing (ageing) employees, career planning.
- Continuous training plus occupational recycling and promotion.
- Flexible employment schedules.
- Age-mixed teams.
- Job re-design, ergonomics and function identification.

- Maintaining and promoting good health and capacity.
- Promoting age diversity.
- Age awareness/combating age discrimination.
- Intergenerational collaboration (e.g. tandem training).

Age management and age diversity should be the concern of all of the key actors in the labour market, including government, employers' organisations and trade unions. At the heart of this concern is the employment contract: the relationship between workers and employers. If employers have a duty to create the conditions in which individuals can manage their own careers and ageing then workers themselves have a parallel duty to take advantage of all opportunities to improve their work ability. The two sides of the age management coin can be illustrated as seen in Table 7.

Table 7. Age management in practice

Workers' work ability	Work environment
Educational qualifications and skills	Age awareness
	Flexible work organisation
Ability to work in teams	Flexible working time
Ability to work autonomously	Diversity (equal opportunities)
Commitment to continuous training and lifelong learning	Career planning, promotion
Flexibility and mobility	Continuing training
	Healthy and safe working conditions

Source: Walker; 2006.

Conclusion

The active ageing approach provides a framework for the development of global, national and local strategies on population ageing. By pulling together the three pillars for action of health, participation and security, it offers a platform for consensus building that addresses the concerns of multiple sectors and all regions. Policy proposals and recommendations are of little use unless follow-up actions are put in place. The organisation level is the best place for it.

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