

**Written Comments to the OECD Health Committee**

September 2026

Report on Demographic change and mental health: addressing the needs of ageing populationsMental health and the 21st century megatrends

General Comments

Business at OECD (BIAC) welcomes the paper's comprehensive analysis of the mental health implications of population ageing, particularly its emphasis on the bidirectional relationship between mental and physical health, multimorbidity, and the need for integrated, person-centred and proactive approaches to healthy ageing.

We welcome the paper's emphasis on integrated, age-responsive approaches to mental health and its recognition that mental and physical health risks reinforce one another in later life. We encourage the paper to place prevention and supported self-care more centrally within the healthy ageing agenda, with explicit recognition of responsible self-care as a complement to, rather than a substitute for, appropriate clinical and mental health services. Health literacy, access to trusted information, and appropriate support can empower older adults to maintain their health, manage suitable day-to-day health needs, recognize changes that require professional attention, and participate more actively in decisions about their care. Enabling people to maintain their health and wellbeing through healthy behaviours, social participation, responsible self-care, and timely professional support can help preserve autonomy, resilience, and quality of life, while strengthening prevention, supporting NCD management, promoting healthy ageing, and helping health systems preserve scarce clinical capacity.¹

We particularly welcome the recognition of self-management as a key component of person-centred care. Supported self-management can equip older adults, including those living with chronic conditions and multimorbidity, with the knowledge, confidence and appropriate tools to manage everyday health needs, alongside clear pathways to professional care when needed.

The paper's discussion of polypharmacy also highlights the importance of a complete view of medicine use. Older adults may use prescription medicines alongside non-prescription medicines

¹ GSCF. The Global Social and Economic Impact of Self-Care. July 2026. Available from: <https://www.selfcarefederation.org/resources>: The Global Self-Care Federation's 2026 research estimates that current self-care using registered non-prescription medicines generates 24 million QALYs, saves 2.2 billion hours of physician time, and delivers approximately USD 144 billion in annual health-system savings globally. These estimates are not specific to older adults or mental health but illustrate the potential contribution of responsible self-care to preserving health-system capacity. European evidence also points to the potential contribution of self-care to health-system sustainability. AESGP research estimates that current self-care practices generate EUR 23.2 billion in annual net savings in medical services and products in Europe and that, without self-care, around 120,000 additional physicians would be required, or each physician would need to work an additional 2.4 hours per day. This is particularly relevant in the context of demographic change and increasing pressure on the European health workforce.

and other self-care products. Policies on medicines optimisation, medication review and health literacy should therefore support safe, informed use of all products and encourage dialogue with pharmacists and other community-based healthcare professionals to reduce avoidable interactions, duplication and inappropriate use.

The role of pharmacists ensuring safe and effective use of medicines for older people, and the very high frequency of interaction between older people and community pharmacy teams is highly important. Community pharmacists manage polypharmacy and are involved in transitions of care, detecting early signs of depression and cognitive impairment, recommendations relating to deprescribing of high-risk psychotropics, alleviating carer strain, and connecting isolated individuals to community resources through social prescribing. In particular, we recommend that the OECD examine the way pharmacists are utilised in Japan in the care of that country's super-aged population. We include several examples from Japan in the specific comments below.

We would also like to draw attention to employment as an important protective factor for mental health. Particularly in cases of loneliness, social isolation, or depressive symptoms, it should therefore be assessed whether continuing to work—for example, part-time—can make a positive contribution to stabilizing mental health. This can also be taken into account as part of medical or rehabilitative recommendations.

Health-promoting working conditions are crucial for maintaining employment over the long term. In addition to part-time arrangements, greater attention should be paid to age- and health-appropriate tasks as well as suitable work organization. From a preventive perspective, it is essential to maintain the ability to work for as long as possible and to enable employees to continue working in roles that match their abilities.

Furthermore, prevention, rehabilitation, and reintegration should take precedence over early retirement. Even for employees nearing retirement age, rehabilitation and reintegration options should be thoroughly evaluated and not ruled out solely on the basis of age. This requires well-functioning coordination between medical care, rehabilitation, and the workplace, as well as support services tailored to individual needs.

In addition, mental health is a challenge for all age groups. While older workers are increasingly becoming the focus of attention due to demographic change, studies in Germany show a higher prevalence of anxiety disorders and depression, particularly among young people—and especially among young women. Measures to promote mental health should therefore be designed to span generations and take all age groups into account equally.

We also believe there is a significant opportunity to strengthen the report by making physical activity and movement a more explicit policy priority within the healthy ageing framework. While the paper rightly emphasises addressing ageism, creating age-friendly environments, integrated care and long-term care reform, there is no equivalent pillar focused on active ageing through physical activity, movement and sport participation. This is a notable gap, given that the report itself identifies reduced physical activity as a factor in several pathways associated with poorer outcomes in later life, including frailty, falls, depression and retirement transitions. Physical activity is a cost-effective, cross-cutting intervention that can support physical health, mental wellbeing, independence and social participation. Although referenced under age-friendly environments, this does not fully reflect its broader preventive and therapeutic benefits.

We therefore encourage stronger policy recommendations that recognise physical activity as a core component of healthy ageing, including accessible community-based opportunities and pathways linking health and social care services with qualified exercise and physical activity providers as part of a person-centred prevention and support continuum.

Lastly, the final recommendations should more explicitly recognise the role of public, private and non-profit providers in delivering integrated care; place greater emphasis on hospitals, rehabilitation and transitions between care settings; and recognise that successful system transformation requires adequate workforce capacity, sustainable financing and appropriate incentives.

The issue of mental health also requires an approach that is not only curative, but preventive, as part of healthy ageing. Hospitals of all statuses, public and private, which receive millions of people and their relatives every year, can be essential vectors of prevention, particularly in mental health. This requires European health systems to resolutely take the preventive turn, and for hospitals to be recognised and valued for their innovative prevention initiatives. Mental health prevention must be fully taken into consideration, in the same way as other prevention issues, and the innovations at work open prospects of hope for patients that must be supported.

Specific Comments

- **Paragraph 5:** Paragraph 5 states that demographic change is likely to stretch the capacity of the mental health system as well as the wider health system and highlights shortages of psychiatrists, nurses, psychologists and other professionals. We believe the implications for healthcare delivery capacity could be developed further. The demographic challenge is not only a question of increasing the number of mental health professionals. It also requires the wider healthcare workforce to be equipped to identify and respond to mental health needs among older patients with multimorbidity, frailty and complex care needs.
 - In addition, workforce shortages affect all healthcare providers. Policy responses should therefore encompass public, private and non-profit providers participating in national health systems. A sufficiently broad approach to workforce planning is particularly important in countries where public and private providers share responsibility for delivering hospital and specialist care.
 - Suggested addition: “Workforce planning should encompass all providers contributing to national health systems, including public, private and non-profit providers. In addition to increasing the number of specialist mental health professionals, countries should strengthen multidisciplinary teams and equip the wider healthcare workforce with the skills required to identify and manage mental health needs among older adults.”
- **Paragraph 16:** The paper identifies several major risk factors for poor mental health in later life including loneliness and social isolation, chronic disease and multimorbidity, retirement and loss of social roles, bereavement, frailty and declining functional ability. Many of these risk factors can be addressed through living a more active lifestyle with age appropriate physical activity.
- **Paragraphs 17-24:** Given the strong bidirectional relationship identified between mental health and NCDs, the paper could give greater recognition to prevention and supported self-management of physical health as part of healthy ageing. Responsible self-care can contribute through health promotion, healthier behaviors, symptom recognition, self-monitoring, appropriate medicine use, and timely engagement with healthcare professionals. This is consistent with wider healthy-ageing work: the Global Coalition on Aging’s work on NCDs and healthy ageing calls for older people to be more explicitly integrated into NCD and mental health strategies, while the International Federation on Ageing advocates integrated, person-centered approaches that prioritizes prevention and early intervention across the life course. The Aging with Heart Alliance also calls for

prevention across the continuum of care, stronger access to early detection and community-based treatment, and integrated models that empower patients.

- **Paragraphs 25-29:** The paper identifies high levels of mental health needs among people with frailty and long-term care needs and discusses the relationship between care models and psychological wellbeing. It states that community care is associated with improved psychosocial wellbeing compared with more institutional forms of care, while recognising that institutional care remains necessary for some populations.
 - We believe the quality of care should not be associated primarily with the setting in which care is delivered. Hospital, residential and other institutional settings remain essential for patients with complex clinical needs, severe illness, frailty or significant multimorbidity. The relevant policy objective should be to ensure that every setting provides high-quality, person-centred care and is effectively connected to other parts of the health and social care system.
 - Suggested replacement wording: "Care quality and mental health outcomes depend primarily on the organisation, quality, staffing and person-centredness of care rather than on ownership or setting alone. Community, hospital and residential services should therefore be viewed as complementary components of integrated care pathways, with the appropriate setting determined by the individual's clinical, functional and psychosocial needs."
- **Paragraph 27:** The discussion of polypharmacy would benefit from recognising the full range of products an older person may use, including non-prescription medicines and other self-care products as relevant. Medication reviews and reconciliation should capture these products alongside prescribed therapies. We also encourage reference to the role of pharmacists in supporting medicines literacy, identifying potential interactions or duplication, and helping older adults make safe and appropriate self-care choices.
 - Paragraph 27 outlines the risks of polypharmacy in older adults, including inappropriate psychotropic prescribing, anticholinergic burden, and fall-related injuries. Explicitly referencing pharmacist-led medication reviews, deprescribing, and care transitions would connect these documented risks with established primary care solutions across OECD countries.
 - **Proposed addition:** "To mitigate these risks, structured medication management, regular medication reviews, post-discharge reconciliation, and deprescribing interventions led by community pharmacists have proven effective in addressing prescribing cascades, reducing inappropriate legacy psychotropics, managing anticholinergic burden, and decreasing medication-related falls and hospitalisations among older adults ([Martin et al., 2018](#); [Tesfaye et al., 2026](#); [Ming et al., 2021](#)). For example, Japan's visiting pharmacist services support older adults with complex regimens to live safely at home ([Taguchi et al., 2024](#); [Onda et al., 2015](#)), while the NHS Discharge Medicines Service in the United Kingdom significantly reduces post-discharge medication harm and readmissions ([Thayer et al., 2023](#); [NHS England, 2021](#)). In Japan, pharmacists are legally required to continuously ascertain and follow up on patients' medication use, treatment effects, changes in physical condition, and adverse events after the medicines have been supplied."
- **Caregiver support (Page 23, Paragraph 41; see also Pages 33-34, Paragraph 91):** Paragraphs 38-41 and Paragraph 91 emphasise that informal caregivers face substantial mental health risks, including depression and Prolonged Grief Disorder, yet lack structured

support mechanisms in routine care. Acknowledging community pharmacy touchpoints highlights an accessible setting for identifying caregiver strain early, providing practical medication adherence solutions, and connecting carers to community resources.

- Proposed addition (insert at the end of the paragraph): "Informal caregivers frequently visit community pharmacies to collect prescriptions and manage supplies for dependents, making pharmacy teams an accessible touchpoint to identify signs of carer strain early, provide practical medication management support (such as dose administration aids), and facilitate referral to counselling and respite services. In Japan, pharmacist home visits are provided under public health and long-term care insurance. These visits support carers by identifying early changes in physical condition, cognitive function, and mood, while coordinating care with physicians, nurses, and others, including at the time of hospital admission and discharge."
- **Paragraph 32:** The paper already notes that retirement may support wellbeing by allowing more time for physical activity. Consider adding: "Policies and programmes that support healthy transitions into retirement could therefore include opportunities to maintain or increase physical activity alongside interventions that promote social connection, purpose and participation."
- **Inclusion of community pharmacy organisations in national strategy development (Pages 38-41, Paragraphs 114, 122 and Table 5.1):** Section 5 outlines core system transformation recommendations, including the adoption of the 4Ms framework (Table 5.1) and the development of integrated primary care models (Paragraph 122). Recommending formal consultation with national pharmacy organisations would ensure the Medication and Mentation pillars are operationalised effectively across frontline primary care networks.
 - Proposed addition: "To ensure effective co-ordination across primary care disciplines, national frameworks and collaborative care models should be developed in direct consultation with primary healthcare professional bodies, including national pharmacy organisations. This engagement reflects pharmacists' frontline roles in polypharmacy management, medication safety, and community-based mental health support."
- **Paragraph 44:** The draft notes that bereavement can lead to decreased physical activity, social withdrawal and isolation. Consider acknowledging the corresponding intervention opportunity: maintaining engagement in appropriate physical activity, particularly through accessible community-based opportunities, may be relevant within broader strategies to support older adults following bereavement and reduce withdrawal and isolation.
- **Paragraph 69:** The paper notes that older adults are more likely to receive mental healthcare from non-psychiatrists and therefore stresses the importance of ensuring that non-specialist practitioners can identify mental ill-health. We support this approach but recommend explicitly including hospital professionals and multidisciplinary teams.
 - Suggested addition: "Training should extend beyond specialist mental health services to healthcare professionals working in hospitals, rehabilitation, primary care, home care and residential settings. Multidisciplinary training can improve recognition of mental health conditions and strengthen coordination between physical and mental healthcare."
- **Paragraphs 69-70:** We support the emphasis of community pharmacists as highly accessible health professionals, who can play an important role in recognising changes in health, providing advice on appropriate self-care and non-prescription medicine use, and

referring people to medical or mental health services when symptoms or risks require further assessment. We suggest reflecting pharmacists and other community-based healthcare professionals within the multidisciplinary workforce described in the paper.

- Proposed addition: "Given that community pharmacies represent one of the most accessible and frequently visited primary healthcare touchpoints for older adults (Berenbrok et al., 2020; Todd et al., 2014), embedding validated screening tools, signposting, and multidisciplinary referral pathways within community pharmacy can improve early identification of depressive symptoms and help alleviate pressures on specialist care."
- **Paragraph 103: Addressing loneliness and social isolation, including social prescribing:** Paragraph 103 outlines the growing role of social prescribing in addressing loneliness, bereavement, and social isolation among older people. Explicitly including community pharmacists alongside general practitioners within social prescribing networks would expand referral channels, leveraging pharmacy premises as highly accessible community hubs for socially isolated individuals.
 - Proposed amendment (amend the fourth sentence): "Primary care providers, including general practitioners and community pharmacists, can identify potential service users and refer them to community programmes to assess their specific needs and connect them to appropriate non-clinical services."
- **Paragraphs 113-118:** Health literacy could be recognized more explicitly as an enabler of healthy ageing, particularly where ageism contributes to underdiagnosis or older adults internalize the belief that declining physical or mental health is simply part of ageing. Access to clear, age-appropriate information can support informed decisions, symptom recognition, appropriate help-seeking and more confident engagement with health and social care services. This would also align with the International Federation on Ageing's healthy-ageing approach, which identifies combating ageism, person-centered care, and improved health literacy as important enablers of functional ability and well-being in older age.
- **Paragraph 118:** We strongly support patient education and empowerment as interventions to address ageism and improve access to care. We suggest explicitly including health literacy and self-care literacy, with information tailored to older adults' needs and capacities. This should include clear guidance on what can be safely self-managed, responsible use of non-prescription medicines and self-care products, and when to seek professional support.
- **Paragraph 120:** The paragraph mentions that policy action should focus on embedding mental health objectives within age-friendly policies. This includes designing urban and rural environments that facilitate social interaction and physical activity, expanding community-based programmes that promote social participation and reduce loneliness, and ensuring that older adults are actively involved in the design of services and environments that affect them. Whilst this is encouraging, the opportunity to better embed physical activity is significant and should be more strongly featured and emphasised.
 - Retirement can create opportunities for increased physical activity and wellbeing; Bereavement can lead to reduced physical activity, which contributes to worsening mental and physical health; Fear of falls can reduce activity, leading to further frailty and poorer mental health outcomes; Age-friendly environments should facilitate both social participation and physical activity; Social prescribing programmes can include recreational activities such as football, gardening and other community-based activities that improve wellbeing and reduce loneliness

- Whilst the paragraph includes recommended policy action focused on “environments that can enable physical activity”, the report stops short of explicitly positioning physical activity as a protective mental health intervention, which is a fundamental omission that should be considered.
- Suggested revision: “This includes designing urban and rural environments that facilitate social interaction and physical activity; expanding accessible, community-based opportunities for physical activity and social participation; reducing barriers that prevent older adults from remaining active and connected; and ensuring that older adults are actively involved in the design of services and environments that affect them.”
- **Paragraphs 121-123:** We welcome the paper’s reference to self-management and its recommendation to expand prevention and psychosocial interventions that support coping, self-management and social participation. We encourage the final paper to situate self-management within the broader concept of self-care, as defined by the World Health Organization, and to frame supported self-care as a practical component of integrated, person-centred care. This broader approach recognises the ability of individuals, families and communities to promote and maintain health, prevent disease and cope with illness, with or without the support of a health or care worker, while maintaining clear links to professional care. Alongside clinical and psychosocial support, older adults should have access to the knowledge, tools and professional support needed to maintain health, manage appropriate everyday and chronic health needs, and navigate effectively between self-care and professional care. Community-based services, including pharmacists and pharmacy-based support where appropriate, should be recognised as part of the primary and community care ecosystem, helping to strengthen continuity between physical and mental health, reinforce the link between prevention, day-to-day self-management and timely escalation to clinical care, and support a continuum of care that spans health promotion, disease prevention, symptom recognition, self-monitoring and early action. (GSCF, EcoSoc 2.0, 2026).
 - Consider also explicitly including physical activity among the mental health promotion and prevention interventions available within integrated, person-centred models of care, including pathways connecting health and social care providers with qualified community-based physical activity and exercise resources.
 - We strongly support the direction and recommends that hospitals be explicitly included in the description of integrated pathways. For older patients with multimorbidity, hospital care is often a central point of coordination between different medical specialties and between acute, rehabilitation, mental health and long-term care. Hospitals can also provide important opportunities for early identification and intervention.
 - Suggested addition to paragraph 122: “This includes strengthening collaborative care models, improving information sharing between providers, and ensuring continuity of care across settings, including primary care, hospitals, specialist mental health services, rehabilitation, home care and long-term care.”
- **Paragraphs 121-124:** The recommendations refer generally to “health systems” and “providers” but do not explicitly recognise the diversity of provider models through which healthcare is delivered in OECD countries. We recommend adding an explicit principle of provider neutrality. The relevant distinction should be whether a provider meets applicable

standards of quality, safety, accessibility and accountability, rather than whether the provider is publicly or privately owned.

- Suggested addition: “Integrated care policies should be provider-neutral and should make use of the capacity and expertise of all providers participating in regulated or publicly financed healthcare systems. Public, private and non-profit providers should be able to contribute on an equitable basis, subject to common requirements for quality, safety, accessibility, transparency and accountability.”
- **Paragraph 124:** For older adults receiving long-term care, medicines and self-care support should form part of holistic, person-centred care planning. We suggest that medication assessment and monitoring systematically consider non-prescription medicines and other self-care products, and that older adults and informal caregivers receive clear, accessible information to support safe use and identify when professional advice is needed. The paper also identifies the need for system transformation but gives relatively limited attention to the financing and reimbursement conditions required to achieve it. Integrated care requires investment in workforce, infrastructure, digital interoperability, coordination and training. Payment mechanisms should support rather than discourage coordination between providers and sectors
 - In the long-term care recommendations, consider expanding “supporting autonomy, meaningful activities and social engagement” to read “supporting autonomy, appropriate opportunities for physical activity, meaningful activities and social engagement.” This would align the recommendations with the paper’s earlier discussion of inactivity, falls, frailty, depression and reduced engagement among older adults with care needs.
 - Suggested addition: “System transformation also requires sustainable financing and payment arrangements that support integrated care. Countries should assess whether reimbursement and contracting mechanisms create barriers to coordination between providers or encourage fragmented delivery. Appropriate financing should support prevention, early intervention, multidisciplinary care, rehabilitation and continuity across care settings.”
- **Paragraphs 125-128:** The sustainability case for prevention and self-care could be acknowledged within the proposed system transformation. The latest GSCF evidence shows that preventive self-care can contribute across the disease life cycle, including prevention, early recognition, day-to-day management of chronic conditions and avoidance of unnecessary healthcare use. This can complement the paper’s objective of moving from fragmented and reactive approaches towards more integrated and proactive systems for older adults. Published 2026 research on the triple value of self-care also provides a practical example: a UK analysis of allergic-rhinitis self-care modelled reductions in primary-care and A&E utilization and associated environmental benefits, illustrating how appropriate self-care can contribute to system capacity as well as wider social, economic and environmental value.
- **Paragraph 128:** The paper concludes that the capacity of countries to respond to ageing-related mental health challenges will be critical for the sustainability of health systems and the wellbeing of older generations. We strongly support this conclusion but recommends explicitly connecting sustainability with the mobilisation of the full available healthcare capacity. Europe will not be able to address demographic pressures by relying on one category of provider alone. Public and private providers should be enabled to work together and contribute their capacity, expertise, infrastructure and innovation.

- Suggested addition to the conclusion: “Ensuring sustainable responses to population ageing will require the mobilisation of the full capacity of healthcare systems. Effective cooperation between public, private and non-profit providers, supported by appropriate regulatory and financing frameworks, can increase access, strengthen resilience and support the delivery of integrated and person-centred care.”

Supporting Resources

1. Global Self-Care Federation. The Global Social and Economic Value of Self-Care: Self-Care at the Forefront of Prevention. GSCF, 2026. [Access here.](#)
2. Global Self-Care Federation. How self-care contributes to the risk-reduction, prevention & management of NCDs. GSCF, 2025. [Access here.](#)
3. World Health Organization. Self-care for health and well-being. WHO, 2026. [Access here.](#)
4. Pascual P, Caudwell A, De Man S, et al. Exploring the Impact of Delivering Allergy Medication as Self-Care on Healthcare Greenhouse Gas Emissions in the United Kingdom. *Advances in Therapy*, 2026. [Access here.](#)
5. Association of the European Self-Care Industry (AESGP). Self-Care in Europe: Economic and Social Impact on Individuals and Society. 2023. [Access here.](#)
6. Global Coalition on Aging. Tackling NCDs Through Healthy Aging: An Opportunity to Achieve Health and Well-Being for All. 2025. [Access here.](#)
7. Aging with Heart Alliance / Global Coalition on Aging. Call to Action to Prioritize Combatting Cardiovascular Disease to Tackle NCDs and Achieve Healthy Aging. 2025. [Access here.](#)
8. International Federation on Ageing. Noncommunicable Diseases and Fostering Healthy Ageing resources. [Access here.](#)
9. International Federation on Ageing. Fostering Healthy Ageing. [Access here.](#)
10. International Longevity Centre UK. Healthy Ageing and Prevention Index. [Access here.](#)