Regional framework for action on ageing and health in the Western Pacific (2014–2019)
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Foreword

This Regional Framework for Action on Ageing and Health in the Western Pacific (2014–2019) is the first one of its kind for the Region. Member States are taking an historic—and timely—step to address the growing needs of the Region’s ageing population.

Though countries may be at different stages, all must prepare for the inevitable trend of population ageing. The proportion of the people above age 60 is growing faster than any other age group in the world — a trend that speaks to the success of health and development programmes as it presents new challenges for societies.

The Western Pacific Region is home to one of the world’s most “silver” societies, Japan, as well as low- and middle-income countries where rapid population ageing means they will have less time to prepare for the needs of increasing numbers of older people.

To meet these challenges, Member States adopted a resolution on ageing and health at the sixty-fourth session of the WHO Regional Committee for the Western Pacific in October 2013. The resolution endorsed the framework, which provides evidence-based guidance and options for Member States on actions for achieving progress on ageing and health.

Too often people focus only on the challenges of ageing. While not simple, we already know much of what needs to be done to address ageing and health in a timely and appropriate manner: fostering age-friendly environments, promoting healthy ageing across the life course, reorienting health systems to meet the needs of older people and strengthening the evidence base on ageing and health.

In this way, we will ensure that older people remain valued and vital resources in our communities.

I urge Member States to use the framework to identify options for strengthening the health sector response to ageing. WHO remains committed to collaborating with Member States, forging partnerships and strengthening political commitment and advocacy to foster accelerated action on ageing and health.

Working together, we can attain the highest possible level of health and well-being for all the people of the Western Pacific Region.

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Acronyms

MIPAA  Madrid International Plan of Action on Ageing
NCD   noncommunicable disease
OPA   older people’s association
SAGE  WHO Study on Global AGEing and Adult Health
TCAM  traditional, complementary and alternative medicine
UNESCAP  United Nations Economic and Social Commission for Asia and the Pacific
WHO  World Health Organization
Executive summary

People are living longer than ever before. Globally and in the Western Pacific Region, the proportion of people aged 60 years and over is growing faster than any other age group. Some countries are already addressing population ageing and finding ways to meet the health needs of older people; others face a narrow window of time to prepare. All countries are exploring ways to help older people retain their health, functional capacity, social participation and security. Population ageing brings new challenges to health policy and health systems, but also new opportunities and areas for action. This Regional Framework for Action on Ageing and Health in the Western Pacific explores these challenges and areas of action. The framework is not prescriptive; it considers current evidence and new ideas as a starting point for further discussions within countries and in the Region as a whole.

Ageing and health are complex, cross-cutting matters that require action across different teams, institutions and sectors. In collaboration with other partners, the health sector has a crucial responsibility to foster age-friendly environments, promote healthy ageing across the life-course and prevent disease and functional decline among older people. It is necessary to reorient health systems to respond to the needs of older people and strengthen the evidence base on ageing and health.

The WHO Regional Office for the Western Pacific supports Member States in developing, implementing and monitoring policies and programmes for active and healthy ageing and age-friendly health systems. In accordance with United Nations principles and World Health Organization mandates, this framework highlights key issues and suggests actions in four key pillars:

Summary of suggested actions

Foster age-friendly environments through action across sectors

- Advocate the creation of age-friendly cities and communities to formal and informal leaders.
- Foster a health-in-all-policies approach by identifying and supporting opportunities for whole-of-government and whole-of-society initiatives across sectors such as social protection, transport, employment, housing and urban planning.
- Strengthen existing multisectoral mechanisms to address ageing and health issues and advocate the inclusion of the health issues and needs of older people into national development plans and into laws, policies and actions on ageing.
- Reduce older people’s exclusion and marginalization by fostering their social participation, highlighting their contribution to society, encouraging intergenerational exchange, supporting older people’s associations and other community networks, and raising public awareness through increased cooperation between the health and social sectors, through mass media and social media channels.
- Build new and extend existing networks or partnerships with international, regional, national and local stakeholders to share experience and lessons learnt, and jointly advance actions on ageing and health, with attention to the role of older people’s associations.
Promote healthy ageing over the life-course and prevent functional decline and disease among older people

- Advocate age-friendly initiatives in a range of settings and programmes targeting specific priority health issues.
- Increase access to proven, effective interventions for health promotion and disease prevention, targeted to specific conditions, while also raising awareness that healthy behaviours, adopted from birth, can improve health in old age.
- Institute proven priority interventions addressing functional decline and frailty among older people, such as those for chronic disease self-care and fall-prevention.
- Strengthen self-help and community support for healthy ageing, including linking with the disability agenda.
- Improve the health literacy of older people, increasing their knowledge of available activities for health promotion and disease prevention in their communities and in the health system. Encourage their participation in design, delivery and evaluation of these activities through intergenerational dialogue, advocacy and positive media messages.
- Address the needs of specific groups of people with higher risk of noncommunicable diseases, taking account of gender norms, roles and relations, and specific factors facing marginalized groups.

Reorient health systems to respond to the needs of older people

Older people should have integrated services that meet their needs

- Ensure that services respond to the health needs and expectations of older people, including by fostering age-friendly primary care as the entry point to the continuum of care from community care and prevention, through outpatient care to specialist, hospital and residential care.
- Place older people at the centre of health service development. Ensure they participate in the design, implementation and evaluation of health plans and strategies, including those for subsectors (for example, health workforce, financing, health information, etc.) and disease control. Encourage action on ageing and health that is human rights-based, gender-responsive and equity-enhancing.
- Enhance the quality of service delivery by tailoring services to the specific health needs of older people and stimulate quality assessment and exchange of good practices on ways to bridge care interfaces, including in the areas of self, family and community care.
- Ensure coordinated delivery of health and social care for older people with chronic conditions and long-term care needs, especially marginalized groups. Mobilize multi-disciplinary teams of social and health workers to ensure continuity of care, support home-based, community and informal caregivers and build older people’s capacity for self-care.
- Increase long-term care capacity, including home and community care, to avoid inappropriate use of acute facilities and to maintain the health and social participation of older people. Create financing mechanisms for long-term care that are appropriate to the country context, with a provision for strengthening over time, paying particular attention to health inequities faced by excluded population groups.
Health workers need appropriate skills

- Enhance health workforce capacity to respond to the health needs of the ageing population, by addressing the quantity and skill mix of workers, enhancing their understanding of the link between healthy behaviours across the life-course and good health in older age, and upgrading their skills and capacity to care for older people who are frail, ill or disabled.

- Reorient health professional education towards the health needs of older people and improve the attractiveness of relevant specialties (such as gerontology and geriatrics) and of work with older people, through marketing, recognition, incentives and career opportunities.

Older people need affordable services and financial protection

- Develop benefit packages to meet the health needs of older people, covering both infrequent high-cost and frequent low-cost expenditures, and promote equitable access to essential medicines and health technologies, reflecting the rights of older people to maintain their health and active social participation.

- Prioritize financial protection systems for vulnerable older people, taking into account their health care needs and capacity to pay.

Access to medicine and health technologies improves the care of older people

- Adopt proven steps to increase the rational use of medicines and health technologies, focusing on older people’s specific needs. These include: improving adherence to treatment for patients with chronic conditions; reviewing prescribing practices; and increasing the health awareness of older people, their caregivers and communities, so as to improve the demand for appropriate health technologies.

- Enable older people to maintain their independence and to access care at home and in communities by promoting innovative health technologies, including in eHealth and mHealth.

Strengthen the evidence base on ageing and health

- Develop and strengthen systems and capacity to collect and analyse routine, disaggregated data, complemented by periodic population surveys and qualitative studies, in order to monitor and understand trends and challenges in older people’s health and functional status, their services and the social determinants of their health.

- Strengthen the monitoring and evaluation of laws, policies, plans and interventions on ageing and health, in order to identify, document and share information on best buys and good practices.

- Identify research priorities for ageing and health in the Region, and strengthen partnerships across sectors and stakeholders (including international organizations, academic research units, nongovernmental organizations, older people’s associations and centres of excellence) to produce improved models of integrated service provision for older people.

- Improve knowledge translation to inform policy-making on ageing and health, including through policy dialogue and the dissemination of policy briefs, national reports and relevant studies.
Background
1. Background

The Western Pacific Region is ageing rapidly (1)

Population ageing is a key public health challenge for all Member States in the Western Pacific Region, regardless of size and income level. In 2010, the Region had more than 235 million people aged 60 years and over, accounting for over 13% of the total population. Over 30 million people or almost 2% of the population were very old (aged 80 years and over). In the Region as a whole, 77% of older people (aged 60 years and over) and 66% of the very old live in low- and middle-income countries. Population ageing reflects the success of past public health and development efforts. Now societies and health systems must find ways to maintain the optimal health and functional capacity of older people and their social participation and security.

Globally and in the Region, the proportion of older people in the population is growing faster than any other age group, due to both declining fertility and longer life expectancy. Although starting from a lower base (i.e. the percentage of older people in the population), the rate of increase in older people is especially rapid in low- and middle-income countries. As Figure 1 shows, Australia, Japan and New Zealand took 50 years to double the percentage of older people in their population from 7% to 14%, whereas Cambodia, the Lao People’s Democratic Republic and Papua New Guinea are expected to do so in less than 30 years (2). This means they have less time to prepare their response to the social, economic and public health implications of population ageing.

In the years from 1990 to 2009, mean life expectancy at birth in the Region rose from 69 to 75 years (3). In the same period, life expectancy at age 60 also increased from 18 to 20 years (4), with variation among Member States. For example, in this period, life expectancy at age 60 remained constant at 17 years in Fiji, but increased from 17 to 19 years in China, from 21 to 24 years in Australia, and from 18 to 24 years in the Republic of Korea (5).

The rising burden of disease in older people presents a challenge for Member States

Population ageing is a global trend, with wide variation in pace and health impacts among countries and within countries. Many older people maintain good physical and mental health; others experience significant disability and disease. Recent information on the situation and trends with respect to death and illness/disability among older people in the Region is summarized here.

Figure 1. Population ageing, selected countries, Western Pacific Region, 1940–2060

In the Western Pacific Region, cardiovascular disease, malignant tumours (cancers) and respiratory disease are the three leading causes of death for both men and women aged 60 years and over (see Figures 2 and 3). Cardiovascular disease alone accounts for 46% of all deaths in this age group. With respect to differences by sex, overall cancer mortality is 30-50% higher for older men than for older women, with lung, stomach and liver cancers accounting for most of the difference, especially in low- and middle-income countries (6). In low- and middle-income countries, cervical, stomach and liver cancers are major causes of death in older women (7). In high-income countries, colon and prostate cancer are the major causes of cancer death for older men, while older women die more often from lung, breast and colon cancer (8).

The same three disease groups, cardiovascular disease, cancer and respiratory disease, are also the leading causes of morbidity among older people in the Region, followed by unintentional injuries, including falls. The share of people living with disability steadily increases with age and, since women live longer overall than men, a larger proportion of older women than men live with disability. Impairment of vision and hearing is very common in older people. For example, 44% of older people in the Region have some vision loss and 93% of these live in low- and middle-income countries (9). Hearing loss is

Figure 2. Leading causes of death in older people (men and women aged 60 and over), Western Pacific Region, 2008

Figure 3. Top 10 causes of disability-adjusted life years (DALYs) lost for men and women aged 60 to 79 years, Western Pacific Region, 2004
also a common disability in older people and reduces their quality of life through social isolation and loss of independence (10).

The global burden of mental illness is increasing, with many older people living with anxiety, depression and cognitive decline (11). For example 17% of older people in the Region suffer from depression (12), with more women than men affected. However, older men have higher rates of both attempted and completed suicide (13). Globally, dementia is the second leading cause of disability (see Box 1); on average, a new person is estimated to become afflicted every four seconds (14). As Figure 4 shows, the prevalence of dementia is projected to increase further, especially in low- and middle-income countries (15). This trend is closely linked to population ageing, particularly the increase in people aged 80 years and over (16).

Institutions and policies need to adjust pro-actively to population ageing (17)

Population ageing, and the related burden of illness and disability, have far reaching implications for the Region’s Member States. There will be impacts on economic growth, labour markets, pension schemes, family composition, housing and living arrangements, as well as on pensions and health and social services. This situation calls for institutional arrangements and policies that allocate resources appropriately, plan and deliver effective programmes, and empower older people to enjoy the highest attainable standard of health. Several countries in the Western Pacific Region have already passed laws, framed national policies and strategies, and put in place institutional arrangements to respond to population ageing. Others are considering this issue, but have not yet taken action.

A country may address its overall strategic response to the health challenges of ageing either through a national plan on ageing that includes a specific section on health or through a health sector strategy that has a defined focus on ageing. Within the overall strategy, several Member States have developed policies and institutional arrangements on ageing (18). Institutional responsibilities for ageing typically lie with ministries of (social) welfare, health or labour (19). The specific division of roles has important consequences for policy focus, with the Ministry of Social Welfare often using poverty reduction as an entry point, while the link to health and health care is more direct.

Box 1. Dementia—a public health priority

Population ageing will influence disease trends and patterns including a rise in chronic and degenerative conditions. WHO has identified dementia, including Alzheimer’s disease, as a major public health priority for all countries, regardless of income level. Globally, there are estimated to be 7.7 million new cases of dementia annually and the numbers will increase as the population ages further. About 25%–30% of people aged 85 or older experience some degree of cognitive decline. Early signs of dementia are often mistaken for “normal” signs of ageing, which delays diagnosis and treatment. Dementia affects not only those living with the disease but also their families, carers and communities. While factors causing dementia remain unclear, and there is no definitive treatment, with appropriate social and environmental support older people with dementia may live and participate in society for many years. The policy response must focus on providing a suitable environment and on support for both those suffering dementia and their carers, especially in resource poor communities.

where the Ministry of Health is in the lead (20). Several countries have set up national committees to coordinate policies on ageing across ministries, providing a high level mechanism for integration and collaboration across sectors (21). Ageing related issues also cut across the different elements of the health system, such as leadership and governance, service delivery, health financing, health workforce, essential medicines, technologies and health information (22). Countries need to be aware of different options for policy and institutional arrangements, share good practice for maintaining the health of older people (23).

**International context and WHO mandate on ageing and health**


The United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) supports countries and monitors their progress on MIPAA implementation in the Region. Following Madrid, the Asia-Pacific Region adopted the Shanghai Implementation Strategy in 2002 (28). UNESCAP held meetings in 2007 in Macao (China) and in 2012 Bangkok (Thailand) to provide guidance on implementation to Member States and to review progress (29).

WHO participated in both World Assemblies on Ageing, and collaborates with Member States, other United Nations agencies and other partners to address the health

**Figure 4. Projected number of people (millions) with dementia in low- and middle- income countries and in high-income countries, worldwide, 2010-2050**

implications of population ageing, globally and in the Western Pacific Region. At Madrid in 2002, WHO put forward the concept of “active ageing” to foster the health, participation and security of older people and to enhance their quality of life (30). This Regional Framework for Action on Ageing and Health in the Western Pacific strongly advocates health promotion over the life-course as an effective strategy for healthy and active ageing, taking account of gender and cultural factors. Policies for healthy and active ageing include support for preventive approaches, adoption of healthy lifestyles, and development of inclusive, participative and innovative health systems, based on international good practice (see Box 2) (31).

World Health Assembly resolution WHA65.3 (Strengthening noncommunicable disease policies to promote active ageing, May 2012) requests the WHO Director-General to support Member States, including through multisectoral approaches to healthy ageing, integrated care for older people, and support for providers of formal and informal welfare services (32).
WHO has supported action on ageing and health in the Western Pacific Region since the 1980s. The Regional Committee for the Western Pacific adopted resolutions to promote healthy ageing and age-friendly health care in 1981 (WPR/RC32.R15), 1985 (WPR/RC36.R23), 1996 (WPR/RC47.R12) and 1998 (WPR/RC49.R11). In May 2011, the Regional Office for the Western Pacific convened an informal expert consultation to advise on the Region’s work on population ageing (33). Participants stressed the importance of a proactive response through actions within and beyond the health sector (34). World Health Day 2012, with the theme “Good health adds life to years”, offered the opportunity to raise awareness and focus attention on the issue (35).

This framework builds on these initiatives and lessons learnt. It also makes use of recent regional analysis undertaken with Member States, including a comparative study of the health of older people in selected countries through analysis of existing survey data sets (36), and a review of policies related to ageing and health in selected countries (37). An expert consultation in April 2013 and a meeting of Member States in July 2013 reviewed the analyses and recommended future action (38). The framework is intended to form a basis for discussions within and among Member States on adequately responding to the health implications of population ageing in the Western Pacific Region.
Regional framework for action on ageing and health
2. Regional framework for action on ageing and health

Vision

The vision of the framework is of an age-friendly Region where older people are adequately supported to maintain their health and lead active lives. An age-friendly Region sees population ageing as an opportunity and the health of older people as a resource for society. It holds the highest attainable standard of physical and mental health to be a fundamental right of all older people, without discrimination. An age-friendly Region upholds the participation of older people in all aspects of daily life as a core principle. The vision acknowledges that action for healthy ageing must take place across the life-course and also across sectors, ensuring an environment that supports older people to remain healthy, active, empowered and socially engaged. The vision commits to building health systems oriented to provide older people with integrated services and information that meet their needs.

Overarching principles guiding action on ageing and health

A human rights-based approach

The right to enjoy the highest attainable standard of health (“the right to health”) was first set down in the WHO Constitution in 1946, and has since been recognized in many international, regional and national instruments, including Article 12 of the International Covenant on Economic, Social and Cultural Rights. The rights of older people are included in General Comments No. 6 (1995) and No. 14 (2000) of the Committee on Economic, Social and Cultural Rights, and General Recommendation No. 27 (2010) on the rights of older women of the Committee on the Elimination of Discrimination against Women.

Realization of the right to health requires an environment that enables everyone to be as healthy as possible. This environment covers health care and factors which contribute to health such as housing, food, information, gender equality and freedom from neglect or abuse (see Box 3).

Non-discrimination and equality

A human rights-based approach to the health of older people is guided by the principles of non-discrimination and equality. States have an obligation to ensure equality and

Box 3. Abuse of older people

Although region-specific figures are not available, WHO estimates that between 4% and 6% of older people worldwide face some form of abuse. Older people, especially those with disability or clusters of health problems, become dependent on others and are thus vulnerable to abuse. The abuse can be physical, verbal, psychological/emotional, sexual and/or financial in nature and have severe consequences for health and well-being.

non-discrimination in laws and policies, in the distribution of resources, in the underlying determinants of health and in the delivery of health services.

Stigma and discrimination are important barriers to older peoples’ enjoyment of their right to health (40). Leadership and specific action are needed to move away from negative images of ageing to the view that older people are valuable assets for their families, communities and society as a whole (41). The health sector has a role in ensuring that men and women can lead full and productive lives and retain their independence as they grow older.

Equity

It is recognized that older people are not a homogeneous group and face varying health risks. For example, 50% of smokers die of their smoking habit, but smoking rates vary among both men and women by level of education. Figure 5 shows the results of a study that found smoking was generally more common among men with lower education. There are persistent and growing health inequities, both among and within countries in the Region (42). Reduction of inequity can improve health outcomes, while promoting social justice and human rights for marginalized groups (43).

The principles of non-discrimination and equality do not imply equal treatment for all but do require the identification of groups of older people who are at particular risk of illness or injury. The collection and analysis of information, disaggregated wherever possible by age, sex, education, income and urban/rural location, can inform equity-focused policy-making on ageing and health (44). Groups facing particular health inequities, defined as unfair and avoidable differences in health, might require particular consideration in policy development and service planning (45).

Gender equality

Gender equality is a fundamental human right as well as a key determinant of health. As they grow older, women and men face some of the same health problems, such as cardiovascular disease, cancer, mental illness and sensory impairment. However, they differ with regard to the rates, trends and specific types
of disease. For example, men are more affected by lung cancer, while cervical and breast cancers are major causes of death in women. Collection and analysis of health data by sex can improve the targeting of resources to address the health needs of women and of men.

Some differences in health between men and women arise from their biological differences (e.g., prostate, breast and cervical cancers). But addressing other variations in health status and disease trends requires understanding of gender norms, roles and relationships. For example, higher lung cancer rates among men are linked to their higher smoking rates. In countries where smoking rates among women have increased, a subsequent increase in lung cancer in women is observed.

Deterioration in the health of older people often results from events and circumstances in earlier life. To understand and reduce the health problems of older women and men, we need to consider their experience across the life-course (46). Different roles and experiences of women and men over time give them different exposure to risk factors such as smoking, alcohol use, diet and physical activity (47). Gender also influences health-seeking behaviour and access to services. For example, some health problems of older women result from their reproductive health experience, often related to limited control over their sexuality and fertility, and difficulty in obtaining appropriate information or care. Equitable access to appropriate health services for older men and women is a core dimension of their right to health. Considering gender in the design, implementation and evaluation of policies and programmes for ageing and health can improve their acceptability and effectiveness.

**Older people’s participation**

Active, informed participation of older people in decisions related to their health and well-being is central to a human rights-based approach and is a core element of MIPAA and of the United Nations Principles for Older Persons (48). Policies and programmes

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**Box 4. Older people’s associations (OPAs) in Cambodia**

OPAs are community-based organizations of older people formed to improve the well-being of older people, their families and communities. OPAs provide social support and deliver services. In Cambodia, with very low coverage of formal social protection, OPAs act as a safety net for households, particularly in rural areas. They tackle issues of livelihood and food security, for example by establishing rice banks and adapting farming practices to households with older members. They help with access to primary health care, providing care at home for frail and bedridden older people, and offer health cost subsidies and basic social welfare assistance. OPAs mobilize older community members and advocate for better access to essential services. Since their inception, all OPAs in Cambodia, representing close to 14,000 members in 2010, have called on the Government to expand the eligibility criteria for the ID Poor card, which identifies members of poor households, to cover all households with a member aged 70 years and over. The ID Poor card entitles the holder to subsidized fees for essential services, including primary health care. The Government of Cambodia has welcomed the participation of older people in policy-making on ageing and health, and has endorsed national guidelines on the establishment of OPAs and on home-based care.

Source: Older People’s Associations in rural Cambodia. Phnom Penh: HelpAge International; 2010.
should empower older people to contribute to and remain active members of their communities, according to their capacity, for as long as possible. Helping older people to maintain their health and independence adds value to their community and saves on the cost of care. The inclusion of older people requires removing negative stereotypes of ageing, which do not reflect today’s reality. The new view accepts older people, not as a homogenous, needy group, but as diverse in their skills, abilities, aspirations and needs, as is the population as a whole.

All people, including older people, have the right to participate in decisions that directly affect them, such as the design, implementation and monitoring of health policies and programmes. Participation should be active, free and meaningful. Planning is needed to ensure the participation of marginalized groups, such as people aged 80 and over, older people living in poverty, those with disabilities and older carers. Meaningful participation and community leadership require adequate financial and technical support. In many countries, older people’s associations (OPAs) are proving to be a promising model for supporting and mobilizing older people as well as strengthening their participation in society and policy-making (see Box 4).

**Goals and timeframe**

The goals of the framework are to:

a. *Increase attention to ageing and health in the Western Pacific Region*

   There is a need for effective laws, policies and actions at regional and national levels, which are informed by evidence on the health of older people and the implications of population ageing for health system design and reform and which are responsive to each Member State's level of development, population structure and disease pattern.

b. *Suggest action to address new challenges and set priorities on ageing and health in the Region*

   Rapid ageing of the population means there is a narrow window of time to prepare, especially in low- and middle-income countries. Priorities include building age-friendly environments, exploring old and new ways to promote healthy ageing across the life-course, reorienting health systems to respond to the needs of older people, and strengthening the evidence base.

c. *Strengthen leadership on ageing and health in the Region*

   The aim is to build capacity in Member States, specifically in ministries of health, to provide national leadership on ageing and health. In addition, WHO must be able to provide leadership and support on ageing and health in the Region. WHO has a growing role in advocating, with Member States and other stakeholders, for stronger action on ageing and health. Successful action on ageing and health must be built on collaboration with other sectors and on a health-in-all-policies approach.

The framework covers six years (three WHO biennia), from 2014 to 2019.
Pillars of action on ageing and health

The framework has four pillars of action, one for each of the four strategic priorities identified for the Region. The four pillars are:

1. foster age-friendly environments through action across sectors;
2. promote healthy ageing across the life-course and prevent functional decline and disease among older people;
3. reorient health systems to respond to the needs of older people; and
4. strengthen the evidence base on ageing and health.

Issues of gender, equity and human rights are integrated across the framework (see Figure 6).

**Figure 6. Overview of the regional framework for action on ageing and health in the Western Pacific**
Foster age-friendly environments through action across sectors

Objective

To foster age-friendly environments through action, engagement and collaboration across sectors and stakeholders, including local communities, families and older people themselves.

Background

The economic, physical, political and social environment can be supportive of healthy ageing or it may pose barriers to the independence, health and well-being of older people (49). For example, the built environment will affect older people’s health. Neighbourhoods need to be safe, well lit and provide even walking paths with places to rest. Age-friendly public transport can improve older people’s mobility, social participation and access to health and other services.

Healthy ageing is a complex process, involving a range of factors beyond the scope of the health sector. The health system needs to work with other sectors to identify the social, economic, political, and environmental determinants of and pathways to healthy ageing. The health sector can lead in advocating action for healthy ageing with other sectors, including social protection, transport, housing, urban planning and employment. Existing national and local multi-sectoral mechanisms should be used for oversight of whole-of-government and whole-of-society approaches to ageing and health. National development plans are important policy instruments and should include key commitments and priorities for healthy ageing. The ministry of health has a critical role in ensuring that health is adequately addressed in developing and implementing comprehensive national strategies or plans on ageing.

The WHO Global Network of Age-friendly Cities and Communities, started in 2007, aims to ensure that socioeconomic development enables healthy and active ageing through supportive urban environments (50). The Network’s list of core indicators for age-friendly cities is a valuable reference tool for urban planners and others. It covers eight domains: outdoor spaces and buildings; transportation; housing; social participation; respect and social inclusion; civic participation and employment; communication and information; and community support and health services.

Older people should be empowered play an active role in shaping their social environment and local policies for healthy ageing (for example, in emergency planning and response, see Box 5) (51). The existence of social networks and communities, as well as community-based mechanisms and structures, including OPAs, can promote the social inclusion and participation of older people, help determine whether they feel well, or are at risk of physical or mental illness and what social support is necessary to help overcome their problems (52).

Suggested actions:

- Advocate the creation of age-friendly cities and communities to formal and informal leaders.
Box 5. Strengthening age-friendly preparedness and response in health emergencies and disasters

As a group, older people are at higher risk than the general adult population during health emergencies and disasters, due to their high prevalence of sensory or cognitive disability and lower levels of physical fitness and mobility. Planning for emergencies and disaster management must give particular attention the strengths and weaknesses of this group, and actively engage older people in the planning and decision-making. For effective protection of this group’s health and wellbeing, disaster planning and preparedness should ensure that older people are:

- aware of relevant health and disaster risks and familiar with local plans for risk reduction and disaster preparedness, response and recovery;
- able to play an active role in risk reduction, and emergency planning and response;
- assisted to maintain their independence, within the constraints of the situation, or be helped to regain their autonomy to the extent possible; and
- provided appropriate age-friendly support and service either directly or distance communication technology, according to the stage and severity of the emergency.

The following plans and activities should be prepared: (1) mapping the location of older people in the area of the disaster plan, (2) provision of evacuation plans and advice in the event of an emergency, and (3) ensuring transportation to evacuation facilities and to alternative housing if needed. Wherever possible, the disaster preparedness team should hold regular meetings, simulations and drills with older people, allowing them to become familiar with actions needed and the key support personnel, in the event of an emergency or disaster.

Strategic recommendations follow three broad directions, namely: (1) enhancing participation of older people and increasing their awareness of the steps to take in emergencies; (2) developing and implementing guidelines and practices responsive to their needs; and (3) promoting cross-sectoral collaboration in all phases of the health and emergency disaster preparedness and management.


- Foster a health-in-all-policies approach by identifying and supporting opportunities for whole-of-government and whole-of-society initiatives across sectors such as social protection, transport, employment, housing and urban planning.
- Strengthen existing multisectoral mechanisms to address ageing and health issues and advocate the inclusion of the health issues and needs of older people into national development plans and into laws, policies and actions on ageing.
- Reduce older people’s exclusion and marginalization by fostering their social participation, highlighting their contribution to society, encouraging intergenerational exchange, supporting OPAs and other community networks, and raising public awareness through increased cooperation between the health and social sectors, through mass media and social media channels.
- Build new and extend existing networks or partnerships with international, regional, national and local stakeholders to share experience and lessons learnt, and jointly advance actions on ageing and health, with attention to the role of OPAs.
Promote healthy ageing across the life-course and prevent functional decline and disease among older people

Objective

To reduce exposure to risk factors and promote healthy behaviours across all stages of life, empowering people to maintain their health as they grow older and delaying functional decline and ill health.

Background

The health and well-being of older people are strongly related to events and circumstances in their earlier years. Poor health and disability are not inevitable consequences of ageing. The extent to which a person is physically active, eats a healthy diet, avoids tobacco and limits the use of alcohol will affect their health and well-being in both early and later life (53). Healthy lifestyle choices at all ages help people to remain well and active as they grow older and can delay the onset of chronic disease (54).

Effective support for a healthy lifestyle is linked to action for age-friendly environments, discussed above in the first pillar of action. Evidence also points to the value of selected traditional, complementary and alternative medicines (TCAM) and practices to promote health and prevent or delay disease and functional decline among older people (55). Health promotion and disease prevention activities should fit the specific needs and circumstances of older people, with the aim of adding good health to their years of life (56). Improving health literacy can also help older people to adapt to the decline in their functional capacity as they grow older (57).

Older people comprise a large share of those with the noncommunicable diseases (NCDs), which are the leading causes of preventable illness and disability. Reducing exposure to NCD risk factors is a priority for health policy-makers across the Region. In the Western Pacific Regional Action Plan for Noncommunicable Diseases, WHO has identified a set of evidence-based “best-buy” interventions for tackling NCDs that is highly cost-effective as well as appropriate and feasible for low- and middle-income countries, where health systems may be often tend to be relatively weak (58). As such, efforts on NCDs, for example as part of an NCD action plan, play an important role in promoting healthy ageing across the life-course.

The early detection, prevention and management of functional and cognitive decline are of particular relevance for older people (59). Frailty is associated with increased risk

Box 6. Falls and injuries among older people

Globally, falls are a leading cause of accidental death. Age is a major risk factor for falls, and people aged 65 and over suffer the greatest number of fatal falls. Those who survive a fall often face permanent functional disability or need specialist or institutional care. The prevention of falls involves removing environmental hazards and training older people to improve physical strength and balance.

of physical, cognitive and functional impairment (see Box 6). Older people who are frail or in functional decline are more likely to experience health problems, requiring community, hospital or long-term care.

**Suggested actions:**

- Advocate age-friendly initiatives in a range of settings and programmes targeting priority health issues.
- Increase older people’s access to proven, effective interventions for health promotion and disease prevention, targeted to specific conditions, while also raising awareness that healthy behaviours, adopted from early, can improve health in old age.
- Institute proven priority interventions addressing functional decline and frailty among older people, such as those for chronic disease self-care and fall-prevention.
- Strengthen self-help and community support for healthy ageing, including linking with the disability agenda.
- Improve the health literacy of older people, increasing their knowledge of available activities for health promotion and disease prevention in their communities and in the health system. Encourage their participation in design, delivery and evaluation of these activities through intergenerational dialogue, advocacy and positive media messages.
- Address the needs of specific groups of people with higher risk of NCD, taking account of gender norms, roles and relations, and specific factors facing marginalized groups.
Reorient health systems to respond to the needs of older people

Objective

To reorient and strengthen health systems to make them responsive to the needs of older people, starting with the provision of acceptable, accessible and effective health services across the continuum of care.

Background

Population ageing has profound implications for health policy, planning and practice. Despite the benefits of health promotion and disease prevention, health systems must respond to the inevitable health needs of older people. All Member States need to strengthen and reorient their health systems to provide older people the services they need. Most health systems are limited in their ability to prevent, manage and treat chronic disease, or other common conditions such as vision and hearing loss, falls and dementia. The starting point for service improvement is to develop a model for integrated, person-centred services across the continuum of care (see Figure 7). Ideally this action would be linked to broader efforts to strengthen health systems.

Older people need access to responsive integrated services

Most health service systems are oriented and resourced to treat acute episodes of ill health. But many older people require secondary prevention, screening and early diagnosis, as well as management of their chronic conditions, frailty and functional decline. Effective care of older people requires teamwork and coordination: between health care and social care; with families, communities, health facilities and social support agencies; with social insurance and health insurance entities; and among general and specialist health professionals.

Figure 7. Reorient health systems to respond to the needs of older people
At the macro level, ensuring that older people have access to integrated, people-centred services starts with including the principles and priorities of aged care into national health policies, strategies and plans, as well as relevant legislation. These principles and priorities must also be incorporated into subsectoral health policies, such as those for health workforce, health financing, health information and health technology, and the policies and plans for disease control, particularly for NCDs, nutrition, mental health and health promotion. Legislation on issues such as insurance coverage, benefit packages and costs, as well as subsidies for co-payments, needs to be reviewed and adjusted to meet the needs of older people.

At the micro level, the needs of older people should be mainstreamed across the service delivery system, using suitable entry points to integrated service delivery. Integrated service models can help provide the continuum of care needed by all population groups, as outlined in the WHO Western Pacific Regional Strategy for Health Systems Based on the Values of Primary Health Care (61). The integrated service continuum spans promotion, prevention, treatment, management, rehabilitation, palliation and end-of-life care. Integrated service models need to address specific barriers to access for older people, which might include discrimination, complexity, information gaps and costs (direct and indirect).

Age-friendly primary care plays a key role in timely assessment of the health of older people, in early diagnosis of mental or physical health conditions, and in linking to other services (62). The primary level of care may be the best starting point to develop an age-responsive care pathway through the wider health system. Age-friendly primary care can also link with innovative models of self-care, and home and community care. Transitional care options, including step-down care (see Box 7), can facilitate movement along the care continuum, which is particularly important for older people.

Hospitals must also become more age-friendly, through change to the physical environment, for example, in the access to wards and other facilities, and also through change to service delivery, to address the needs and preferences of older people and facilitate their rehabilitation, participation and independence. Secondary and tertiary care must also be age-friendly, because the complex problems of many older people may involve several health disciplines. Investment is needed in specialist skills such as geriatrics and gerontology. The specialists provide care, set service standards, advise on policy and programmes, and train others. Rehabilitation units and services must also plan for increasing use by older people.

Box 7. Step-down care—a potential way forward

A step-down care facility is a non-hospital, community-based unit, also described as a transitional or intermediate care facility. It is used when people no longer need hospital care but are not ready to resume level of independence. Step-down care relieves hospitals of the cost and bed-occupancy of people who are in recovery and now need support for rehabilitation. Step-down care aims to return older people to their homes and communities in the short to medium term. The facilities provide medical oversight and follow up of rehabilitation involving a range of types of physical therapy, speech therapy, cognitive stimulus and practice in the activities of daily living. In the Western Pacific Region, Australia, Japan and Singapore provide step down care for older people and others. Given the rapid increase in older people in the Region, there is an urgent need to share experience and good practice in step-down care across all Member States.
With regard to long-term care, older people in low- and middle-income countries are still mostly cared for in the family, while high-income countries offer more institutional care, although access may not be equitable (63). However, reliance on family care is becoming less feasible due to the increase in numbers of old people, the rising participation of women in the formal workforce, rural-to-urban migration that may leave older people behind and the decline in multi-generational households. Efforts should begin now to test practical solutions to these trends. Community-based options may offer new ways to tailor long-term care at home or in the community.

Types of long-term care range from home and community care through to residential and higher level hospital care. In the past much of the burden of long-term care has been taken by families, but some countries have established long-term care institutions for a substantial proportion of older people. With changes in family structures and social dynamics, increase attention is being given to find new ways to provide longer term care at home or in the community.

Ensuring an adequate balance of long-term care arrangements requires appropriate policies and financing. Several options are available. Some countries in the Region have separate health financing from long-term care financing, through separate insurance mechanisms. Others have prioritized voluntary and community based financing models. Financing mechanisms for long-term care should be as simple as possible and tailored to the country context and level of development. For many Member States, ensuring sufficient fiscal space will be critical to a sustainable long-term care program. Given the rapid pace of ageing, many countries are under pressure of time to put in place financing reforms to meet the needs of older people.


With regard to long-term care, older people in low- and middle-income countries are still mostly cared for in the family, while high-income countries offer more institutional care, although access may not be equitable (63). However, reliance on family care is becoming less feasible due to the increase in numbers of old people, the rising participation of women in the formal workforce, rural-to-urban migration that may leave older people behind and the decline in multi-generational households. Efforts should begin now to test practical solutions to these trends. Community-based options may offer new ways to tailor long-term care to the needs of older people (see Box 8) (64). OPAs, as well as patient groups and support groups, can help older people to remain independent longer through self-care or community support. These changes pose new challenges for health workforce planning and health and education systems, especially in the context of levels of health literacy.

**Health workers need appropriate skills**

Population ageing will affect health workforce planning in the Region in at least two ways. First, the demand for health workers is likely to increase. Sufficient numbers of health workers will be needed to handle the rising health care needs of ageing populations. This higher demand will occur in the face of the global trend of skilled health workers migrating away from low- and middle-income countries. At the same time, health workers themselves are growing older (see Box 9). Second, population ageing will increase the demand for specific skills and competencies, with implications for both work arrangements and learning systems. Multi-disciplinary teams are needed.
for effective management of chronic conditions and co-morbidities (65). This might involve staff of different specialties working as a team within a health care institution, or across sectors linking with rehabilitation and social services. Teams might also include a range of health professionals, from specialists to general practitioners, community workers and informal or family carers. The response to population ageing will involve testing new approaches in multi-disciplinary teamwork and learning. The new approaches will also set new standards for quality of care and modify career pathways and education systems. Issues of the recognition, compensation and training of informal carers also require further attention in order to support effective service delivery and quality.

Given the expected magnitude of population ageing, all health workers need basic understanding and skills related to the health needs of older people (66). Ageing needs to be a core segment of pre- and in-service training for health professionals. Curriculum change requires cooperation by ministries of health and education and relevant regulatory bodies.

In addition to improving the competence of general health staff in the care of older people, more specialists are needed in disciplines such as gerontology and geriatrics. But few Member States can provide relevant post-graduate training, and these courses may not be a popular choice for medical and nursing students. Action is needed to fill current staffing gaps, and to plan for expansion of training in geriatrics and gerontology. In-service training should be provided for primary care providers, with priority to those dealing with older people. Advocacy is needed to show decision-makers the important role of these specialities, to expand related career paths and to adapt human resource policies and plans. This advocacy should be linked with broader discussion of resource allocation in the health sector to meet the needs of older people.
Older people need affordable services and financial protection

Health expenditure and health financing mechanisms vary widely across countries in the Western Pacific Region. Population ageing will interact with other factors, including inefficiency and waste, in contributing to the continuing increase in the cost of health care (67).

Population ageing exerts three types of pressure on health spending (68). The first arises from the increased use of health services, as older people make up an increasing proportion of the population. Spikes in health expenditure occur for acute illnesses and accidents, and again at the end of life, including for palliative care (69). Second, cumulative costs from the increased number of people requiring detection and management of chronic conditions add to health spending by households and the health system (70). Third, many older people have low incomes, particularly in low- and middle-income countries where social security systems are weak. Many of these older people cannot pay out of pocket for their health care. Current health financing schemes in most Member States are not designed or funded to absorb these pressures.

Benefit packages through health insurance or public funding schemes need to better reflect the health needs of older people. This includes financial protection for the cost of managing chronic health conditions as well as acute health shocks. Government should also prepare to meet other health-related needs of older people, such as housing, transport, rehabilitation and devices to maintain independence. For example, eyeglasses represent a low-cost, high-impact option, in terms of the improved health, independence, participation and quality of life for older people.

Questions on health financing for older people need to be addressed with some urgency, in line with the priorities and strategies identified in the WHO Health Financing Strategy for the Asia Pacific Region (2010–2015) (71). The starting point should be the household’s capacity to pay, or funding on basis of need, and should not perpetuate the image of older people as a financial burden to society. As mentioned earlier, older people may be particularly vulnerable to financial barriers to access to services. On the other hand, in many societies, population ageing will increase the economic and political influence of older people. They should participate in defining benefit packages and related issues of age-friendly health financing. In some countries, OPAs have organized older people in efforts to reduce and subsidize the costs of services and drugs (72).

Access to medicine and health technologies will improve the care of older people

Innovation in assistive devices and essential medicines as well as efforts to move towards universal access, have great potential to improve the health and independence of older people. Despite recent progress in the Region, Member States face challenges in ensuring access to essential medicines of assured quality (73). High-income countries are confronting issues such as ensuring rational use of drugs and cost containment. Low-income countries and most middle-income countries struggle to ensure access to essential medicines, especially for the poor and vulnerable. Overall, medicines are the second-largest item of household expenditure, after food. Many households in low- and lower-middle-income countries face difficult choices, as they must pay out of pocket for medicine. Older people with chronic and often multiple diseases are at risk of running short of medicines. In some places, they also may receive unnecessary medicines, which creates problems due to older people’s susceptibility to medication-related adverse events. Strategies are needed to improve prescribing and the use of medicines among older people, to reduce inappropriate poly-pharmacy, to ensure older people complete their courses of medication and to respond to and monitor adverse drug events.
A key dimension of universal coverage is the adoption of affordable health technologies.¹ Better use of health technology can improve older people’s quality of life, for example, through medication management and diagnostics, by combating social isolation, fostering intergenerational exchange and bridging geographical distance within families. Technology may include mobile phone communication and applications (‘apps’), and tele-links to health and social service providers, with new advances rapidly being introduced.

Assistive devices² of particular relevance to older people include hearing or visual aids, walkers or wheelchairs and tools for remote or independent health monitoring. Assistive devices can empower older people to maintain their health and participate in their community, and at a lower cost than institutional care. Assistive devices for older people are frequently the same as those used by younger people with disability, so increasing access to assistive devices has synergies and benefits for both groups.

To a varying extent, all countries in the Region face challenges with regard to the availability, accessibility, acceptability and quality of essential medicines and health technologies for older people. In some settings, older people are high-risk/high-cost users, while in others they lack access even to basic medicines and technologies, due to weak health systems or financial and social barriers. In many Pacific island countries and areas, for example, the lack of appropriate assistive devices is a major issue.

On the supply side, problems include product availability and supplier engagement, weak incentives for manufacturers to enter the market or sustain production, and lack of global supply. Affordability is a concern for some devices such as hearing aids, which may be relatively expensive for the user, but can greatly improve autonomy and quality of life. Such cost-effective technologies should be included in health benefit packages or subsidy schemes. Access to devices may also be limited due to lack of personnel trained to fit, maintain and monitor the devices, particularly in home or community settings. Equally important is to ensure the availability of suitable information about medicines and technologies for professionals, communities, caregivers and older people. OPAs often have the potential to organize and monitor access to technologies, especially for marginalized groups of older people. In many settings, ensuring the acceptability and quality of technologies is a challenge. For example, wheelchairs or eyeglasses require some level of individual customization and quality control.

Older people with multiple conditions are at risk of under- or over-treatment. For example, older people in high-income countries take multiple medications at a time, raising the chance of adverse drug interactions (74). With increasing chronic disease and co-morbidities in older people, countries need to find ways to overcome the barriers noted and deliver assistive technologies and drugs as part of the health system to reduce the use of duplicative and inconsistent supply mechanisms.

**Suggested actions:**

**Older people should have access to integrated services that meet their needs**

- Ensure that services respond to the health needs and expectations of older people, including by fostering age-friendly primary care as the entry point to the continuum of care from community care and prevention through outpatient care to specialist, hospital and residential care.

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¹ Defined as the application of organized knowledge and skills in the form of devices, medicines, vaccines, procedures and systems developed to solve a health problem and improve quality of lives.

² Defined as a tool that empowers a person who requires assistance to perform the daily activities essential to maintain health and autonomy (WHO Kobe Centre, 2004).
• Place older people at the centre of health service development. Ensure they participate in the design, implementation and evaluation of health plans and strategies, including those for subsectors (for example, health workforce, financing, health information, etc.) and disease control. Encourage action on ageing and health that is human rights-based, gender-responsive and equity-enhancing.

• Enhance the quality of service delivery by tailoring services to the specific health needs of older people and stimulate quality assessment and exchange of good practices on ways to bridge care interfaces, including in the areas of self, family and community care.

• Ensure coordinated delivery of health and social care for older people with chronic conditions and long-term care needs, especially marginalized groups. Mobilize multi-disciplinary teams of social and health workers to ensure continuity of care, support home-based, community and informal caregivers and build older people’s capacity for self-care.

• Increase long-term care capacity, including home and community care, to avoid inappropriate use of acute facilities and to maintain the health and social participation of older people. Create financing mechanisms for long-term care that are appropriate to the country context, with a provision for strengthening over time, paying particular attention to health inequities faced by excluded population groups.

**Health workers need appropriate skills**

• Enhance health workforce capacity to respond to the health needs of the ageing population, by addressing the quantity and skill mix of workers, enhancing their understanding of the link between healthy behaviours across the life-course and good health in older age, and upgrading their skills and capacity to care for older people who are frail, ill or disabled.

• Reorient health professional education towards the health needs of older people and improve the attractiveness of relevant specialties (such as gerontology and geriatrics) and of work with older people, through marketing, recognition, incentives and career opportunities.

**Older people need access to affordable services and financial protection**

• Develop benefit packages to meet the health needs of older people, covering both infrequent high-cost and frequent low-cost expenditures, and promote equitable access to essential medicines and health technologies, reflecting the rights of older people to maintain their health and active social participation.

• Prioritize financial protection systems for vulnerable older people, taking into account their health care needs and capacity to pay.

**Access to medicine and health technologies will improve the care of older people**

• Adopt proven steps to increase the rational use of medicines and health technologies, focusing on older people’s specific needs. These include: improving adherence to treatment for patients with chronic conditions; reviewing prescribing practices; and increasing the health awareness of older people, their caregivers and communities, so as to improve the demand for appropriate health technologies.

• Enable older people to maintain their independence and to access care at home and in communities by promoting innovative health technologies, including in eHealth and mHealth.
Strengthen the evidence base on ageing and health

Objective

To strengthen evidence-based policy- and decision-making on ageing and health in the Western Pacific Region by: stimulating research on new solutions for healthy ageing; monitoring trends in the health and functional status of older people and their access to health services; improving the completeness of patient information and its availability across points of service delivery.

Background

Member States need reliable information on population ageing and health to inform policy and service improvement and to track changes over time. Despite progress, knowledge gaps remain in several dimensions of ageing and health. These include:

- health trends among older people
- determinants and risk factors for older people’s health
- effective ways to prevent and manage age-related conditions such as dementia and functional decline
- the behavioural and social dimensions of ageing
- interventions to improve the health status of older people, promote healthy behaviour across the life-course and strengthen the social, work and built environments for older people
- the impact of current laws and policies on ageing and health, within the different social, institutional and political contexts of Member States

Sources of Information on ageing and health include: health facilities, civil registration and vital statistics systems, surveys, operational research, and social security and health insurance systems. Cross-national and intra-country surveys in many Member States have generated substantial information (see Appendix 2). However, there is a need to standardize methods and indicators across countries in order to compare and synthesize findings (75). Regular surveys at five- or 10-year intervals would allow analysis of trends in the health and functionality of older people, to inform policy-making and planning.

At a global level, the Population Division of the United Nations Department of Economic and Social Affairs and the World Health Statistics database are potentially useful sources of information. The longitudinal WHO Study on Global AGEing and Adult Health (SAGE) (76) is a good example of collecting standardized, comparable and comprehensive longitudinal information on the health and well-being of older adults and the ageing process. Although SAGE includes only one country of this Region (China), it provides useful insights into the health of older people and is a model for studies in other countries. The minimum list of indicators for tracking implementation of the Madrid International Plan of Action on Ageing (see Appendix 3) is also a valuable source of indicators to strengthen the evidence base on ageing and health.

The value of information from household surveys, services and programmes is increased if they can be disaggregated by key stratifiers - age, sex and urban/rural - as well as others such as education, income and ethnicity. The capacity to collect, analyse and use
disagged data in decision- and policy-making needs to be strengthened among key stakeholders in the Member States, such as national statistics offices and health information units in health ministries. Capacity building efforts in these agencies should preferably be linked to similar efforts in academic and research organizations, as a continuing source of skilled people.

Across the Region, electronic health and hospital records are increasingly used for inpatient care and monitoring, but to date, few places can share this information among service providers and facilities. Responding to the health needs of an ageing population requires strengthened patient data to manage chronic conditions and to monitor and improve the quality of care. Systems should be designed to streamline productive use of the information (with appropriate privacy safeguards) and to reduce the collection of duplicate, incomplete or unnecessary patient information.

Systems and standards for identifying patients and sharing health records have not yet been widely implemented, especially in the Region’s in low- and middle-income countries. Significant reductions in the administrative burden and waste from duplicated tests and procedures, and the availability of more complete, longitudinal health and medical records, can increase the quality of screening, diagnosis and management along the continuum of care from primary to tertiary facilities.

The Region needs research and analysis on laws and policies on ageing and health, taking into account the diversity of Member States at different levels of development and with different social, institutional and political histories (77). The Asia Pacific Observatory on Health Systems and Policies is one initiative to strengthen policy-focused analysis on ageing and health (78). Studies should also include comparative analysis, both quantitative and qualitative, of the health of older people and their access to health services, and evaluation of the implementation and effectiveness of policies, programmes and interventions. Where appropriate, participative research and analysis helps build awareness and support for policy reforms and programme improvements. Study findings can inform the development of appropriate care models with regard to type of service, participation of the public and private sectors and quality. In line with the WHO Regional Strategy for Traditional Medicine in the Western Pacific (2011–2020) (79), analysis is also needed of the extent to which TCAM can support the health and well-being of older people, especially given the strong role of TCAM in the Region.

A knowledge generation agenda of this scope and magnitude requires the active involvement of different partners. The ministry of health has a leadership role to incorporate relevant indicators and stratifiers into existing data systems and to advocate for their inclusion in information collected by other ministries and stakeholders. Partners in studies and information system design may include international organizations, universities, medical schools and research institutions, as well as older people themselves, for example through older people’s nongovernmental organizations and OPAs. Special effort should be made to include hard-to-reach groups and those subject to discrimination or marginalization, and to reflect the needs and expectations of older people.

The next step is to ensure that the evidence generated is disseminated to stakeholders and is used to inform policy-making or knowledge translation. This may involve documenting and sharing knowledge through policy briefs and policy dialogues, for example through the Asia Pacific Observatory on Health Systems and Policies. The WHO Knowledge Translation in Ageing and Health Framework is a valuable reference in this regard. It highlights seven important elements of knowledge translation, including
context, linkages, push and pull factors, and the evaluation of knowledge translation efforts (80). There are many barriers to knowledge translation, and more operational research and better dissemination of findings are needed to demonstrate the practical application of knowledge translation to stakeholders. The existing body of good practice in knowledge translation can help strengthen the evidence base on ageing and health in the Region.

Suggested actions:

- Develop and strengthen systems and capacity to collect and analyse routine, disaggregated data, complemented by periodic population surveys and qualitative studies, in order to monitor and understand trends and challenges in older people’s health and functional status, their services and the social determinants of their health.

- Strengthen the monitoring and evaluation of laws, policies, plans and interventions on ageing and health, in order to identify, document and share information on best buys and good practices.

- Identify research priorities for ageing and health in the Region, and strengthen partnerships across sectors and stakeholders (including international organizations, academic research units, nongovernmental organizations, OPAs and centres of excellence) to produce improved models of integrated service provision for older people.

- Improve knowledge translation to inform policy-making on ageing and health, including through policy dialogue and the dissemination of policy briefs, national reports and relevant studies.
The way forward
3. The way forward

The framework offers a basis for discussion to identify options for suitable action on ageing and health, update or develop national plans and policies, monitor their implementation, document successes, and mobilize resources. The framework builds on and complements various other frameworks and strategies in relation to ageing and health that have been developed by WHO and other partners, as cited at appropriate places in this document (81). Moving forward on ageing and health calls for action to strengthen political commitment, advocacy and partnerships.

Foster political commitment on ageing and health

Awareness of population ageing issues in the Region is limited and public support for action in this area remains low. Ageing and health issues are often marginal to policy debates, and are raised by special interest groups, charitable nongovernmental organizations and donors. Commitment of high-level policy-makers and decision-makers is crucial to take this agenda forward. Governments, which have the primary duty to protect and fulfil human rights, need to create enabling environments in which older people can enjoy the highest attainable standard of health. Given the magnitude and speed of population ageing in the Region, as well as the close links of ageing to other health sector priorities, such as NCDs and universal health coverage, policymakers should give particular attention to ageing and health during the time period of this framework.

There is also a need to increase public understanding of ageing, to challenge stereotypes, to recognize the role of older people as a resource and to highlight their contribution to society (see Box 10). Policy-makers, mass media, civil society and the general public need to understand the realities of population change, the needs of older people and the best ways to respond.

Strengthen partnerships and advocacy

The subject of ageing and health straddles many institutions and agencies, from government authorities to nongovernmental partners and older people themselves. Partnerships across the health, education and social security sectors, with public and private actors, as well as with OPAs, will be crucial in taking this agenda forward in the Region.

There are a number of entry points for advocacy and collaboration on ageing and health. First, local governments, which often organize and fund local health and social care, need to be strongly engaged. Second, mass media can work with the health and social care sectors to strengthen public awareness on ageing through a range of communication channels, highlighting the positive contributions of older people in fields such as politics and local government, in literature, science, medicine, education and industry, and in their local communities. Third, civil society organizations, including women’s and youth groups, religious and charitable organizations, and, in particular, OPAs at regional, national and local level, can help guide policy-making on ageing, health and well-being. Technical conferences and other forms of interaction can strengthen awareness and support of professional groups in the health and social sectors. Fourth, the health sector should assist the education sector in including messages in the school curriculum that advocate respect for and the social inclusion of older people.
Share knowledge and build capacity

Strengthening the Region’s response to ageing and health involves increasing technical collaboration and strengthening capacity in Member States. The Region is home to some of the “oldest” societies in the world (e.g., Japan), from which other countries in the Region and the world have much to learn. At the same time, the trend in ageing and related health conditions is of concern to all countries and areas in the Region. Developed countries are dealing with its challenges now, but we know that population ageing is inevitable for developing countries. Crucially, the speed of population ageing is expected to be especially rapid in low- and middle-income countries in our Region, giving them less time to prepare than was available to the high-income countries. All countries will need to develop comprehensive national policy frameworks that respond to the needs of their older people and are tailored to their specific contexts.

The WHO Regional Office for the Western Pacific is committed to use its convening power and engage in technical collaboration with Member States in developing appropriate policies and action plans. Supporting the exchange of experience, disseminating information and networking among countries in the Region and beyond can stimulate needed policy changes and actions.

Next steps

Member States are requested to consider whether the actions put forward in the framework are appropriate and can be adapted to their particular situation and the local context. This framework serves as a starting point for discussion within and between Member States and for guiding evidence-informed policy making around four areas: fostering age-friendly environments, promoting healthy ageing across the life-course and preventing functional decline and disease among older people, reorienting health systems to respond to the needs of older people, and strengthening the evidence base on ageing and health.

The framework is a work in progress. The way forward will depend on the collective ability of Member States and partners in the Region to share experiences, learn from each other, mobilise needed human and financial resources, and demonstrate political commitment and leadership in strengthening the health sector response to ageing. WHO will support this agenda by fostering leadership, collecting and sharing evidence, strengthening partnerships, and engaging in technical collaboration. Together, we can build an age-friendly Western Pacific Region where older people are empowered to maintain their health and lead active lives.

Box 10. Reinventing ageing

Moving forward and implementing policies and actions on ageing and health will also require a change in mind-sets and attitudes. Many assumptions that we make today about ageing and the health of older people were developed a long time ago when social and demographic patterns were still substantially different. These often negative images and stereotypes do not reflect the reality of ageing but create additional barriers for effective policy-making and implementation. WHO has been highlighting the importance of “reinventing ageing”, framing older people as a resource for society. Reinventing ageing also comes with new opportunities for building synergies with other global agendas, including on disability.

Appendix 1: Key definitions in ageing and health

**Active ageing:** The process of optimizing opportunities for health, wellbeing, participation and security in order to enhance quality of life as people grow older.

**Age-friendly:** “As an overarching principle, health-care services must aim to provide the highest attainable standards of health, conducive to promoting active ageing and health over the life-course and to maintaining life in dignity. Towards this end, health-care services must meet the following essential criteria: availability; accessibility; comprehensiveness; quality; efficiency; non-discrimination; and age-responsiveness. (…) The principle of non-discrimination should be upheld to ensure equal distribution and treatment, as well as the prevention of abuse, taking into account the economic, social, psychological and physical vulnerability of older persons.” (WHO Perth Framework for Age-Friendly Community-Based Health Care, 2002)

**Assistive device:** Equipment that enables an individual who requires assistance to perform the daily activities essential to maintain health and autonomy and to live as full a life as possible. Such equipment may include, for example, motorized scooters, walkers, walking sticks, grab rails and tilt-and-lift chairs.

**Care:** “The application of knowledge to the benefit of a community or individual. There are various levels of care:

- **intermediate care:** A short period of intensive rehabilitation and treatment to enable people to return home following hospitalization or to prevent admission to hospital or residential care.
- **primary care:** Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system. It is the basis for referrals to secondary and tertiary level care.
- **secondary care:** Specialist care provided on an ambulatory or inpatient basis, usually following a referral from primary care.
- **tertiary care:** The provision of highly specialized services in ambulatory and hospital settings.”

**Caregiver:** A person who provides support and assistance, formal or informal, with various activities to persons with disabilities or long-term conditions, or older people. This person may provide emotional or financial support, as well as hands-on help with different tasks. Caregiving may also be done from long distance.

**Chronic care:** The ongoing provision of medical, functional, psychological, social, environmental and spiritual care services that enable people with serious and persistent health and/or mental conditions to optimize their functional independence and well-being, from the time of condition onset until problem resolution or death. Chronic care conditions are multidimensional, interdependent, complex and ongoing.

**Healthy ageing:** An approach which recognizes that growing older is a part of living; recognizes the interdependence of generations; recognizes that everyone has a responsibility to be fair in their demands on other generations; fosters a positive attitude throughout life to growing older; eliminates age as a reason to exclude any person from participating fully in community life; promotes a commitment to activities which enhance well-being and health, choice and independence, and quality of life for all ages; encourages communities to value and listen to older people and to cater for the diverse preferences, motivations, characteristics and circumstances of older persons in a variety of ways.

**Health system:** WHO has defined a health system as “all organizations, people and actions whose primary intent is to promote, restore or maintain health.” Good health services are further defined as those that “deliver effective, safe, quality personal and non-personal interventions to those who need them, when and where needed, with minimum waste of resources”.

**Integrated service delivery:** “The organization and management of health services so that people get the care they need, when they need it, in ways that are user friendly, achieve the desired results and provide value for money.” (WHO Technical Brief No. 1, 2008)
Older person: A person may be defined as aged on a number of criteria including chronological age, functional assessment, legislation or cultural considerations. There is no commonly accepted definition that is valid across countries in the Western Pacific Region. This framework uses the term older people to include those aged 60 and over; and the term very old for those aged 80 and over.

Population ageing: The increase over time in the proportion of the population of a specified older age. “Ageing” is defined as the lifelong process of growing older in all respects (cellular, organ, whole-body) throughout the life-course.
# Appendix 2: Overview of data sources on ageing and health

<table>
<thead>
<tr>
<th>Country</th>
<th>Data source</th>
<th>Year</th>
<th>Further information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Multi-country Survey Study</td>
<td>2001</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DYNOPTA studies</td>
<td></td>
<td><a href="http://dynopta.anu.edu.au/">http://dynopta.anu.edu.au/</a></td>
</tr>
<tr>
<td></td>
<td>World Health Survey</td>
<td>2002–2004</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chinese Longitudinal Healthy Longevity Survey</td>
<td>2002</td>
<td><a href="http://www.geri.duke.edu/china_study/">http://www.geri.duke.edu/china_study/</a></td>
</tr>
<tr>
<td>Lao People’s Democratic Republic</td>
<td>World Health Survey</td>
<td>2002–2004</td>
<td></td>
</tr>
<tr>
<td>Malaysia</td>
<td>World Health Survey</td>
<td>2002–2004</td>
<td></td>
</tr>
<tr>
<td></td>
<td>LiLACs</td>
<td>2010</td>
<td></td>
</tr>
<tr>
<td>Republic of Korea</td>
<td>World Health Survey</td>
<td>2002–2004</td>
<td></td>
</tr>
<tr>
<td>Singapore</td>
<td>Multi-country Survey Study</td>
<td>2001</td>
<td></td>
</tr>
<tr>
<td></td>
<td>KLoSA</td>
<td>2006</td>
<td></td>
</tr>
<tr>
<td>Viet Nam</td>
<td>Multi-country Survey Study</td>
<td>2001</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Survey of the Aged Living in the Community–Singapore (ASEAN)</td>
<td>1996</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Viet Nam Ageing Study (VNAS)</td>
<td>2010–2011</td>
<td></td>
</tr>
<tr>
<td></td>
<td>World Health Survey</td>
<td>2002–2004</td>
<td></td>
</tr>
</tbody>
</table>

Source: The health of older people in selected countries of the Western Pacific Region. Manila: World Health Organization Regional Office for the Western Pacific; 2014a (forthcoming).
Appendix 3: Minimum list of indicators for tracking progress of implementation of the Madrid International Plan of Action on Ageing

Notes:
* "Older persons" refers to those aged 60 years and over.
* Please ensure that all quantitative indicators are calculated by rural/urban residence, poverty status and other relevant national classifications.
* Age refers to five-year age groups.

### Basic demographic indicators

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Source of data</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number and proportion of older persons aged 60 years and over in the population by age/sex</td>
<td>Population census, Household survey</td>
</tr>
<tr>
<td>2. Proportion of older persons living in urban areas, by age and sex</td>
<td>Population census, Household survey</td>
</tr>
<tr>
<td>3. Rate of population growth of older persons by age</td>
<td>Population census</td>
</tr>
<tr>
<td>4. Proportion of older persons living alone by age and sex</td>
<td>Survey</td>
</tr>
<tr>
<td>5. Proportion of older persons by type of living arrangement by age and sex</td>
<td>Population and housing census, Survey</td>
</tr>
<tr>
<td>6. Proportion of older persons who are migrants by type of migration (national, international) by age and sex</td>
<td>Population census, Ministry of the Interior, Department of Commerce, Ministry of Labour, Ministry of Foreign Affairs, Ministry of Justice/Border Patrol, Immigration records, Survey</td>
</tr>
</tbody>
</table>

### Priority direction I: Older persons and development

<table>
<thead>
<tr>
<th>Outcome indicators</th>
<th>Source of data</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Proportion of the population living below national poverty line by sex</td>
<td>Survey, Population census</td>
</tr>
<tr>
<td>(ages 15–59 and 60 and over)</td>
<td></td>
</tr>
<tr>
<td>2. Proportion of the population living below international poverty line (US$ 1.25/day)</td>
<td>Survey, Population census</td>
</tr>
<tr>
<td>(ages 15–59 and 60 and over)</td>
<td></td>
</tr>
<tr>
<td>3. Literacy rate, disaggregated by age/sex, benchmarked against literacy rate of adults aged 25 to 59 years</td>
<td>Survey, Ministry of Education, UNESCO statistics, UNICEF statistics</td>
</tr>
<tr>
<td>5. Proportion of older persons covered by some form of old age income security programme (contributory or non-contributory) by age/sex and poverty status</td>
<td>Ministry of Labour, Nongovernmental organization information, Survey</td>
</tr>
</tbody>
</table>
### Priority direction I: Older persons and development (continued)

| 7. | Unemployment rate of older persons benchmarked against the labour force under 60 years of age | Ministry of Labour  
Labour force survey  
Trade union statistics  
Central Bank |
|---|---|---|
| 8. | Proportion of older persons providing and receiving support (e.g. monetary, care, etc.) to younger members of family (community/ neighbourhood) by age/sex | Survey  
Community-based organization information  
Nongovernmental organization reports  
Research reports |
| 9. | Proportion of older persons living in households with access to telephone, land line or cell, or personal computer, by age/sex | Population and housing census  
Household survey  
Telephone company records |
| 10. | Proportion of older persons reported voting in last election benchmarked against proportion for general population | Survey  
Electoral register  
Ministry of Justice  
Government reports |

### Instrumental indicators

| 11. | Inclusion of specific needs of older persons in all phases (preparedness, relief and reconstruction) of humanitarian and disaster relief programmes | Government disaster response agency records  
Red Cross/Red Crescent records  
Nongovernmental organization information  
Donor records |
| 12. | Number of national-level organizations of older persons represented in government policy-making processes | Government information  
Parliamentarian reports  
Nongovernmental organization information  
Community-based organization information |
| 13. | Inclusion of issues of older persons relating to the three priority areas of the Madrid Plan (development, health and enabling environments) in national and sectoral development plans, including poverty reduction strategies | National development plans  
Poverty Reduction Strategy Papers |
| 14. | Existence of statutory retirement age | Ministry of Labour  
Social security/pension department  
Trade union records |
| 15. | Existence of universal pension | Ministry of Labour  
Social security/pension department  
Trade union records |
| 16. | Existence of policies facilitating employment of older persons (no age discrimination, special tax incentives for employment, etc.) | Ministry of Labour  
Ministry of Justice  
Nongovernmental organization Information |

### Priority direction II: Advancing health and well-being into old age

#### Outcome indicators

| 1. | Life expectancy: a) at birth; b) at age 60; and c) at age 80 disaggregated by sex | Ministry of Health  
WHO statistics  
National Human Development Report  
Epidemiological surveillance  
Survey |
| 2. | Disability-free life expectancy: a) at birth; b) at age 60; and c) at age 80 disaggregated by sex | Ministry of Health  
WHO statistics  
National Human Development Report  
Epidemiological surveillance  
Survey |
<table>
<thead>
<tr>
<th>Priority direction II: Advancing health and well-being into old age (continued)</th>
</tr>
</thead>
</table>
| 3. Mortality rates of older persons from non-communicable diseases by age/sex | Ministry of Health  
WHO statistics  
National Human Development Report  
Epidemiological surveillance  
Survey |
| 4. Mortality rates of older persons from external causes (homicide, suicide, accidents) by age/sex | Ministry of Health  
WHO statistics  
National Human Development Report  
Epidemiological surveillance  
Survey |
| 5. Proportion of older persons covered by medical insurance | Ministry of Health  
Ministry of Labour  
Survey  
Insurance company records |
| 6. Proportion of older persons reporting satisfaction with quality of life and their health, by age/sex and benchmarked against general population | Surveys  
Research reports |
| 7. Disability rate by age/sex benchmarked against the disability rate for persons aged 15–59 | Ministry of Health  
WHO statistics  
National Human Development Report  
Epidemiological surveillance  
Survey |
| 8. Prevalence of risk factors in older persons (smoking, physical inactivity, overweight/obesity, alcohol abuse, etc.), disaggregated by age/sex | Ministry of Health  
Survey |
| 9. HIV prevalence among older persons, disaggregated by age/sex and benchmarked against general population | Ministry of Health  
Survey  
Research reports |
| 10. Prevalence of mental health problems among older persons by diagnosis and age/sex | Ministry of Health  
WHO statistics  
Survey |
| 11. Proportion of older persons reporting to be informed about various aspects of HIV/AIDS and benchmarked against general population | Survey |

**Instrumental indicators**

| 12. Number and proportion of physicians with specialized training in geriatric care or health care of older persons | Ministry of Health  
Survey |
| 13. Number and proportion of primary health care workers (nurses, physical therapists, district health workers, lab technicians, social workers, etc.) with geriatric training | Ministry of Health  
Survey |
| 14. Inclusion of data on older persons in national HIV/AIDS statistics (both infected and caregivers) | Ministry of Health  
Nongovernmental organization  
Information |
| 15. Does the national health plan address the specific needs of older persons | Ministry of Health |
| 16. Does the national disability plan specifically address the needs of older persons | Ministry of Health |
| 17. Number and proportion of public/private health care facilities with geriatric care | Ministry of Health  
Survey |
| 18. Existence of primary health-care services specifically designed for older persons | Ministry of Health  
Survey  
WHO reports  
Community-based organization reports  
Nongovernmental organization reports  
Research reports |
| 19. Existence of guidelines and standards of health-care provision and rehabilitation services for older persons | Ministry of Health  
Nongovernmental organization  
Information |
| 20. Availability of training programmes in care-giving skills and medical care for older caregivers of HIV/AIDS patients | Ministry of Health  
Nongovernmental organization  
Information |
### Priority direction III: Ensuring enabling and supportive environments

**Outcome indicators**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Source(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Proportion of older persons living in households with safe water,</td>
<td>Population and housing census</td>
</tr>
<tr>
<td>improved sanitation and access to electricity, disaggregated by age/sex</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td></td>
<td>Survey</td>
</tr>
<tr>
<td></td>
<td>Agricultural census</td>
</tr>
<tr>
<td>2. Proportion of older persons living on their own who need assistance</td>
<td>Survey</td>
</tr>
<tr>
<td>with activities of daily living and are receiving support by age/sex</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td></td>
<td>Nongovernmental organization reports</td>
</tr>
<tr>
<td></td>
<td>Research reports</td>
</tr>
<tr>
<td>3. Proportion of older persons reporting neglect, abuse or violence</td>
<td>Police records</td>
</tr>
<tr>
<td>by age/sex</td>
<td>Hospital records</td>
</tr>
<tr>
<td></td>
<td>Social services records</td>
</tr>
<tr>
<td></td>
<td>Ministry of Justice</td>
</tr>
<tr>
<td></td>
<td>Nongovernmental organization information</td>
</tr>
<tr>
<td>4. Reported incidences of neglect, abuse or violence of older persons</td>
<td>Government information</td>
</tr>
<tr>
<td>by age/sex</td>
<td>Police records</td>
</tr>
<tr>
<td></td>
<td>Hospital records</td>
</tr>
<tr>
<td></td>
<td>Social services records</td>
</tr>
<tr>
<td></td>
<td>Ministry of Justice</td>
</tr>
<tr>
<td></td>
<td>Nongovernmental organization information</td>
</tr>
<tr>
<td>5. Proportion of older persons reporting discrimination/loss of respect</td>
<td>Survey</td>
</tr>
<tr>
<td>because of age, by age/sex</td>
<td>Community-based organization reports</td>
</tr>
<tr>
<td></td>
<td>Nongovernmental organization reports</td>
</tr>
<tr>
<td></td>
<td>Research reports</td>
</tr>
</tbody>
</table>

**Instrumental indicators**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Source(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Existence of a national policy to make transportation accessible to</td>
<td>Ministry of Transportation</td>
</tr>
<tr>
<td>older persons</td>
<td></td>
</tr>
<tr>
<td>7. Existence of national legislation to combat elder abuse</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td></td>
<td>Ministry of Justice</td>
</tr>
<tr>
<td>8. Existence of national programmes combating elder abuse</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td></td>
<td>Ministry of Justice</td>
</tr>
<tr>
<td></td>
<td>Nongovernmental organization information</td>
</tr>
</tbody>
</table>
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Endnotes

1 The draft framework builds on evidence produced by a comparative analysis of the health of older people in selected countries in the Western Pacific Region, see WHO Regional Office for the Western Pacific, 2014a (forthcoming).

2 WHO Regional Office for the Western Pacific, 2012a.

3 Ibid.

4 Ibid.

5 Ibid.

6 WHO Regional Office for the Western Pacific, 2012a.

7 Ibid.

8 Ibid.

9 WHO Regional Office for the Western Pacific, 2014a (forthcoming).

10 WHO Regional Office for the Western Pacific, 2012a.


12 WHO Regional Office for the Western Pacific, 2012a.

13 Ibid.


17 The draft framework builds on evidence produced by a review of ageing and health policies in selected countries of the Western Pacific Region, see WHO Regional Office for the Western Pacific, 2014b (forthcoming).


19 Ibid.

20 Ibid.

21 Ibid.

22 Ibid.

23 Ibid.


27 Ibid.


31 Ibid.

32 World Health Assembly, 2012.

33 WHO Regional Office for the Western Pacific, 2011a.

34 Ibid.

35 WHO, 2012c.

36 WHO Regional Office for the Western Pacific, 2014a (forthcoming).

37 WHO Regional Office for the Western Pacific, 2014b (forthcoming).

38 WHO Regional Office for the Western Pacific, 2013a. WHO Regional Office for the Western Pacific, 2013b.


40 WHO, 2012c.

41 Ibid.

42 Asia Pacific-HealthGAEN, 2011.

43 WHO, 2012c.

44 WHO Regional Office for the Western Pacific, 2012b.

45 Ibid.

46 WHO Regional Office for the Western Pacific, 2011b.

47 Ibid.


49 WHO, 2012c.


53 WHO Regional Office for the Western Pacific, 2005.

54 WHO Regional Office for the Western Pacific, 2003.

55 See, for example, Chung et al, 2009.

56 WHO Regional Office for the Western Pacific, 2005.

57 WHO Regional Office for the Western Pacific, 2008.

58 WHO, 2012c.

59 WHO Regional Office for the Western Pacific, 2012a.

60 WHO Regional Office for the Western Pacific, 2010.


62 WHO Regional Office for the Western Pacific, 2014b (forthcoming).


65 WHO Regional Office for the Western Pacific, 2012c.

66 WHO, 2010b.

67 Rechel, B. et al., 2009.


69 Ibid.

70 WHO Regional Office for the Western Pacific and WHO Regional Office for South-East Asia, 2009. HelpAge International, 2010; Department of Economic and Social Affairs of the United Nations Secretariat, 2011.

71 WHO Regional Office for the Western Pacific, 2012d.

72 See, for example, Ballentine, 2008.

73 WHO Regional Office for the Western Pacific 2014a (forthcoming).

74 Please see also: http://www.who.int/healthinfo/

77 WHO Regional Office for the Western Pacific, 2014b (forthcoming).

78 For more information, please see also: http://www.wpro.who.int/asia_pacific_observatory/en/, accessed 15 August 2013.

79 WHO Regional Office for the Western Pacific, 2012e.

80 WHO, 2012d.


