COMMENTARY

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Healthy aging for whom? Sarcopenia, inequities, and access to care

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Abstract

Healthy aging has become an important global public health goal, but the opportunity to age with preserved functional ability is not equally distributed across populations. Sarcopenia provides a useful lens through which these inequalities can be understood because its development and consequences are influenced not only by biological aging but also by socioeconomic conditions, physical activity opportunities, nutrition, living environments, social support, and access to healthcare. Evidence indicates that socioeconomic disadvantage is associated with a greater likelihood of probable sarcopenia among community-dwelling older adults. In Brazil, studies conducted in both rural and urban populations have also highlighted relationships between sarcopenia-related characteristics and occupational status, physical activity, marital status, income, and other social factors. These findings challenge approaches that place the responsibility for healthy aging primarily on individual behavior. Older adults cannot be expected to maintain muscle strength and physical function when opportunities for exercise, adequate nutrition, preventive care, transportation, and rehabilitation are unequally distributed. Primary healthcare therefore has an important role in identifying functional decline and connecting older adults with accessible interventions. Physiotherapy can contribute through functional assessment, exercise prescription, fall prevention, rehabilitation, health education, and community-based strategies. However, expanding physiotherapy services alone is insufficient if structural barriers remain unaddressed. A more equitable approach to sarcopenia requires health systems to move beyond the identification of individual risk and incorporate social determinants, territorial inequalities, and access to care into prevention and management strategies. Healthy aging should not be defined only by how long people live, but also by whether they have a fair opportunity to remain mobile, independent, and socially engaged.

Keywords: Sarcopenia, healthy aging, health inequities, social determinants of health, healthcare access, physiotherapy

Healthy aging is not equally available

Healthy aging is frequently presented as a desirable outcome for individuals and populations. However, an important question remains: healthy aging for whom? The World Health Organization defines healthy aging as the process of developing and maintaining the functional ability that enables well-being in older age [1]. This concept represents an important shift from viewing aging exclusively through the presence or absence of disease. Functional ability depends on the interaction between an individual's intrinsic capacity and the physical, social, and health environments in which they live [1]. This perspective is particularly relevant to sarcopenia.

Sarcopenia is now recognized as a progressive and generalized skeletal muscle disorder in which low muscle strength is the primary characteristic, while low muscle quantity or quality confirms the diagnosis and poor physical performance indicates severe sarcopenia [2]. Although biological aging is an important component of its development, sarcopenia does not occur in a social vacuum.

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Sarcopenia should also be distinguished from frailty. Although these conditions are closely related, they are not synonymous. Sarcopenia primarily concerns skeletal muscle health, whereas frailty reflects a broader state of reduced physiological reserve and increased vulnerability to stressors. Thus, sarcopenia may contribute to frailty, but frailty encompasses multiple physiological and functional domains beyond muscle health [1, 2].

Sarcopenia and the social gradient of aging

Health inequalities accumulate across the life course. Education, occupation, income, housing, nutrition, working conditions, social protection, and access to healthcare can influence health trajectories long before old age [3]. The same principle may apply to muscle health. A study of 3,342 community-dwelling older adults in Ireland found that 23.4% had probable sarcopenia, with a significantly higher prevalence among individuals with lower socioeconomic position compared with those with higher socioeconomic position (28.9% versus 18.1%). Disadvantaged socioeconomic position remained independently associated with probable sarcopenia after adjustment for other factors [4]. These findings are important because they challenge the assumption that sarcopenia is primarily an inevitable consequence of chronological aging.

When "lifestyle" is not simply a choice

Physical activity is one of the most important modifiable factors in the prevention and management of functional decline. Exercise interventions, particularly resistance-based exercise, can improve muscle strength and physical function among older adults with sarcopenia [5]. However, recommending physical activity is not equivalent to ensuring that physical activity is possible. An older person living in a neighborhood without sidewalks, public parks, transportation, community exercise programs, or safe spaces may face very different opportunities from an older person living in an environment designed to support mobility. The built environment may therefore become part of the sarcopenia discussion. A recent systematic review found evidence linking characteristics of the built environment and perceived neighborhood conditions with physical frailty and sarcopenia among older adults [6]. This issue is particularly relevant in socially vulnerable communities, where environmental barriers may reinforce physical inactivity and functional decline.

The same reasoning applies to nutrition. Telling an older adult to increase protein intake is insufficient when food insecurity, low income, limited access to fresh foods, dental problems, living alone, or difficulties preparing meals restrict the person's ability to follow nutritional recommendations. Thus, healthy behaviors should not be interpreted exclusively as individual choices. They are also shaped by the environments in which choices are made.

The Brazilian context: territory matters

The Brazilian context illustrates how social and territorial conditions can intersect with sarcopenia. In a study of older adults living in rural areas of Ceará, low muscle strength was more frequent among individuals who were not working, while reduced muscle mass was associated with older age, not living with a spouse, and inadequate physical activity. Reduced gait speed was also more frequent among older adults who were not working [7]. These findings are particularly relevant because rural aging may involve barriers that are not adequately captured by conventional clinical assessments. Geographic distance from healthcare services, transportation limitations, socioeconomic vulnerability, and reduced availability of specialized professionals may influence the possibility of receiving preventive and rehabilitative care.

More recent evidence from Northeast Brazil reinforces the importance of this discussion. In a sample of 736 older adults registered in primary healthcare units in Ceará, lower physical activity levels were strongly associated with a higher likelihood of screening positive for sarcopenia risk. Associations were also observed with sex, marital status, and occupational status [8]. These findings do not mean that socioeconomic or demographic characteristics should be treated as deterministic causes of sarcopenia.

Physiotherapy and the democratization of functional health

Physiotherapy has an important role in addressing sarcopenia because its scope extends beyond the treatment of established disability. Physiotherapists can contribute to early functional assessment, exercise prescription, resistance training, balance training, mobility interventions, fall prevention, rehabilitation, and health education. Evidence supports exercise as an effective strategy for improving important outcomes in older adults with sarcopenia, with resistance exercise and combined resistance and balance or aerobic training showing relevant benefits [5]. However, the challenge is not simply determining whether an intervention works. It is also to determine who can access it. An intervention that is highly effective in a specialized rehabilitation center may have limited population impact if it is unavailable to older adults living in underserved communities.

This is why physiotherapy should increasingly consider community-based and primary healthcare strategies. Exercise programs can be adapted to different levels of functional capacity and delivered through primary healthcare facilities, community centers, group programs, and other accessible settings when appropriate [6-8]. The objective should be to bring functional health promotion closer to where older adults live. This approach also changes the role of physiotherapists. Instead of acting only after disability has emerged, the profession can contribute to maintaining functional capacity throughout the aging process.

Conclusions

Healthy aging is often discussed as though it were an individual achievement. Sarcopenia reminds us that it is also a social and political issue. Older adults do not enter later life with the same functional reserves, resources, environments, or opportunities. Some can access exercise, adequate nutrition, preventive care, and rehabilitation with relative ease. Others face barriers that make the same recommendations considerably more difficult to follow.

Therefore, the question should not only be whether we are helping people live longer. We should ask who is being given the opportunity to age with strength, mobility, independence, and dignity. Sarcopenia offers an important opportunity to rethink healthy aging through the lens of equity. Screening, exercise, nutrition, and rehabilitation remain essential, but they must be embedded within health systems capable of reaching those who are most vulnerable.

Declarations

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