Global movement for inclusive societies for older persons

Innovations in community-based strategies

Alex Ross, Director
WHO Centre for Health Development
Kobe, Japan

Building societies for older ages
Building societies for all ages

Equity Autonomy Dignity

- Inclusiveness =
  - Participation, engagement
  - Responsive systems
  - Focus on functional and cognitive decline and needs (ADL, IADL)
  - Understanding and addressing inequities
  - Determinants of health; active ageing approach
  - Data and evidence driven
- Innovation =
  - Transforming systems
  - Informal and formal care
  - Person centred, home/community based
  - Frugal, affordable, appropriate
  - Coordinated care
  - Integration, with focus on cultures and incentives
  - Technological enablers
  - Quality assurance

Presentation

1. Older Adults Population Trends & Epidemiology
2. Living longer and healthier
3. Global movements
   a. MIPAA, UHC, Post-2015
   b. AFC
4. Innovation: Integrated, person-centred communities & systems
   a. Data and evidence

Population Trends and Epidemiology

The number of older persons will triple

from 500 million today to 1.3 billion in 2050

One in four people will be 60 years or older

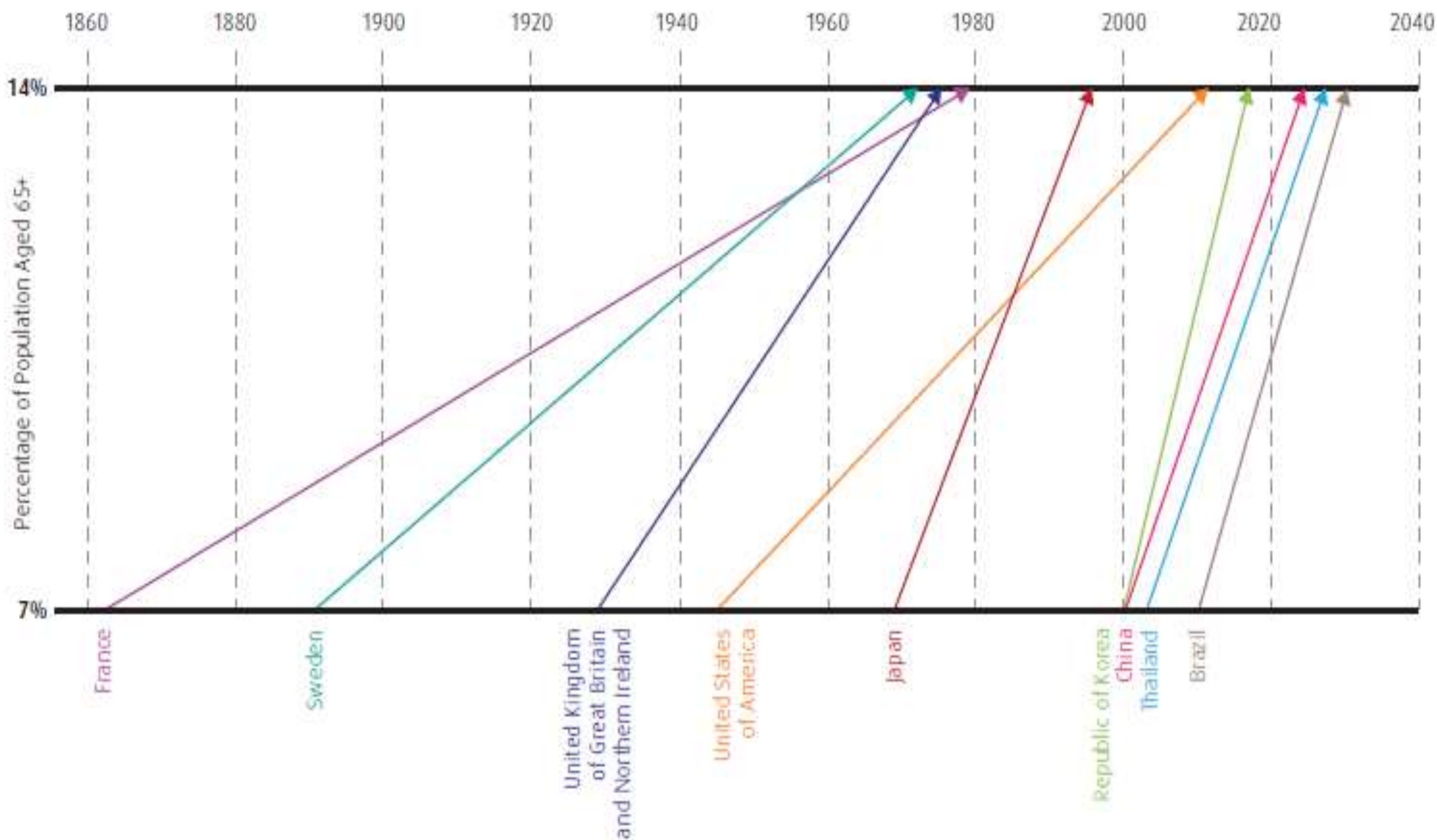
Within this group, one in four people will be 80 years or older

ESCAP - 2012

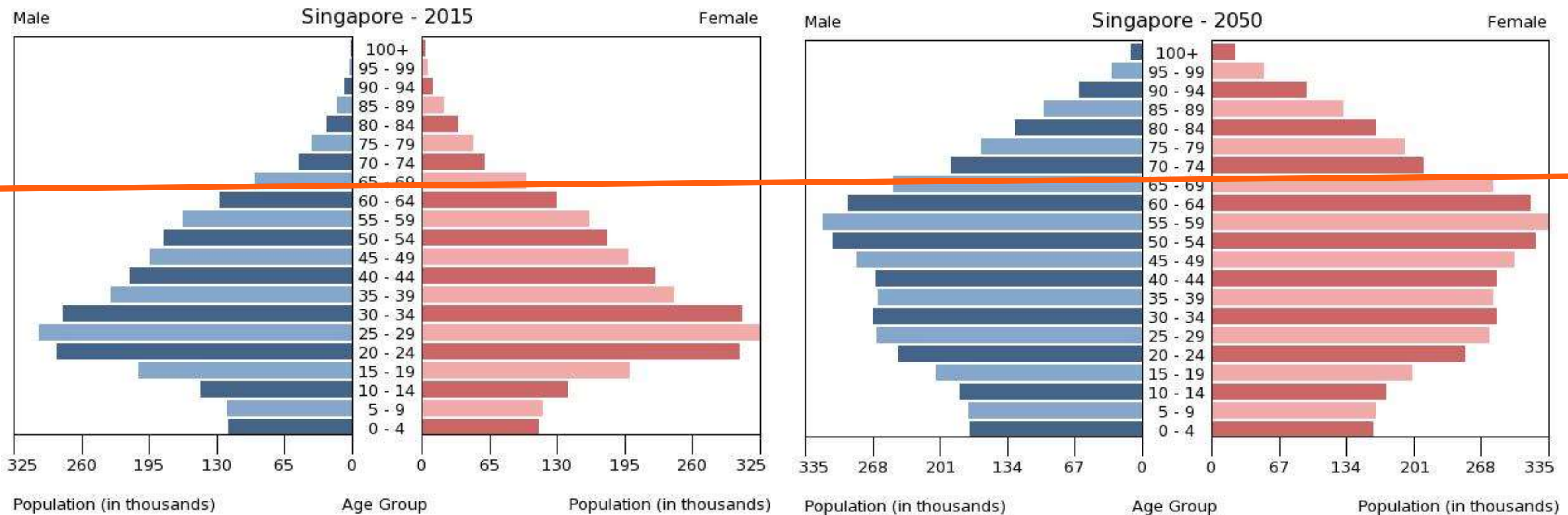
Demographic changes

- **Decreasing fertility**
- **Increasing life expectancy**
- **Speed of ageing**
- **Increasing dependency ratio**
- **Feminization of ageing**
- **Increasing older old**
- **Increasing number single**
- **Living alone or in couples**
- **Rising inequities/poverty**
- **Broader: urbanization, migration, immigration**

Rapid Ageing: accelerating speed, low preparation time

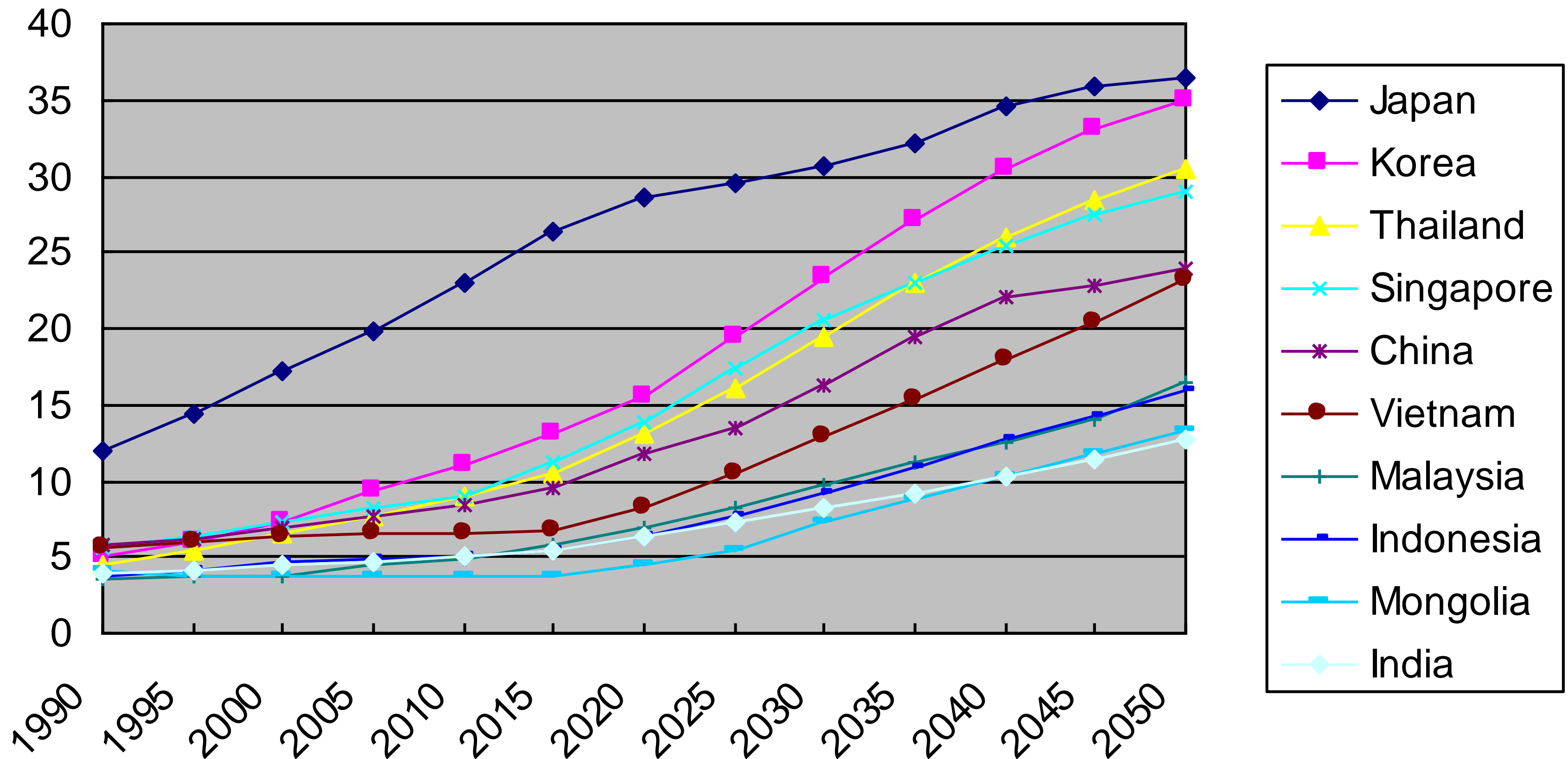


Singapore: Age pyramids



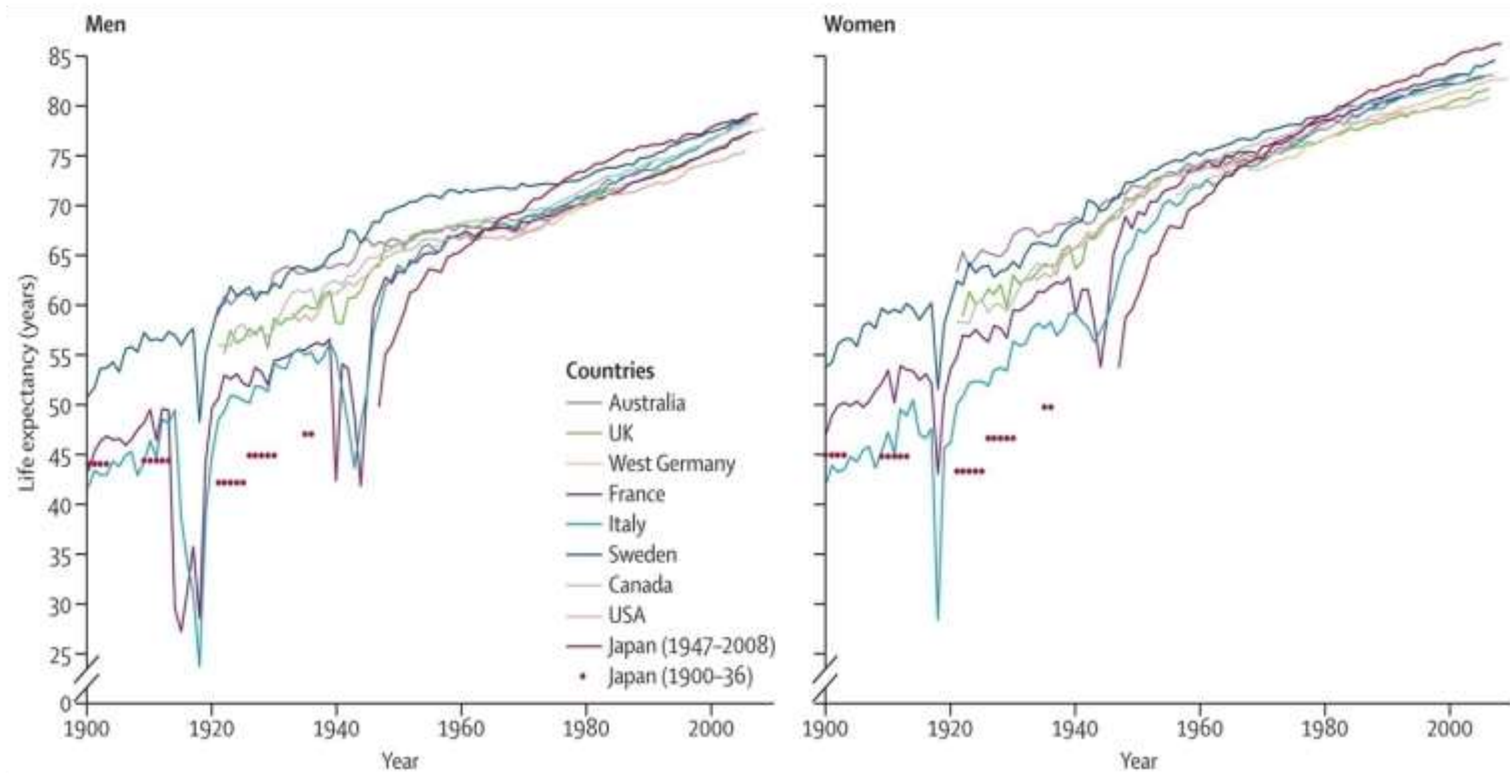
Source: US Bureau of the Census
http://www.census.gov/population/international/data/idb/region.php?N=%20Results%20&T=12&A=separate&RT=0&Y=2050&R=-1&C=SN

Population ratio of 65 years of age or older in Asia region, 1990-2050



Data extracted from: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, World Population Prospects: The 2012 Revision, http://esa.un.org/unpd/wpp/index.htm

Trends in life expectancy at birth, 1900—2008

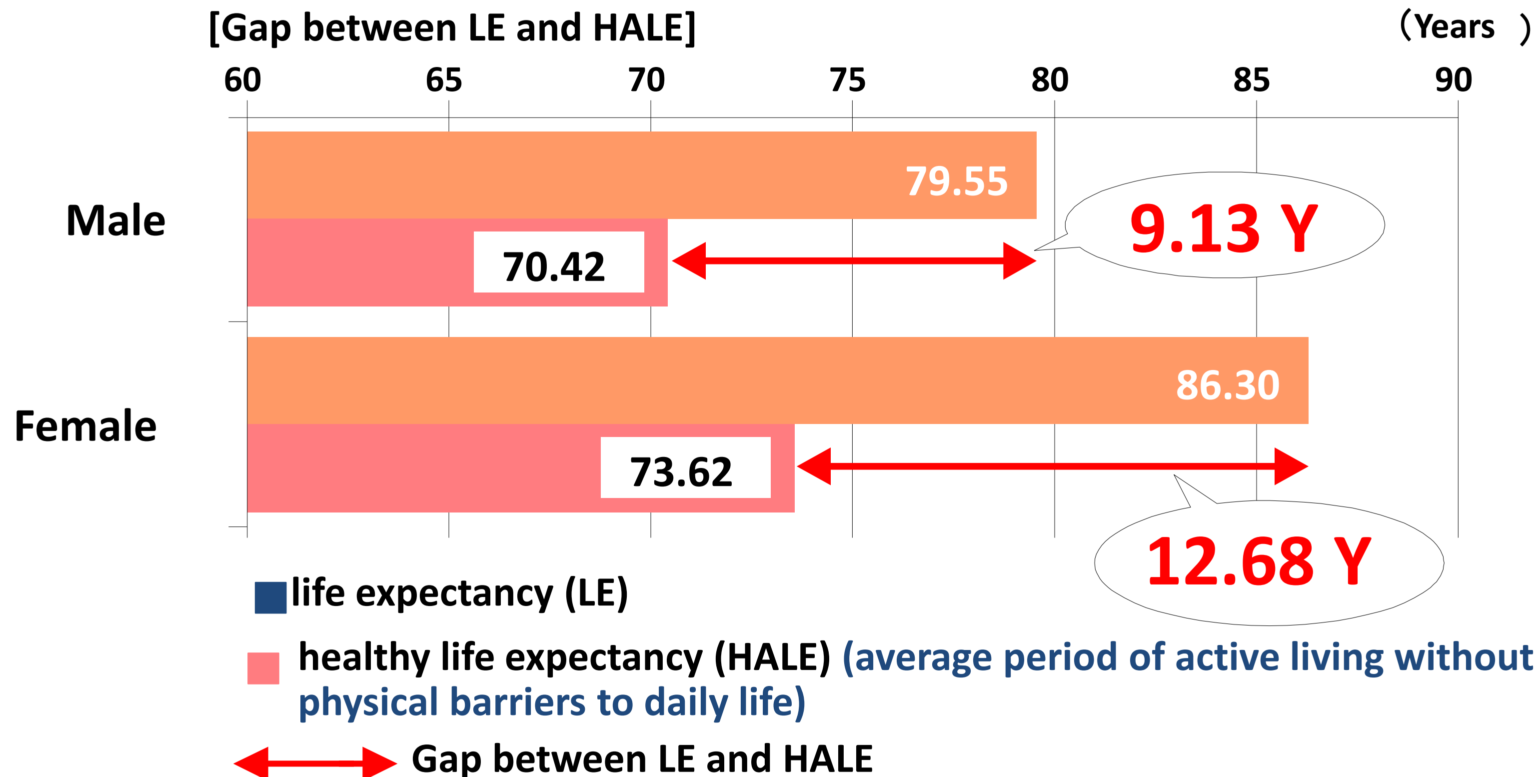


Source: Figure 1, What has made the population of Japan healthy?, Lancet Special Series on Japan

4

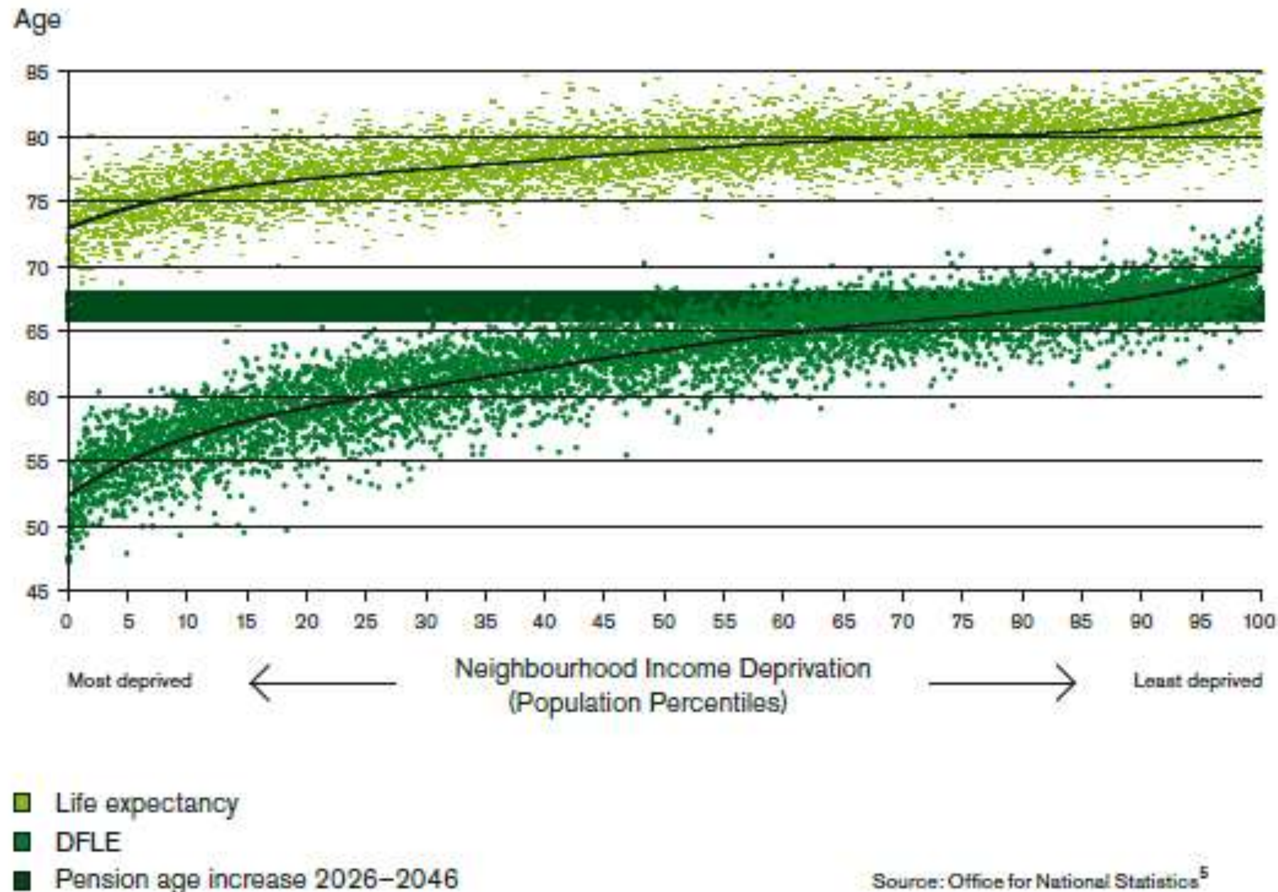
Need to narrow the gap (about 10 years) between life expectancy (LE) and healthy life expectancy (HALE)

Male LE and HALE are about 70 years and about 80 years respectively.
Female LE and HALE are 74 years and 86 years respectively.
The gap between LE and HALE is increasing in the last decade.



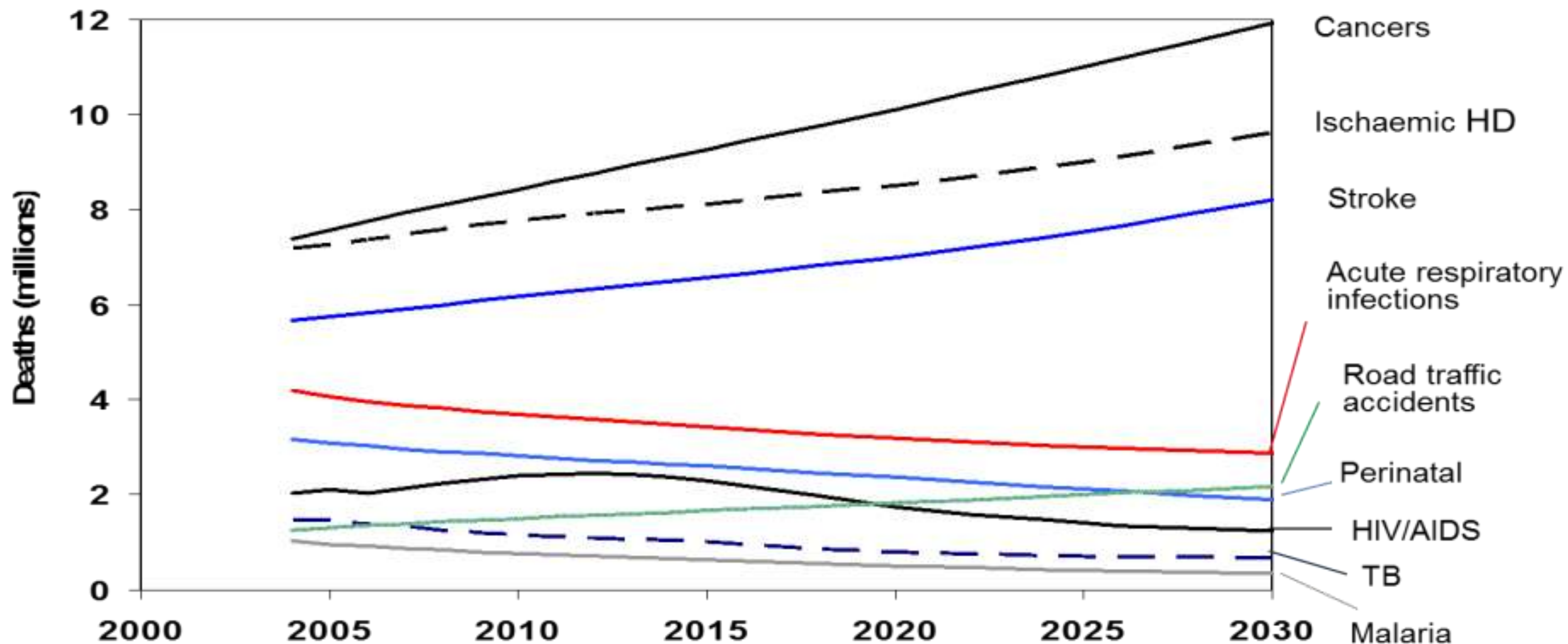
Source: LE data derived from the Complete Life Table (2010), Ministry of Health, Labour and Welfare (MHLW). HALE data derived from the report of "Future prospects of healthy life expectancy and cost-benefit of measures against lifestyle diseases" research project funded by MHLW.

Rising Inequities and their impact: Example of the UK



Source: Marmote, 2013; Steverink, N., *Successful development and ageing: theory and intervention*, in *Oxford Handbook of Geropsychology*, N. Pachana and K. Laidlaw, Editors. 2014, Oxford University Press: Oxford.

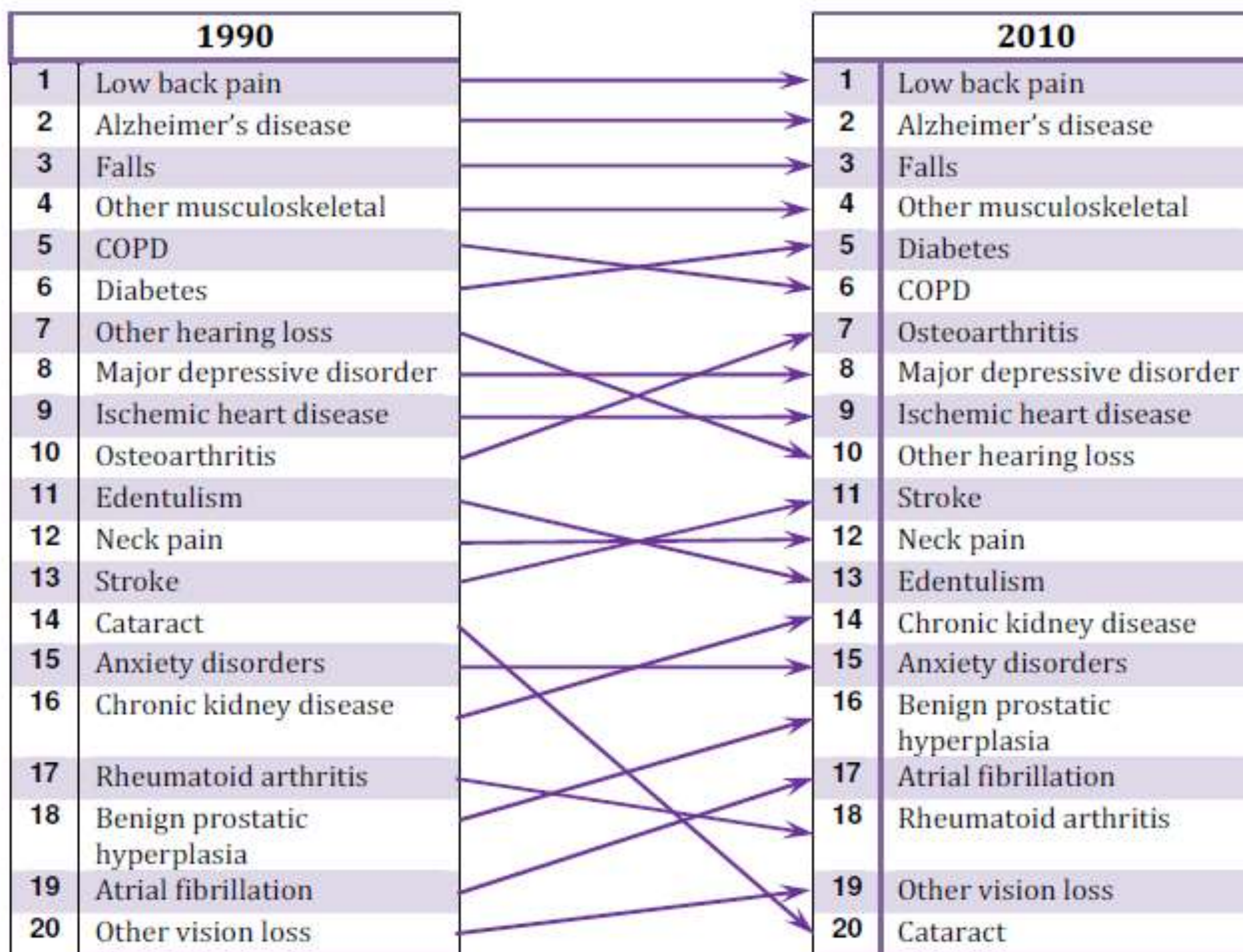
Growing number of cases of non-communicable diseases as causes of deaths



Updated from Mathers and Loncar, PLoS Medicine, 2006

Courtesy of Prof Takemi, Councilor, Japanese Diet

Global burden of disease (top 20 causes) in both sexes, aged 70+ years (years lived with disability), developed countries, 1990 and 2010



Disabilities for population aged 70 or over, 2007-10 (% of total population)

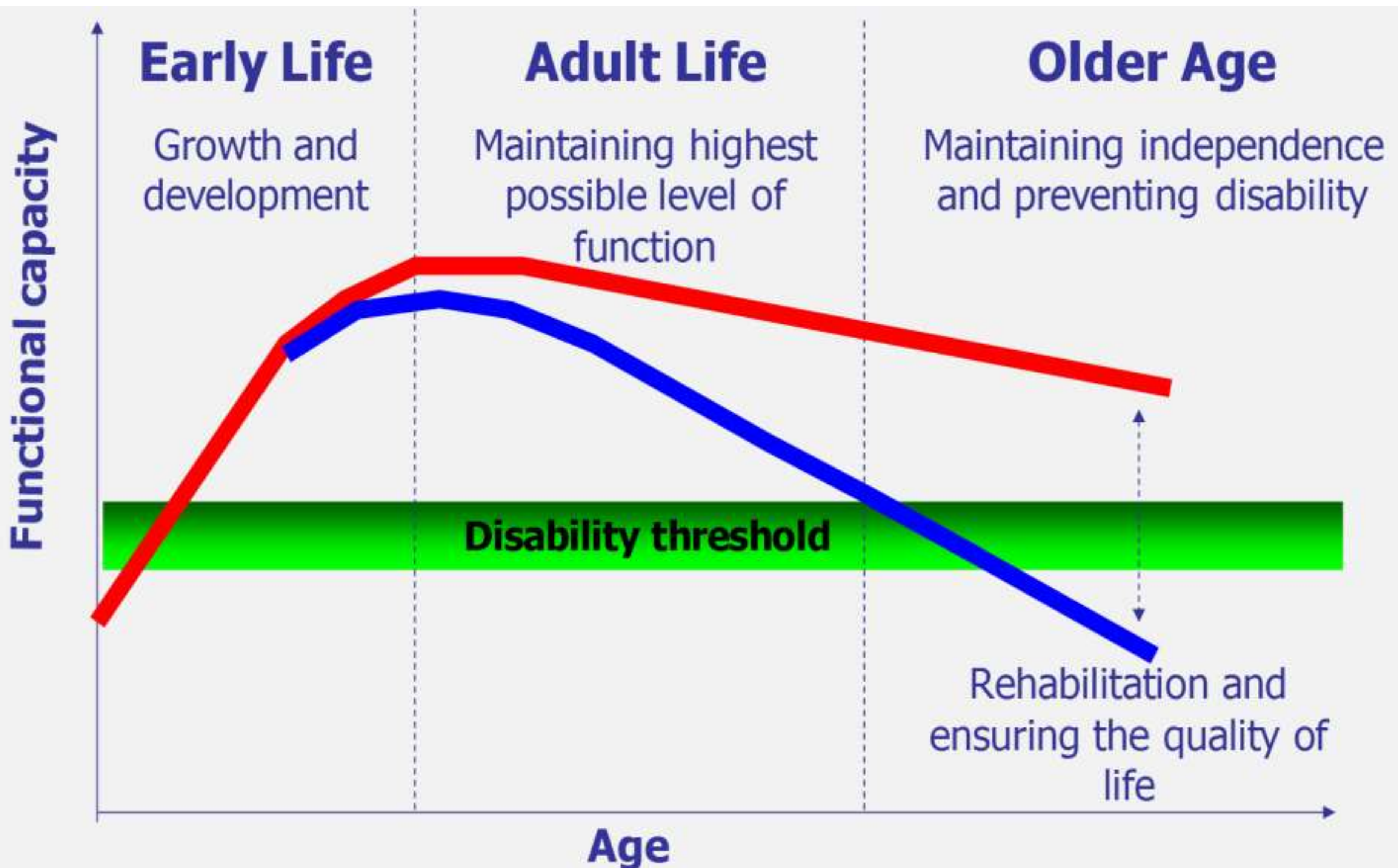
	Any disability (%)	Difficulty moving around (%)	Difficulty with self care (%)	Difficulty with cognition (%)
China	85.4	40.4	19.7	68.0
Ghana	88.1	63.4	35.8	74.3
India	97.3	72.5	36.3	80.7
Mexico	79.7	54.3	31.3	54.6
Russia	98.1	85.6	56.4	74.7
South Africa	86.0	51.7	24.8	67.6

Source: He et al (2012).

4 biggest causes of disability

Living Longer and Healthier

Life-course Approach to Health



WHO Promotes a Life Course Approach to Healthy and Active Ageing

- Health promotion at all ages
- Early detection and quality care, from prevention to long-term and palliative care
- Physical and social environments that foster the health and participation of older people
- Reinventing ageing – changing social attitudes to encourage the participation of older people

What are our goals?

- Goals:
  - Remain at home
  - Increase quality of life, wellbeing, dignity, resiliency
  - Productive, autonomous
- Increase health promotion and prevention (esp. NCDs)
- Social inclusion & connectivity, mental health support
- Implementation of UHC: person-centred
- Focus on
  - inequities: Healthy Lfe and Lfe gap
  - Prevent/manage functional and cognitive decline - prevent further frailty
- Cost efficiency; sustainability; value for money

Emerging Priority Issues

- Dementia
- UHC and ageing → sustainability?
- Self care, personal empowerment
- Health and social systems
- Community mobilization
- Transition to responding to functional and cognitive decline
- Role of technology as enabler
- Quality – access – caregivers – facilities

We have identified ten key objectives of dementia policy for countries to consider

Risk reduction

The risk of people developing dementia is minimised (1)

First symptoms appear

Diagnosis

Dementia is diagnosed quickly once someone becomes concerned about symptoms (2)

Care coordination and the role of technology

Care is coordinated, proactive and delivered closer to home (9)

The potential of technology to support dementia care is realised (10)

Progression of dementia

Early dementia

Living in the community and relying on informal care

Store

Communities are safer for and more accepting of people with dementia (3)

Those who wish to care for friends and relatives are supported (4)

Advanced dementia

Greater need for formal care services and specialised accommodation

People living with dementia live in safe and appropriate environments (5)

People living with dementia can access safe and high quality social care services (6)

Health services recognise and effectively manage people living with dementia (7)

End of life

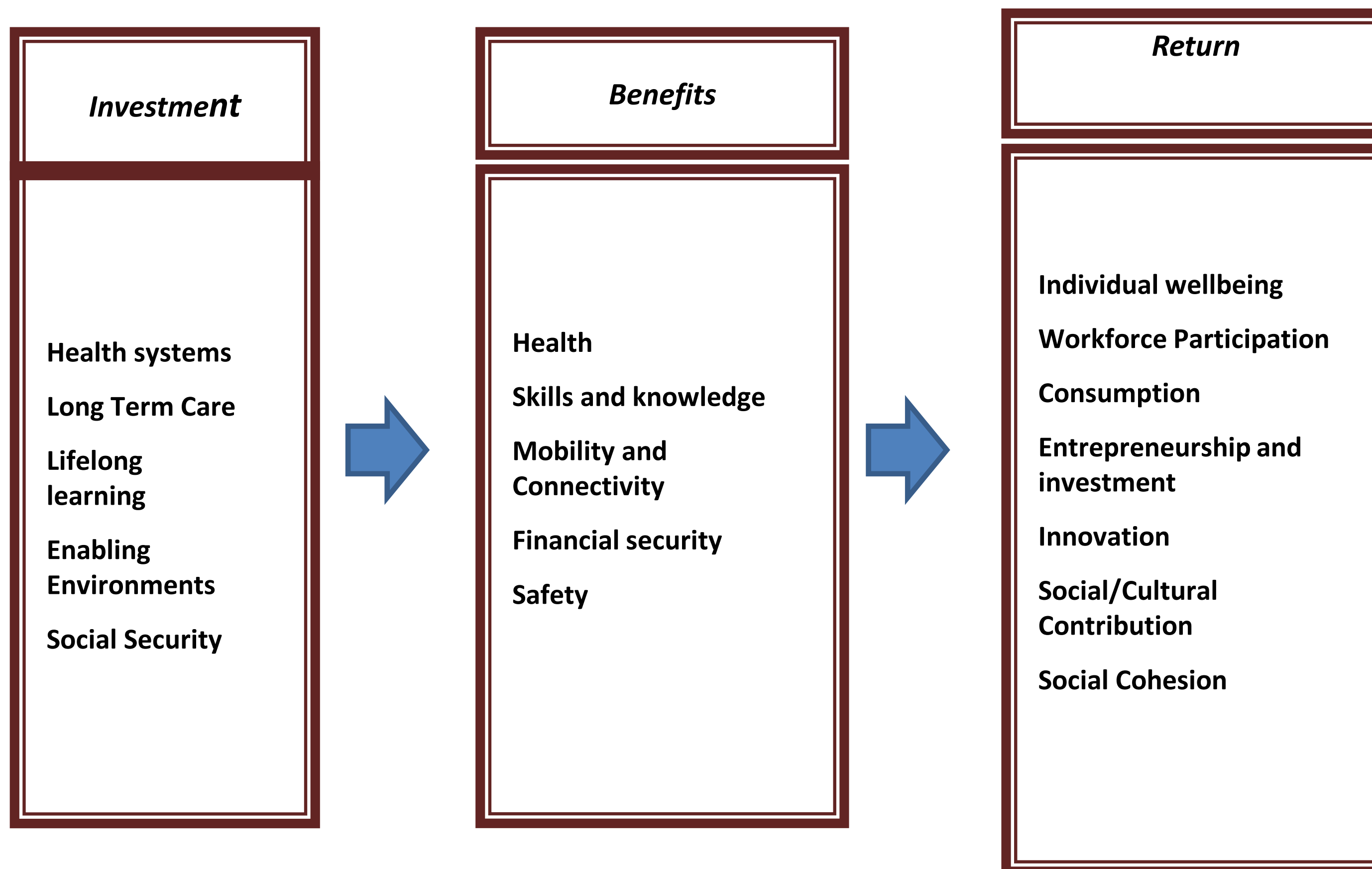
End of life care for people with dementia presents specific challenges

People living with dementia die with dignity in the place of their choosing (8)

Innovation: systems

- Models of **integrated health and social service delivery**
  - Greater linkage between ageing and disability communities
  - Palliative care, rehabilitation
- **Coordinated,** community based care and support
- Improved **referral patterns**; support for informal caregivers (incl. family caregivers
- Empowering and inclusion of older persons; social inclusion & connectivity.
- Balance of **social and technological innovation:**
  - early diagnosis and care; treatment; managing multiple chronic conditions; enhancing mobility, revising the built environment
  - Blend social, technological, medical innovation: appropriate, affordable; safe and effective
  - Reduce institutionalization: which technologies and approaches?
- **Multiple domains**: diagnostics, medicines/vaccines, care systems, mHealth and ICT, redesigning housing; Address risk factors for LTC and decline into frailty: vision, hearing, eating and drinking, falls prevention, etc

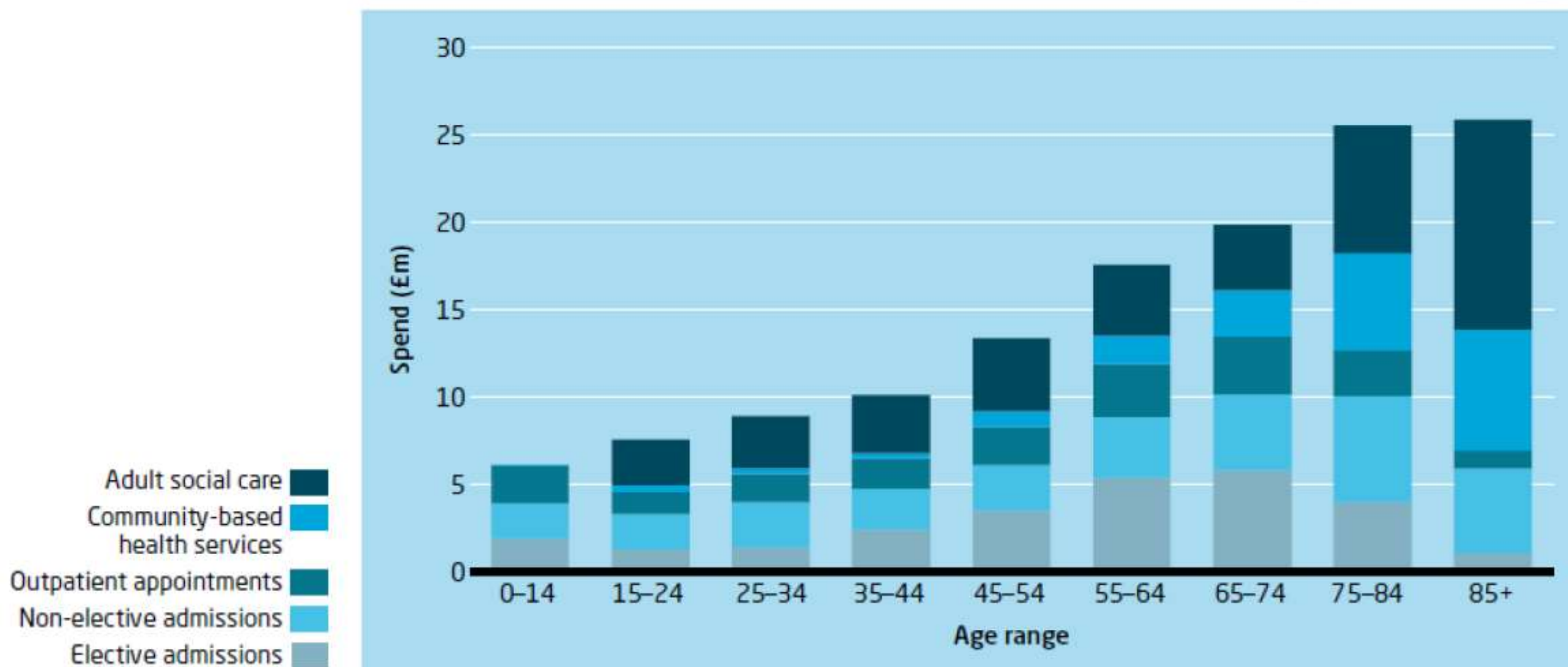
Investment and Return in Ageing Populations



Source: WHO **(adapted from work of the World Economic Forum's Global Agenda Council on Ageing 2013)**

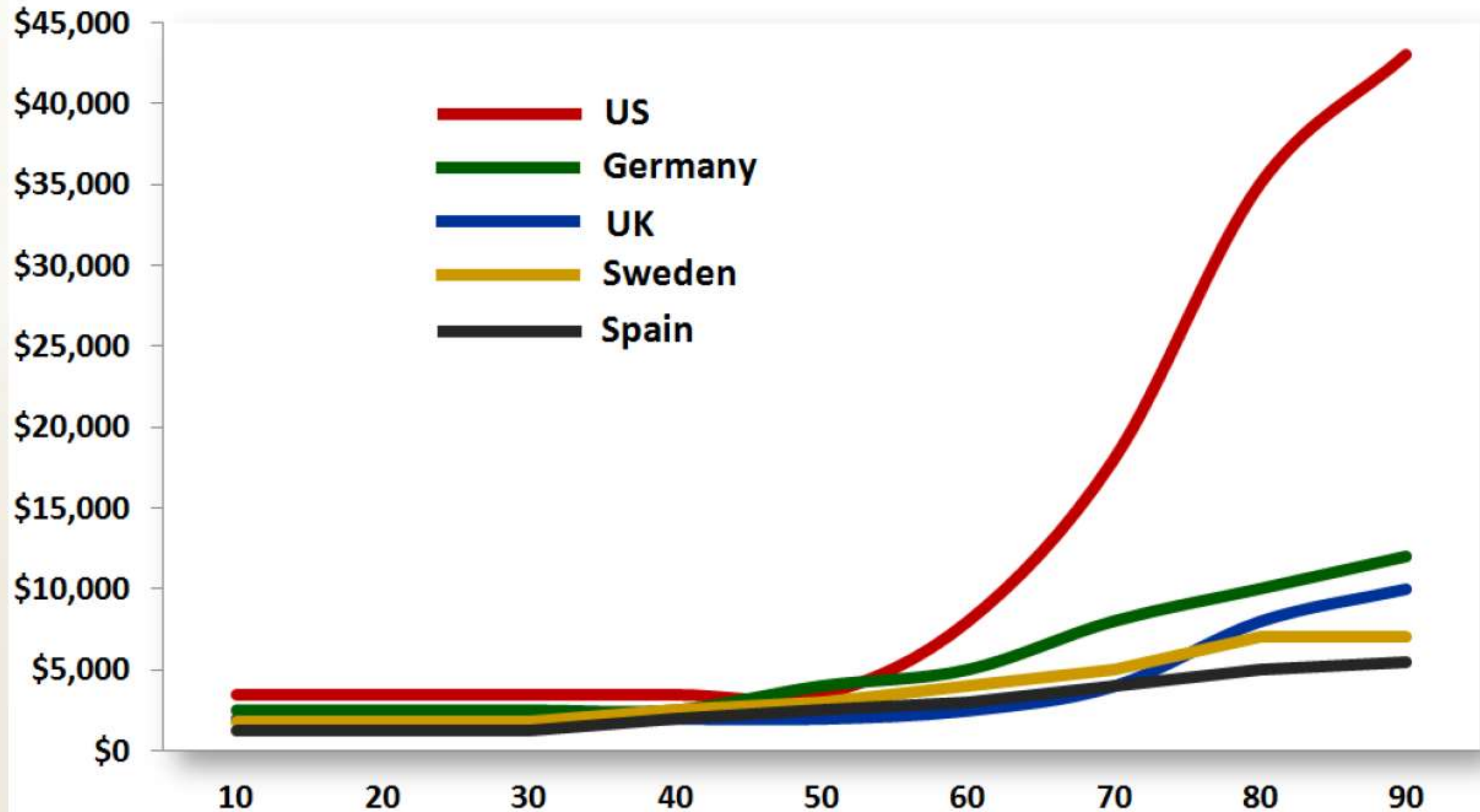
Future: Rising health and social costs

Annual cost by age and service area for Torbay (pop 145,000) 2010/11



Source: Oliver et al, 2014

World Health Organization


Annual Per Capita Healthcare Costs by Age
$45,000
$40,000
$35,000
$30,000
$25,000
$20,000
$15,000
$10,000
$5,000
$0
US
Germany
UK
Sweden
Spain
10
20
30
40
50
60
70
80
90
World Health Organization
Source: Fischbeck, 2009

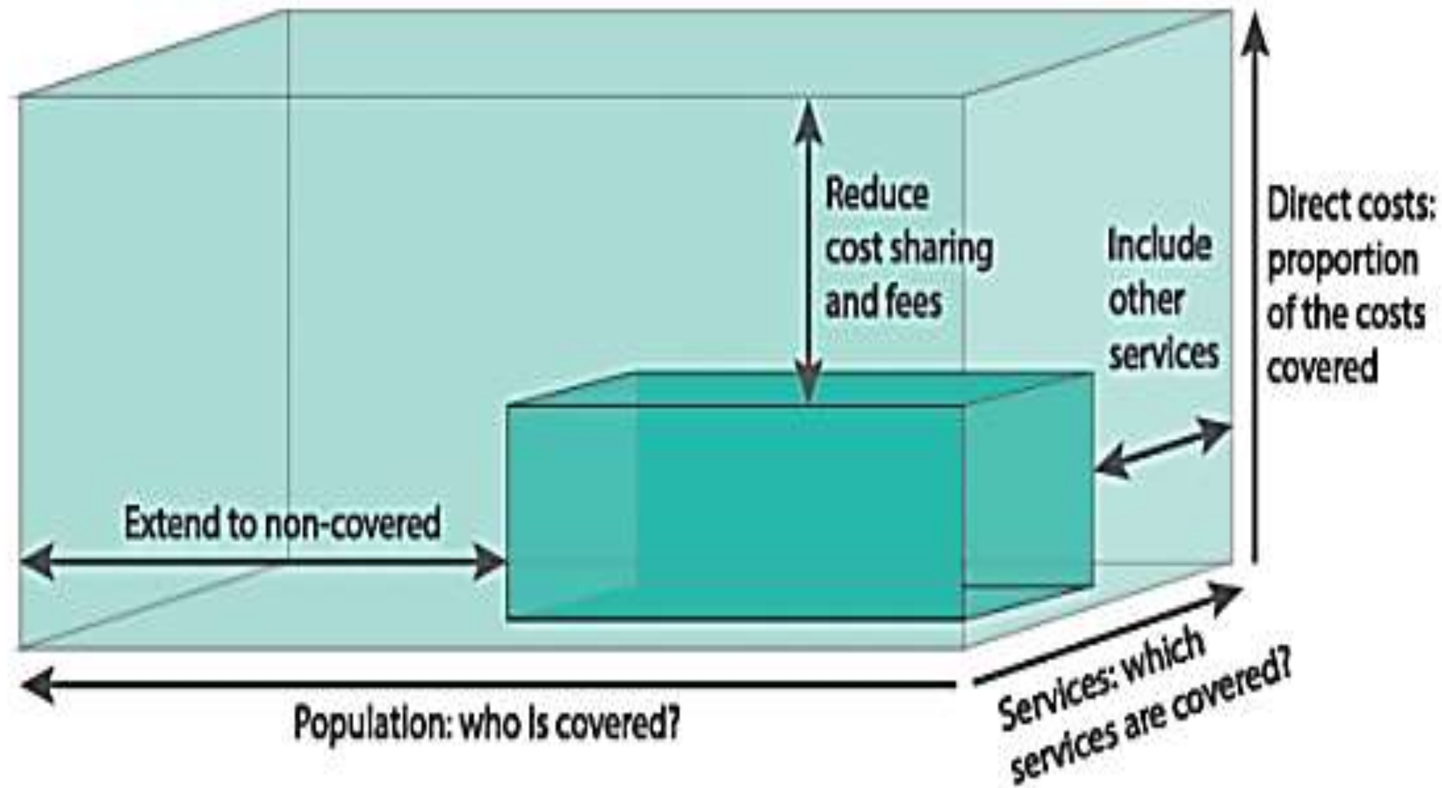
Global Movements and Policy Frameworks

New Opportunities: Post-2015 Development Goals

Health	Inequality	Cities
Universal Health Coverage	Bottom 40%	Environment
MDG+	Equal opportunity	Sustainability
NCD/risk factors	Migration	Settlements

Source: Proposal of the Open Working Group on Sustainable Development Goals, July 2014

UHC can improve health equity



Policy Frameworks: MIPA

Three pillars of the Madrid International Plan of Action

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

MIPA Policy Framework: UNESCAP Review*

21 countries have national policies on older persons

Australia, Bangladesh, Cambodia, China, Fiji, India, Indonesia, Japan, Lao People's Democratic Republic, Malaysia, Maldives, Mongolia, New Zealand, Nepal, Republic of Korea, the Philippines, Samoa, Sri Lanka, Thailand, Turkey and Viet Nam

12 countries have passed national laws

China, Democratic People's Republic of Korea, India, Indonesia, Japan, Mongolia, Nepal, the Philippines, Republic of Korea, Sri Lanka, Thailand and Viet Nam

8 countries have established special bodies on ageing within ministries

Indonesia, Kiribati, Palau, Papua New Guinea, Singapore, Sri Lanka, Thailand and Viet Nam

* Armenia, Australia, Azerbaijan, Bangladesh, Brunei Darussalam,, Cambodia, China, Democratic People's Republic of Korea Fiji Georgia India Indonesia Iran (Islamic Republic of), Japan, Kazakhstan Maldives Mongolia Myanmar Nepal Pakistan Philippines Republic of Korea Russian Federation Samoa Thailand Turkey Tuvalu Uzbekistan Viet Nam

MIPA Framework: UNESCAP Review
Several countries acknowledge gender in their policies

e.g. …The Republic of Korea - Second Basic Plan on Low Fertility and Aging Society

…Indonesia - The National Plan of Action for Older Person Welfare

…Australia - National Male Health Policy

ESCAP - 2012

MIPA Framework: UNESCAP Review
1. Older persons and development

Participation

A majority of countries have action plans, programmes or committees dedicated to facilitate the older persons participation in decision-making (consultative bodies and/or involvement in national plans on ageing).

Employment

Though many countries have introduced actions to promote employment of older persons, 30% did not take any specific measures.

Social protection

Retirement protection is only available in a few member states.

Universal Health Coverage only available in very few countries (Australia, Japan, New Zealand, The Republic of Korea, Sri Lanka, Thailand) with efforts ongoing in China, The Philippines for example.

ESCAP - 2012

MIPA Framework: UNESCAP Review
2. Advancing health and wellbeing into old age

Health promotion

80% of member states have policies, programmes of plans to ensure provision of accessible and affordable health-care services – UHC or specific health care schemes.

Geriatric and gerontology training

Geriatric and gerontology training for health care providers receives substantial budget allocation from member states. Some countries provide life-long learning through vocational training (**Australia, Bangladesh, China, New Zealand**).

Self-care and support systems

Integrated care service delivery models supporting older persons living at home pioneered by **New Zealand (e.g Canterbury district); Thailand** has established elderly clubs.

ESCAP - 2012

MIPA Framework: UNESCAP Review

3. Ensuring enabling and supportive environments

Ageing in place

Only a limited number of countries have identified policies or programmes to enable older persons remain in their homes. However, several members have programmes focusing on providing housing to the elderly.

Mobility and transport

Growing trend for provisions related to affordable and accessible transportation such as discounts, special fares, priority seating, etc. Often linked to persons with disabilities programmes/policies.

Accreditation programmes for caregivers

Only a few countries have an accreditation system, though most have standards in place for residential care services.

ESCAP - 2012

WHO is committed to support Member States in addressing ageing and health

1. New WHO World Report on Ageing (2015)

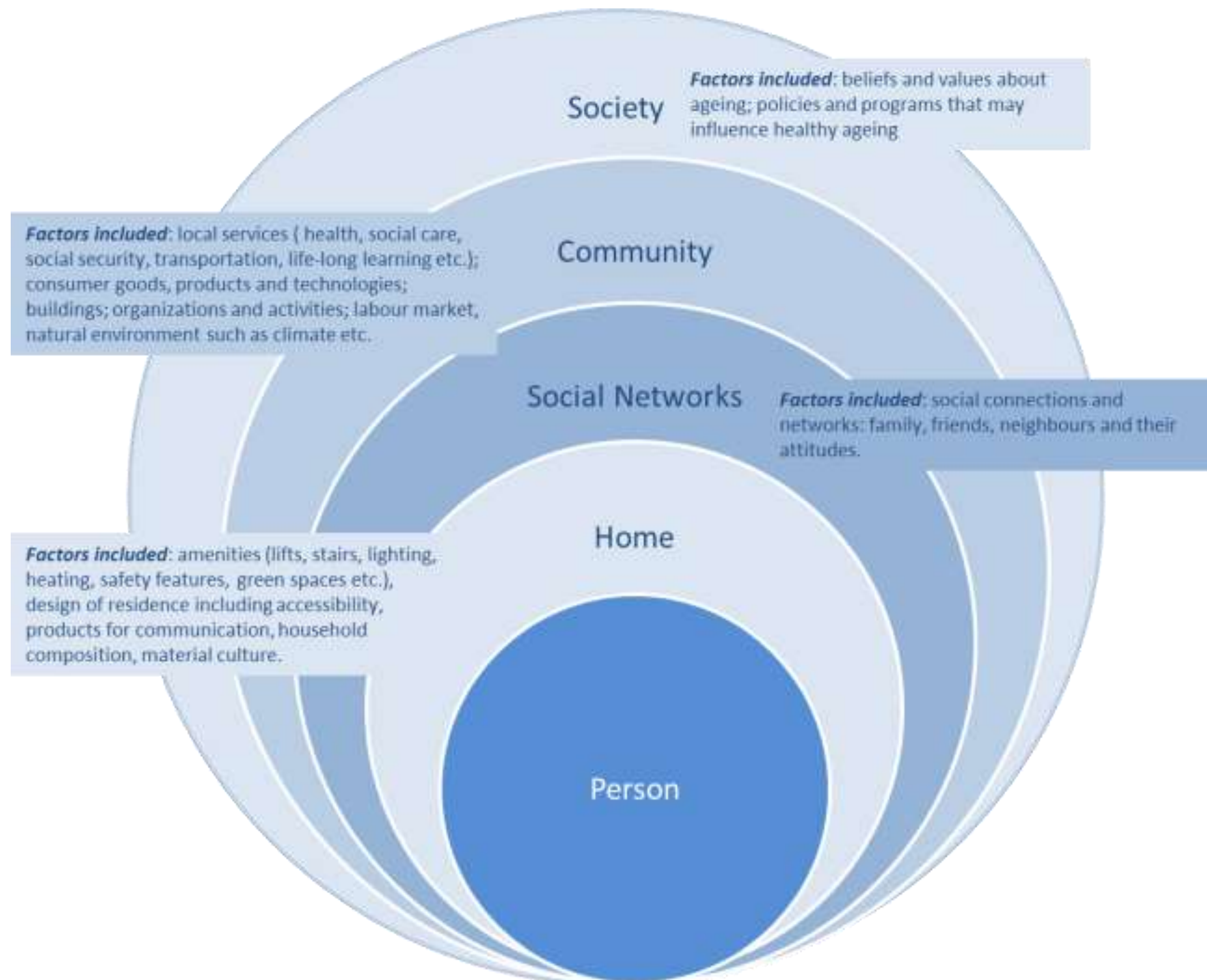
2. WPRO Regional Framework for Action on Ageing and Health in the Western Pacific (2014-2019)

3. WHO Kobe Centre: UHC, Innovation and Ageing Populations
   a. Urban environment
   b. Measurement: Urban HEART and AFC indicators, J-AGES collaboration
   c. Innovation: technology, social

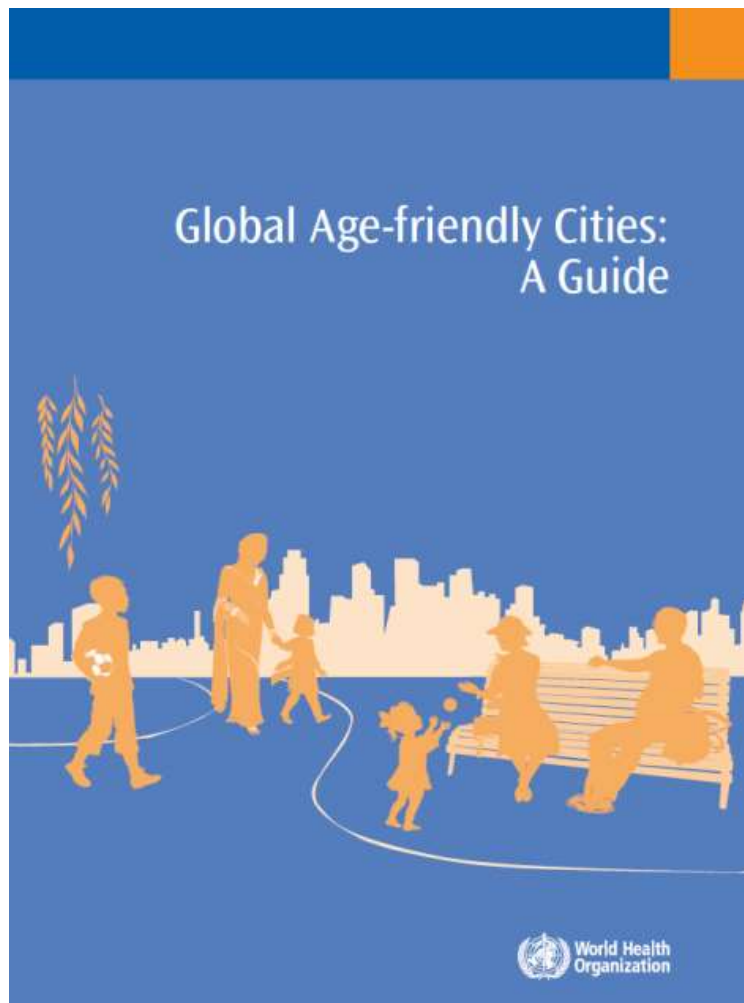
4. Selected WHO initiatives
   a. Age Friendly Cities
   b. GATE Initiative
   c. Dementia Ministerial
   d. UHC – integrated person-centred health, HRH, etc

WHO Active Ageing Framework

WHO: Environments of healthy ageing and related factors



Age-friendly Cities
Create conditions for a flourishing older life



- Civic participation and employment
- Respect and Social Inclusion
- Social participation
- Outdoor spaces and buildings
- Housing
- Communication and information
- Transportation
- Community and health services

Age-friendly Cities Initiatives in China

- **National law** on protecting the rights of the elderly added a new chapter on ***Age-friendly Environments***
- Develop **national accessibility standards** and criteria for public spaces and facilities
- Facilitate the creation of age-friendly infrastructure, facilities and services
- Piloting AFC and **"barrier-free cities"**

Source: China National Committee on Ageing, 2013

“Ageing in Place” in Singapore

- Focus on older people who cannot live with their family or who would like to live independently
- Home modifications and new homes with structural features such as lifts, non-slip bathrooms, corridor railing, wheelchair access
- Government maintains focus on traditional family roles and structures to increase fertility rates and support the growing elderly population (e.g. Maintenance of Parents Act)

Source: Wen WK. Futures of ageing in Singapore. *Journal of Futures Studies*, 2013, 17(3): 81-102.

WHO Western Pacific Regional Office

Regional Framework for Action on Ageing and Health in the Western Pacific (2014-2019)

Innovation:

Integrated, person-centred communities & systems

Key Innovation Needs

- Complex needs, great variation: individual, communities; inequities; functional/cognitive dependent
- Integrated health and social delivery systems: easier said than done
  - Focus on the individual and their needs
  - Comprehensive assessments
  - Coordinated care/support
  - Focus on bureaucratic cultures, financing, incentives
  - Human resources for health and social services
  - Informal care (family) support
  - Differentiated services, location, access, providers
- Measuring impact

Japan: Older adults' priorities concerning housing and living environment, 2005, 2010

Cabinet Office, Government of Japan. http://www8.cao.go.jp/kourei/ishiki/h22/sougou/zentai/

Accessible home features (handrails, barrier-free)

Access to public transportation and shopping

Access to healthcare and long-term care

部屋の広さや間取り、外観が自分の好みに合うこと

子どもや孫などの親族と一緒に住んだり、または近くに住めること

災害や犯罪から身を守るための設備・装置が備わっていること

豊かな自然に囲まれていたり、静かであること

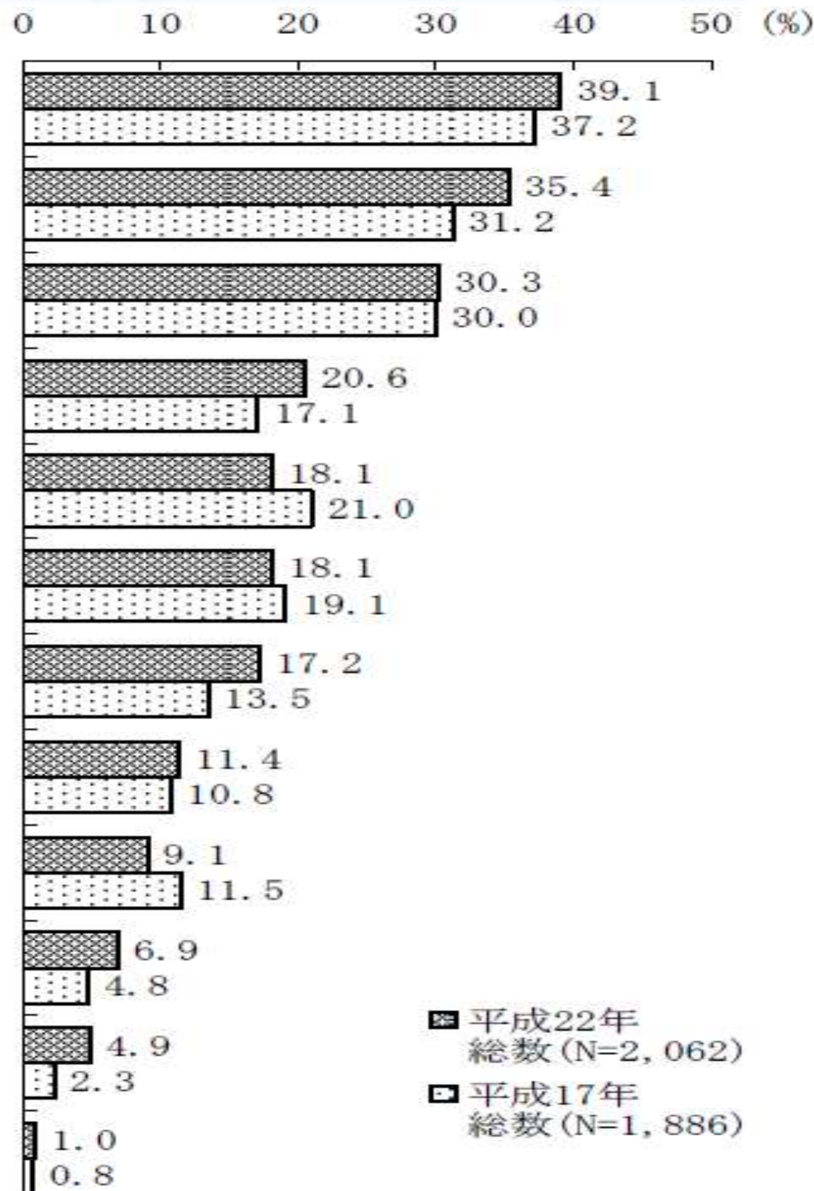
近隣の道路が安全で、歩きやすく整備されていること

親しい友人や知人が近くに住んでいること

趣味やレジャーを気軽に楽しめる場所であること

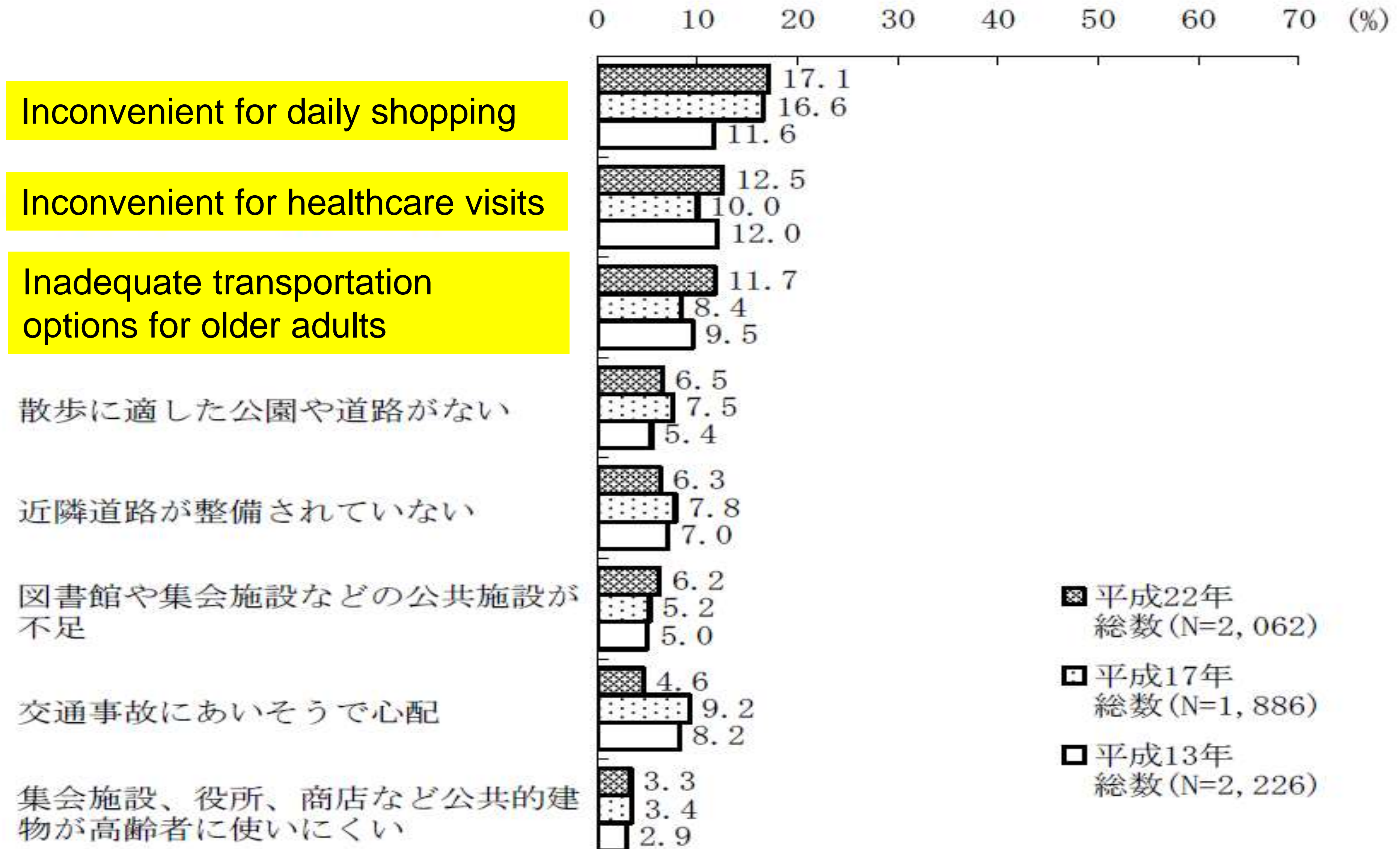
ペットと一緒に暮らせること

職場に近かったり、現在の職業に適した場所に面していること



Japan: Older adults' main problems with neighbourhood environment, 2001, 2005, 2010

Cabinet Office, Government of Japan. http://www8.cao.go.jp/kourei/ishiki/h22/sougou/zentai



Health Needs

- Under-nutrition
- NCDs: tobacco, hypertension, physical exercise, diet, alcohol over-use, poor social engagement
- Frailty, sarcopenia
- Cognitive impairment
- Sensory impairment
- Multiple morbidities
- Mental health, stress

Community interventions

- Information dissemination
- Physical exercise, nutrition programmes
- Comprehensive case management
- Inclusion of older persons in programmes
- Self-care
- Volunteers
- Changing attitudes, reduce stigma
- Learning programmes

Urban planning and environment

- Purposeful urban planning: older person "lens"
  - Spatial planning for integrated services, housing, transport, exercise, social connectivity
- Built environment: housing, transport modification
- Safety, walkability
- Sight/hearing/mobility impairments
- Equity and affordability
- Local government: intersectoral engagement
- Supporting social inclusion

Social Care

- ADL/IADL based + comprehensive needs assessment
- Respite care
- Informal caregivers
- New workforce needs: training
- Quality
- Reduce fragmentation
- Stigma, ageism
- Women and workforce

Integration

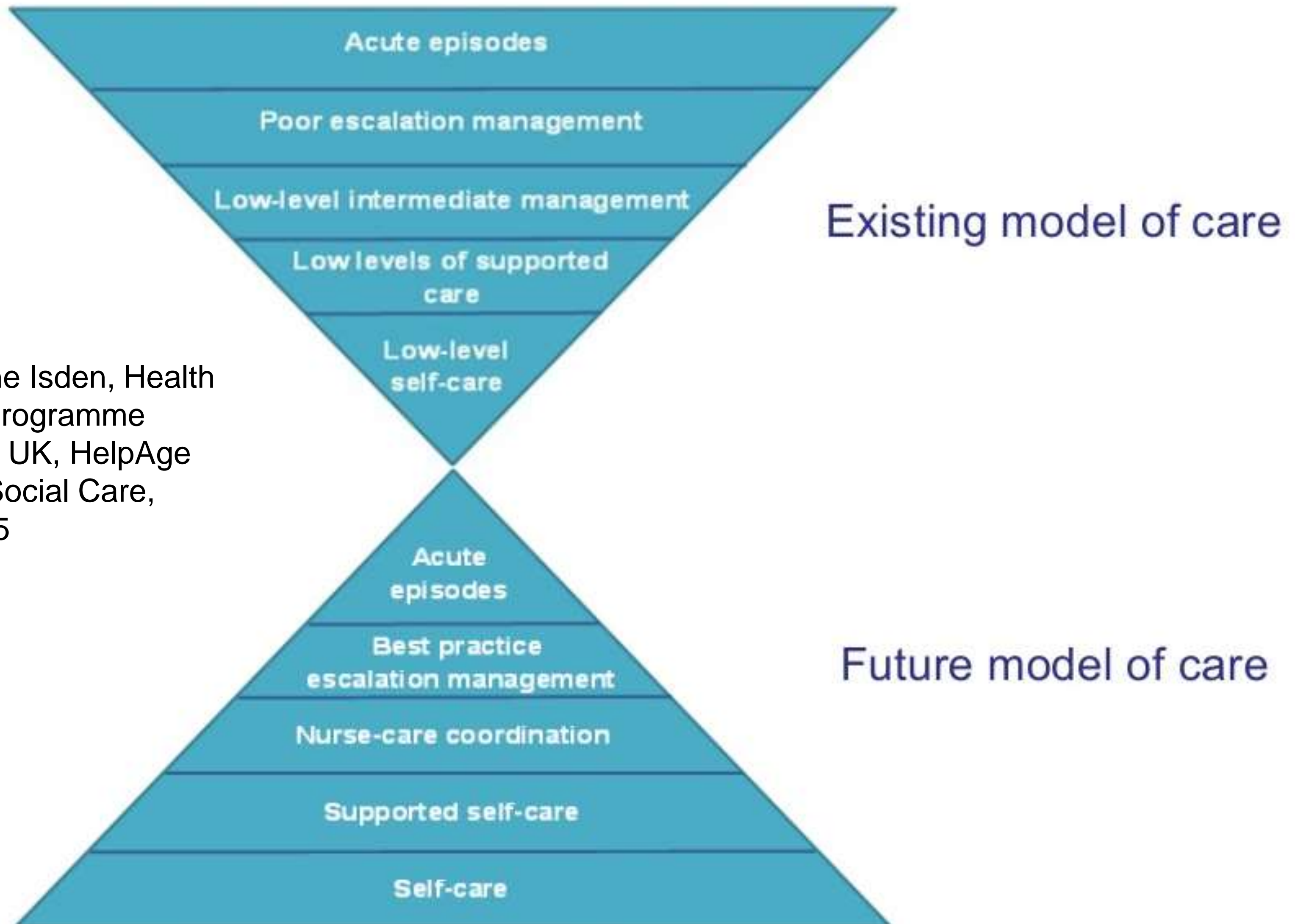
- Bureaucratic & professional cultures
  - Different funding streams, eligibility & entitlements
  - Different training, standards, culture, salaries
- Financing, incentives
- Differentiation of needs: social, health (acute, chronic, pain management), palliative care and rehabilitation, dementia
- Disability and ageing communities
- Silo mentality → coordination of services/care; referral
- Health and social worker training: cadres, training, incentives, payments for informal carers, etc
- Home based vs short stay vs long term care (residential)

Health vs social care in England

National Health Service	Care and support
• Provides primary, secondary and tertiary healthcare services • Free at the point of need • Comprehensive, universal services • Fully funded through general taxation • Locally commissioned, but within a clear national system • Fairly little local variation in services provided	• Provides care in care homes, in day facilities and in people's home • Means-tested and needs-tested at point of need • Local councils set local criteria and commission care • Far fewer national rules or guide lines • Huge geographical variation in types of services, funding and rules

Source: Ruthe Isden, Health Influencing Programme Director, Age UK, HelpAge Meeting on Social Care, January 2015

Making the change….



Source: Ruthe Isden, Health Influencing Programme Director, Age UK, HelpAge Meeting on Social Care, January 2015

Policies

- Income security, pension: social protection
- Financing: social, health insurance + alignment
  - Equity protections
- Access to services (health and social)
- Integrated planning and strategies
- Inclusion of older persons
- Elder abuse
- Built environment (zoning laws, housing, transport…)
- Guidelines/standards: quality, NCDs,

Examples

- Thailand:

a) Promote healthy individual and self care (physical and mental) b) voluntary social activities and income generation c) self care and family care at home + home visits d) family care at home, integrated health and social care; third party care (volunteers, CHW) e) home improvements

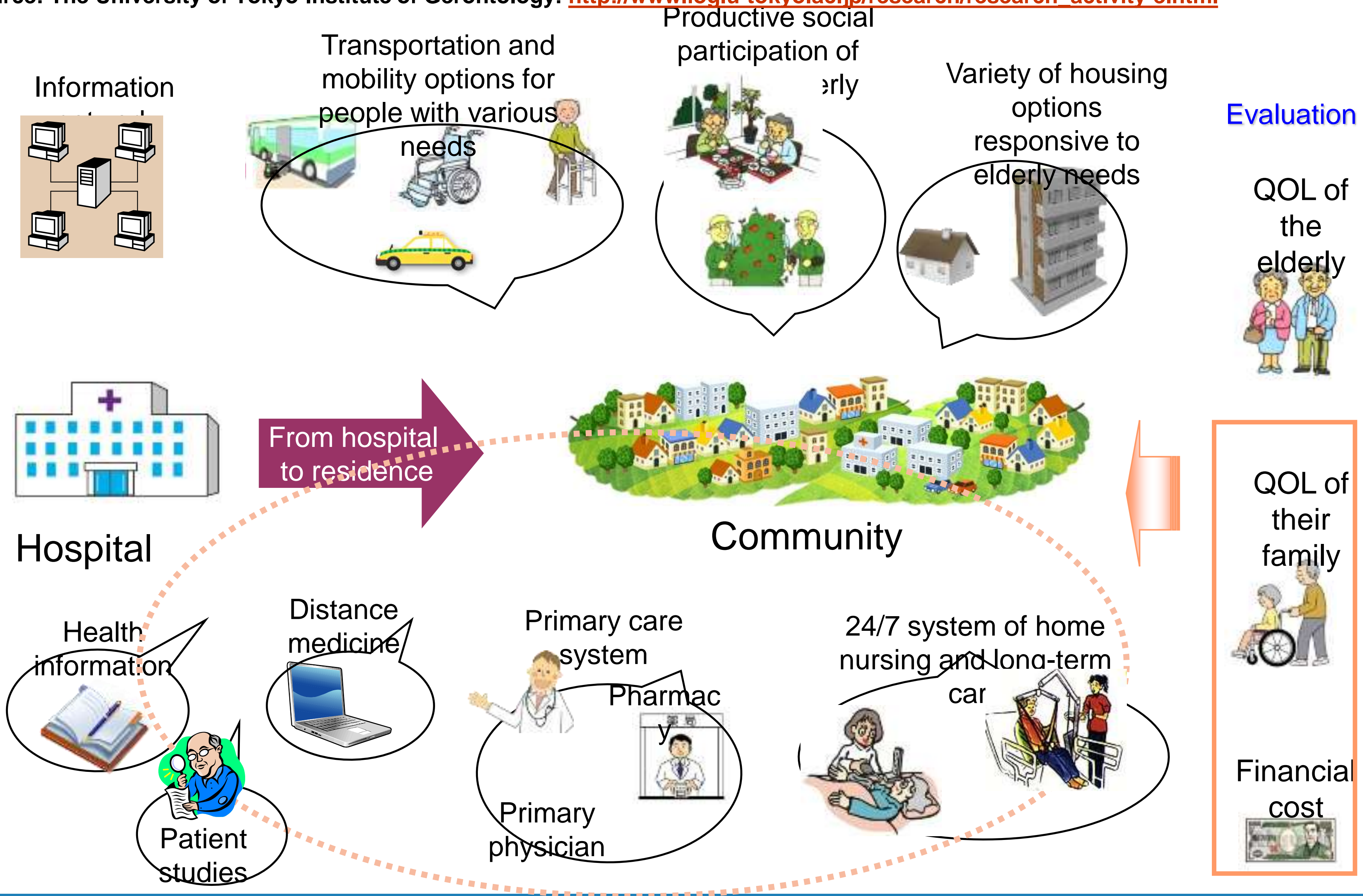
- Korea:

LTC insurance (eligibility criteria);

Integrated system of individual needs assessment + home care + domestic support + day care services + spatial planning

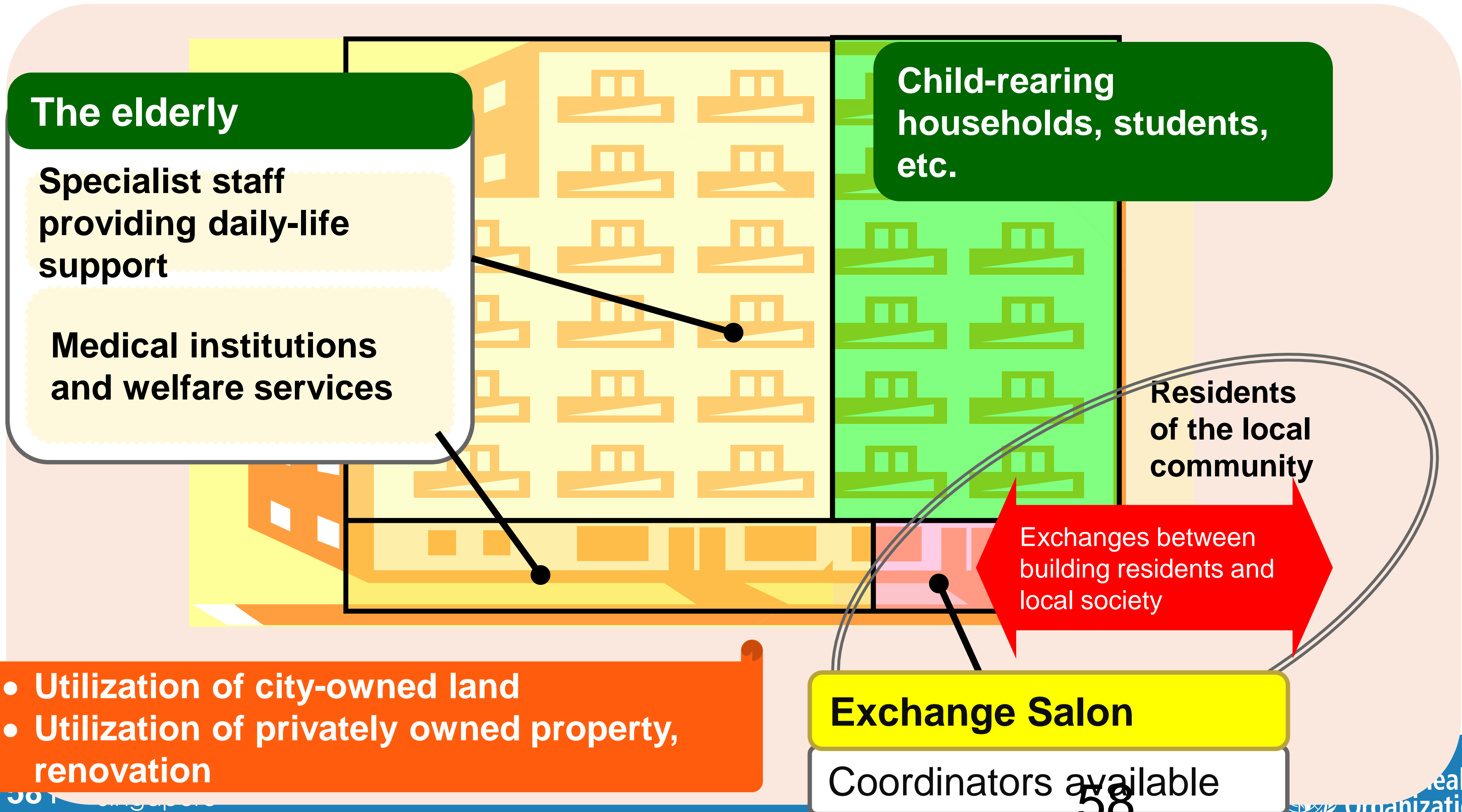
Example of research: for Aging in Place：A community-based social experiment (University of Tokyo Institute of Gerontology)

Source: The University of Tokyo Institute of Gerontology: http://www.iog.u-tokyo.ac.jp/research/research_activity-e.html



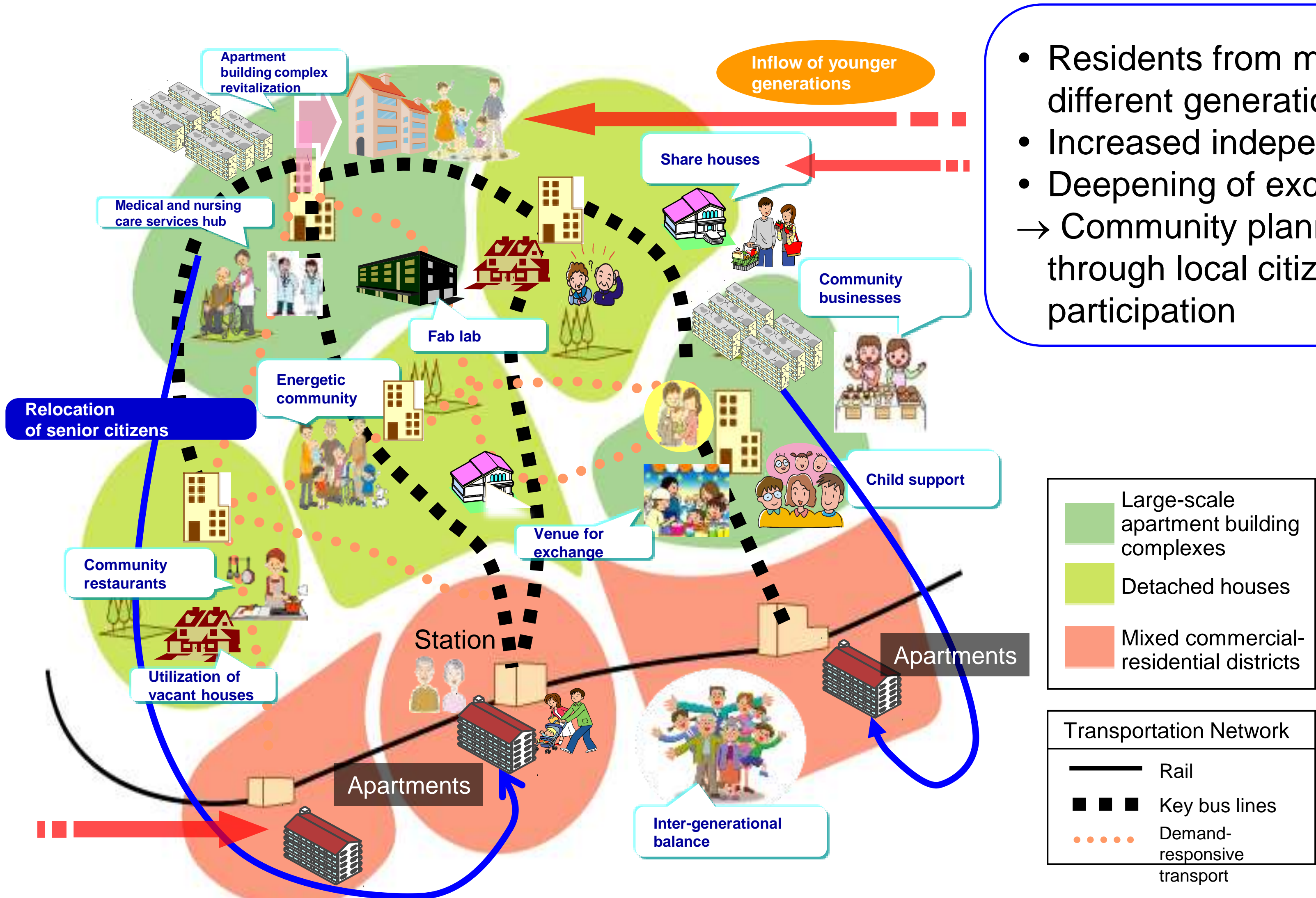
New Type of Urban Structure
① Housing

Deepening of independently initiated exchanges between numerous generations
→ Apartment complexes whose residents mutually support each others' lives



- Utilization of city-owned land
- Utilization of privately owned property, renovation

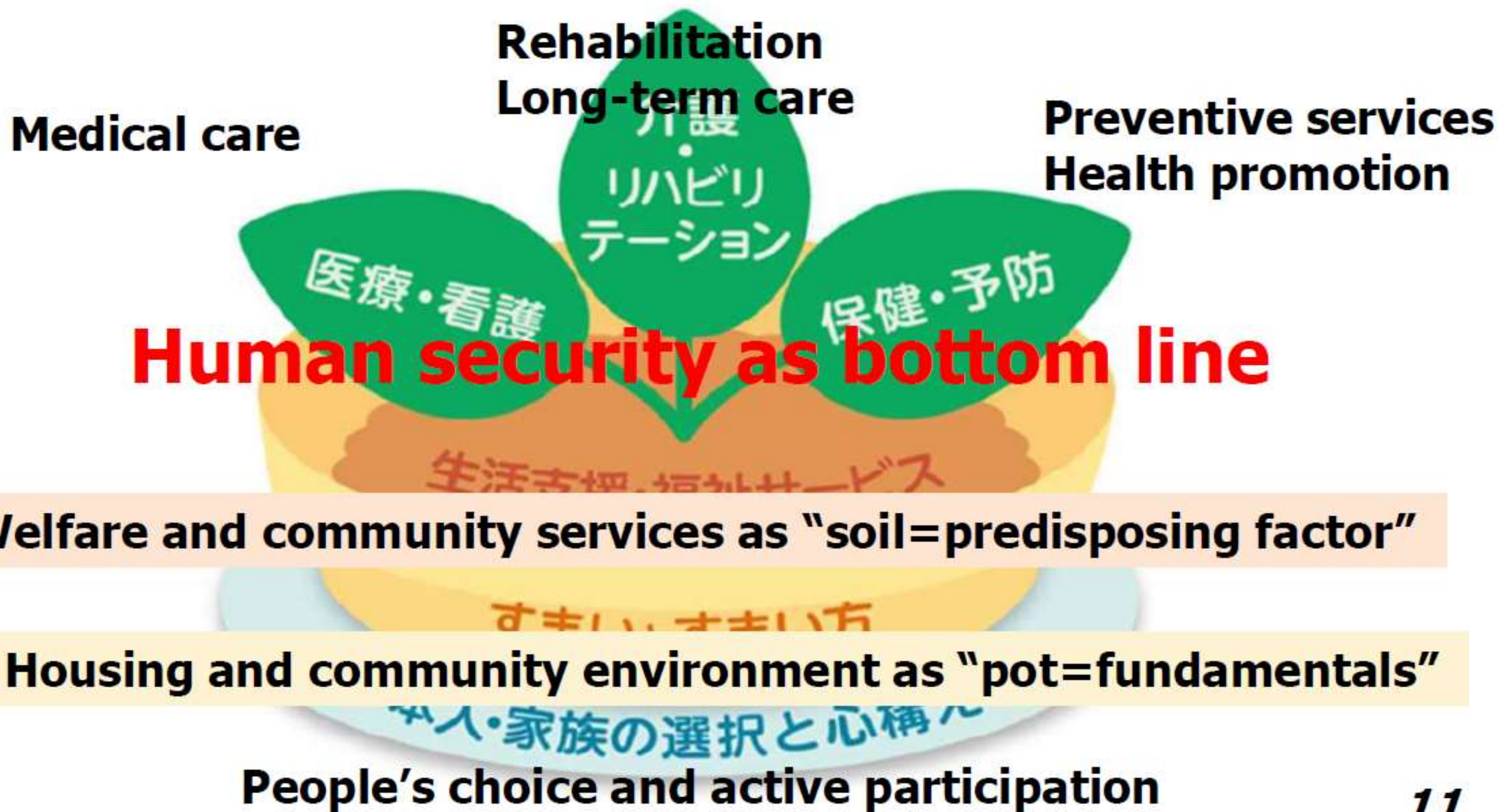
New Type of Urban Structure
② Local Community



- Residents from many different generations
- Increased independence
- Deepening of exchanges

→ Community planning through local citizen participation

Integration of healthcare, welfare, and community programs ("Three-leaves and pot" model)



Source: Prof Hideki Hashimoto, Department of Health and Social Behaviour, University of Tokyo, Presentation at PMAC2015 Side Event

Role of Older Persons' Associations

- Older Person's Association (OPA) Cambodia
  - 60 associations with 14,000 members (as of 2010)
  - Social/peer support, food security, livelihoods, healthcare, homecare for older people and formation of older people's associations

- PUSAKA Indonesia
  - 110 in Jakarta alone (50-60 people per Pusaka)
  - Focus on disadvantaged older people, the majority widows or other vulnerable women
  - Home-based care including meals, home visits, routine health check-ups, religious guidance, clothing, social/exercise activities, support accessing clinics/health centres

Assistive Health Technology (AHT) Knowledge & Science on Assistive Health Products (AHP) Eyeglasses to supportive robots

World Health Organization
Centre for Health Development

Ecosystem of Patient-Centered Technologies

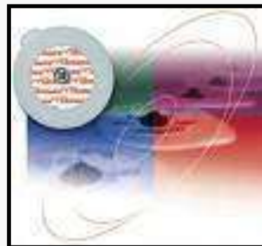
Patient Education and Support

Medication Management

Social Networks

Apps and Gaming

Remote Patient Monitoring



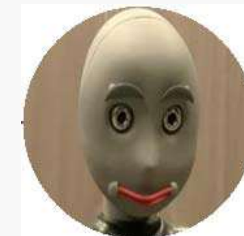
Provider and Caregiver Communications

Personal Health Records

mHealth

Mood and Depression Scanners

Sensors



Assistive Technologies

Emerging evidence base

1. Innovations in **assistive and medical technologies** – Understanding needs, setting priorities

2. **Social innovations** – Assessing the usefulness of new models of care for older populations

KEY WHO REPORTS

Systematic review commissioned by the World Health Organisation

The Needs, Availability and Affordability of Assistive Devices for Older People in 8 Countries in the Asia Pacific Region:

Australia, China, Fiji, Japan, Malaysia, Republic of Korea and Vietnam.

DRAFT

http://www.who.int/en

and

http://www.who.int/kobe_centre/en/

World Health Organization

Summary Report:

Consultation on Advancing Technological Innovation for Older Persons in Asia

World Health Organization

Centre for Health Development

Report

WHO Global Forum on Innovations for Ageing Populations

10-12 December 2013 Kobe, Japan

World Health Organization

SURVEY OF NEEDS FOR ASSISTIVE AND MEDICAL DEVICES FOR OLDER PEOPLE IN SIX COUNTRIES OF THE WHO WESTERN PACIFIC REGION

China, Japan, Malaysia, the Philippines, the Republic of Korea and Viet Nam

Evaluate the health equity impact of policy and action:

Is it making a difference? Why or why not?

We need data

Photo Source: University of Ouagadougou, ISSP

AFC Core Indicators (Draft)

Equity Measures

- Inequality between two reference groups
- Population attributable risk

Age-Friendly Environment Outcomes

Physical environment

- Neighbourhood walkability
- Accessibility of public spaces and buildings
- Accessibility of public transportation vehicles
- Accessibility of public transportation stops
- Affordability of housing

Social environment

- Positive social attitude toward older people
- Engagement in volunteer activity
- Engagement in paid employment
- Engagement in socio-cultural activity
- Participation in local decision-making
- Availability of information
- Availability of health and social services
- Economic security

Impact on Wellbeing

- Quality of life

Measures of social capital

- Community involvement and social networks
- Perceptions of other people and institutions
- Safety in local area
- Interest in politics and perceptions of government
- Family, community and government assistance into and out of the household
- Informal personal care provision/receipt

WHO Study on global AGEing and adult health (SAGE) collaborating countries

SAGE-HIV studies

SAGE-INDEPTH studies

SAGE survey countries

0 900 1,800 3,600 Kilometers

The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Data Source: World Health Organization
Map Production: Public Health Information and Geographic Information Systems (GIS)
World Health Organization

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SAGE Indicators

Household measures	Individual measures
• Roster of all the individuals in the household • Household health intervention coverage • Health insurance • Health expenditure • Indicators of permanent income • Health occupations	• Socio-demographics • Health state description • Health state valuation • Risk factors • Mortality • Coverage of health interventions • Health system responsiveness • Health system goals and social capital • Interviewer observations

National surveys of health and ageing

- Korean Longitudinal Study on Ageing (KLoSA)
- China Health, Ageing & Retirement Longitudinal Study (CHARLS)
- Japanese Study of Ageing & Retirement (JSTAR)
- Longitudinal Ageing Study in India (LASI)
- Pilot Panel Survey and Study on Health, Aging, and Retirement in Thailand (HART)
- Indonesian Family Life Survey (IFLS)
- East Asian Social Survey (EASS) – China, Japan, Korea, Taiwan

Visualizing data for policy makers and health practitioners (Japan)

データ　フィルター

町丁目
- 0.0 - 179.4
- 179.5 - 632.0
- 632.1 - 1,073.0
- 1,073.1 - 2,464.4
- 2,464.5 - 9,149.0

診療所
歯科医院
病院

人口総数 >> 人口総数

八丁堀2丁目: 667

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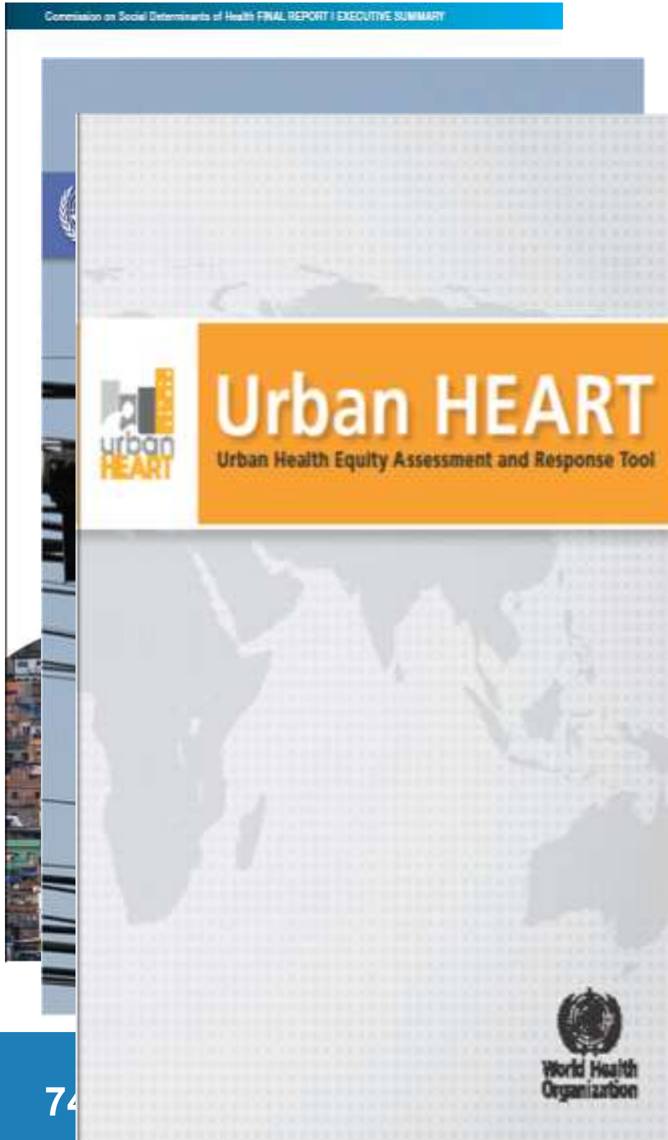
地区名	指標値
	0
京橋1丁目	101
京橋2丁目	209
京橋3丁目	132
佃1丁目	2,623
佃2丁目	9,149
佃3丁目	1,204
入船1丁目	862
入船2丁目	767
入船3丁目	641
八丁堀1丁目	83
八丁堀2丁目	667
八丁堀3丁目	1,147
八丁堀4丁目	849
八重洲1丁目	78

地区名	指標値

Not Available

10000
5000
0

URBAN HEART



User-friendly guide to identify and act on health inequities

Assessment: an indicator guide

Response: guide to best practices

Target audiences

Local/national authorities	Academia and communities

World Health Organization

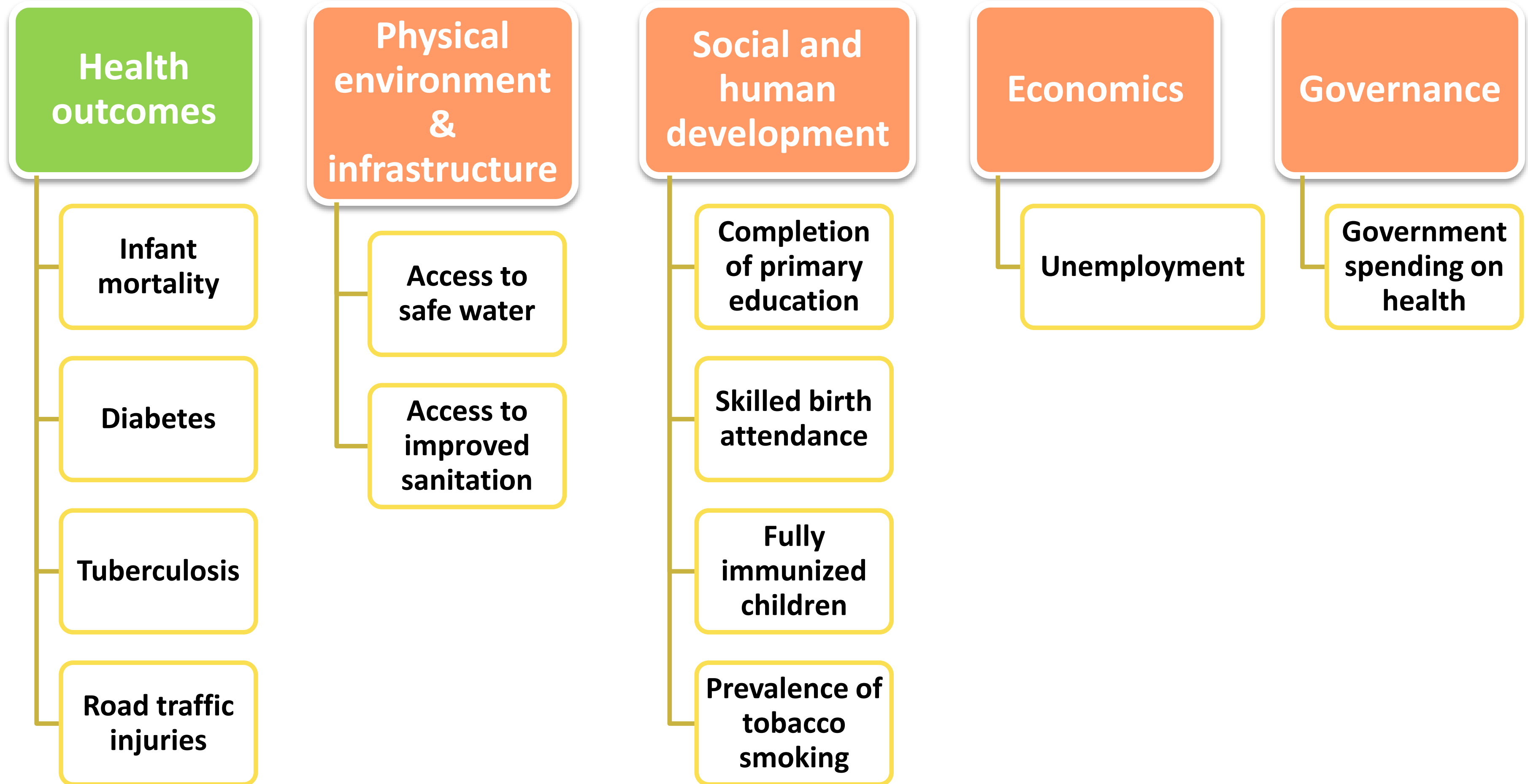
URBAN HEART

SOME CITY EXPERIENCES: TORONTO (CANADA)

Neighbourhood	N ID	Unemployment	Low Income	Social Assistance	High School Graduation	Marginalization	Post Secondary Completion	Municipal Voting V1	Community Places for Meeting	Walk score	Healthier Food Stores	Green Space	Premature Mortality	Mental Health	Preventable Hospitalizations ACSCH V2	Diabetes	R	Y
Domains		Economic Opportunity			Social and Human Development			Governance	Physical Environment & Infrastructure				Population Health					
Reds		28	24	26	27	28	46	24	28	22	29	28	23	24	43	44		
Yellows		75	74	53	87	57	36	82	79	101	81	86	68	66	54	56		
Greens		37	42	61	26	55	58	34	33	17	30	26	49	42	43	40		
Toronto Rate		9.3	22.2	10.0	N/A	2.4	68.9	45.7	15	71	3.9	45.5	211.1	73.4	243.8	8.5		
Neighbourhood Range		5.0-17.1	5.6-49.8	0.4-29.1	Low/Ave/Hi	1.0-3.4	37.5-91.7	34.5-58.3	3.4-39.9	42-99	0.47-22.3	11.3-113.5	118.0-573.0	47.4-96.8	79.3-608.7	4.1-14.0		
		Unemployment	Low Income	Social Assistance	High School Graduation	Marginalization	Post Secondary Completion	Municipal Voting V1	Community Places for Meeting	Walk score	Healthier Food Stores	Green Space	Premature Mortality	Mental Health	Preventable Hospitalizations ACSCH V2	Diabetes		
Agincourt North	129	11.3	25.8	6.4	Hi	2.6	57.2	39.1	5.6	66	3.55	27.6	139.2L	61.1	163.3L	9.5H	4	7
Agincourt South-Malvern West	128	10.7	27.1	7.0	Ave	2.6	60.6	41.7	9.6	66	3.22	22.2	161.9L	70.4	183.6L	9.5H	2	10
Alderwood	20	7.4	10.1	4.3	Ave	2.0	63.5	47.9	7.5	70	0.62	30.6	256.9H	80.0	294.0	8.5	3	7
Annex	95	7.3	19.1	3.9	Ave	1.8	85.0	49.8	25.7	94	7.62	21.5	234.1	73.3	235.7	5.5L	1	6
Banbury-Don Mills	42	7.1	14.0	3.8	Hi	2.4	80.7	50.4	6.2	67	1.37	56.8	163.5L	78.7	137.3L	6.5L	1	5
Bathurst Manor	34	7.8	17.5	6.6	Ave	2.6	72.9	44.8	13.2	61	1.56	91.6	148.3L	78.7	173.7L	8.5	0	9
Bay Street Corridor	76	9.3	26.7	3.5	Ave	2.2	89.2	39.7	20.1	99	12.98	23.5	294.2H	85.4H	163.7L	5.1L	2	4
Bayview Village	52	8.4	21.1	3.5	Hi	2.4	83.4	54.8	6.4	71	1.07	52.5	127.5L	64.5	163.9L	6.0L	2	6
Bayview Woods-Steeles	49	10.4	23.0	4.9	Hi	2.6	81.7	42.2	5.0	57	0.79	84.1	158.7L	84.3	161.1L	7.1L	3	4
Bedford Park-Nortown	39	6.3	11.2	2.1	Ave	1.6	80.1	47.0	10.4	73	5.32	17.5	119.1L	87.0H	99.5L	5.6L	1	5
Beechborough-Greenbrook	112	11.6	28.6	22.8	Low	3.4	41.6	39.6	19.1	62	3.38	39.2	306.7H	65.7E	324.5	12.5H	10	5
Bendale	127	10.5	23.6	9.8	Ave	3.0	61.0	45.9	10.3	64	3.23	46.7	215.3	76.1	249.5	11.5H	3	12
Birchcliffe-Cliffside	122	10.6	14.5	8.2	Ave	1.8	65.8	53.1	10.6	71	1.76	35.4	317.6H	78.4	345.8H	8.2	2	9
Black Creek	24	13.6	33.5	29.1	Low	3.0	40.9	45.0	16.8	62	1.70	64.1	228.3	58.4L	315.6H	12.7H	9	6
Blake-Jones	69	9.6	28.6	13.1	Ave	2.6	67.2	51.1	30.1	89	5.70	17.6	301.1H	58.0E	248.9	8.1	4	10
Briar Hill-Belgravia	108	7.8	20.6	10.0	Ave	2.8	65.1	44.6	13.5	81	6.03	15.8	205.0	65.2E	236.1	9.9H	1	13
Bridle Path-Sunnybrook-York Mills	41	5.8	8.0	0.4	Hi	1.4	89.1	43.1	4.5	58	0.90	59.8	147.1L	88.9H	153.7L	4.5L	3	2
Broadview North	57	10.9	22.0	11.3	Low	2.6	70.2	51.7	18.5	74	7.78	48.8	229.5	64.7E	252.4	7.9L	1	12
Brookhaven-Amesbury	30	9.7	26.2	19.2	Ave	2.8	50.3	42.4	15.2	62	4.22	38.2	225.4	82.9	299.1H	11.5H	4	10
Cabbagetown-South St. James Town	71	7.4	20.4	8.2	Ave	1.8	80.4	58.0	30.1	91	11.66	50.8	367.4H	85.9H	327.5H	6.6L	2	4
Caledonia-Fairbank	109	9.8	18.1	11.7	Low	2.4	44.3	37.6	15.6	69	4.61	36.0	222.9	67.3	214.0	10.6H	4	11
Casa Loma	96	6.0	11.0	1.8	Ave	2.0	87.1	53.5	16.4	80	2.48	31.0	179.7	90.0H	196.9	4.6L	0	6
Centennial Scarborough	133	7.8	10.0	3.0	Hi	1.6	76.6	46.7	6.1	54	1.13	36.8	170.2L	79.3	170.3L	9.5H	3	4
Church-Yonge Corridor	75	8.4	31.8	10.9	Low	1.8	82.1	47.8	26.8	98	12.38	22.3	352.0H	81.7	281.7	6.5L	4	4
Clairlea-Birchmount	120	9.7	27.2	10.9	Ave	2.6	64.4	46.0	8.8	69	2.33	53.6	271.7H	74.7	327.8H	10.9H	3	12
Clanton Park	33	7.5	17.5	5.0	Hi	2.2	78.0	42.0	13.6	63	3.89	27.1	176.8L	81.0	196.4L	8.7	0	9
Cliffcrest	123	9.1	16.7	8.5	Ave	2.2	63.6	50.7	3.7	54	0.92	44.6	253.2H	81.1	245.2	9.5H	3	10
Corso Italia-Davenport	92	10.0	16.3	9.4	Low	2.6	58.4	41.4	27.3	79	11.65	32.1	181.4	65.4	263.5	9.2H	2	9
Crescent Town	61	16.2	35.5	16.9	Low	2.8	67.4	46.1	12.6	77	6.53	62.0	284.4H	47.4EL	324.8H	10.9H	8	6
Danforth Village - Toronto	66	6.5	14.2	6.6	Ave	2.4	71.8	50.7	23.7	86	7.46	13.3	258.2H	64.6E	332.3H	8.3	5	8
Danforth East York	59	7.0	16.7	6.3	Ave	2.0	69.1	55.8	18.5	77	6.75	18.5	225.7	58.1L	272.9	8.5	2	8
Don Valley Village	47	11.1	25.4	8.0	Ave	2.4	77.5	41.0	14.9	79	1.36	37.8	146.1L	71.9	156.1L	7.6L	2	10
Dorset Park	126	11.4	24.8	11.5	Ave	2.8	58.9	40.5	10.0	68	4.48	23.0	197.5	72.5	327.4H	12.4H	6	9
Dovercourt-Wallace Emerson-Junction	93	7.9	21.4	10.3	Low	2.4	60.8	44.8	34.6	88	10.06	19.1	225.2	62.1	276.8	9.5H	4	9
Downsview-Roding-CFB	26	10.0	21.7	16.2	Low	3.0	50.1	41.7	12.2	59	2.21	64.5	225.6	67.4	230.8	10.8H	6	8
Dufferin Grove	83	6.9	21.4	11.4	Ave	2.6	68.1	46.7	26.1	90	11.43	14.0	183.6	77.2	240.0	8.5	1	9

Toronto prioritized key health equity issues using Urban HEART across 140 neighbourhoods. Urban HEART is being used as a criteria to identify and monitor Neighbourhood Improvement Areas.

Urban HEART Core Indicators



URBAN HEART: Qualitative

SOME CITY EXPERIENCES: INDORE (INDIA)

Slum→ Sub-Indicator↓	Nandbagh	Ganesh Dham	Shivkantnagar	Avantika Nagar	Bajrangpura	Sugandhanagar	Jagannath Nagar	Pushp Nagar	New Prince Nagar	Prince Nagar	New Jagdesh nagar	Jagdesh Nagar
1. Presence of a functional community toilet and/or families have individual toilet in their home)	Red	Yellow	Red	Yellow	Green	Yellow	Green	Green	Yellow	Green	Green	Green
2. Presence of a functional community water stand post and/or domestic water connections)	Red	Yellow	Red	Yellow	Green	Red	Green	Yellow	Yellow	Green	Yellow	Green
3. Unpaved)/broken roads in lanes inside the slum	Red	Yellow	Yellow	Yellow	Green	Yellow	Red	Green	Yellow	Green	Red	Green
4. Slum does not have cemented Naalis (drains)	Red	Red	Red	Red	Green	Red	Red	Green	Yellow	Green	Red	Green
5. Regularity of Garbage lifting	Red	Red	Red	Red	Yellow	Red	Red	Red	Green	Green	Red	Red
6. Disposal of solid waste through a soak pit/septic tank/ sewer line	Yellow	Green	Red	Green	Yellow	Green	Yellow	Red	Red	Green	Yellow	Green
7. Households using wood/coal as cooking fuel	Yellow	Yellow	Yellow	Green	Green	Yellow	Yellow	Green	Yellow	Green	Yellow	Green
8. Household Electricity Connection	Red	Green	Green	Green	Green	Green	Green	Green	Green	Green	Red	Green

Urban HEART was used to map inter-slum and neighbourhood inequities. Community interventions were applied to address concerns of slum clusters.

STEP 5: PRIORITIZE HEALTH EQUITY GAPS AND GRADIENTS

urban HEART

INDICATOR	DIST. A	DIST. B	DIST. C	DIST. D	BASELINE	BENCHMARK
TUBERCULOSIS	234	123	45	74	100	50
DIABETES	75	36	100	83	75	50
SAFE WATER	67	75	95	77	70	90
GREEN SPACES	12	8	20	6	10	25
IMMUNIZATION	88	55	85	72	75	90
OBESITY	5	12	27	23	10	8
UNEMPLOYMENT	28	16	10	20	15	5
POVERTY	18	22	5	18	20	10
PARTICIPATION	74	86	62	90	60	80
GOVT. EXPENDITURE	2343	4525	25346	6777	3346	5000

J-AGES

Japan Gerontological Evaluation Study (J-AGES)

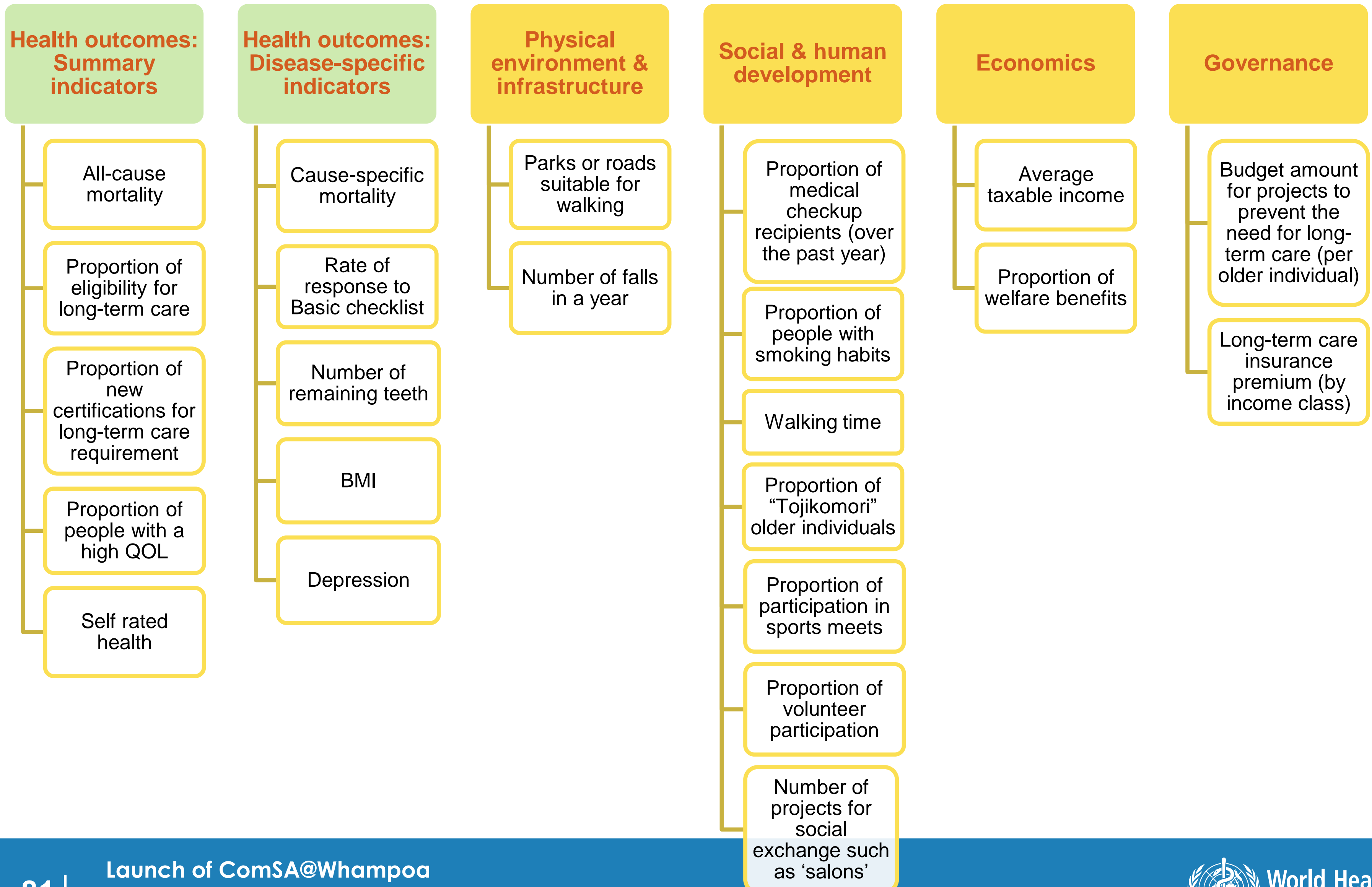
- Longitudinal study of the elderly population in Japan since 1999
- Based on a bio-psycho-social model of health
- To develop a benchmarking system to evaluate Japanese policies on healthy ageing
- Financed by Ministry of Health, Labor and Welfare

Japan Gerontological Evaluation Study
AGES

Survey Items

- **Health status** indicators: self-rated health, chronic conditions, health behavior, oral health, nutrition/diet, tobacco, alcohol, ADL/IADL, etc
- **Psychological** indicators: depression, subjective well-being, etc
- **Social** indicators: social support, social capital, social participation
- **Socioeconomic status** indicators: income, education, relative deprivation, pension, etc
- **Environmental** indicators: road safety, parks and recreation, accessibility, etc

JAGES HEART 2011 Core Indicators



Core indicators 2011

Summary indicators

1. All-cause mortality
2. Proportion of people eligible for long-term care
3. Proportion of new certifications for long-term care requirement
4. Proportion of people with a high QOL
5. Self rated health

Specific

6. ~~Cause-specific mortality~~
7. Rate of response to Basic checklist
8. Number of remaining teeth
9. low BMI
10. Depression

Physical env.

11. Parks or roads suitable for walking
12. Number of falls in a year

13. Proportion of having health checkup

Human & Social development

14. Proportion of people with smoking habits
15. Walking time
16. Number of "shut-in" older individuals
17. Proportion of participation in sports clubs
18. Proportion of volunteer participation
19. Number of projects for social exchange such as 'salons' (community center programs)

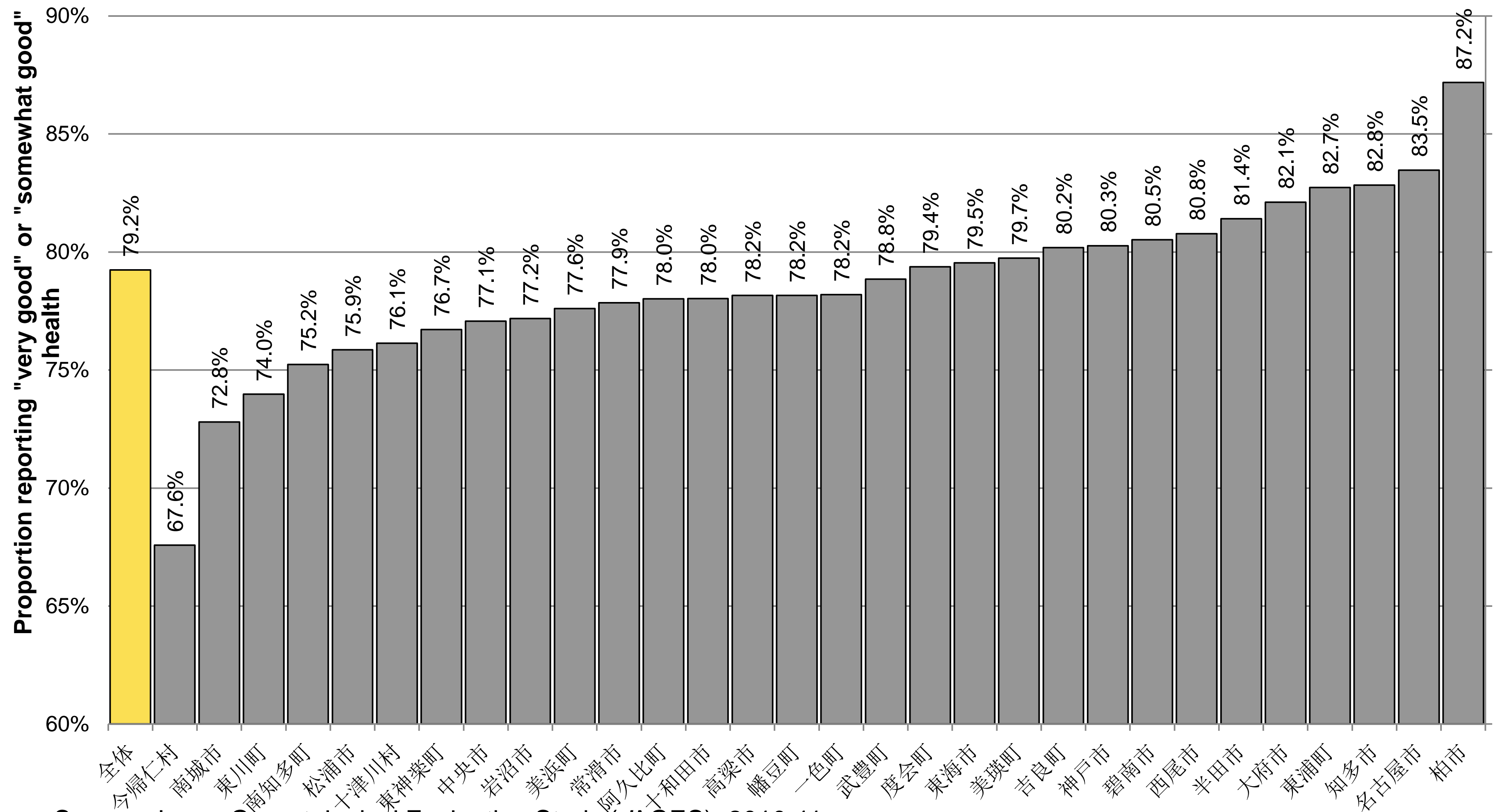
Economics

20. Average taxable income
21. Proportion of welfare benefits

Governance

22. Budget amount for projects to prevent the need for long-term care (per older individual)
23. Long-term care insurance premium (by income class)

Disparity in Subjective Health Status (65<)
Between Municipalities - Japan



Source: Japan Gerontological Evaluation Study (JAGES), 2010-11

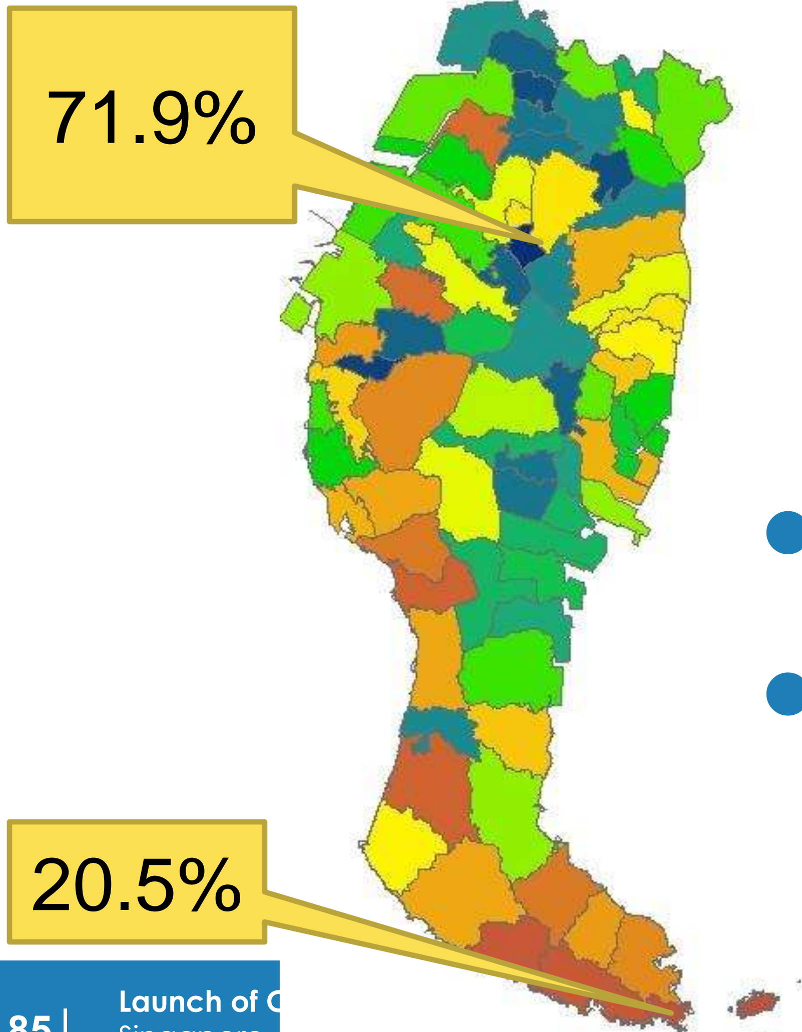
World Health Organization

Rate of falls from below 15% to over 45%

Percentage of people who fell down at least once in the past year (entire older population)
2010 survey

Proportion of people engaging in sports-related activities

Hirai, AGES Project
(2009, unpublished)



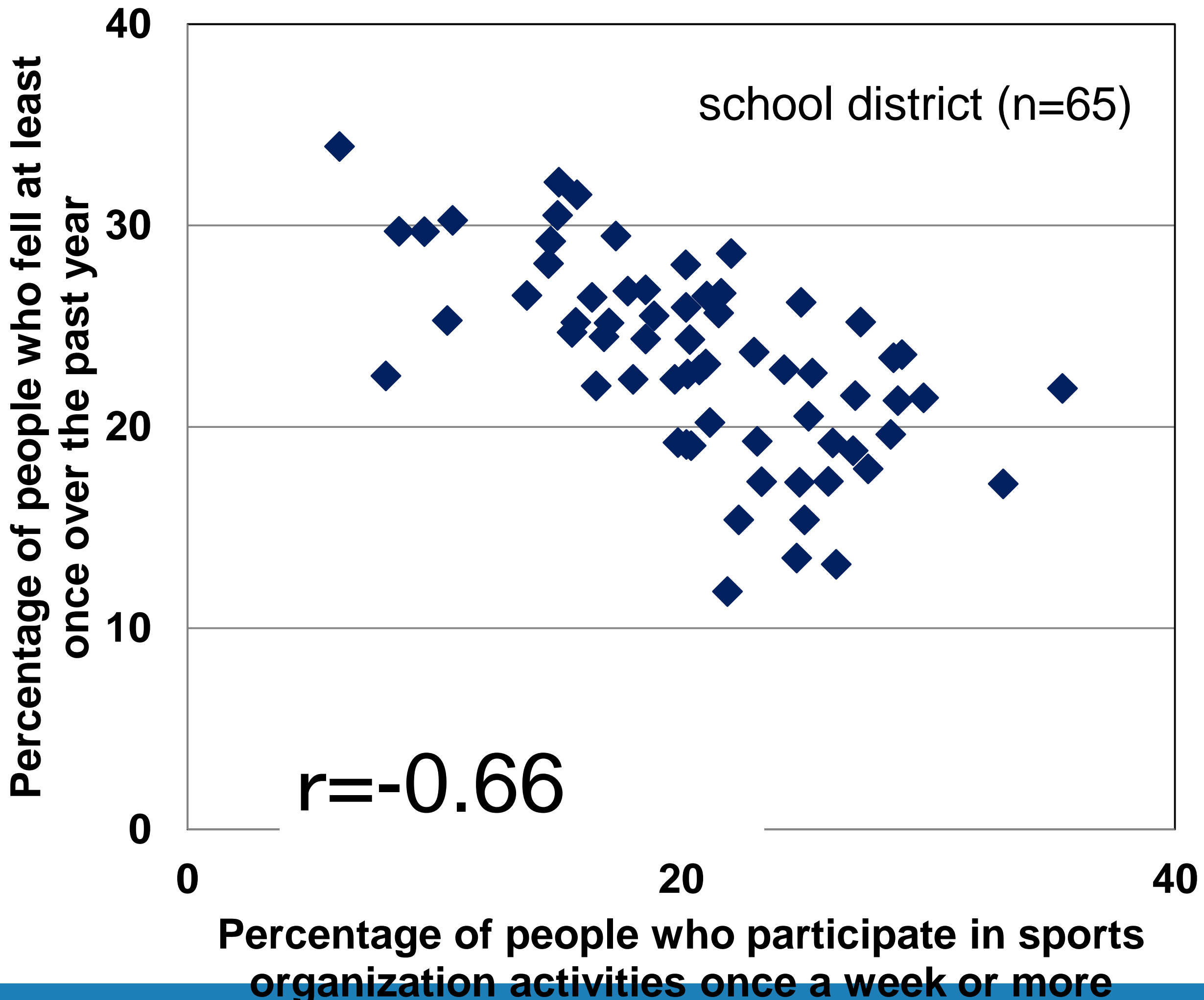
The percentage of all respondents (total n=15,515) who answered that they participate in sports activities (ground golf, gateball, walking, jogging, fitness, etc.)

- The difference 3.5 times
- After adjusting for age:

  21.6-67.4%

Fall rate and rate of sports organization participation by school district

Only 65-74 year olds (n=16,713)



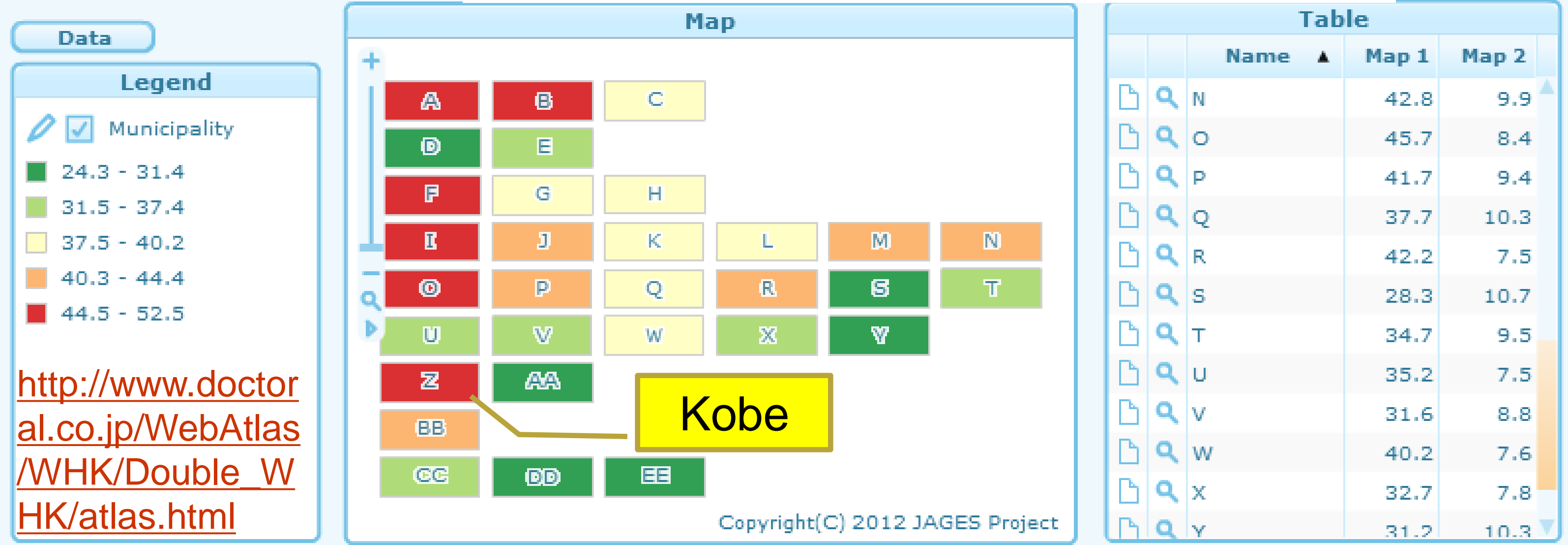
29072 people who responded to postal surveys (response rate: 62.4%) from among those who were not eligible to receive long-term care benefits from 6 insurers (9 municipalities)

Fall rate: 11.8-33.9%
Correlated to rate of sports organization participation

% of Participation in hobby group & Depression (GDS-15:>=10)
JAGES HEART 2011

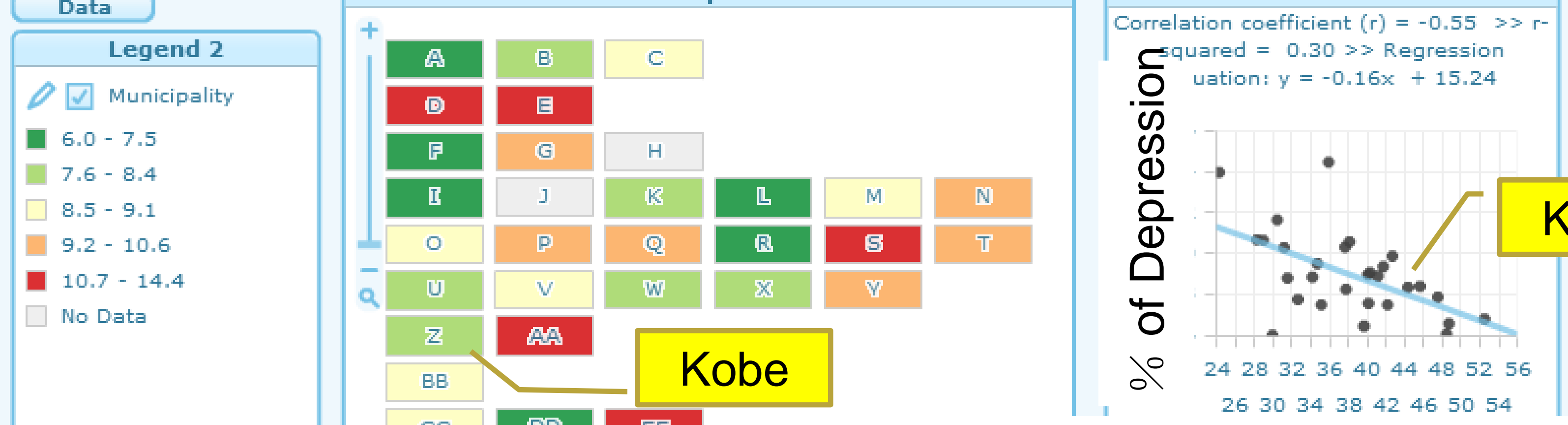
N=31 municipalities (limited to 75+ y.o.)

趣味グループ参加率 >> 後期高齢者



Name	Map 1	Map 2
N	42.8	9.9
O	45.7	8.4
P	41.7	9.4
Q	37.7	10.3
R	42.2	7.5
S	28.3	10.7
T	34.7	9.5
U	35.2	7.5
V	31.6	8.8
W	40.2	7.6
X	32.7	7.8
Y	31.2	10.3

リスク指標 老人用うつスケール10~15点の者の割合 >> 後期高齢者 >> 2010



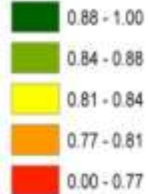
% of Participation in hobby group

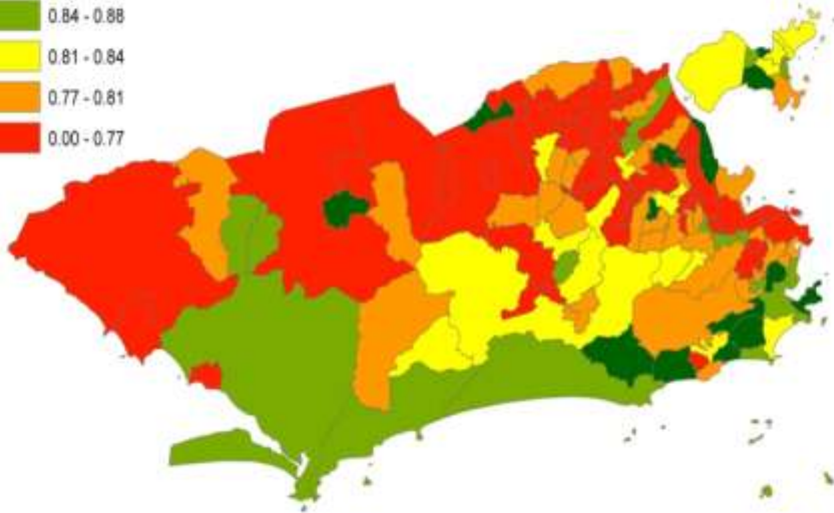
Label(A - EE) : Municipalities which participate in the JAGES Project.

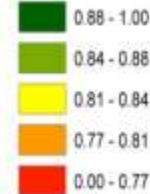
World Health Organization
Centre for Health Development

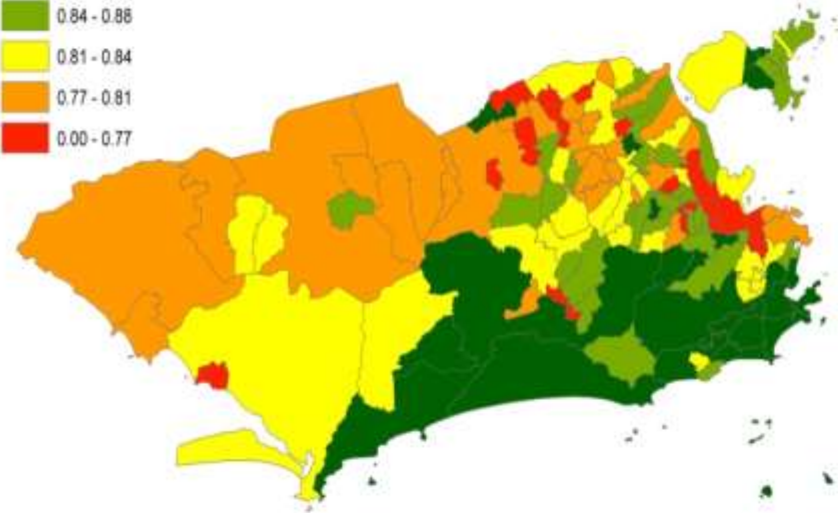
URBAN HEALTH INDEX

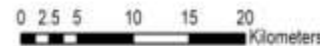
TRENDS IN MORTALITY: RIO DE JANEIRO











Neighbourhood analysis of Rio de Janeiro, Brazil
2002-2010
Urban Health Index of Mortality: *diabetes, ischaemic heart disease, breast/cervical cancer, HIV, TB, infant mortality, traffic accidents, homicides*

Moving forward will require:

- Political commitment
- Advocacy
- Strengthened partnerships

Conclusions

Key moment in history
to plan and be opportune to transform systems for more inclusive, person-centred approaches and services for healthy and active ageing.

Conclusions

Social protection and social security systems still lack comprehensive coverage and fall short of providing adequate levels of support

Focus on inequities, their causes, and actions to redress

Self-care, older persons living with functional and cognitive impairments and with disabilities need to be addressed more significantly

Transforming systems and expanding innovation, with monitoring and evaluation, required.

Further exploration of new models of care/support, and role of technology enablers.

Conclusions

Focus more on the impact of ageing as significant gaps remain in the preparation for and adjustment to an ageing future; impact on sustainability of UHC programmes

Integrate health and social care;
Reduce complex, fragmented systems
Pay attention to collaboration and common cultures between services and professionals

Engage individuals in their care across the life course; focus on prevention and early intervention

Develop new financial incentives and social/health insurance models

Conclusions

Successful self-care and family care requires support – small amounts of practical and emotional support and access to information and advice are key

Proactive shaping of markets to ensure they deliver the variety and quality of services people need

Reduce stigma (especially for dementia) and change attitudes towards ageing

Monitor the impact of interventions

CommSA@Whampoa

- A bold experiment and effort to inform all of us
- We look forward to engaging with you, sharing and learning from you.

WHO Resources

- **Ageing and Health**
  - WHO Ageing and Life Course http://www.who.int/ageing/en/
  - Age-friendly World http://agefriendlyworld.org/en/
- **WHO Centre for Health Development (WHO Kobe Centre)**
  - http://www.who.int/kobe_centre/en/
- **WHO WPRO**
  - http://www.wpro.who.int/topics/ageing/en/
- **Social Determinants of Health**
  - WHO Social Determinants of Health http://www.who.int/social_determinants/en/
  - Action: SDH http://www.actionsdh.org/examples.aspx

Webpage

www.who.int/kobe_centre

E-mail

wkc@who.int

Thank you!

Regional framework for action on ageing and health: Action pillars

1. Foster age-friendly environment 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
4. Strengthen the evidence-base on ageing and health

Proportion of population aged 60 and over, 2012 and 2050

(Darkest colour = 30% or more)