Ageing unequally

The Daily Mail, a conservative British newspaper, continued in its tradition of courting controversy with a headline on April 13, 2021, "Why making women retire later comes with hidden cost: State picks up £5600 bill for the caring of elderly relatives that could have been covered by women if they were not still working". The response on Twitter was immediate and unamused (with one user, Kate Jarman, responding "Hey Siri, explain structural misogyny, patriarchy and sexism in a headline.") However, looking past the clickbait headline reveals an important issue.

The research was done by Ludovico Carrino, Mauricio Avendano and Vahe Nafilyan. The authors took advantage of a recent change in the age at which women can claim the State Pension in the UK. For women born after 1949, the age at which they can claim the State Pension was raised from 60 to 65 years old between 2010 and 2018. Carrino and colleagues found that the increased age threshold led to older women working longer hours and, consequently, substantially reduced the amount of care given to dependent older relatives. Furthermore, this deficit in care burden was not met by an increase in either formal or informal care from elsewhere, effectively lowering older patient welfare. Carrino and colleagues emphasise that most of the care for older people in OECD countries is informally provided, at a cost of £132 billion annually for the UK in 2015—a figure close to total public health expenditure. In the UK, more than 30% of caregivers are between ages 55 and 65 years, and are predominantly women.

These data are striking because they shine the spotlight on older women. We have a dearth of age, gender, and sex disaggregated data, and their absence has important implications for healthy longevity.

Part of the issue is that women tend to live longer than men and have a higher number of chronic health conditions. Despite this, older women are more likely to be excluded from clinical trials. For example, an Article investigating eligibility criteria for oncology trials found that women and those aged 75 years and older were the most frequently excluded populations. The National Institutes of Health (NIH) only instituted the Inclusion Across the Lifespan policy in 2019 to ensure adequate inclusion of older patients in NIH-funded research because older patients remain frequently excluded from any clinical trials not explicitly done in older populations. Notably, in an assessment of nearly 2500 COVID-19-related studies, less than 5% of investigators had pre-planned for sex-disaggregated data analysis in their studies. This is despite the fact that from a physiological perspective, being older and a woman tends to increase the risk of experiencing drug-related adverse events, with a review in 2001 finding that eight of ten drugs that were withdrawn in the USA were withdrawn due to increased health risks to women. Consequently, in a Review in this issue, Rochon and colleagues show the importance of considering both gender and sex when considering medication discontinuation or de-escalation.

From a socioeconomic perspective, older women are more likely to be caregivers and less likely to have a spouse or partner provide medical supervision or care. This can potentially place older women at increased risk of harm. In this issue, Huynh and colleagues report the results of their analysis of incidence of acute myocardial infarction (AMI) in Region Jönköping County, Sweden, from March 1 to July 31, 2020 (ie, during a high peak of the COVID-19 pandemic) compared with the same period during previous years. They found a significant decrease in the incidence rate ratio for women aged 70 years or older. The authors speculate that these findings do not reflect a true decrease in AMI in this population during 2020, but rather reflect the difference between men and women's health-seeking behaviours, with women feeling that they do not want to trouble others leading to a delay in seeking medical attention, which has been found not to be the case for men. In a linked Comment, Lafont and Mennuni suggest that this difference in presentation with AMI could also arise from women living alone and thus potentially not receiving the assistance that they need to get to hospital.

These three findings, ostensibly quite different, converge to paint a worrying picture of the extra burden shouldered by older women. All people in societies will age. If societies are going to age successfully there must be the opportunity to age equally. The first step in ensuring equality of ageing is to root out hidden inequities that are built into society and its expectations. For this to happen, as a minimum first step, we must actively plan to collect good quality age, gender, and sex disaggregated data as standard. ■ *The Lancet Healthy Longevity*

For more on **oncology trials' exclusion criteria** see https://www.nature.com/articles/s41586-021-03430-5

For more on **COVID-19 sex-disaggregated data reporting** see https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)00384-6/fulltext#%20

For more on **polypharmacy by sex and gender** see **Review** page e290

For **AMI incidence in Sweden** see **Articles** page e283 and **Comment** page e236