BRIEFING PAPER

MAJOR DEVELOPMENTS IN HEALTH AND AGEING

PREPARED BY

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Note: The views expressed herein are for information, debate, and discussion and do not necessarily represent formal policies of AARP.

Global Ageing and Public Health

Worldwide population ageing raises fundamental questions for health policy-makers[1]. How to help population remain independent and active as they age? How to strengthen ageing-related health promotion and prevention policies? As people live longer, how can the quality of life in old age be improved? Will large number of older people bankrupt health care and social security systems? How to best balance the role of the family and the state when it comes to caring for people who need assistance as they grow older? How to support the major role that older people play as carers?

These questions apply to both the developed and the developing world, but are particularly pertinent to the latter as the pace and scope of ageing in developing countries are particularly challenging. Developed countries had become rich by the time they aged, developing countries are ageing faster within a context of poverty, without having fully addressed other pressing problems such as poor nutrition, high prevalence of infectious diseases, low educational levels, and lack of sanitation.

Epidemiological Transition

The reduction of infectious diseases has led to a considerable increase in life expectancy, resulting in increases in chronic and ageing-related conditions in parallel to unhealthy changes in lifestyles such as physical inactivity, smoking and unhealthy diet. This shift in disease pattern from communicable to non-communicable diseases (NCD) is known as the 'epidemiological transition.' Already pervasive in developed countries, this transition is now global adding extra burdens to countries still suffering from the burden of communicable diseases.

NCD and injury are fast becoming the leading causes of disability and premature deaths in all regions. From the total of 58 million deaths in 2005, they accounted for 35 million, 80% of which in developing countries.

The epidemiological transition, combined with fast population ageing, represents a challenge for public health and health care systems. Worldwide, older people with chronic diseases and disabilities are living longer than ever before, but with multiple and complex pathologies, which require appropriate health systems' responses.

From Acute Care to Chronic Care

Health systems play a pivotal role in the prevention and management of chronic conditions as well as in the promotion of health and wellbeing. They are therefore urgently required to respond to the epidemiological transition.

In order to compress morbidity and improve functional capacity of older persons, health care systems need organizational changes. Management and delivery of health services need to adopt holistic and integrated approaches. This shift requires a framework in which primary health care (PHC) moves away from the current acute care

[1] For an overview of the demographic transition see also the background paper prepared by the UN Population Division

focus to a chronic care model. PHC needs to respond to the lack of cohesiveness and coordination between services within and across settings - including community and home care. In addition, PHC needs to provide and promote the continuity from health promotion and disease prevention to integrated care including long term and terminal care. This requires a multidisciplinary perspective and community-based teamwork, ensuring coordination of activities across the entire continuum of care.

A Life Course Approach

There is increasing recognition of the importance of adopting a life course approach to health as individuals age. Ageing is a life-long process, which begins before we are born and continues throughout life. The functional capacity of our biological systems (e.g., muscular strength, cardiovascular performance, respiratory capacity, etc) increases during the first years of life, reaches its peak in early adulthood and naturally declines thereafter. The slope of decline is largely determined by external factors throughout the life course. The natural decline in respiratory function, for example, can be accelerated by factors such as smoking and air pollution, leaving an individual with lower functional capacity than would normally be expected at a particular age. Health in older age is therefore to the largest extent a reflection of individuals' circumstances and actions during the whole life span. Thus we can influence how we age by practicing healthier lifestyles and adapting to age-associated changes. However, some life course factors may not be modifiable at the individual level - such as economic disadvantages and environmental hazards that directly affect the ageing process and predispose to disease in later life.

A life course perspective calls on policy-makers and civil society to invest in the various phases of life, especially during key transition points when risks to well-being and windows of opportunity are greatest - to include 'in utero' development, early childhood, adolescence, transition from school to the workforce, parenthood, menopause, and widowhood. Policies that reduce inequalities protect individuals at these critical times.

Active Ageing - Concept and Definition

The World Health Organization launched at the Madrid Assembly the "Active Ageing Policy Framework". The concepts and principles enunciated in this document have since been widely implemented in policy formulation in both developed and developing countries. The Policy Framework called on policy makers, practitioners, NGOs and civil society to optimize opportunities for health, participation and security in order to enhance quality of life for people as they age. This requires a comprehensive approach that takes into account the gendered and the cultural nature of the life course.

A Determinant of Healthy, Active Ageing Approach

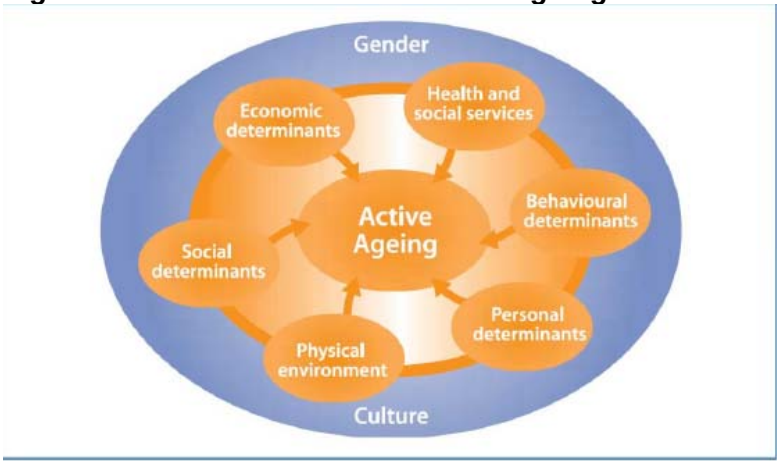
There is now clear evidence that health care and biology are just two of the factors influencing health. The social, political, cultural, and physical conditions under which people live and grow older are equally important.

Active ageing depends on a variety of "determinants" that surround individuals, families and societies. These factors directly or indirectly affect well-being, the onset and progression of diseases and how people cope with them. The determinants of active ageing are interconnected and the interplay between them is important. For example,

older people who are poor (economic determinant) are more likely to be inadequately housed (physical environment), may suffer violence (social determinants) and not eat nutritious foods (behavioural determinants).

Figure 1 shows the major interconnected determinants of active ageing. Gender and culture are cross-cutting factors that affect all others.

Figure 1. The determinants of active ageing



Active Ageing Determinants: Health and Social Services

In order to be comprehensive, health systems should provide a continuum of gender - and age-responsive care from health promotion and prevention to acute and palliative care.

In many settings, ageing women do not have the same access to health care as men or younger women. For example, in many countries, older women are less likely to receive cataract surgery and eye care due to the costs, gender and age discrimination, and lack of support for and information about treatment. Health inequities may be the result of direct or indirect gender and age discrimination, low financial status and limited access to health security schemes.

Current important issues:

- Strengthening PHC services
- Incentives for health promotion/ disease prevention interventions
- More attention to mental health in older age
- Issues related to long-term care and end of life
- Minimum curricula in old age care: all future health professionals should receive comprehensive training

Example of WHO's response: age friendly PHC

Strengthening PHC capacity to deal with older persons' needs is the critical for both developing and developed countries if the "highest possible number of older persons are to remain living in their communities, with their families, enjoying the highest possible level of quality of life for as long as possible". The "WHO Age friendly PHC Centres" project aims to make PHC more accessible and user-friendly for the growing numbers of older persons throughout the world and thereby contribute to better prevention and

improved management of chronic diseases. Accordingly, an "Age-friendly PHC Centre Toolkit" reflecting general principles on how PHC workers can better respond to the needs of older persons was developed. Piloting and evaluating of this toolkit is proceeding in several developing countries (completion by mid-2007).

Active Ageing Determinants: Personal

It has been estimated that only twenty to twenty-five percent of variability in the age at death is explained by genetic factors and although biology and genetics are key determinants of health in older age, evidence suggests that factors related to gender-influenced roles and socio-economic status are also important in determining health and well-being in older age. However, it is often difficult to disentangle all these different factors. The influence of genetic factors on the development of chronic conditions also varies significantly. For example, some individuals have a genetic predisposition to certain types of cancer; however, even when this risk is high, it is not a foregone conclusion that they will develop the disease in their lifetime. Moreover, sex and gender commonly interact in synergistic ways. While women live longer than men, they experience more disability and co-morbidity than men in older age. At the same time, gender related coping mechanisms and personality features might make some individuals more easily adaptable to ageing-related changes than others.

Current important issues:

- How to address inequalities in health in older age, particularly those related to gender and socio-economic differences
- How to 'train' individuals to adapt and cope with adverse effects of ageing
- As the knowledge about the human genome unfolds how to extend the benefit to the largest possible number of ageing individuals.

Example of WHO's response: falls prevention

Most falls in older age could be prevented - thus avoiding incalculable human suffering and economic costs. Injuries caused by falls are a major cause of reduced quality of life in older age: disability, chronic pain, loss of autonomy, and declining opportunities for social participation. Annually 28-35% of older people experience falls leading to millions of housebound older people worldwide. Falls affect the course of active ageing and increase the care burden. WHO is currently preparing a Global Report on falls prevention in older age, which includes international and regional perspectives, and offers recommendations based on best practices and policy strategies based on effective interventions.

Active Ageing Determinants: Behavioural

Much of the physical decline that occurs with ageing is related to health behaviours particularly those related to poor nutrition, physical inactivity, smoking and excessive alcohol consumption. Preventive interventions based on these four risk factors have a huge impact on health in older age. Yet, health services are not, by and large, geared towards health promotion and disease prevention. The message that ''*it is never too late*" needs to be disseminated more decisively.

Current important issues:

- Development of culturally appropriate, gender responsive guidelines for the four main risk factors for NCD.
- Effective use of media

- Adequate training of health professionals on behavioural change, particularly at PHC level.

Example of WHO's response: "Integrated Health Systems Response to Rapid Population Ageing in Developing Countries (INTRA)"

To better understand the real and perceived factors influencing older persons' health-seeking behaviour, quantitative and qualitative research, entitled INTRA, was conducted in 18 developing countries. INTRA consisted of a series of three research projects each focusing on the development of sustainable PHC policies addressing population ageing in developing countries.

To further understand the multiple and complex health care and social needs of older people, INTRA's overall focus was on assessing the responsiveness and preparedness of the PHC sector and on making recommendations for reorienting the delivery of PHC services to assist older person more appropriately.

INTRA I, the first in the series of the INTRA project, aimed at investigating the problems associated with the promotion and protection of the health of older people and explored how age-related chronic conditions could be prevented, and better managed through the PHC system. The INTRA II project aimed at providing in-depth information on the current provisions of health and social services for older persons and exploring the opportunities for their improvement through the perspectives of three groups of stakeholders - health care providers, users, and policy maker. INTRA III project, focused on understanding health and non-health seeking behaviours of non-users of PHC services.

Active Ageing Determinants: Social

Health in older age requires close attention to important social influences, such as education and literacy; violence and abuse; ageism and social exclusion; human rights; social support; and leadership and empowerment.

People with low educational levels have shorter lives and fewer years in good health. This inequality in health expectancy is greater in women than men, reflecting the high levels of illiteracy and lower educational levels among older women.

Furthermore, social exclusion is often the result of discrimination based on gender, age, race, ethnicity, ability and socioeconomic status. In many societies, widows are particularly vulnerable to social exclusion. Older people in countries in transition often experience a deep sense of social isolation, in the face of political and social upheavals and unemployment.

Current important issues:

- Policy and practices that encourage social support and discourage social exclusion need to be fostered.
- The agenda on human rights need to address ageism and adapt a rights -based rather than a needs-based approach.
- Emergency situations such as natural disasters are becoming more common, and increasingly affecting ageing societies.

Example of WHO's response: Emergency situations

The situation of older persons within families and communities is both a source of vulnerability and of contribution when humanitarian emergencies occur, whether from

natural causes or as a result of conflicts. Older persons both receive and provide care and support within families: when the support of family members is disrupted in emergencies, older persons may be especially vulnerable. Because they often care for children, older persons face a "double protection burden" in crises. Older persons contribute to emergency response in many ways besides providing care, for instance, they provide the voice of experience and spiritual strength in coping based on previous emergencies, knowledge of the surroundings and the community. WHO is collaborating with government and non-governmental partners to examine case studies of several major emergencies and develop recommendations to improve the inclusion of older persons' needs and contributions in emergency planning, response and recovery.

Active Ageing Determinants: Economic

Three aspects of the economic environment have a particularly significant effect on active ageing: income, work and social protection.

Income: Active ageing policies need to intersect with broader schemes to reduce poverty at all ages. While poor people of all ages face an increased risk of ill health and disabilities, older people are particularly vulnerable.

Social protection: In all countries, families provide the majority of support for older people who require help. However, as societies develop and the tradition of generations living together begins to decline, countries are increasingly called to develop mechanisms that provide social protection for older people who are unable to earn a living and are alone and vulnerable.

Work: if more people enjoyed better opportunities for decent work (properly remunerated, in adequate environments, protected against risks) earlier in life, people would reach old age in better health and able to continue participate in the labour force; all of society would benefit.

Recently gathered evidence from developed countries shows that health care costs are concentrated in the last year - or last three years - preceding death, and that the older an individual is at time of death, the lower in relative terms are the associated costs.

Current important issues:

- More research on end of life care costs
- Health care costs: the interface with social security systems
- Private-public partnership
- Mechanism to protect the poor in all countries
- Evaluation of long-term care funding scheme

Example of WHO's response: age friendly cities

In the context of rapid urbanization, and of high increasing concentrations of older persons in cities, promoting active ageing in urban communities is a major current WHO focus. An "age-friendly city" which values accessibility and inclusion in all aspects of urban life addresses the economic determinants of active ageing by minimizing inequalities and enhancing opportunities for participation and security. Over thirty cities around the world are collaborating in a WHO initiative to consult older persons from differing socio-economic levels to determine existing opportunities and barriers in access to appropriate housing, transportation, social, cultural, recreational and civic activities, community support services, as well as opportunities for income-generating activity. In partnership with older persons, collaborating cities will use the local information to inform

urban policies and practices. Based on the research findings in all cities, WHO will develop a global Age-Friendly City Index to guide policy development.

Active Ageing Determinants: Environmental

Physical environments that are age friendly can make the difference between independence and dependence for all individuals but are of particular importance for those growing older. For example, older people who live in an unsafe environment or areas with multiple physical barriers are less likely to get out and therefore more prone to isolation, depression, reduced fitness and increased mobility problems. Specific attention must be given to older people who live in rural areas, to accessible and affordable public transportation services, and to hazards in the physical environment that can lead to debilitating and painful injuries among older people including within the home environment. Attention should be paid not only to the physical but also to the social environment.

Current important issues:

- Elder abuse in all its forms is prevalent in all societies and its prevalence is likely to increase as a reflection of fast population ageing. Advocacy, training and legal frameworks need to be strengthened.
- A "society for all ages" needs to adopt comprehensive, multisectoral policies embracing the principles of 'universal design'

Example of WHO's response: PHC to deal with elder abuse

WHO defines elder abuse as 'a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to all older people. At the Madrid Assembly, WHO launched with multiple partners a report, based on the first-ever international study on elder abuse 'missing voices.' Since then the Organization has focused on strengthening PHC preparedness to prevent and appropriately deal with this worldwide problem.

Main Challenges for Healthy Ageing

Supporting and promoting optimum health through policy and practice as people grow older is a pivotal investment in the wellbeing of individuals, families and society. WHO is, for instance, collaborating as a partner with European countries and NGOs in systematic efforts to assess the best available evidence on interventions that effectively promote healthy ageing, formulate recommendations based on the evidence and facilitate their implementation in the European Union and beyond. The project has confirmed the efficacy of key health promotion interventions that include promoting physical activity, supporting smoking cessation, preventing falls, fostering supportive social networks and voluntary engagement and providing preventive health services such as immunization and home care. A review of policies and interventions across jurisdictions shows significant gaps in the implementation of effective practice. Policy statements can be vague in their commitment to ageing, or they may focus on a few determinants and policy sectors only (such as health care services). A problem encountered in many community-based programmes is the lack of stable resources to ensure sustainability, or the resources to adequately measure outcomes. Of still greater concern is the shortage of efforts to reach the hard-to-reach and address inequalities in health related to gender, culture and socio-economic disadvantage. To realize the potential of the "longevity dividend", the critical challenge addressed to governments

worldwide is to implement systematic, sustained and multisectoral "healthy, active ageing" policies that include all older persons, with particular emphasis on reaching disadvantaged, hard-to-reach groups. While the above mentioned project is project is focused on Europe, the knowledge gained is relevant worldwide.