REPORT

INFORMAL EXPERTS’ CONSULTATION ON HEALTHY AGEING

IN THE WESTERN PACIFIC REGION

Convened by:

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NOTE

The views expressed in this report are those of the participants in the Informal Experts’ Consultation on Healthy Ageing in the Western Pacific Region and do not necessarily reflect the policies of the World Health Organization.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for governments of Members States in the Region and for those who participated in the Informal Experts’ Consultation on Healthy Ageing in the Western Pacific Region from 9 to 10 May 2010, Manila, Philippines.
SUMMARY

Population ageing is occurring at an unprecedented rate in the Western Pacific Region. Rapid declines in fertility levels and increases in life expectancy have led to a rapid and dramatic increase in the proportion of people aged 60 and over in the Region. This trend towards population ageing poses complex challenges for the health sector and beyond. However, it should also be viewed as a notable success story in 20th century public health. With this success come great social and economic opportunities in high-income and low- and middle-income countries alike.

In 1991, the United Nations General Assembly articulated a set of principles for older persons that underpin the construction of a society that promotes healthy and active ageing. These principles include independence, participation, care, self-fulfilment and dignity. The 2002 Madrid International Plan of Action on Ageing builds on these principles, espousing a vision “that persons everywhere are able to age with security and dignity and to continue to participate in their societies as citizens with full rights”. WHO has a vital role to play in realizing this vision for healthy ageing in the Region.

To this end, an Informal Experts’ Consultation on Healthy Ageing in the Western Pacific Region was held from 9 to 10 May 2011, in Manila, Philippines, to give guidance on:

(1) developing a regional framework of action on healthy ageing; and

(2) priority actions WHO could take in cooperation with Member States to promote healthy ageing.

The meeting brought together 10 temporary advisers to interact with the WHO Secretariat. The discussions centred primarily on the role and key actions which WHO can and should play in the healthy ageing agenda within the Region. The discussions spanned a set of five themes: health systems and service models; disease prevention; social protection; intersectoral action; and improving the evidence base. Various recommendations across these themes were discussed over the two days and are included in this report. Recurring themes in the discussions included:

(1) Advocacy to promote reorientation of ageing towards a more positive paradigm, i.e. one that views older people as a resource.

(2) The importance of policies based on a life course approach.

(3) Intersectoral action for healthy ageing that identifies win-win actions in collaboration with other sectors.

(4) The need to provide concrete policy examples and accessible evidence for policy-makers in Member States.

(5) The need for a standardized set of healthy ageing indicators across the Region.

(6) A focus on identifying and using successful processes that already exist for pushing a new healthy ageing agenda.

Participants will be consulted on a continuing basis in the course of formulating a regional action plan.
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**Key words:**

Aging, Aged, Health services for the aged, Health promotion
1. BACKGROUND

1.1 Population ageing in the Western Pacific Region

Population ageing is occurring at an unprecedented rate in the Region. Rapid declines in fertility levels and increases in life expectancy have resulted in a dramatic increase in the proportion of persons aged 60 and over (Figure 2).

Figure 2. Percentage of men and women aged 60 and over, Western Pacific Region (1950-2050)

Population ageing is a feature of all countries in the Region. Nevertheless, the significant heterogeneity among countries with respect to population ageing has obvious implications for policy and planning. Population ageing should, however, be viewed as a notable success story of 20th century public health. With this success come great social and economic opportunities in high-income and low- and middle-income countries alike.

1.1.1 The global context

In 1991, the United Nations General Assembly set forth a set of principles of older persons that underpin the construction of a society that promotes healthy and active ageing. These principles include independence, participation, care, self-fulfilment and dignity. The Madrid International Plan of Action on Ageing, 2002 (MIPAA) builds on these principles, espousing a vision “that persons everywhere are able to age with security and dignity and to continue to participate in their societies as citizens with full rights.”

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This vision, applied at a regional level through the 2002 Shanghai Implementation Strategy for the MIPAA, communicates a broad, society-wide perspective for healthy and active ageing. In turn, the 58th session of the World Health Assembly (2005) passed a resolution on strengthening healthy and active ageing, urging Member States and WHO to step up its efforts in this area.

It is important that the vision for healthy ageing in the Region encompass the notion of the “society for all” described by the programme of action adopted at the World Summit for Social Development in Copenhagen in 1995,\(^3\) in which "generations invest in one another and share in the fruits of that investment, guided by the twin principles of reciprocity and equity”. Indeed, population ageing represents a unique opportunity. If older people can retain their health, and if they live in an environment that promotes their active participation, their experience, skills and wisdom will undoubtedly be a resource for society.

1.1.2 A regional framework for action

With these seminal meetings and documents in mind, the rapid increase in population ageing in the Region presents a set of complex challenges for the health sector and beyond. While all health systems have to deal with population ageing, many Member States face particular challenges, with high rates of ageing, lower levels of economic development and weak health system capacities.

WHO has a vital role to play in setting the healthy ageing agenda in the Region through its core functions, namely:

(1) Providing leadership and engaging in partnerships.
(2) Stimulating knowledge generation, translation and dissemination.
(3) Setting norms and standards, promoting their implementation and monitoring.
(4) Articulating ethical and evidence-based policy options.
(5) Providing technical support and building institutional capacity.
(6) Monitoring key ageing-related health trends.

To this end, an Informal Experts’ Consultation on Healthy Ageing in the Western Pacific Region was held from 9 to 10 May 2011, in Manila, Philippines, to give guidance on:

(1) developing a regional framework of action on healthy ageing; and
(2) priority actions WHO could take in cooperation with Member States to promote healthy ageing.

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1.2 Objectives

The Consultation was held to give guidance on

(1) developing a regional framework of action on healthy ageing; and

(2) priority actions WHO could take in cooperation with Member States to promote healthy ageing.

The meeting agenda is found in Annex 1 and the list of participants Annex 2.

2. OPENING SESSION

Dr Shin Young-soo, Regional Director, reflected on WHO’s vision of supporting people across the world to attain the highest level of health and their many different challenges such as emerging diseases, health security and health systems and the heterogeneous nature of the Region, which WHO backs Member States in addressing. He urged moving towards a holistic, intersectoral approach in addressing the challenges that come with population ageing. He concluded with a warm invitation to the experts to contribute their experience and knowledge to help define a customized path for healthy ageing in the Region.

Following a round of introductions, Dr John Beard, WHO Director, Department of Ageing and Life Course, provided an overview of WHO’s approach to population ageing. He noted that ageing is an issue of increasing focus for WHO and will form the topic for World Health Day 2012. Successfully addressing the challenges from ageing requires action on two fronts: strengthening primary health care and adopting a broader cross-sectoral approach. Two cross-cutting streams of action are also needed -- advocacy, particularly to “rebrand” population ageing from a burden to a resource, and knowledge generation and translation.

Ms Anjana Bhushan, WHO Technical Officer in Health and Development and Responsible Officer for the meeting, provided an overview of the meeting objectives. She reflected on WHO’s core functions, particularly at the regional level. She noted the diversity among countries in the Region, with Japan having the largest share of older persons and several low-income countries having much younger populations. In low-income countries, especially, ageing is likely to pose a serious burden on their economies. The challenge in the Region is persuading governments to place a higher priority on ageing, while they still have a window of opportunity to prepare for it, rather than after it has already become a pressing phenomenon. There is a need for differentiated strategies, between low- and middle-income countries, which are likely to have younger populations, and high-income ones, where the share of older persons in the population is already likely to have become significant. She presented a possible framework to guide the discussions along these lines (Figure 1).
In discussions that followed, one participant noted the breadth of the issue and difficulty in knowing the best entry points for action but stressed the need for a strong focus on vulnerable populations. The need for consensus on the plans for long-term care also noted. A number of participants mentioned the significant knowledge gaps in understanding how populations are ageing the Region.

3. TECHNICAL SESSIONS

3.1 Appropriate health systems and service models for ageing

Summary of key discussion points

- The public and private mix
- Resource rationing
- Primary health care
- Appropriate health worker competencies
- Dealing with changing family structures
- Rebranding the ageing paradigm
- Advocacy

Dr Dean Shuey, WHO Team Leader for Health Services Development, facilitated the session and gave an introductory presentation about appropriate health systems and service models for ageing in the Region. He noted the values that underpin primary health care and the need for services to be available, accessible, acceptable and of sufficient quality for all sections of the population. Countries need to work out for themselves the respective service delivery models suited to their own context, particularly with reference to:

1. Appropriate services for current need. Some countries will need to ensure long-term care for the elderly, while others will have to continue prioritizing maternal and child health;
2. Continuity of care and seamless referral;
3. Health care team set-up; and
Dr Shuey prompted the group to consider a number of key questions around achieving a continuum of care across the life cycle; facilitating better teamwork; making health facilities more accessible to older people; defining benefits packages; methods for empowering older people to be their own advocates in reform; and the broader question of resource rationing. Older persons require physical, social and mental care services. Health systems for older persons should ensure the integration and coordination of these three types of services together.

In discussions that followed, the role of the private sector in service delivery was brought up. There is a role for the private sector, which should indeed be harnessed, but it is the role of the state to set the terms of engagement rather than leaving these to be determined by market forces. There is a need to get the incentives correct to get the private sector to respond suitably.

On resource rationing, a number of participants noted its inevitability. However, equity and need, rather than age, should be the criteria that determine how resources will be rationed. Rather than in an ad hoc way, decisions on this issue should be explicitly made based on a set of principles, for example, thorough burden of disease analysis or by defining a minimum care package.

A strong emphasis on primary health care within the service delivery model is critical, particularly as a way of overcoming costs. Participants discussed the importance of creating more inclusive teams, with less reliance on doctors and more on other health workers. The idea of local primary health care (PHC) hubs that provide highly accessible care with appropriate expertise was raised. Other key issues raised included the role of information and communication technologies, a renewed focus on accessible health care environments for older people and the need to integrate primary health care and the curative model that currently exists as separate silos.

To ensure the needed primary health care focus, health professional education should create appropriate skill sets among health professionals to deal with an ageing patient population. A greater role for generalist community workers was noted.

It is important to have a service delivery transition that reflects changing family structures, in the context of demographic changes as well as trends such as urbanization. Smaller family sizes because of lower fertility rates pose an increasing burden on the next generation, with both direct and indirect effects, including children staying home from school to care for grandparents or the disproportionate burden of informal care on women and girls in families. The care work done by women is a key gender issue especially in urbanized societies, whereas earlier, this role might have been shared by the community as a whole. More efforts to create community capacity were suggested, including strengthening the capacity of the “younger-old” (who are part of the working age population), to look after the “older old” (who are really the dependent population). For the “younger old” appropriate health services can thus be seen as an investment.

The idea of rebranding the population ageing paradigm found appeal among the group. Too often, government and society view older people as a burden. Appropriate investments throughout the lifecycle -- e.g. working with schools, mentoring, strengthening social capital and networks -- can ensure that people remain a valuable resource for communities.
Advocacy for older people is critical. Older people can also be empowered to become their own advocates. The older peoples clubs being run through much of South-East Asia are a successful model for collective advocacy for and by older people. Examples of guardianship models were cited from Australia and Japan. However, some lobby groups of older people come from wealthier backgrounds and their issues, e.g., senior citizen’s discounts on flights may not necessarily represent the needs of the elderly from more vulnerable groups.

Key actions suggested for WHO with regard to health systems and service models are summarized below.

### Recommended actions

- Identify a set of service delivery models, based on primary health care or close-to-client services that work across the spectrum from promotion to prevention to cure to rehabilitation to palliation and are age-friendly.
- Within these service delivery models and packages, foster team work, continuity and appropriate skill sets that go beyond a doctor-nurse model.
- Assist Member States in identifying their stewardship role in public-private partnerships (in the context of service delivery models).
- Support Member States to undertake health planning (including defining the ageing component) in the context of national development plans.
- Develop tools that help Member States identify the vulnerable and/or socially excluded among the elderly.
- Support Member States in prioritization, based on assessment of need, access and feasibility.
- Explore the potential of information and communication technology (ICT) for age-friendly services, e.g., mobile phone technologies for information dissemination, tracking and /follow-up, etc.
- Build horizontal services based on those that already exist.
- Facilitate a process inclusive of older people and community.

### 3.2 Disease prevention approaches for healthy ageing

**Summary of key discussion points**

- Pros and cons of the intergenerational self-help clubs (ISHC) model
- Rebranding the healthy ageing paradigm
- Indicators for successful ageing
- Balancing primary and secondary prevention
- Use of information and communication technology

Dr Hai-Rim Shin, WHO Team Leader for Noncommunicable Diseases and Health Promotion, facilitated the session and presented estimates and projections of the noncommunicable disease (NCD) burden in the Region and current disease prevention and health promotion strategies, both those targeting the life course and those for the over-60 age group.
In his presentation, Mr Quyen Tran, of HelpAge International, explained the intergenerational self-help clubs (ISHC) model increasingly implemented in South-East Asia. ISHCs are based on collectivist values and fulfil a number of roles, especially in remote villages, including tangibles, such as PHC services, health promotion activities, data collection and microcredit services, and intangibles, such as empowerment of older people and building social capital.

In the discussions, participants noted the need to strengthen the current evidence base evaluating the effectiveness of the ISHC model and the potential to integrate the model into current policies and actions on ageing.

Participants suggested that NCD provide another key context for WHO’s advocacy to rebrand the ageing paradigm. Since illness is a natural part of the ageing process, it was suggested that the terminology should change from “healthy ageing” to “successful ageing”. A lively discussion followed about indicators to measure successful ageing. It was suggested that these should cover various dimensions, including being alive (rather than dead), continuing to live within the community (rather than in a residential hospice), a sense of well-being (good or better self-rated health, which should encompass at least average levels of positive affect and independence in the instrumental activities of daily living) and financial security. WHO can help refine these indicators and their definitions.

An appropriate balance is needed between primary and secondary prevention interventions in the context of ageing as a public health issue. The group agreed that primary prevention should be prioritized, especially throughout the life course, with secondary prevention being more important as people age. In addition, there is a need to ensure integration and coordination between health services for three types of well-being, physical, mental and social.

One participant noted some interesting developments in information and communication technologies (ICTs) in creating a more inclusive society for older people, such as, for example, through the use of tablets such as the iPad.

Key actions suggested for WHO with regard to disease prevention approaches for healthy ageing are summarized below.

**Recommended actions**

- Work out agreed-upon terminology and measures and indicators for “active ageing”.
- Identify and document good practice examples of policies and programmes, e.g. on ICTs to promote healthy ageing and social inclusion of older people.
- Rigorously assess the performance and outcomes of old peoples clubs and formulate guidelines for their programmatic implementation or upscaling.
- Identify ageing policies that address the structural determinants of health.
- Create options for both primary and secondary (service models, session 1) prevention.
- Provide support to identify and enhance the contributions of older people.
- Further define the ageing concept within the context of current health programmes.
- Incorporate the ageing component into health promotion paradigms.
3.3 **Social protection and ageing**

*Summary of key discussion points*

- Quality of appropriate services
- Institutional care
- Workforce
- The built environment
- Systems for shared learning on policy
- Palliative care

Dr Dorjsuren Bayarsaikhan, WHO Team Leader for Health Care Financing, facilitated the session and gave an introductory presentation on social protection in the Region, particularly how it pertains to coverage for health care. He outlined three important dimensions of universal coverage, namely, population coverage, service coverage and financial protection.

This was followed by a presentation by Ms Yuki Murakami of the Organisation for Economic Co-operation and Development (OECD), detailing a number of policy strategies currently used by OECD member countries to deal with long-term care and social protection.

In his presentation, Dr Osamu Utsunomiya, Director, Ageing and Health Division, Health and Welfare Bureau, Japan, outlined the wide range of current policy strategies to provide services to the elderly in Japan, which has the largest proportion of older people in the world.

In the discussions that followed, one participant emphasized the need to ensure services not only of adequate quantity, but also of adequate quality. Few current services, particularly institutional care, offer the incentives, either to providers or patients, for patients to “get better”. There is a need to identify the type of care that is the most appropriate for ensuring the long term trajectories of healthy ageing to which societies aspire, including improving quality of life and independence.

There is a need for Member States to reorganize their health system in tandem with social health insurance system, before a significant share of their population becomes elderly. Cost containment mechanisms also need to be developed well before a society becomes aged.

There are two-way links between health and the economy. Economic growth and development can help the health sector in general and health services of the elderly in particular. On the other hand, with education, health is a key component of human capital development. Therefore, improved population health, including among older persons, can contribute to economic growth. As a population ages, it loses a significant proportion of its human capital. Therefore, there is a need for greater investment in the health of the middle aged and the elderly among the population as a whole.

Health, income security and job opportunities are key issues related to social protection for older people. The poorest segments of the population typically include the disabled and the elderly, among whom older women may be the worst off.

Current trends in institutional care pose various challenges. This modality of care has been inappropriately used in some high-income countries. Concerns were raised that some low- and middle-income countries view institutional care as a gold standard. An appropriate balance is needed between care in the home and models that provide more intensive support. This is an area, among others, where countries have much to learn from the successes and mistakes of others. WHO can facilitate this policy learning process.
A number of issues pertaining to the health workforce were raised. In particular, the inequitable distribution of the workforce within and between countries is exacerbated by the brain drain of skilled health workers from low- and middle-income countries to high-income countries. Further, all countries face high rates of health worker turnover because of hard work conditions, low salaries, part-time work, lack of career progression and low job satisfaction.

Other issues to be discussed within the session included creating accessible and inclusive built environments for older people and the importance of also ensuring palliative care.

Key actions suggested for WHO with regard to social protection and ageing are summarized below.

### Recommended actions

- Review, assess and improve healthcare benefits to ensure greater access and use of needed services by the elderly with adequate financial protection.
- Define the appropriate and integrated service benefits and service providers based on community needs, cost effectiveness and feasibility in building a trajectory for healthy ageing.
- Analyse examples of good (and bad) practice and lessons learned from ageing policies and practices in high-income countries, including roles and incentives for informal caregivers.
- Formulate policy and financing options for long-term care for low- and middle-income countries outlining their pros and cons.
- Examine models for long-term care and their financing, including cost-control measures.
- Define the roles of the state, civil society and the private sector in providing long-term care and social protection.
- Support universal coverage in the Region, including coverage for the elderly, quality health care services and costs.
- Promote “proportional universalism” – targeting vulnerable groups from a platform of universal coverage.
- Support policies and actions to protect low- and middle income countries against brain drain.
- Advocate to governments for their critical role and early action in the context of a fast-changing environment and family structures.

### 3.4 Intersectoral action for healthy ageing

**Summary of key discussion points**

- The need to focus outside the health sector
- Identifying key sectors
- Process for effective intersectoral action
- Action on the built environment as a conduit for intersectoral action
- Evidence generation and dissemination
Dr Cherian Varghese, WHO Technical Officer Noncommunicable Diseases, facilitated the session and made an introductory presentation, outlining an intersectoral action approach for addressing the social and environmental determinants of healthy ageing. He discussed the need for advocacy targeting key government departments that fall outside the traditional health sector to take action towards healthy ageing across the life course. He also cited WHO's Age-Friendly Cities initiative as a good example of action on the social and environmental determinants of health.

Professor Hal Kendig, Head of Department, Ageing, Work and Health Research Unit, University of Sydney, Australia, made a presentation reflecting on useful strategies for engaging other departments for intersectoral action. Acknowledging that health is usually a peripheral issue, health ministries, or those championing intersectoral action for healthy ageing, must look to the core business of the target sector and look for “win-win solutions” as well as overall gains for society, such as a healthy and engaged older population contributing to economic growth.

In the discussions that followed, participants further commented on strategies for intersectoral action. Given the relatively weak position of many health ministries vis-à-vis other sectors, there is a need to enable these more powerful ministries to secure their core interests while including mutual gains for a healthy ageing agenda. Key ministries, such as finance and the prime minister's office, were identified as key players. Another participant warned about becoming “health imperialists”, dictating terms to other sectors or ministries for the sake of improving health.

The group agreed that ageing provides an opportune vehicle for implementing and consolidating intersectoral action for health since many other sectors are currently interested in it. Key ministries or sectors with which to ensure buy-in on the ageing agenda include the prime minister’s office, treasury or finance, education, employment, transport, community services, commerce and industry and housing.

“Stealth interventions” may be more effective in some cases than overt interventions. For example, cities would like to attract tourists by promoting urban development and parks, which is good for NCD and the environment, too.

Participants agreed that this is an area where advocacy and the empowerment language and mechanisms of human rights are important. For example, having a source of income that gives independence to the older person is empowering. The economic arguments on ageing are also crucial. Health is a core component of economic development. For example, education and job training opportunities for older persons can protect their health. In some developing countries, retirement ages are rather low, to address the need to make room for young workers entering the labor force. Such policies may soon need to be revisited. The emerging “silver market” will also become a powerful economic force in many countries.

Participants suggested a number of practical initiatives for collaboration, including involving older people to teach primary and secondary school curricula or as a useful resource in child care programmes. Microcredit programmes can also potentially involve the elderly, particularly in low- and middle-income countries.

Various participants emphasized the importance of the built environment as a determinant of healthy ageing. This is an area where some intersectoral action for healthy ageing is already taking place, such as through the healthy cities and islands approach.
Key actions suggested for WHO with regard to intersectoral action for healthy ageing are summarized below:

<table>
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<th>Recommended actions</th>
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<tbody>
<tr>
<td>Facilitate the establishment and dissemination of an evidence base of examples from the Region and around the world of what works in intersectoral action that governments can tailor to their local and national situations.</td>
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<tr>
<td>Identify key messages and resources that health ministries can use in dialogue with other ministries, using ageing as a vehicle.</td>
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<tr>
<td>Conduct ageing impact assessments of policies on a selected basis.</td>
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<tr>
<td>Select key sectors and work out activities for World Health Day 2012.</td>
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<tr>
<td>Conduct a study of the most vulnerable among older people in the Region.</td>
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<tr>
<td>Identify examples and case studies of how older people from poorer socioeconomic groups are playing active roles to fulfill community need and are reimbursed or recognized for this.</td>
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<tr>
<td>Link the Alliance for Healthy Cities and the Age-Friendly Cities network. Build on the network to include new cities.</td>
</tr>
<tr>
<td>Implement or scale up age-friendly approaches based on intersectoral action, e.g. healthy islands.</td>
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3.5 An improved evidence base for healthy ageing

Summary of key discussion points

- Identifying the most-needed knowledge
- Assessing the current evidence base
- Key knowledge gaps
- Common sets of questions and indicators to enhance comparability among studies in the Region
- Stewardship role for WHO

Ms Rebecca Dodd, WHO Technical Officer for Health Policy and Systems Research, facilitated the session and made an introductory presentation on the Region’s healthy ageing research agenda. She discussed the need to identify the current knowledge gaps but also to look towards generating the appropriate quantity and quality of evidence for the heterogeneous group of Member States.

In her presentation, Ms Murakami outlined the key datasets maintained currently by various OECD countries, e.g. the National Institutes of Health and Medicaid in the United States of America. She noted key areas for future evidence generation such as projecting spending across sectors, not just the health department; the cost-effectiveness of policy interventions for healthy ageing; and a need for more data from the low- and middle-income countries. She finished by identifying the need for strong governance in coordinating and sharing this evidence and ensuring it is used efficiently and effectively.
In her presentation, Professor Joy Natividad, University of the Philippines, identified the need for using a common set of methodologies and indicators to ensure greater comparability of data. She noted that the Region should work towards deciding on a set of common indicators and measures for healthy ageing across the life course, including basic social, economic, leisure, accommodation and health-related domains.

In his presentation, Professor Hal Kendig, Ageing, Work and Health Research Unit, University of Sydney, identified specific research stewardship roles for WHO at the regional and global levels. He noted an important role for WHO at the regional level would be to facilitate a discussion on what we want and need to know and oversee processes for regional knowledge sharing, e.g. host a basic knowledge hub that indexes continuing research. At the global level, he suggested that the World Health Survey could include a set of standardized ageing questions.

In discussions that followed, participants noted the need to first determine the minimal set of information needed to initiate informed policy decisions on healthy ageing. This can include, for example, building consensus around interventions for disease prevention, e.g. screening.

Second, there is a need to determine what is currently known about these key areas. Much ageing-related research is continuing in the Region, e.g. the Study of Global Ageing and Adult Health (SAGE). However, it is not coordinated, making it hard to identify knowledge gaps. The group discussed the resource-intensive nature of developing new studies and the underutilization of current datasets. Participants noted that most current research is conducted in high-income countries. There is need to build research capacity and output in low- and middle-income countries.

Comparative analysis on the health of older persons is needed across a range of countries, from those with low fertility to those with higher fertility profiles. Both the proportion and the speed of ageing are highly relevant factors. Such a comparative analysis can be done by categorizing countries with respect to their populations, as well as their health and social security systems. This would be a persuasive approach for presenting evidence to policy-makers that can guide policies and action.

Concern was expressed about the lack of a consistent set of healthy ageing measures and indicators used within the Region, leading to a lack of comparability between datasets. The group proposed that WHO support the creation of a common set of indicators and accompanying survey questions that could be used regionally and globally. The key areas identified included:

1. function – defining this is a challenge;
2. access to care;
3. basic risk factors for NCD; and
4. mental health.

The Asia Pacific Observatory on Health Systems and Policies could undertake research on ageing similar to that conducted by the WHO Regional Office in Europe. For example, the observatory could, upon the request of policy-makers, take stock of current research and guide future research directions and coordinate such research.
Key actions suggested for WHO with regard to an improved evidence base for healthy ageing are summarized below.

### Recommended actions

- Conduct a large-scale comparative study on the health of older persons, in countries ranging from those with low to higher fertility profiles.
- Work with the Asia Pacific Observatory on Health Systems and Policies to identify specific topics for research that the observatory could then undertake.
- Coordinate and mobilize resources for secondary data analysis.
- Build a core set of ageing-related questions for surveys on function access to care, basic risk behaviour related to NCD and psychological health and happiness.
- Advocate with governments to strengthen evidence-informed policy-making on ageing and to invest in knowledge generation on ageing.
- Raise funds in partnership with Member States to facilitate the filling of research gaps.
- Establish a network of collaborating centres to take forward many of the recommendations.

3.6 **Towards a regional framework for healthy ageing**

In her introductory presentation in this session, Ms Bhushan, the regional focal point for ageing, described the objectives of the session, namely, consolidating the recommendations on actions taken by WHO at regional and global levels.

In his presentation, Mr Donavan Storey of the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) outlined UNESCAP’s current work under the 2002 MIPAA and the outcomes from recent regional meetings on ageing in Macao (China), Bangkok, Thailand, and Nanjing, China.

A facilitated discussion then ensued on the recommendations generated from the technical sessions. Other general points of discussion included mechanisms for communicating and advocating to governments and further ideas on intersectoral action for healthy ageing.

The key areas of action for WHO in advancing the regional healthy ageing agenda, in partnership with other key partners (universities, UNESCAP, etc.), include the following:

1. **Perform an advocacy role in changing the global ageing paradigm to recognize the societal benefits of population ageing if appropriate investments are made in people throughout their life cycle.**

2. **Assist in building service delivery models that provide a good continuum of health care, are accessible and include home- and community-based care.**

3. **Help build inclusive physical environments that are barrier-free for older people.**

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4 The final recommendations are listed separately in the sections related to the various technical sessions.
(4) Oversee the formulation of a set of indicators on the health of older persons.

(5) Assist Member States in addressing human resources capacity for population ageing.

All presentations are found in Annex 3.

4. CLOSING SESSION

Dr Henk Bekedam, WHO Director for Health Sector Development, and Dr Han Tieru, WHO Director for Building Healthy Communities and Populations, led the closing session.

Contributing to the final round of suggestions, participants stressed the need to provide concrete advice to Member States about appropriate policies, programmes and strategies for healthy ageing. They should be standardized across the Region but with the flexibility to be tailored to the range of different settings. A life course approach and intersectoral action would be important principles underpinning action. In due course, ageing could be put on the agenda of a future Regional Committee Meeting.

Participants noted the importance of using existing processes for engagement with Member States across the Region to advance action on the group’s recommendations. One participant suggested initial engagement with Member States in two phases:

(1) Provide a general list to Member States outlining key areas for consideration in a healthy ageing agenda, including information about basic demographic indicators and the existence of a strategy for engaging older people. Use this frame to focus the attention and highlight entry points for action and level of intervention.

(2) Work on indicators. Then facilitate access to a menu of studies available in the Region; case studies; policy analysis through engagement with the Asia Pacific Observatory on Health Systems and Policy.

A number of participants indicated a desire to continue the dialogue through a network that could be facilitated by WHO.

In closing the meeting, Dr Bekedam and Dr Han thanked the participants for their ideas and recommendations on actions to promote healthy ageing in the Region and expressed WHO’s strong intention to act on them. They asked for the continued support and engagement of participants in the process of creating a framework for action on health and ageing in the Region.
<table>
<thead>
<tr>
<th>Time</th>
<th>Monday, 9 May 2011</th>
<th>Time</th>
<th>Tuesday, 10 May 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:00</td>
<td>Registration</td>
<td>8:30</td>
<td>Session 4: Intersectoral action for healthy ageing</td>
</tr>
<tr>
<td>08:30</td>
<td>Opening session</td>
<td></td>
<td>Facilitator: Dr C. Varghese, WHO Technical Officer, NCD</td>
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<tr>
<td></td>
<td>Opening remarks: Dr Shin Young Soo, Regional Director</td>
<td></td>
<td>Presentation: Prof Hal Kendig, The University of Sydney</td>
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<tr>
<td></td>
<td>Introduction of participants</td>
<td></td>
<td>Discussion</td>
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<tr>
<td></td>
<td>Presentation: Dr J. Beard, WHO Director, Ageing an Life Course</td>
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<tr>
<td></td>
<td>Presentation: Ms A. Bhushan, WHO Technical Officer, Health in Development</td>
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<tr>
<td></td>
<td>Group photo</td>
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<tr>
<td>9:30</td>
<td>Break</td>
<td>10:00</td>
<td>Session 5: An improved evidence base for healthy ageing policymaking</td>
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<td></td>
<td></td>
<td></td>
<td>Facilitator: Dr R. Dodd, Technical Officer, Health Policy and Systems Research</td>
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<td></td>
<td>Presentation: Ms Y. Murakami,, OECD</td>
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<td>Presentation: Prof J. Natividad, University of the Philippines</td>
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<td>Presentation: Prof Hal Kendig, University of Sydney</td>
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<td></td>
<td></td>
<td></td>
<td>Discussion</td>
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<tr>
<td>10:30</td>
<td>Session 1: Appropriate health systems and service models for ageing</td>
<td>10:30</td>
<td>Session 6: Towards a regional framework for healthy ageing</td>
</tr>
<tr>
<td></td>
<td>Facilitator: Dr D. Shuey, WHO Team Leader, Health Services</td>
<td></td>
<td>Facilitator: Ms A. Bhushan, WHO Technical Officer, Health in Development</td>
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<tr>
<td></td>
<td>Discussion</td>
<td></td>
<td>Presentation: Mr D. Storey, UNESCAP</td>
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<td></td>
<td>Discussion</td>
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<tr>
<td>12:00</td>
<td>Lunch</td>
<td>12:00</td>
<td>Lunch</td>
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<tr>
<td>13:30</td>
<td>Session 2: Disease prevention approaches for healthy ageing</td>
<td>13:30</td>
<td>Session 6: Towards a regional framework for healthy ageing</td>
</tr>
<tr>
<td></td>
<td>Facilitator: Dr Hai-Rim Shin, WHO Team Leader , NCDs and Health Promotion</td>
<td></td>
<td>Facilitator: Ms A. Bhushan, WHO Technical Officer, Health in Development</td>
</tr>
<tr>
<td></td>
<td>Presentation: Dr Quyen Tran, HelpAge International</td>
<td></td>
<td>Presentation: Mr D. Storey, UNESCAP</td>
</tr>
<tr>
<td></td>
<td>Discussion</td>
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<td>Discussion</td>
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<tr>
<td>15:00</td>
<td>Break</td>
<td>15:00</td>
<td>Break</td>
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<tr>
<td>15:30</td>
<td>Session 3: Social protection and ageing</td>
<td>15:30</td>
<td>Closing session: Way forward and next steps</td>
</tr>
<tr>
<td></td>
<td>Facilitator: Dr D Bayarsaikhan, WHO Team Leader, Health Care Financing</td>
<td></td>
<td>Co-facilitators: Dr H. Bekedam, WHO Director, Health Sector Development; Dr Han Tieru, WHO Director, Building Healthy Communities and Populations</td>
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<tr>
<td></td>
<td>Presentation: Ms Y. Murakami, OECD</td>
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<tr>
<td></td>
<td>Presentation: Prof Kim Yong-Ik, Seoul National University</td>
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<tr>
<td></td>
<td>Presentation: Dr O. Utsunomiya, Health and Welfare Bureau, Japan</td>
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<td></td>
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<tr>
<td></td>
<td>Discussion</td>
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</tbody>
</table>
ANNEX 2

INFORMAL EXPERTS’ CONSULTATION ON HEALTHY AGEING
IN THE WESTERN PACIFIC REGION
9-10 May 2011
Manila, Philippines

LIST OF TEMPORARY ADVISERS, RESOURCE PERSONS AND SECRETARIAT

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Annex 2

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Annex 2

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Session 3

Financial trend of the long-term care insurance

Total cost of the long-term care insurance has been annually increasing (becomes twice for eight years)

Category 1 premium (national average (monthly amount weighted average))

Category 1 premium has increased 40% from 1st phase (2000–2002) to 4th phase (2009–2011)


2,911 Yen → 3,293 Yen → 4,090 Yen → 4,160 Yen

Simulation of the Cost of the LTCI

The Cost of the LTCI is estimated to be ¥20 trillion.

The Cost of the Medical Insurance is estimated to be ¥66-70 trillion in 2025. (¥35 trillion in 2009)
Annex 3

Session 3

Increase in the Number of the Elderly with Dementia

<table>
<thead>
<tr>
<th>End of September, 2002</th>
<th>Long-term care support required</th>
<th>Whereabouts at time of application (unit: 10,000 people)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>In home</td>
</tr>
<tr>
<td>Daily life dependence level II or over</td>
<td>334</td>
<td>210</td>
</tr>
<tr>
<td>Daily life dependence level III or over</td>
<td>24</td>
<td>19</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily life dependence level II or over</td>
<td>631</td>
<td>1,030</td>
<td>1,803</td>
<td>1,899</td>
</tr>
<tr>
<td>Daily life dependence level III or over</td>
<td>34</td>
<td>53</td>
<td>99</td>
<td>170</td>
</tr>
</tbody>
</table>

*Figures in the lower columns show the ratio to the population aged 65 or over (%)
*Figures are the estimated ones for the elderly judged as II or over with “Daily life dependency level of the elderly with dementia” used for certification of long-term care needs. They are not diagnosed as dementia definitely.

Source: Report of long-term care research group, June 2003

Estimation of Future Forms of the Elderly Households

(10,000 households)

<table>
<thead>
<tr>
<th></th>
<th>2005</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>4,906</td>
<td>5,028</td>
<td>5,060</td>
<td>5,044</td>
<td>4,983</td>
</tr>
<tr>
<td>Householder aged 65 or over</td>
<td>1,355</td>
<td>1,568</td>
<td>1,803</td>
<td>1,899</td>
<td>1,901</td>
</tr>
<tr>
<td>Single</td>
<td>386</td>
<td>466</td>
<td>562</td>
<td>631</td>
<td>673</td>
</tr>
<tr>
<td>(percentage)</td>
<td>28.5%</td>
<td>29.7%</td>
<td>31.2%</td>
<td>33.2%</td>
<td>35.4%</td>
</tr>
<tr>
<td>Couple only</td>
<td>465</td>
<td>534</td>
<td>599</td>
<td>614</td>
<td>594</td>
</tr>
<tr>
<td>(percentage)</td>
<td>34.3%</td>
<td>34.0%</td>
<td>33.2%</td>
<td>32.3%</td>
<td>31.2%</td>
</tr>
</tbody>
</table>

Note: Percentages show the ratio to the households of which a household member is 65 or over
Source: Estimation of the number of households in Japan (estimation in October 2008), National Institute of Population and Social Security Research
Session 3

Fundamental Standpoint and Content of a Reform of Long-Term Care Insurance System (2005)

○ Establishment of a bright and active super-aging society
  • Substantial increase in those in a slight care-need condition
  • The services for those in a slight condition fail to improve conditions of such users

○ Sustainability of the system
  • Parity in the burden between users at home and facilities

○ Comprehensive social security
  • As increase in the elderly who live alone or suffer from dementia
  • Enhanced in-home care support
  • Coordination between nursing care and medical care
  • Improvement of the quality of service driven by users' selection
  • Special considerations to low-income persons
  • Replacing clerical work of municipal governments

Shift to a prevention-oriented system

○ Creation of new preventive benefits
  ○ Creation of community support projects

Review of benefits for facilities

○ Review of housing and food expenses
  ○ Special consideration to low-income persons

Establishment of a new service system

○ Creation of community-based services
  ○ Creation of a community comprehensive support center
  ○ Improvement of residential services

Securing and improvement of the quality of service

○ Disclosures of information of long-term care services
  ○ Review of care management

Review of burden sharing and system management

○ Review of Category 1 premiums
  ○ Strengthening of the fraction of insurers

Enhancement of Community-based Medical Care and Long-Term Care Services

Present situation

- Shortage of variety of in-home care service and quantity
- Shortage of housing and facilities

In the case of a community with a population of 10,000 people

In 2025

- Continue to live at the community being many years
- Receiving better services by own choice
- Expanding facility and housing services as Sweden
- Various in-home services such as 24-hour operation
- Smaller institution statistics for community unit care

Number of people who are 65 years old or older: 1988 (15% of total out of 1,000 people)
Number of people who are 85 years old or older: 1988 (3% of total out of 1,000 people)
Number of people who are 65 years old or older: 2025 (25% of total out of 1,000 people)
Number of people who are 85 years old or older: 2025 (5% of total out of 1,000 people)
Annex 3
Session 3

Ratio of certified persons by care level


<table>
<thead>
<tr>
<th>Care Level</th>
<th>Support</th>
<th>Care Level I</th>
<th>Care Level II</th>
<th>Care Level III</th>
<th>Care Level IV</th>
<th>Care Level V</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3.1%</td>
<td>5.2%</td>
<td>2.5%</td>
<td>2.2%</td>
<td>2.0%</td>
<td>1.8%</td>
<td>16.8%</td>
</tr>
</tbody>
</table>

Residential situation of the elderly in some countries (ratio of capacity)

- Japan (2005)
  - Retirement housing (6.8%)
  - Homes for the elderly (3.7%)
  - Total: 10.5%

- The UK (2001)
  - Retirement housing (2.3%)
  - Homes for the elderly (4.2%)
  - Total: 6.5%

- Sweden (2005)
  - Retirement housing (2.3%)
  - Homes for the elderly (4.2%)
  - Total: 6.5%

- Denmark (2006)
  - Retirement housing (2.3%)
  - Homes for the elderly (4.2%)
  - Total: 6.5%

- The US (2000)
  - Retirement housing (2.3%)
  - Homes for the elderly (4.2%)
  - Total: 6.5%

*Source: Housing for the Elderly in the World, Gakushu Shinsa (Building Center of Japan)

*Data are from UN, World Population Prospects: The 2005 Revision

"Comprehensive Community Care System"

Daily Living Zone (within 30 minutes distance)

Five viewpoints that realize "Comprehensive Community Care"

- Promotion of preventive services
  - Promotion of preventive services so as not to become in need of care, as well as care services that enhance the independence of the elderly

- Securing various life-support services (guardianship, meal delivery, shopping, etc.) and rights advocacy
  - Providing various life-support services (life support such as guardianship or meal delivery, rights advocacy services such as property management) that accommodate the increase of elderly living alone or with spouse only or divorced elderly

- Enhancing the provision of residents for continuous living of the elderly (Collaboration with the Ministry of Land and Transport)

- Promotion of preventive services so as not to become in need of care, as well as care services that enhance the independence of the elderly
**Session 3**

Outline of the reform bill to amend the Long-term Care (LTC) Insurance Law and other related laws to strengthen the basis for the provision of long-term care services (tentative) (2011 REFORM)

Implement the measures to promote “Comprehensive Community Care System” that provides medical services, long-term care services, preventive services, residential arrangements and life-support services in a seamless manner in order for the elderly to live independent life in the community.

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<tbody>
<tr>
<td>1.</td>
<td>Strengthen the cooperation of medical care services and long-term care services</td>
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<tr>
<td></td>
<td>1) Promote “Comprehensive Community Care” that provides medical services, long-term care</td>
</tr>
<tr>
<td></td>
<td>services, preventive services, residential arrangements and life-support services in a</td>
</tr>
<tr>
<td></td>
<td>cooperative manner.</td>
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<tr>
<td></td>
<td>2) Assemble LTC Service Plan that take into account regional needs and issues in each</td>
</tr>
<tr>
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<td>daily living zone (ex. junior high school zone, community center zone, etc.)</td>
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<td>3) Establish “Periodical Round Blue On Demand Service” that accommodate 24 hours and “</td>
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<td></td>
<td>Combined Service” to meet the need of the elderly living alone and in need of heavier</td>
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<tr>
<td></td>
<td>care</td>
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<tr>
<td></td>
<td>4) Combined and comprehensive provision of preventive service and life-support service at</td>
</tr>
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<td></td>
<td>the discretion of the Insurer (municipalities)</td>
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<tr>
<td></td>
<td>5) Temporary postponing the establishment of Sanatorium-type Medical Ward</td>
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<tr>
<td>2.</td>
<td>Securing the care worker and betterment of quality of services</td>
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<tr>
<td></td>
<td>1) Allowing renewal of Certified Care Worker and other care workers who take appropriate</td>
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<tr>
<td></td>
<td>education</td>
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<td></td>
<td>2) Postponing the review of process for obtaining license of Certified Care Worker</td>
</tr>
<tr>
<td></td>
<td>3) Complete enforcement of labor laws in care service industry - Strengthening</td>
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<tr>
<td></td>
<td>disqualification and revocation regulation for care service industry to avoid the</td>
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<td>4) Reform of “Disclosure of Care Service Information” system by abolishing the mandatory</td>
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<td></td>
<td>investigation</td>
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<tr>
<td>3.</td>
<td>Enhancing the residents for elderly</td>
</tr>
<tr>
<td></td>
<td>1) Adding articles that protect the residents of for-profit nursing homes</td>
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<tr>
<td></td>
<td>2) Allowing the establishment of the Special Nursing Homes for the Elderly to “Social</td>
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<td></td>
<td>Medical Corporation”,更改 the provision of elderly residents with services by the</td>
</tr>
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<td></td>
<td>collaboration of the Ministry of Health, Labour and Welfare and the Ministry of Land</td>
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<tr>
<td></td>
<td>and Transportation (Revision of “Elderly Residence Law”)</td>
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<tr>
<td>4.</td>
<td>Promoting measures for demented elderly</td>
</tr>
<tr>
<td></td>
<td>1) Promote the rights advocacy of the elderly to enhance use of Civil Guardian system</td>
</tr>
<tr>
<td></td>
<td>2) Promote the policy measures for demented elderly by municipalities</td>
</tr>
<tr>
<td>5.</td>
<td>Enrichment of the function of Insurer</td>
</tr>
<tr>
<td></td>
<td>1) Securing accordance between the LTC Service Plan and plans for medical care services</td>
</tr>
<tr>
<td></td>
<td>or residential arrangements</td>
</tr>
<tr>
<td></td>
<td>2) Enabling the designation of specified service provision corporation through public</td>
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<td>offer and selection</td>
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<tr>
<td>6.</td>
<td>Mitigating the increase of insurance premium</td>
</tr>
<tr>
<td></td>
<td>1) Allowing the utilization of mandatory-secured fund for financial stabilization to</td>
</tr>
<tr>
<td></td>
<td>decrease the insurance premiums</td>
</tr>
</tbody>
</table>

**Effective Date: April 1, 2012 (Date of proclamation for “1.5” and “2.2”)**
Annex 3

Session 4

Intersectoral action for healthy ageing
Dr. Cherian Varghese M.D., Ph.D.
Technical Officer, Noncommunicable Diseases

Are we missing the big picture?

Changing times

Upstream interventions

Addressing social determinants of health in multi-sectors
Annex 3

Session 4

Multi-sectoral action for NCD Risk Reduction

- Advocacy, Health Impact Assessment → Health in all policies

 Healthy Cities and Islands

Key components:
- Multi-sectoral cooperation
- Governance and leadership
- Community participation
- Enabling supportive physical and social environment
- Sustained interventions
- Measurement

STAGES OF LIFE

1st Generation Issues:
- Poverty, lack of housing, health care etc.
- Love, care, social interaction, recreation

2nd Generation Issues:
- Housing, money, disease treatment
- Social isolation, mental illness

Primary Care Services: A world of difference

Multisectoral action for health of the elderly

- Advocacy, Health Impact Assessment → Health in all policies

Mechanistic Action

- Demographic
- Components: Physical, mental health, social cohesion
- Metabolic, responsible for chronic conditions
- Social equity
- Represents income inequality
- Social development
- Represents physical development
- Financial equity
- Represents financial development
- Social equity
- Represents social development
- Physical equity
- Represents physical development
- Income equity
- Represents income development

Healthy and Active Elderly Population
Annex 3

Session 4

Priority sectors

Ageing will require collaboration across sectors e.g. housing, treasury, workplace.

Q: What are the key sectors (outside of health) of high relevance to ageing?

Processes for intersectoral action

The Health in All Policies example

Q: What are some the important mechanisms we will use for intersectoral action?

Summary of key questions

Q1: What are the key sectors (outside of health) of high relevance to ageing?

Q2: What are some the important mechanisms we will use for intersectoral action?
Session 5

An improved evidence base for health ageing

Dr. Becky Dodd
Technical Officer, Health Policy & Systems Research

Issue 1
- What is the state of the evidence base on healthy ageing in the region, and what are the major knowledge gaps?
  - Epidemiological dimensions
  - Health systems
  - Long-term care

Issue 2
- Is there relevant knowledge and research from OECD countries that we can draw on in Asia – what are the limitations of doing so?
  - Advantages/Disadvantages of across country learning
  - Utilizing this knowledge base in WPR

Issue 3: Joy Natividad
- What should be the research priorities for healthy ageing in the Asia Pacific region; and what mechanisms and incentives can we use to make sure research gets done and is relevant to policy makers?
  - Balancing country comparability with local specificity
  - Knowledge translation to policy and practice
  - The role of UN in priority setting and facility knowledge translation

Issue 4 Quality of Life (Hal Kendig)
UN IAGGM Research Agenda on Ageing (2007)
- Years are being added to life and a major policy and research challenge is how to add quality to these years. Researchers should ensure that the conceptualisations take account of the views of older individuals.
- Specific topics include: internationally harmonised measures; determinants of life stages and impacts of transitions; factors of individual differences; relationship between development and age; disability and age; standards of living in multi-generational households; effects of urbanisation and modernisation; impacts of life-long learning; and age-friendly environments.

Summary of Key Questions
Q1: What is the state of the evidence base? Gaps?
Q2: Is the knowledge WPR-relevant?
Q3: What are our research priorities going forward?
Q4: How can we ensure knowledge translation to policy?
Annex 3

Session 5: Professor Josefina Natividad
University of the Philippines

- What should be the research priorities for healthy ageing in the Asia Pacific region; and what mechanisms and incentives can we use to make sure research gets done and is relevant to policy makers?
- Balancing country comparability with local specificity
- Knowledge translation to policy and practice
- The role of UN in priority setting and facility knowledge translation

Research priorities on healthy ageing

- Cross country comparative studies using a common instrument and a common research design
  - Basic conditions of older persons in the WPRO (as explanatory variables): demographic, economic, social, living arrangements, leisure
  - Basic measures of health that can be asked in a survey
    e.g. Self Assessed Health, Activities of Daily Living, Nagi measures of functioning, Oral health, current and past illness including chronic diseases

- Anthropometric measures: height, weight, waist circumference, grip strength, blood pressure
- Biomarkers: blood sugar, cholesterol
- Validation studies in WPRO countries especially the developing countries of scales to measure depression
  e.g. CES-D (Center of Epidemiologic Studies Depression Scale)
- Risk behaviors
  e.g. Tobacco, alcohol, betel nut

- Surveys should be nationally representative so that results can be generalized to the population of a given country
- As much as possible, design should be longitudinal to better understand causality and change (e.g. healthy life expectancy)
- Research results should be open for public use to encourage cross-country analysis

In this cross-country survey using a common instrument, each country can include blocks of questions that are specific to the country’s data needs

e.g. access to health care, health insurance, health seeking behaviors

- Comparative case studies
  What works and what doesn’t in what setting
  Best practices
Yong-Jk Kim  
Seoul National University Medical School

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**Aging in Korea**

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### Population change over a century

- Total population: 45.3 million (1955) = 82.9 million (1995) = 41.6 million (2005)
- Elderly population: 4.43% (1955) = 8.2% (1995) = 14.6% (2005)
- Working-age population: 35.0% (1955) = 54.8% (1995) = 26.4% (2005)

---

### Ageing in Korea

---

### Old-age dependency ratios in some OECD countries

- Rapid increase since 1990 in Japan, and since 2010 in Korea

---

### Health Care System and Ageing in Korea
Annex 3

Session 3

National Health Insurance System in Korea: Overview

Operational Structure of the NHIS Program

Beneficiaries of NHIS System

Category of Insured Persons

Health expenditure of NHIS

- 210% increase in total expenditure during 8 yrs
- 151% increase in the proportion of elderly care during 8 yrs

Future increase of health expenditure of NHIS

- Total amount: + 35.2 Trillion KRW (about 325 billion USD) in 2030
- Proportion of the elderly care: 34.2% in 2010 → 56.4% in 2030

Health expenditure of the elderly per month per capita

- Rapid increase in the age group of 85+

Policies for cost containment

- Lifetime health management
- Financial expansion
- Payment system reform
Annex 3

Session 3

Long-term Care Insurance (LTCl) Program

LTCl Brief history

Aug. 2005: Review and conceptual balance of LTC System
Mar. 2004: Establishment of the Committee of Finance
Apr. 2007: Establishment of the LTCl under the Elderly Act
Jul. 2008: Insurance Program

LTCl rating standards and benefits

- Mental status (Degree A)
  - Confusion or disorientation
- Very serious (Degree B)
  - Patient confined to bed, incontinent
- Serious (Degree C)
  - Memory impairment or frequent confusion

- Insurance benefits
  - Institutionalized service: long-term care facilities provide care
  - Home service: home visit social care, home visit nursing, short-term reaper care, home visit bathtub, day and night care
  - Special cash benefit: family care cash benefit, exceptional care cash benefit, nursing expenses of long-term care hospitals

LTCl Expenditure

- Total 2.4 trillion KRW was paid for LTC services in 2010 (52.8%)
- Total 335,735 elderly persons were approved to get care in 2010 (39.7% of all elderly persons)

National Pension

- All residents in Korea from 18 to less than 60 years of age, regardless of their income, are covered under the national pension.
National Pension benefits

- Total 3.46 trillion KRW (Central gov't 72%; Local gov't 28%) was paid in 2009
- 65% (2008) or 70% (2009) of all elderly people received pension benefits

Brief history of Old-age Allowance

- Feb. 2004: The President announced the new Ministry of Health and Welfare
- Dec. 2004: The Ministry of Health and Welfare announced the old-age Allowance
- Apr. 2005: The President announced the Old-age Allowance
- 2005: The Ministry of Health and Welfare announced the Old-age Allowance Program

Benefits of Old-age Allowance

- Paid to 70% of all 65+
  - To single elderly households
    - 50
  - To the elderly couple households
    - 50

National Plan against Low Fertility and Aged Society

- Presidents' Committee on Population
  - July 2003

Brief history

- Feb. 2004: The President announced the new Ministry of Health and Welfare
- Apr. 2005: The President announced the Old-age Allowance
- Aug. 2005: The Ministry of Health and Welfare announced the Old-age Allowance
- Apr. 2006: The President announced the Old-age Allowance Program

Strategies

- Create child-friendly and childcare-friendly environment
- Log the government's efforts for improving QoL in the elderly
- Provide the general public and enhance public awareness
- Improve the living standards of the elderly, improve their health, and enhance support
- Increase the number of elderly to improve the living conditions of the elderly
Session 3

**Strategies**

- Increasing education
- Decreasing child labor
- Creating job opportunities
- Lifiting social welfare

**Activation of the Women and the Disabled**

- Health and hygiene
- Science and technology
- Microfinance

**Human Resource Development**

- Reducing demand and supply
- Training

**Investments for the Plan**

- **Childcare services**
- **Environment**
- **Hospitals/clinics**
- **Infrastructure/transport**

Other Policies

<table>
<thead>
<tr>
<th>Policy Area</th>
<th>Current</th>
<th>Next Year</th>
<th>2024</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical services: Free treatment to the poor</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Education: School fees</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Social Security: Old age pension</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Social Security: Disability pension</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Social Security: Unemployment benefits</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Social Security: Maternity benefits</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Social Security: Retirement benefits</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Social Security: Other benefits</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total social benefits</td>
<td>35,000</td>
<td>40,000</td>
<td>50,000</td>
</tr>
<tr>
<td>Total employment</td>
<td>62,000</td>
<td>70,000</td>
<td>80,000</td>
</tr>
<tr>
<td>Total income</td>
<td>25,000</td>
<td>30,000</td>
<td>40,000</td>
</tr>
<tr>
<td>Total expenditure</td>
<td>20,000</td>
<td>25,000</td>
<td>30,000</td>
</tr>
</tbody>
</table>

**Annex 3**
Long-Term Care Insurance System in Japan

May 9, 2011

UTSUNOMIYA Osamu, MD, NPH, PhD
Health and Welfare Bureau for the Elderly
Ministry of Health, Labour and Welfare

Structure of Long-Term Care Insurance System

Municipalities (Insurers)

<table>
<thead>
<tr>
<th>Tax 50%</th>
<th>Premiums 45%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Municipalities</td>
<td>Professors, 12.5%(*)</td>
</tr>
<tr>
<td>12.5%</td>
<td>12.5%(*)</td>
</tr>
<tr>
<td>20%</td>
<td>30%</td>
</tr>
<tr>
<td>Decided based on the population ratio</td>
<td></td>
</tr>
</tbody>
</table>

Pay 90% of costs

Application

National Health Insurance, Health Insurance Society, etc.

Care needs certification

Insured persons

National pool of money

Note: The number of insured persons is based on the Long-Term Care Insurance Implementation Project (April 2010), Ministry of Health, Labour and Welfare. The number of insured persons is a monthly average for FY2009, obtained from medical services reports submitted by the Social Insurance Medical Fee Payment Foundation to determine the extent of long-term care expenses.
The insured

- The insured under the Long-Term Care Insurance system are (1) people aged 65 or over (Category 1 insured persons) and (2) people aged 40-64 covered by health insurance program (Category 2 insured persons).
- Long-term care insurance services are provided when people aged 65 or over come to require care or support for whatever reason, and when people aged 40-64 develop aging-related diseases, such as terminal cancer and rheumatoid arthritis, and thereby come to require care or support.

<table>
<thead>
<tr>
<th>Eligible persons</th>
<th>Category 1 insured persons</th>
<th>Category 2 insured persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>28.95 million (as of April 1, 2011)</td>
<td>42.33 million (extrapolated monthly premium FY2009)</td>
</tr>
<tr>
<td>Requirement for service provision</td>
<td>- Persons requiring long-term care (bedridden, dementia, etc.)</td>
<td>Limited to cases where a condition requiring care or support results from age-related diseases (specified diseases), such as terminal cancer and rheumatoid arthritis</td>
</tr>
<tr>
<td>Premiums collection</td>
<td>Collected by municipalities (in principle withheld from pension benefits)</td>
<td>Collected together with medical care premiums by medical care insurers</td>
</tr>
</tbody>
</table>

The Long-term Care Insurance Scheme is operated in three-year cycles.

- Municipal governments formulate a long-term care insurance service plan where three years are regarded as one phase (however, one phase is five years until FY2005) and review it every three years.
- Insurance premiums are set every three years based on projected service costs specified in a service plan so that financial conditions can be balanced throughout the next three years. (Insurance premiums are not changed during each three years.)

<table>
<thead>
<tr>
<th>Operation period (FY)</th>
<th>Service plan</th>
<th>Benefit</th>
<th>Insurance premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td></td>
<td></td>
<td>2,911 Yen (National average)</td>
</tr>
<tr>
<td>2001</td>
<td>The first phase</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>The second phase</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>The third phase</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2004</td>
<td>The fourth phase</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2005</td>
<td>The fifth phase</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>The first phase</td>
<td></td>
<td>3,293 Yen (National average)</td>
</tr>
<tr>
<td>2007</td>
<td>The second phase</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>The third phase</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td>The fourth phase</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>The fifth phase</td>
<td></td>
<td>4,090 Yen (National average)</td>
</tr>
<tr>
<td>2011</td>
<td>The sixth phase</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>The first phase</td>
<td></td>
<td>4,160 Yen (National average)</td>
</tr>
<tr>
<td>2013</td>
<td>The second phase</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Session 3

Matrix of Long-term Care Insurance Services

- **Home-visit Services**
  - Home-visit Care, Home-visit Nursing, Home-visit Bathing Service, In-home Care Support etc.

- **Day Services**
  - Day Care, Day Rehabilitation Service etc.

- **Short-stay Service**
  - Short-stay Daily Life Services etc.

- **Residential Services**
  - Day Care Services for the Elderly at Fee-charging Homes and People with Dementia etc.

- **Facility Services**
  - Senior Housing Services, Elderly Housing, Elderly Nursing Home Services etc.

Issues of the Long-Term Care Insurance Law

- **Increase in the elderly population (the first baby boomers join the elderly)**
  - Increase in medical care cost for the elderly
  - Enhancement of measures for preventing the elderly from becoming in need of long-term care (or support) in addition to long-term care services
  - Promotion of individual care

- **Increase in the number of the elderly suffering from dementia**
  - Promotion of care and long-term care for the demented elderly

- **Increase in the number of elderly couple households and single elderly person households**
  - Securing housing for the elderly
  - Establishment of "Living-alone model" that family members are not counted on to provide long-term care

- **Advancement of super-aging society in urban areas**
  - Securing housing for the elderly in urban areas
  - Countermeasures for increasing demand for services based on a future image of the elderly

- **Shortage of housing for the elderly**
  - Development of housing for the elderly and medical care environment (medical treatment and long-term care services)
2) NCDs and Ageing

Fact and figures (cont*)
7. The major risk factors for NCDs are tobacco use, harmful use of alcohol, poor diet and physical inactivity.
8. Eliminating major risks could prevent most NCDs. If the major risk factors for chronic disease were eliminated, at around three-quarters of heart disease, stroke and type 2 diabetes would be prevented; and 40% of cancer would be prevented.
9. NCDs are not only a health problem but a development challenge as well. They force many people into, or entrench them in poverty due to catastrophic expenditures for treatment.

3) Sharing the ISHC model

Issues:
* The number of OP in developing country are rapidly growing (In 94 & 96)
* Large number of Older People (OP) and their families struggle with low incomes and poor overall health status
* Local service providers and authorities have little interaction with OP and insufficient mechanism to promote their roles in the local health promotion and development

3) Sharing the ISHC model

What is ISHC?
* Community based organization
* Membership: from 59-70 members
  * 70% are OPs (aged 55 & over)
  * 70% are women
  * 70% are poor or near poor
* Membership: are local and paid membership fees
* Club management board: 5 people
* Volunteers: 10-15 people
* Self managed
* Meet at least once a month
* Multi-functional (Capacity building, health, livelihood, right and entitlement, social and others)

3) Sharing the ISHC model

Description: Since 2005, HelpAge and Vietnam Women's Union have supported 628 establishment of Intergenerational Self-help Clubs (ISHCs) in Vietnam

* To provide opportunities for OPs to improve the well-being of themselves, their families and communities,
* For OPs to work together to promote their roles and contributions in local health promotion and development,
* To improve their interaction with local authorities, service providers and the local private sector

3) Sharing the ISHC model

The project supports the ISHCs to increase its capacity to manage its activities and to generate its own Income:

ISHC's income

Income sources
- Credit/savings (interest)
- Membership fees
- Local fund raising
- Small NGO/FDA

Usage of income
- Capacity building
- Health: Early and Health care
- Health: Early and Health care
- Awareness & Advocacy
- Funding Raising
- Clubs Self-help Fund
3) Sharing the ISHC model

Intergenerational Self-help Club (ISHC)

- Benefits from having regular self-generated income
- ISHCs are more community led
- ISHCs are able to design, implement and monitor its own activities
- ISHCs are financially sustainable and able to generate increasing income to cover its own running costs and activities – will continue even after the project funding has ended
- ISHCs are dynamic and able to change and grow

The ISHC model is based on "the people know, the people decide, the people do, the people monitor and the people manage".

3) Sharing the ISHC model

Under the health Components: Social & mental health

- Social & Culture performance (Monthly and during holidays)
- Exchanges and sharing between ISHCs (At least once every 6 months)

3) Sharing the ISHC model

Under the health Components: Self-care (healthy living)

- Awareness: appropriate nutrition, healthy lifestyle, information on prevention of non-communicable diseases and simple self-care skills
- (20-30 minutes per month)

3) Sharing the ISHC model

Under the health Components: Homecare (community based - volunteers)

- Volunteer based Homecare (At least 2 visits per week)
- Family Care (Monthly awareness)

3) Sharing the ISHC model

Under the health Components: Health care: Checkup, health insurance and access

- Health checkup (Every 6 months)
- Health Insurance and access (On going)
4) Sustainability and replication of the ISHC approach

Financial sustainability of the ISHC approach

<table>
<thead>
<tr>
<th>Source of Income</th>
<th>Amount in USD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Microcredit</td>
<td>50.00</td>
</tr>
<tr>
<td>2. Savings</td>
<td>25.00</td>
</tr>
<tr>
<td>3. Membership fees</td>
<td>12.50</td>
</tr>
<tr>
<td>4. ISHC business</td>
<td>30.00</td>
</tr>
<tr>
<td>5. Local donations</td>
<td>20.00</td>
</tr>
<tr>
<td>Total</td>
<td>142.50</td>
</tr>
</tbody>
</table>

Note: Does not include in-kind contributions

Income usage breakdown of ISHCs monthly income

<table>
<thead>
<tr>
<th>Usage of ISHC income</th>
<th>Percent</th>
<th>Amount in USD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Microcredit</td>
<td>40.0%</td>
<td>57.00</td>
</tr>
<tr>
<td>2. ISHC social and health activities</td>
<td>40.0%</td>
<td>57.00</td>
</tr>
<tr>
<td>3. Running costs of the ISHC</td>
<td>20.0%</td>
<td>28.50</td>
</tr>
<tr>
<td>Total</td>
<td>142.50</td>
<td></td>
</tr>
</tbody>
</table>

4) Sustainability and replication of the ISHC approach

Cost for the national replication of the ISHC approach in Vietnam

In 2005
Cost: 15,000 USD/ISHCs
Time: 4 years

NOTE: To cover the entire country, Vietnam would need to have around 100,000 ISHCs.

Vietnam would need to invest 5% (100 million USD/year) of National Health budget or less than 0.1% of GDP for a period of 10 yrs

In 2011
Cost: 10,000 USD/ISHCs
Time: 2 years

4) Sustainability and replication of the ISHC approach

Expansion of the ISHC approach in Vietnam

60 ISHCs 167 ISHCs 245 ISHCs 468 ISHCs 628 ISHCs

2005 2007 2009 2010 2011

4) Sustainability and replication of the ISHC approach

Recommendation for wider replication of the ISHC approach in the region

1. Adopt and adapt the Vietnam ISHC approach
2. Support or link with new and existing Older People Groups, Clubs, Organisations or associations in your country
   - China = 400,000 OPAs
   - Vietnam = 100,000 OPAs/OPCs
   - Philippines = more than 10,000 OPAs
   - Thailand = close to 100% of the villages in the country have OPAs
3. Governments and donors provide funding/grants to NGOs and CBGs to replicate the ISHC approach nationwide
4. Startups or improved linkage and collaboration between the OP groups and service providers
5. Support national and regional learning events and researches
Annex 3

Session 2
Session 3

Social Health Protection and Ageing

Dr. Dordjuren Bayarsaikhan
Team Leader, Health Care Financing

Health financing implications of ageing
- Increased health care cost pressures (wider gaps in morbidity, more complex cases)
- Long-term care a particular financing challenge
- Households with elderly often more at risk of facing financial catastrophe and impoverishment

Social health protection and universal coverage
- Access to essential health services, with financial risk protection, for all
- Funded predominantly through taxation and/or social health insurance

Social Health Protection and Ageing

Universal coverage:
Three dimensions and their relevance to ageing
- Population: are older persons covered?
- Services: are services responsive to their needs?
- Financial protection: do older persons have to pay substantially out-of-pocket?

Supporting healthy ageing through social health protection
- Promote social solidarity and cross-subsidies.
- Adopt family-based membership.
- Provide targeted support and social transfers.
- Build on social security strategies and schemes such as pensions.
- Increase private sector participation and involvement.
Help Wanted? Proving and Paying for Long-Term Care

Yuta Murakami
Division of Health, OECD
WPPO Consultation Meeting, Manila May 2000

- Demographic trends & demand for long-term care (LTC)
- LTC workforce
- Financing
- Coverage

Life expectancy at birth, 1970 and 2005

Source: OECD Health Data 2005 and The World Bank World Development Indicators Online.

Steep rise in the share of over 80 years old

Source: OECD Labour and Demographic database

Old people are the main users of LTC

Source: Health Care 2000 and additional Australian and Swedish data
Session 3

- Demographic trends & demand for long-term care (LTC)
- LTC workforce
- Financing
- Coverage

Informal sector remains the dominant supplier of care

Percentage of the population reporting to be informal carers providing help with ADL.

The demand for LTC workers expected to at least double by 2050

Full-time Equivalent Nurses and Personal Carers, % of existing and projected working population.

LTC expenditure in the OECD, 2008 and 2050

% of GDP

LTC cost are projected to at least double by 2050

Public LTC expenditure as a share of GDP.

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Long-term care expenditures by sources of funding, 2007

Similar to health care financing

- Demographic trends & demand for long-term care (LTC)
- LTC workforce
- Financing
- Coverage

Why do we provide LTC coverage?

- Affordability
- Pre-funding
- Pooling
- Fairness and Social Justice

Why do we need coverage for LTC cost?

Risk of catastrophic cost (and severe need) concentrated among the oldest old

Disposable Income falls with age
Irrespective of financing model, moving towards universal LTC benefits is desirable on access and affordability grounds...

... the cost associated with high-care need can account for more than 60% of seniors’ disposable income, including for those from relative high income deciles.

Universal coverage within a single programme are most often discussed...

Tax-funded Nordic model
Social LTC insurance model

But over half of LTC systems in the OECD are "mixes" with some universal benefit

As are well-known – at the other hand of the spectrum – means-tested systems
- England: social-care system
- United States: Medicaid
Annex 3

Session 3

No LTC system is "free"

- Usually free "health/nursing" care
- Usually means-tested coverage of "board"
- All countries have user cost-sharing for personal care:

All OECD countries face pressures to reform

- Safety net systems can be unfair, give rise to unmet need, create "cliff" incentives, discourage savings or encourage "asset planning".
- Comprehensive universal systems can be expensive and raise questions of value for money.
- Fragmented mixed systems can make coordination and evaluation of "need" difficult, encourage cost-shifting.

What are OECD countries doing to control costs and improve efficiency?

1. Better targeting of care benefits and protection of catastrophic care cost
2. Better pooling of financing across generations
3. Facilitating the development of financial instruments

Improving Efficiency Efforts

- Encouraging home and community care
- Improving productivity in long-term care
- Encouraging healthy ageing
- Facilitating appropriate utilisation across health and long-term care setting and care coordination
- Addressing institutional efficiency

Thank you very much!

- Help Wanted? Proving and Paying for Long-Term Care
- OECD new publication released on May 18, 2011
- www.oecd.org/health/longtermcare
WHO's approach to health ageing

Dr. John Beard
Director, Department of Ageing and Life Course,
WHO, Geneva

The demographic transition

Trends in centenarians

Pace of ageing

Source: WHO, World Health Organization
Two key questions

1. Are people living longer?
2. Are people living healthier?
Opening session

Trends in five and ten year life expectancy: but why?

Q: Are older people healthier than previously?

Seeing population ageing as burden on society

To reduce G7 public pension cost by 10% in 2030 (John Bongaarts)

- Fertility (2000-2030) Increase of 0.27 births per woman
- Net migration rate (2000-2050) Increase of 1.8 net migrants per 1,000 population
- Employment ratio (2050) Increase of 9 percent
- Mean age at retirement (2050) Increase of 1.6 years
- Pension benefits (2030) Reduction of 10 percent

Contribution of ageing to growth in healthcare spending

Percentage of total growth in total health spending per capita, total spending, and expenditure on elderly people per country, 2007-2008 to 2013-2014

Percentage of total growth in total health spending per capita, total spending, and expenditure on elderly people per country, 2007-2008 to 2013-2014
Annex 3

Opening session

Future health expenditure (Australia)

<table>
<thead>
<tr>
<th>Year</th>
<th>Total health expenditure</th>
<th>Labour force participation rate of health workforce %</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>$71 Billion</td>
<td>5.7%</td>
</tr>
<tr>
<td>2022</td>
<td>$142 Billion</td>
<td>5.7%</td>
</tr>
</tbody>
</table>

Source: Year of the World Economic and Social Survey 2007

Another view of ageing

From burden to boon

- Health promotion across the life course – the importance of HEALTH
- Creating environments that foster engagement
  - Social
  - Physical
  - Economic
- Access to age-friendly primary health care
  - Integrated
  - Screening, early detection and amelioration of chronic disease
  - Access to medications
  - Skilled and supported workforce
  - LONG TERM CARE (home and institutional)

Age friendly cities

Urban environments that promote active ageing

WHO global network of age-friendly cities

<table>
<thead>
<tr>
<th>Year 3.2</th>
<th>Year 3.3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Join the network: involve older people - baseline assessment of age-friendliness; identify indicators.</td>
<td></td>
</tr>
<tr>
<td>2. Implement evidence-based action plans: measure progress; identify successes and remaining gaps; Develop new action plan.</td>
<td></td>
</tr>
<tr>
<td>Ongoing 3 year cycle.</td>
<td></td>
</tr>
</tbody>
</table>

Source: World Health Organization
Annex 3

Opening session

WHO global network of age-friendly cities

Launch of the Global Network
June 26, 2010

New York: a city for all ages
http://www.agedriendlynyc.org

Why primary health care?
HYPERTENSION

<table>
<thead>
<tr>
<th>APPEC 1</th>
<th>India</th>
<th>S. Africa</th>
<th>Ghana</th>
<th>APPEC 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>% hypertensive</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>51</td>
<td>30</td>
<td>33</td>
<td>55</td>
</tr>
<tr>
<td>Female</td>
<td>61</td>
<td>55</td>
<td>60</td>
<td>59</td>
</tr>
<tr>
<td>Total</td>
<td>56</td>
<td>45</td>
<td>57</td>
<td>59</td>
</tr>
<tr>
<td>% aware</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>39</td>
<td>36</td>
<td>33</td>
<td>19</td>
</tr>
<tr>
<td>Female</td>
<td>49</td>
<td>42</td>
<td>42</td>
<td>27</td>
</tr>
<tr>
<td>Total</td>
<td>45</td>
<td>38</td>
<td>33</td>
<td>23</td>
</tr>
<tr>
<td>% adequately treated</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>12</td>
<td>14</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Female</td>
<td>81</td>
<td>86</td>
<td>92</td>
<td>96</td>
</tr>
<tr>
<td>Number</td>
<td>2091</td>
<td>8260</td>
<td>5635</td>
<td>4320</td>
</tr>
</tbody>
</table>

Why primary health care?
VISUAL AND HEARING LOSS
Opening session

From burden to boon
• Health promotion across the life course – the importance of health
• Creating environments that foster engagement
  • Social
  • Physical
  • Economic
• Access to age-friendly primary health care
• Integrated
• Screening, early detection and management of chronic disease
• Access to medications
• Skilled and supported workforce
• LONG TERM CARE (home and institutional)
• Rethinking ageing

New Jersey Woman Celebrates 100th Birthday — at Work

“Next Stage: Preferences Among Older Workers: Ideal Plan for Living in Retirement

Source: J harness, Interact & Oxfam, 2006

DEPARTMENT OF AGING AND LIFE COURSE,
WORLD HEALTH ORGANIZATION, GENEVA

Internet use in the United Kingdom by Age April 2007

Average monthly hours online per person, per week

Notes: UK Social Survey 2007.
Towards a regional framework on healthy ageing

Ms. Anjana Bhushan
Technical Officer, Health In Development

WHO’s core functions
1. Provide leadership and engage in partnerships
2. Stimulate knowledge generation, translation and dissemination
3. Set norms/standards, promote their implementation and monitoring
4. Articulate ethical and evidence-based policy options
5. Provide technical support and develop institutional capacity
6. Monitor health trends

Pulling it together: the key components
• Health systems:
  - appropriate service delivery models
  - social protection
• Health promotion and disease prevention
• Evidence:
  - monitoring, measurement
  - policy analysis
  - documenting, disseminating good practices
• Cross-cutting: commitment to human rights, gender and equity

A diverse Region
• Various levels of development
• At various stages in epidemiological transition
• At various stages in demographic transition

Tailoring the response

<table>
<thead>
<tr>
<th>Health systems and services</th>
<th>Health promotion and disease prevention</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of development</td>
<td></td>
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<tr>
<td>Epidemiological transition</td>
<td></td>
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<tr>
<td>Demographic transition</td>
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</tbody>
</table>
Annex 3

Session 1

What do older people want from their health system?
The same things that young people want:
- To live their lives in the highest state of health possible
- To have health systems that foster the values of equity, social justice, universality, people-centredness, community participation, scientific soundness, responsibility, self-determination
- Qualify health services that are:
  - Available
  - Accessible
  - Acceptable
  - Quality
- A high quality health system that has four goals:
  - Improved health – absolute and across 15 groups
  - Social and financial risk protection
  - Responsiveness and people-centredness
  - Efficiency – value for money

Appropriate Health Systems and Service Models for Ageing
Dr. Dean Shuey
Team Leader, Health Services Development

Service Delivery Model
- Includes
  - Public health and curative services
  - Personal and non-personal services
- Defines
  - At what level services occur
    - Household, Community, primary care, secondary care, tertiary
    - Where individuals enter the system and how the services connect
  - Who provides those services at each level and with what choices:
    - Paid vs. non-paid, professional vs. para-professional, what type of professional, team vs. individuals
  - Defines how those services are financially supported
- Encourages continuity of care

Service Delivery Package
- Defined at each level of care in the model
- Affordable
- Feasible
- Often depends on learn:
- Seamless referral – in both directions
- Addresses the largest burden of disease
- Can be progressively enlarged

Questions
- The acute care model is ingrained in our health systems – what can be done to encourage a continuum of care across the life cycle?
- Teamwork is felt to provide better care – how can teamwork for the problems of ageing (and everything else) be fostered?
- What is an appropriate team in different settings?
- Health facilities are frequently not friendly towards those with hearing problems, sight problems, immobility, or ageing. How can systems become more responsive to the problems of the ageing and respect autonomy?

Questions (2)
- Benefit packages are notoriously difficult to define – What are the most likely successful methods to define and update such packages?
- Older people do best in a system when they have the ability to advocate, either by themselves or their families – who becomes the advocate for the less competent and those with no one (families) to advocate for them?
- Rationing is felt to be inevitable by many – What are the acceptable/feasible ways to approach this?
Disease prevention approaches for healthy ageing

Dr. Hoi-Rim Shin
Team Leader, Noncommunicable diseases and Health Promotion

Projected burden of NCDs for +60 in WPR

Co-benefits of NCD risk reduction

Key policy strategies

- Life course action
  - Disease prevention and health promotion policy across the life course to be re-orientated to also consider a healthy ageing process
  - Dealing with the diseases of ‘old age’
    - Health promotion in the +60 age group to maintain independence and functionality
  - Balancing upstream and downstream action
    - A balance between influencing individual lifestyle choices/behaviour and structural determinants

Key Questions

Q. Key policy areas?
Q. Life course action and specific initiative for +60 age group?
Q. How to balance upstream and downstream action?
Q. How to deal with a heterogeneous region?
Presentation outline

1. Demographic Changes
2. NCDs and Ageing
3. Sharing of the Intergenerational Self-Help Clubs (ISHC) Approached to Promote Long Term Community Based Healthy Ageing in Vietnam
4. Sustainability and Replication of the ISHC Approach

1) Demographic Changes

Asia has the largest and fastest growing older population

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<tbody>
<tr>
<td>60-64</td>
<td>2.28</td>
<td>2.40</td>
<td>2.31</td>
<td>2.46</td>
<td>2.65</td>
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<td>2.47</td>
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<tr>
<td>65-69</td>
<td>1.50</td>
<td>1.59</td>
<td>1.59</td>
<td>1.59</td>
<td>1.59</td>
<td>1.59</td>
<td>1.59</td>
</tr>
<tr>
<td>70-74</td>
<td>1.34</td>
<td>1.30</td>
<td>1.18</td>
<td>1.09</td>
<td>1.05</td>
<td>1.00</td>
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<tr>
<td>75-79</td>
<td>0.50</td>
<td>0.80</td>
<td>1.09</td>
<td>1.26</td>
<td>1.41</td>
<td>1.62</td>
<td>1.66</td>
</tr>
<tr>
<td>80+</td>
<td>0.54</td>
<td>0.70</td>
<td>0.93</td>
<td>1.26</td>
<td>1.50</td>
<td>1.53</td>
<td>1.57</td>
</tr>
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2) NCDs and Ageing

Fact and figures
1. NCDs are responsible for 63% of all deaths worldwide.
2. 80% of NCDs deaths occur in low & middle-income countries.
3. 3 out of 4 NCD deaths occur in people aged 60 and over.
4. Around the world, NCDs affect women and men almost equally.
5. One billion adults are overweight. Without action, this figure will surpass 1.5 billion by 2015.
6. Tobacco use kills more than five million people a year. This could rise to over eight million by 2030 unless urgent action is taken to control the tobacco epidemic.

Yes, we living longer, but most of those additional years are in poor health.
Session 5

Need for linking academic research outputs with policy planning so that policy decisions are informed by evidence

WHO can advocate for more evidence-informed decision making for WPRO member states especially the developing countries in the Region

Persuade developing country members to invest in data generation
Towards a regional framework on healthy ageing

Ms. Anjana Bhushan
Technical Officer, Health In Development

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Session 1

Appropriate health systems and service models for ageing

- Ensure services are available, accessible, acceptable, and of good quality (AQA)
- Promote access to affordable primary health care
- Actively promote independence and accessible services for those who are no longer independent
- Ensure continuity of care
- Balance resources between settings

Session 6
Session 2
Disease prevention approaches for healthy ageing

- Promote balance between influencing individual lifestyle choice and affecting structural drivers
- Integrate a focus on healthy ageing in all policies
- Address the double burden of disease in LMIC

Session 3
Social protection and ageing

- Promote social solidarity and cross-subsidies
- Provide targeted support and social transfers
- Build on social security strategies and schemes such as pensions
- Ensure universal access to essential health services, with financial risk protection
- Commit to a basic standard of living through universal social protection

Session 4
Intersectoral action for healthy ageing

- Identify the key sectors
- Promote strong processes for:
  - Health in All Policies approaches
  - Collaboration between researchers and policy makers for effective knowledge translation

Session 5
An improved evidence base for healthy ageing

- Identify evidence gaps, with Member States
- Ensure balance between country comparability and local specificity
- Emphasize knowledge translation to policy and practice
Annex 3

Session 6

Informal Experts' Consultation on Health and Ageing in the Western Pacific Region

ESCAP's Programme on Ageing

Donovan Storer
Chief, Social Policy and Population Section
Social Development Division
United Nations Economic & Social Commission for Asia and the Pacific (ESCAP)
30 May 2011

ESCAP - regional arm of the UN for Asia-Pacific

- Part of UN Secretariat
- 62 member states - 58 are regional members
- Most comprehensive UN regional platform dedicated to development
- ESCAP covers the world's most populous region - two-thirds of humanity
- Members range from world's largest, and wealthiest, to some of the smallest and poorest

ESCAP - regional arm of the UN for Asia-Pacific

- ESCAP fosters:
  - Regional cooperation to promote social & economic development
  - Normative, analytical & technical cooperation work at the regional level
- Exercises regional intergovernmental convening power
- Mandated by ECOSOC to coordinate regional UN system work in economic & social sectors
- Focuses on multi-disciplinary responses

Population Ageing in Asia and the Pacific
(Source: World Population Prospects: The 2008 Revision)

ESCAP's programme on ageing

- ESCAP serves as an intergovernmental platform to
  - Develop a regional response to the demographic transition
  - Share knowledge & good practices in addressing population ageing challenges — act as a regional focal point on ageing
  - Promote the Madrid International Plan of Action on Ageing (MIPAA) in Asia-Pacific, identify gaps & regional priorities
- ESCAP provides technical assistance to Governments to:
  - Design & implement policies/programmes that empower & protect older persons
  - Review & appraise the MIPAA Implementation
Session 6

**Madrid International Plan of Action on Ageing (MIPAA)**

**Purpose:**
- To respond to the opportunities & challenges of population ageing in the 21st century
- Promote the development of a society for all ages

**Three pillars:**
- Older persons and development
- Advancing health and well being into old age
- Ensuring enabling and supportive environments

**1st MIPAA Review Process**
- ESCAP conducted a regional survey
- Provided technical assistance to countries in conducting their national review, using a bottom-up multi-stakeholder approach
- Convened the High-level Meeting on the Regional Review of MIPAA in 2007 in Macao, China
  - Adoption of the "Macao Outcome Document" which fed into the global review

**Regional Seminar on Health Promotion & Active Ageing in Asia and the Pacific**

**Key recommendations:**
- The need for health promotion for active ageing
- Universal and equal access to services for older persons (coverage of insurance, disparity b/w rural/urban areas)
- Capacity building of caregivers and health-care professionals
- Strengthen the monitoring of progress in implementing the MIPAA health pillar (data collection and analysis)

**Regional Forum on Elderly Care Services in Asia and the Pacific**

21-22 January 2011, Nanjing, China

**Key recommendations:**
- Establish national policies on ageing & national coordinating body to monitor implementation
- Ensure a continuum of care for older persons
- Enhance human resource development in elderly care
- Promote a positive image of ageing & older persons
- Increase investment in R & D in services & products for older persons (including ICT)
- Strengthen regional cooperation

**Informal Experts' Consultation on Healthy Ageing in the Western Pacific Region: Issues for WHO consideration**

- Development of indicators on health and older persons: Lack of data impacts on the quality and relevance of policy
- Addressing human resource capacity gaps and adaptation of health systems to meet the needs of older persons
- Developing a continuum of health care for older persons, emphasizing home & community-based care
- Further work on enabling age- & barrier-free environments
- Recognizing and realizing the benefits of older populations: managing the current demographic dividend toward a 'second dividend'
- Linking healthy ageing with universal and rights-based social protection throughout the lifecycle
Thank you