

A large, stylized graphic of several hands in various shades of blue, reaching upwards and overlapping each other, forming a shape reminiscent of the letter 'A'.

Health and Ageing

A Discussion Paper





This paper is intended to contribute to an informed debate on healthy and active ageing during the preparations for the Second UN World Assembly on Ageing 2002. The first version of the paper is being released as a document for discussion. For comments or additional copies please contact the following email address: activeageing@who.int

The final version of the paper and a complementary monograph entitled *Active Ageing: From Evidence to Action* will subsequently be published as a contribution to the Second UN World Assembly on Ageing in Madrid (April 2002). Both publications are the result of collaboration between WHO (Department of Health Promotion, Non-Communicable Disease Prevention and Surveillance) and Health Canada.



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How Old is Older?

For the purposes of this paper, “older” people are women and men age 60 and over. This may seem “young” in some developed areas where most people over age 60 enjoy a positive standard of living and good health. Age 60, however, is likely to be a realistic expression of older age in developing countries among people who have not had the advantages in earlier life that lead to a healthy old age. Moreover, age 60 and over is currently being used in all UN demographic projections to describe “older” ages. At the same time, it is important to acknowledge that chronological age is not always the best marker for the changes that accompany ageing. Variations in health status among individual older people of the same age can be dramatic. Decision-makers need to take both of these factors into account when designing policies for their “older” populations.

This text was prepared by Peggy Edwards, a consultant based for six months at WHO under the sponsorship of Health Canada (the Canadian Ministry of Health). The process of preparing the document was guided by Alex Kalache and Irene Hoskins and assisted by Ingrid Keller (WHO, Department of Health Promotion, Non-Communicable Disease Prevention and Surveillance).



1. Global Ageing: A Triumph and A Challenge

Viewed as a whole the problem of ageing is no problem at all. It is only the pessimistic way of looking at a great triumph of civilization. ... Notestein, 1954

Population ageing is one of humanity's greatest triumphs. It is also one of our greatest challenges. As we enter the 21st century, global ageing will put increased economic and social demands on all countries. At the same time, older people provide a precious, often-ignored resource that makes an important contribution to the socioeconomic fabric of our lives.

Population ageing raises some worrisome questions for policy-makers. Will a proportionately smaller number of working adults be able to provide the support that older people need? Will large numbers of older people bankrupt our health care and social security systems? How do we help older people remain independent and active? How do we best balance the role of the family and the state when it comes to caring for older people who need assistance? How can we best make use of older people's wisdom, experience and talents? Now that people are living longer, how can we improve the quality of life in old age?

This paper is designed to address these questions and other concerns about ageing. It is directed toward decision-makers in governments at all levels, the nongovernmental sector and the private sector.

The World Health Organization suggests that we can afford to get old if countries, regions and international organizations enact "active ageing" policies and programmes that enhance the health, independence and productivity of older citizens. The time to plan and to act is now. In all countries, but in developing countries in particular, measures to help older people remain healthy and economically active are a necessity, not a luxury.

These policies should be based on the real needs, preferences and capacities of older people. They also need to take a life course perspective that recognizes the influence of earlier life experiences and does not compromise the needs of future older citizens.

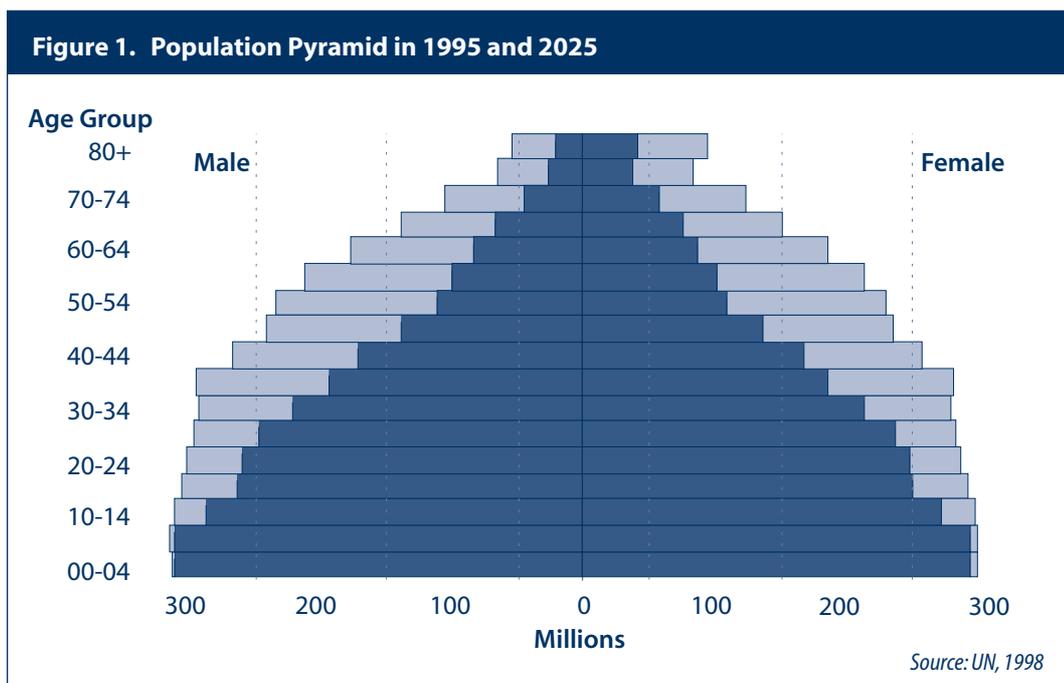
Purpose and Use of This Paper

This paper is designed to stimulate discussion and action among decision-makers who are formulating policies and programmes on ageing.

- Part 1 describes the rapid worldwide growth of the population over age 60, especially in developing countries.
- Part 2 discusses five key challenges associated with an ageing population for governments, the non-governmental sector and the private sector.
- Part 3 explores the concept and rationale for “active ageing” as a goal for policy and programme formulation. Active ageing is built on three pillars: health and independence, productivity, and protection.
- Part 4 summarizes the evidence about the factors which determine whether or not individuals and populations will enjoy independence, productivity and a positive quality of life in older age.
- Part 5 provides a policy framework and concrete suggestions for key policy proposals. These can be readily integrated into national and international plans for action being developed for the Second United Nations Assembly on Ageing which will take place in 2002.

The Demographic Revolution

World-wide, the proportion of people age 60 and over is growing faster than any other age group. Between 1970 and 2025, a growth in older populations of some 870 million or 380% is expected. In 2025, there will be a total of about 1.2 billion people over the age of 60.



As the proportion of children and young people declines and the proportion of people age 60 and over increases, the triangular population pyramid of 1995 will be replaced with a more cylinder-like structure in 2025.



The shift in age distribution is most often associated with the more developed regions of the world. What is less appreciated is the speed and significance of population ageing in less developed regions. Already, most older people live in developing countries. These numbers will continue to rise at a far more rapid rate than in developed countries. It is estimated that by 2025, some 840 million people over the age of 60 will live in developing countries. This will represent 70 percent of all older people worldwide.

Between 1995 and 2020, in Europe and North America the working age share of the population will have declined from 62 percent to

58 percent, and those age 60 and over will make up about one-quarter of the population. Among individual countries, the most aged is Italy, with 24 percent of the population aged 60 or over in 2000 (see Table 1). Japan and many other European countries have percentages nearly as high.

Decreasing fertility rates and increasing longevity will ensure the continued “greying” of the world’s population, despite setbacks in life expectancy in some African countries (due to AIDS) and in some newly independent states (due to increased deaths caused by cardiovascular disease and violence). Sharp decreases in fertility rates are being observed throughout the world. It is estimated that by 2020, 121 countries will have reached total fertility rates below replacement level (average fertility rate of 2.1 children per woman), a substantial increase compared to 1975, when just 22 countries had a total fertility rate below or equal to the replacement level. The current figure is 68 countries.

As the proportion of children and young people declines and the proportion of people age 60 and over increases, the triangular population pyramid of 1995 will be replaced with a more cylinder-like structure in 2025 (see Figure 1).

Table 1. Percentage of Population Aged 60 Years Or Over in Selected Countries, 2000 and 2050

Country	2000	2050
Italy	24%	41%
Germany	23%	35%
Japan	23%	38%
Spain	22%	43%
Czech Republic	18%	41%
USA	16%	28%
China	10%	30%
Thailand	9%	30%
Brazil	8%	23%
India	8%	21%
Indonesia	7%	22%
Mexico	7%	24%

Source: UN, 1998

2. Challenges of an Ageing Population

The challenges of population ageing are global, national and local. Meeting these challenges will require innovative planning and substantive policy reforms in developed countries and in countries in transition.

Developing countries, most of whom do not yet have comprehensive policies on ageing, may face the biggest challenges of all.

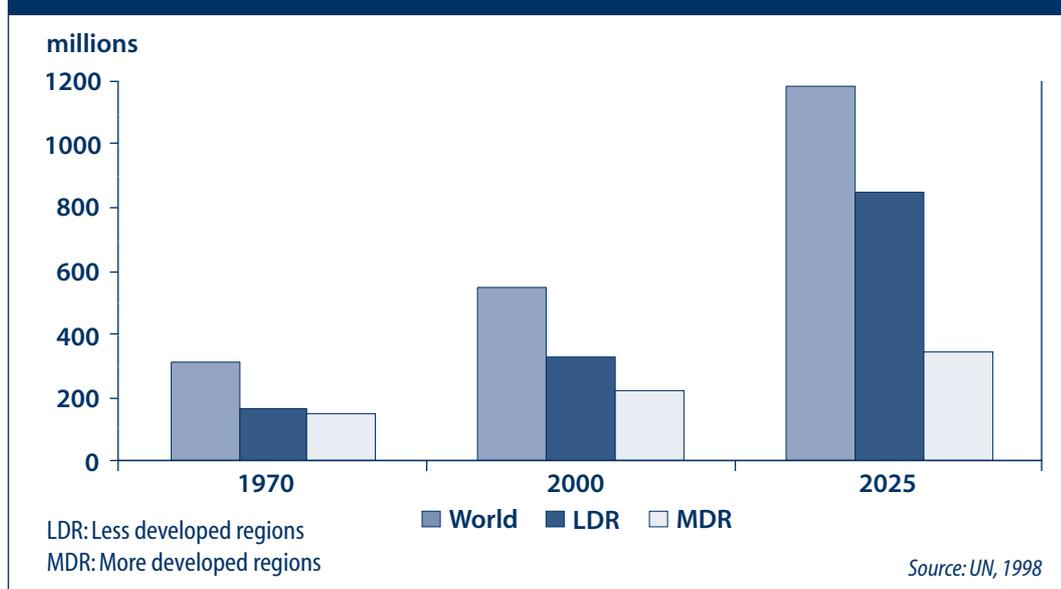
Challenge #1: Rapid Population Ageing in Developing Countries

In 2000, 62 percent of those aged 60 and over lived in less developed regions (see also Figure 2). By 2050, this will increase to 80 percent. In terms of regions, the majority of the world's older people live in Asia (with the largest numbers in Eastern Asia and

China). Asia's share of the world's oldest people will continue to increase the most while the share of Europe will decrease the most over the next 25 years (see Figure 3).

In developing countries socioeconomic development has often not kept pace with the rapid speed of population ageing. For example, while it took 115 years for the proportion of older people in France to double from 7 to 14 percent, it will take China only 27 years to achieve the same increase. Thus, while developed countries grew affluent before they became old, developing countries are growing old before a substantial increase in wealth occurs.

Figure 2. The Numbers of People Over Age 60 in Less and More Developed Regions, 1970, 2000 and 2025





Rapid ageing in developing countries is accompanied by dramatic changes in family structures and roles, as well as in labour patterns and migration. Urbanization, the migration of young people to cities in search of jobs, smaller families and more women entering the formal workforce means that fewer people are available to care for older people when they need assistance.

Challenge #2: Disability and the Double Burden of Disease

As nations age, in parallel to changing living and working conditions, a shift in disease patterns becomes inevitable. These changes hit developing countries the hardest. Even as these countries continue to struggle with infectious diseases, malnutrition and complications from childbirth, they are faced with the rapid growth of non-communicable diseases. This “double burden of disease” strains already scarce resources to the limit.

The shift from communicable to noncommunicable diseases is fast occurring in most of the developing world, where chronic illnesses such as heart disease, cancer and depression are quickly becoming the leading causes of death and disability. This trend will escalate over the next century. In 1995, 51 percent of the global burden of disease in developing and newly industrialized countries was caused by non-communicable diseases, mental health disorders and injuries. By 2020, the burden of these diseases will rise to approximately 70 percent (see Figure 4).

There is no question that policy makers and donors must continue to put resources toward the control and eradication of infectious diseases. But it is also critical to put policies, programmes and intersectoral partnerships into place that can help to halt the massive expansion of chronic, non-communicable

Figure 3. Distribution of World Population Over Age 60 by Region, 1995 and 2025

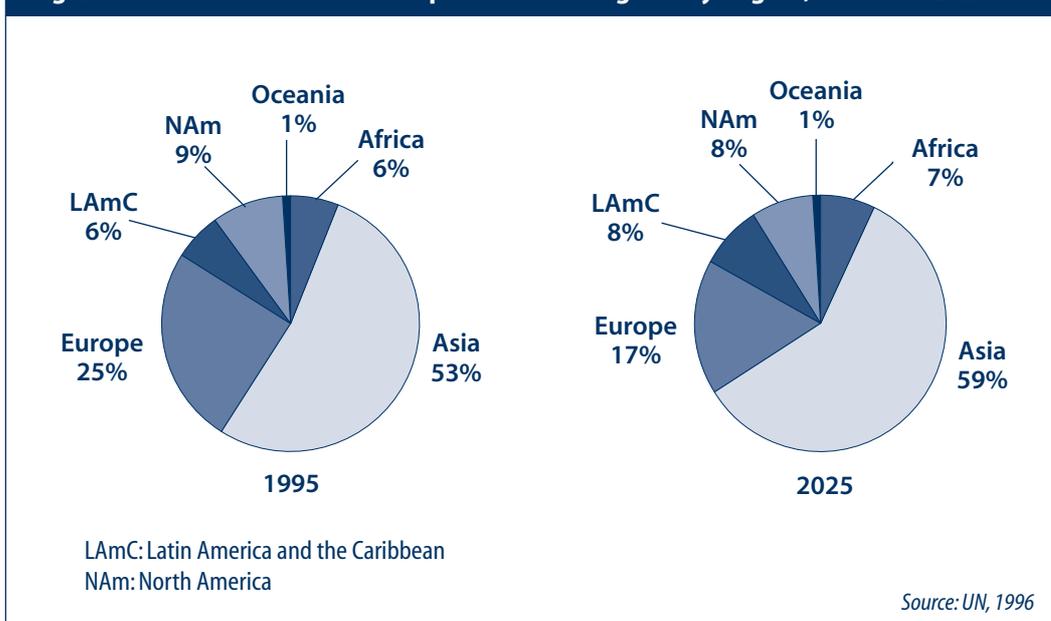
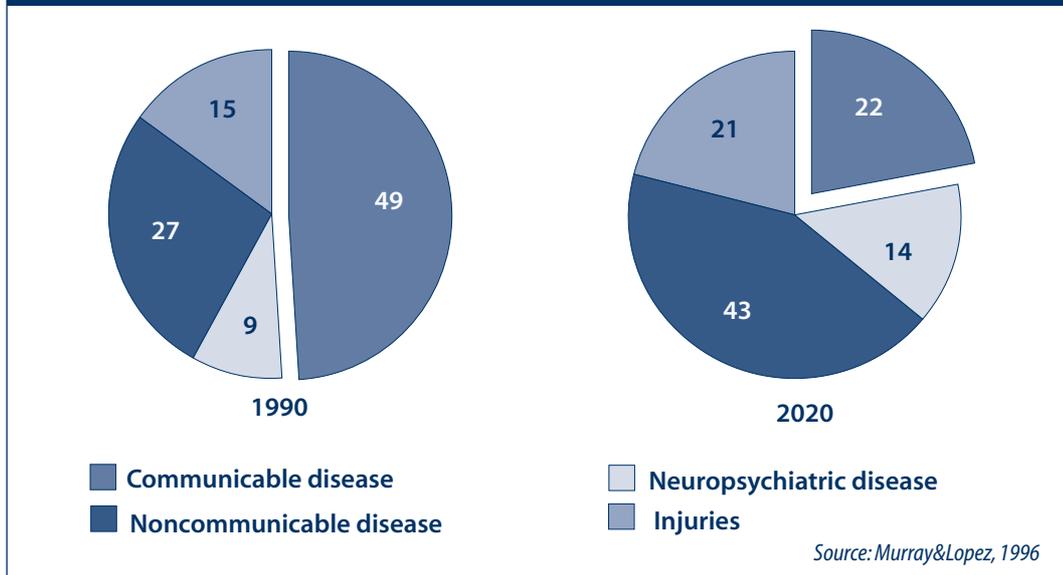


Figure 4. Global Burden of Disease 1990 and 2020 Contribution by Disease Group in Developing and Newly Industrialized Countries



By 2020, over 70 percent of the global burden of disease in developing and newly industrialized countries will be caused by non-communicable diseases, mental health disorders and injuries.

diseases. Those that focus on community-based development, health promotion, disease prevention and increasing productivity are relatively inexpensive but have received little attention so far. Other long-term policies that target malnutrition and poverty will help to reduce both communicable and non-communicable diseases.

In both developing and developed countries, chronic diseases are significant and costly causes of disability and reduced quality of life. An older person's independence is threatened when physical or mental disabilities make it difficult to carry out the basic "activities of daily living" (ADLs) such as bathing, eating, using the toilet and walking across the room, and the "instrumental activities of daily living" (IADLs) such as shopping and meal preparation.

The likelihood of experiencing major disabilities dramatically increases in very old age. Significantly, older adults over the age of 80 are the fastest growing age group within the 60-plus population.

But disabilities associated with ageing can be prevented or delayed. For example, there has been a significant decline over the last 20 years in age-specific disability rates in the U.S.A, England, Sweden and other developed countries. As populations around the world live longer, policies and programmes that help prevent and reduce the burden of disability in old age are urgently needed in both developing and developed countries.

A life course perspective on ageing recognizes that individual diversity tends to increase with age and that older people are not one homogeneous group. Interventions that



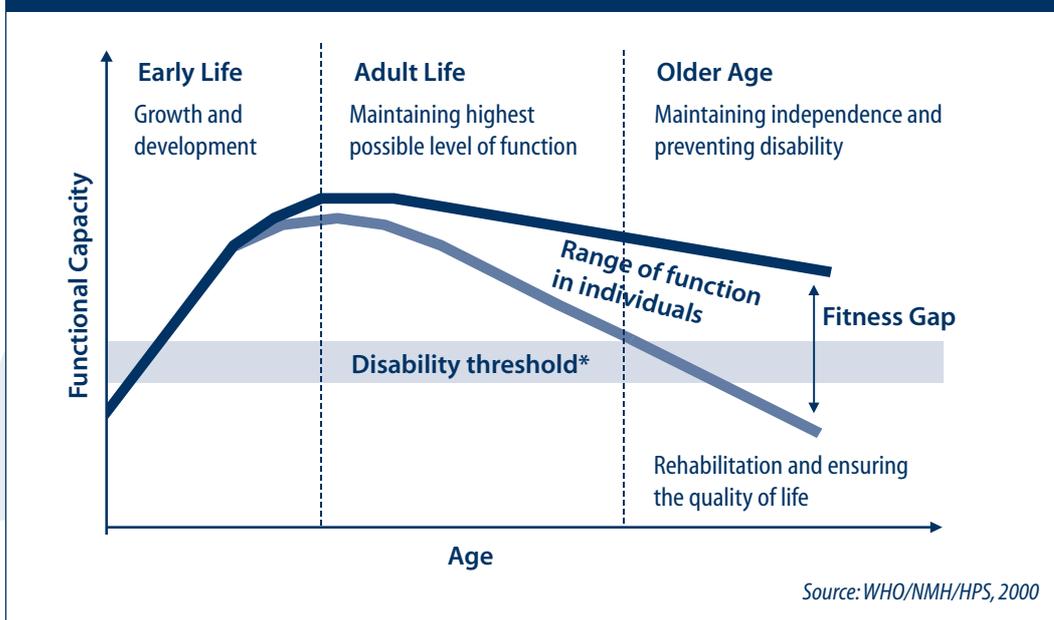
create supportive environments and foster healthy choices are important at all stages of life.

A life course perspective supports activities in early life that are designed to enhance growth and development, prevent disease and ensure the highest capacity possible. In adult life, interventions need to support optimal functioning and to prevent, reverse or slow down the onset of disease. In later life, activities need to focus on maintaining independence, preventing and delaying disease and improving the quality of life for older people who live with some degree of illness or disability (see Figure 5).

One useful way to look at decision-making in this area is to think about enablement instead of disablement. Disabling processes increase the needs of older people and lead to isolation and dependence. Enabling processes restore function and expand the participation of older people in all aspects of society.

A variety of sectors can enact “age-friendly” policies that prevent disability and enable those who have disabilities to fully participate in community life. For example, city governments can offer well-lit streets for safe walking and appropriate transport systems. Recreation services can offer exercise programmes that help older people maintain their mobility or recover the leg strength they

Figure 5. Functional Capacity over the Life Course



Functional capacity (such as ventilatory capacity, muscular strength, cardio-vascular output) increases in childhood and peaks in early adulthood, eventually followed by a decline. The rate of decline, however, is largely determined by factors related to adult life style – such as smoking, alcohol consumption, levels of physical activity, and diet – as well as external and environmental factors. The gradient of decline may become so steep as to result in premature disability. However, the acceleration in decline can be influenced and may be reversible at any age through individual as well as policy measures.

* Changes in the environment can lower the disability threshold thus decreasing the number of disabled people in a given community.

need to be mobile. The education sector can offer life-long learning and literacy programmes. Social services can provide hearing aids or instruction in sign language that enables older people who are hard of hearing to continue to communicate with others. The health sector can offer enabling rehabilitation programmes as well as cost-effective procedures such as cataract surgery and vaccinations against influenza. Governments and international agencies can offer credit schemes and businesses can modify the work environment so that older people can continue to earn an income and to participate in development activities.

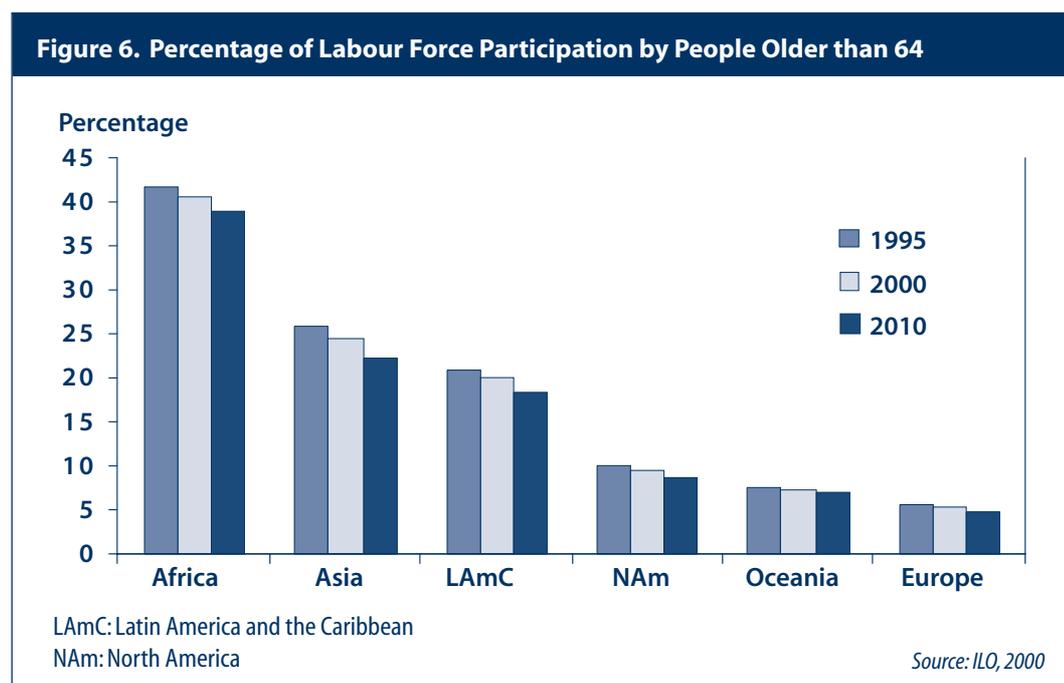
Researchers need to better define and standardize the tools used to assess ability and disability and to provide policy makers with additional evidence on key enabling processes in the broader environment, as well as in medicine and health. Careful attention needs to be paid to gender differences in these analyses.

Support for relevant research is most urgently needed in the less developed countries.

Currently, low and middle-income countries have 85 percent of the world's population and 92 percent of the disease burden, but only 10 percent of the world's health research spending (WHO, 2000).

Challenge #3: Changing An Outdated Paradigm

Traditionally, old age has been associated with sickness, dependence and a lack of productivity. Policies and programmes that are stuck in this out-dated paradigm do not reflect reality. Indeed, most people adapt to change with age and remain independent well into very old age. Especially in developing countries, they continue to work in paid and unpaid work (see Figure 6 for paid work). In all countries, the voluntary activities of older people make an important contribution to society.



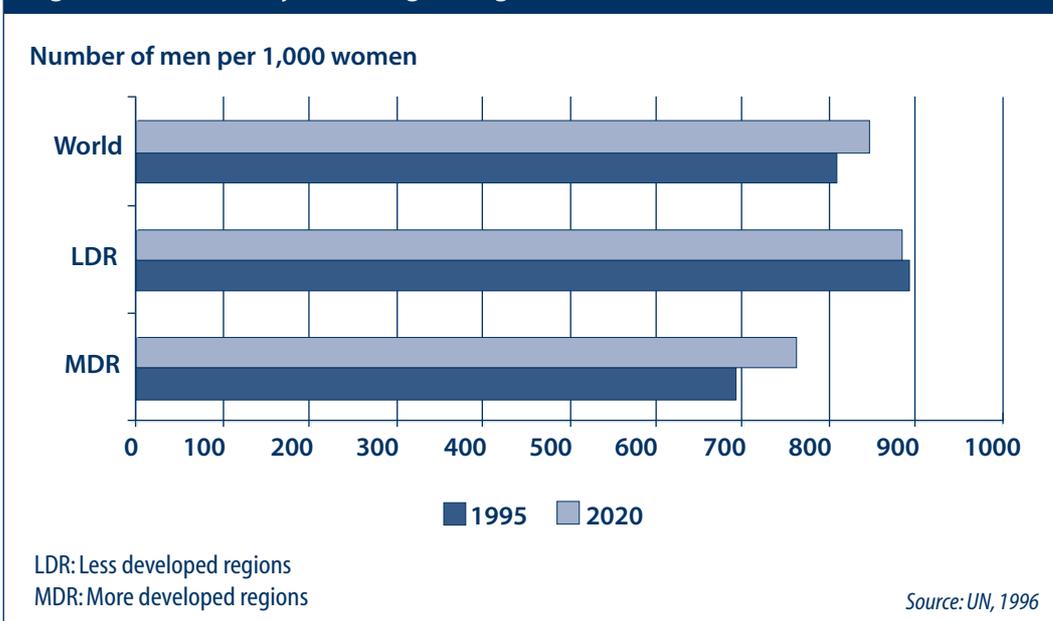


Disease onset and the functional decline that is associated with growing older can be prevented or slowed down at any age. For example, modest increases in physical activity or quitting smoking even in older age can significantly reduce one's risk for heart disease. "Age-friendly" changes in the work environment (such as modifying strenuous agricultural work to lighter tasks) and in the community (such as providing traffic lights that give older people more time to cross the street) enable older people with disabilities to remain independent and productive.

It is time for a new paradigm, one that views older people as active participants in an age-integrated society and as active contributors as well as beneficiaries of development.

This paradigm takes an intergenerational approach that recognizes the importance of relationships and support among and between family members and generations. It reinforces "a society for all ages" – the central focus of the 1999 United Nations International Year of Older Persons. It also challenges the traditional view that learning is the business of children and youth, work is the business of midlife, and retirement is the business of old age. The new paradigm calls for programmes that support learning at all ages and allow people to enter or leave the labour market in order to assume caregiving roles at different times over the life course. This approach will support intergenerational harmony and provide increased security for people in their old age.

Figure 7. Sex Ratios by World Regions Age 60 Years and Over, 1995 and 2020



Sex ratios for populations age 60 and over reflect the larger proportion of women than men in all regions of the world, particularly in the more developed regions.

Challenge #4: The Feminization of Ageing

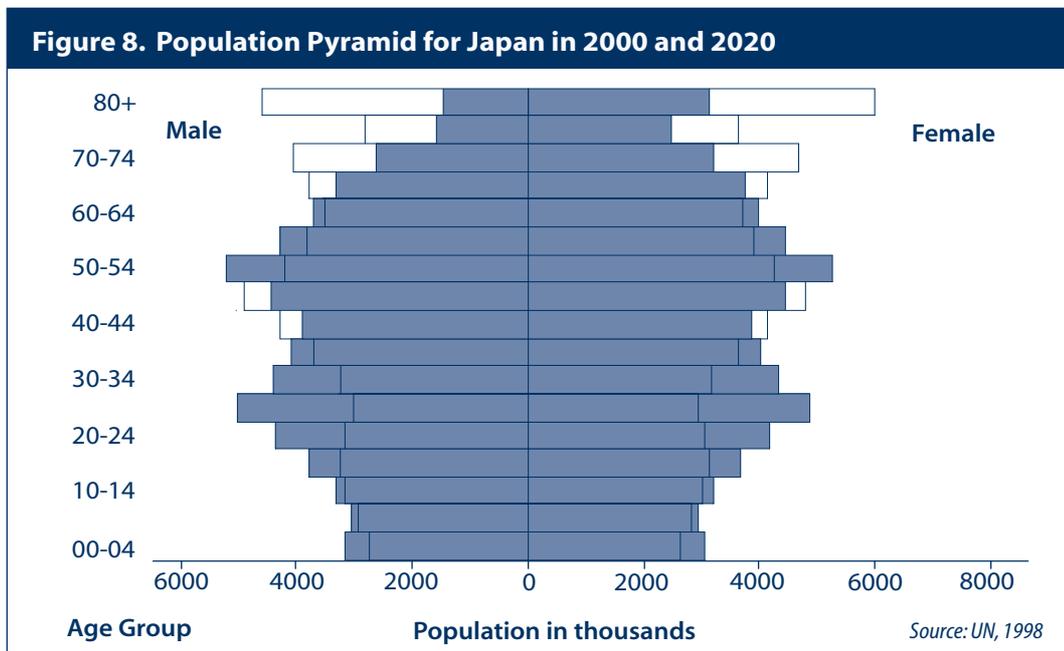
Women live longer than men in almost all areas of the world. For example, for ages 60 and older there were 657 men for every 1,000 women in Europe in 1995. In developing regions overall, there were 893 older men per 1,000 older women (see Figure 7).

Women make up approximately two-thirds of the population over age 75 in Brazil and South Africa. While women have the advantage of longer lives, they are more likely than men to experience domestic violence and discrimination in access to education, income, food, meaningful work, health care, inheritances, social security measures and political power. These cumulative disadvantages mean that women are more likely than men to be poor and to suffer disabilities in older age.

Because of their second class status, the health of older women is often neglected or ignored.

Women are also more likely than men to live to very old age when disabilities and multiple health problems are more common. At age 80 and over, the world average is below 550 men for every 1,000 women. In the more developed regions women age 80 and over outnumber men by more than two to one (see the example of Japan in Figure 8).

Because of women's longer life expectancy and the tendency of men to marry younger women and to remarry if their spouses die, female widows dramatically outnumber male widowers in all countries. For example, in the Eastern European countries in economic transition over 70 percent of women age 70 and over are widows (Botev, 1999).



In contrast to the pyramid form, the Japanese population structure has changed to a cone shape due to population ageing. By 2020 the shape will be similar to an up-side-down pyramid, with persons age 80 and over accounting for the largest population group. The feminization of old age is highly visible.



Older women who are alone are highly vulnerable to poverty and social isolation. In some cultures, degrading and destructive attitudes and practices around burial rights and inheritance may rob widows of their property and possessions, their health and independence, and in some cases, their very lives.

Women's traditional role as family caregivers may also contribute to their increased poverty and ill health in older age. Some women are forced to give up paid employment to carry out their caregiving responsibilities. Others never have access to paid employment because they work full-time in unpaid caregiving roles, looking after children, older parents, spouses who are ill and grandchildren. Thus, the provision of family care is often achieved at the detriment of the female caregiver's economic security and good health in later life.

Perhaps the most dramatic example of how caregiving affects the lives and health of women is the current situation in countries with a high prevalence of HIV and AIDS. Numerous studies have found that most adult children with AIDS return home to die. Wives, mothers, aunts, sisters, sisters-in-law and grandmothers take on the bulk of the care. Then, in many cases, these women take on the care of their orphaned grandchildren.

Challenge #5: Ethics and Inequities

As populations age, a range of ethical considerations come to the fore. They are linked to resource allocation, intervention choices related to the undue hastening or delaying of death, genetic research and manipulation, and a host of dilemmas linked to long-term care and the human rights of poor and disabled older citizens. Advocacy, ethical decision-making and upholding the rights of all older people must be central strategies in any plan on ageing.

The exclusion and impoverishment of older people is often a product of structural inequities in both developing and developed countries. Inequities experienced in earlier life in access to education, employment and health care, as well as those based on gender and race have a critical bearing on status and well-being in old age. For older people who are poor, the consequences of these earlier experiences are worsened through further exclusion from health services, credit schemes, income-generating activities and decision-making.

In many cases, the means for older people to achieve dignity and independence, receive care and participate in civic affairs is not directly available to them. These conditions are often worse for older people living in rural areas and in situations of conflict or humanitarian disasters.

Table 2. Percentage of the Population Below International Poverty Lines in Selected Countries

Country	Population (millions)	Percentage with <1PPP* dollar/day	Percentage with <2PPP dollar/day
China	1,278	22%	58%
India	1,014	53%	89%
Indonesia	212	12%	59%
Brazil	170	24%	44%
Nigeria	111	31%	60%
Ethiopia	63	46%	89%
Thailand	61	<2%	24%

*PPP: Purchasing Power Parity

Source: World Bank, 1998/99.

Women are universally disadvantaged in terms of poverty and exclusion, although they contribute greatly to the survival and well-being of families. Special efforts are essential to ensure the participation of older women in development initiatives.

In all regions of the world, relative wealth and poverty, gender, ownership of assets, access to work and control of resources are key factors in socioeconomic status. Recent World Bank data reveal that in many developing countries well over half of the population lives on less than two purchasing power parity (PPP) dollars per day (see Table 2).

It is well known that socioeconomic status and health are intimately related. Everywhere, the poor of all ages suffer more disabilities and earlier deaths, and the very poor suffer the most. With each step up the socioeconomic ladder, people live longer, healthier lives (Wilkinson, 1996).

In recent years, the gap between rich and poor and subsequent inequalities in health status has been increasing in all parts of the world (Lynch et al, 2000). Failure to address this problem will have serious consequences for the global economy and social order, as well as for individual societies and people of all ages.



3. Active Ageing: The Concept and Rationale

If ageing is to be a positive experience, longer life must be accompanied by continuing opportunities for independence and health, productivity, and protection. The World Health Organization uses the term “active ageing” to express the process for achieving this vision.

Active ageing is the process of optimizing opportunities for physical, social, and mental well-being throughout the life course, in order to extend healthy life expectancy, productivity and quality of life in older age.

The term “active ageing” was adopted by the World Health Organization in the late 1990s. It is meant to convey a more inclusive message than “healthy ageing” and to recognize the factors and sectors in addition to health care that affect how individuals and populations age. Other international organizations, academic circles and governmental groups (including the G8, the Organization for Economic Cooperation and Development, the International Labour Organization and the Commission of the European Communities) are also using “active ageing”, primarily to express the idea of continuing involvement in socially productive activities and meaningful work.

Thus, the word “active” refers to continuing involvement in social, economic, spiritual, cultural and civic affairs, not just the ability to be physically active. Older people who are ill

or have physical restrictions due to disabilities can remain active contributors to their families, peers, communities and nations.

Maintaining independence – one’s ability to control, cope with and make decisions about daily life – is a primary goal for both individuals and policy makers. Health that enables independence is the key facilitator of an active ageing experience.

An active ageing approach to policy and programme development has the potential to address all of the challenges of both individual and population ageing. Ultimately, it allows older people to optimize their potential for independence, good health and productivity while providing them with adequate protection and care when they require assistance. Potentially, when health, labour market, employment, education and social policies support active ageing:

- fewer adults will die prematurely in the highly productive stages of life
- fewer older people will have disabilities and pain associated with chronic diseases
- more older people will remain independent and enjoy a positive quality of life
- more older people will continue to make a productive contribution to the economy and to important social, cultural and political aspects of society in paid and unpaid jobs and in domestic and family life

- fewer older people will need costly medical treatment and care services (WHO, forthcoming).

The active ageing approach is based on a recognition of the human rights of older people and the United Nations Principles of independence, participation, dignity, care and self-fulfillment. It shifts strategic planning away from a “needs-based” approach (which assumes that older people are passive targets) to a “rights-based” approach that recognizes the rights of older people to equality of opportunity and treatment in all aspects of life. It supports their responsibility to exercise their participation in the political process.

Active ageing policies and programmes support both a life course perspective and intergenerational solidarity. Today’s child is tomorrow’s grandmother or grandfather. The quality of life they will enjoy as grandparents will depend on the threats or opportunities they experienced in early life. They and their grandchildren are explicitly linked in a social contract of intergenerational interdependence.

There are good economic reasons for enacting policies and programmes that promote active ageing – in terms of increased productivity and reduced costs in care. People without disabilities face fewer impediments to continued work. They use less medical care and require fewer caregiving services. Indeed, due to the decline in disability rates between 1982 and 1994 in the U.S.A, the deferred savings in nursing home costs alone were estimated to be \$17.3 billion in 1994 (Singer and Manton, 1998).

It is far less costly to prevent disease than to treat it. For example, it has been estimated that a one-dollar investment in measures to encourage moderate physical activity leads to a cost-saving of \$3.2 in medical costs alone (U.S. Centers for Disease Control and WHO, 1999). This same intervention also encourages social interaction, which is highly associated with mental health and psychological well-being in older people.

Active Ageing: The Role of the Health Sector

To promote active ageing, health policies and programmes need to:

- reduce the burden of excess disabilities, especially in poor and marginalized populations
- reduce the risk factors associated with the causes of major diseases and increase the factors that protect health and well-being throughout the life course
- develop primary health care systems that emphasize health promotion, disease prevention and the provision of cost-effective, equitable and dignified long-term care.
- advocate and collaborate with other sectors (such as education, housing and employment) to affect positive changes in the broad determinants of healthy, active ageing (see next section).



4. What Determines Active Ageing? Understanding the Evidence

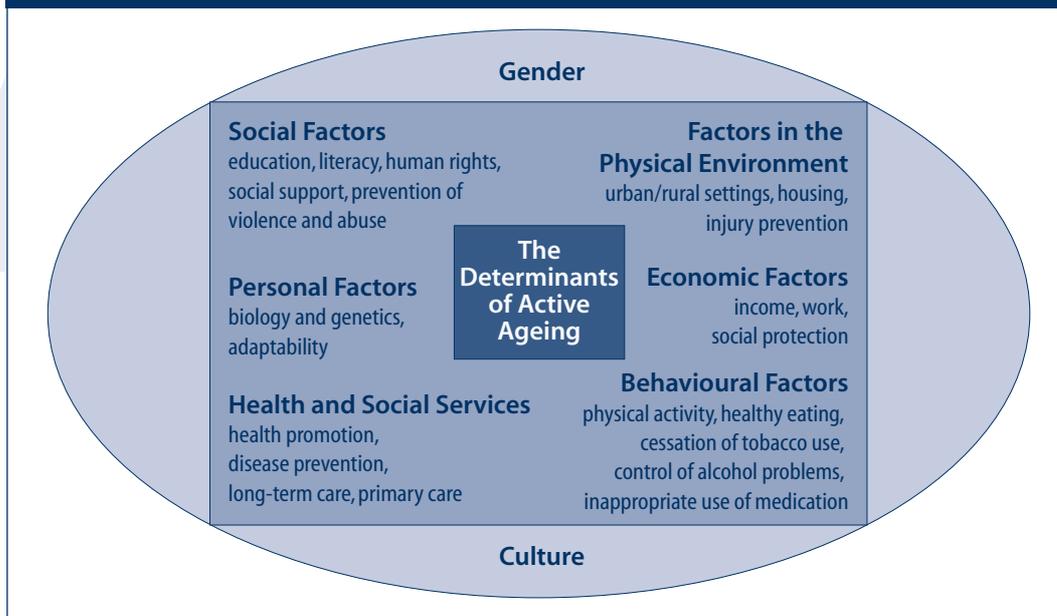
Health and productivity depend on a variety of factors or “determinants” that surround individuals, families and nations. Understanding the evidence we have about the determinants of active ageing will help us design policies and programmes that work.

Cross-Cutting Factors: Gender and Culture

Gender and culture are “cross-cutting” determinants of active ageing because they influence all of the other determinants. Gender can have a profound effect on such factors as social status, how older people access health care, meaningful work and nutritious foods. Cultural values and traditions determine to a large extent how a given society views older

people and whether or not co-residency with younger generations is the preferred norm. Cultural factors can also influence personal behaviours and health. For example, traditional diets in the Mediterranean countries have a protective effect against several non-communicable diseases (WHO/Tufts, forthcoming). Sound policies use gender and culture as “lenses” through which to consider the appropriateness of various policy options and to consider how they will affect the well-being of different population subgroups.

Figure 9. The Determinants of Active Ageing



Health and Social Service Systems

To promote active ageing, health systems need to take a life course perspective that focuses on health promotion, disease prevention, equitable access to primary care and a balanced approach to long-term care. Health and social services need to be integrated, equitable and cost-effective.

Health promotion is the process of enabling people to take control over and to improve their health. *Disease prevention activities* include activities to prevent and manage non-communicable disease and injury (primary prevention) and to screen for the early detection of chronic diseases (secondary prevention). These activities reduce the risk for painful and costly disabilities.

Long-term care has been defined by the WHO as “the system of activities undertaken by informal caregivers (family, friends and/or neighbours) and/or professionals (health and social services) to ensure that a person who is not fully capable of self-care can maintain the highest possible quality of life, according to his or her individual preferences, with the greatest possible degree of independence, autonomy, participation, personal fulfillment and human dignity.”

Thus, long-term care includes both informal and formal support systems. The latter may include a broad range of community and public health, primary care, palliative care and rehabilitation services as well as institutional care in supportive housing, nursing homes, hospices, etc. and treatments to halt or reverse the course of disease and disability. Mental health services should be an integral part of long-term care. The under-diagnosis of

mental illness, particularly of depression in older people is increasingly recognized. However, suicide rates among older people suggest the need for even more recognition and action.

One of the greatest challenges in health policy is to strike a balance among support for self-care (older people looking after themselves), informal support (family members and friends helping to care for older people) and formal care (health and social services).

All over the world, family members (mostly women) and neighbours provide the bulk of support and care to older adults that need assistance. Some policy makers fear that providing formal care services will lessen the involvement of families. The research shows that this is not the case. When appropriate formal services are provided, informal care remains the key important partner (WHO, 1999).

Most people agree that the best place to care for older people is at home. But caregivers (who are often old themselves) must be supported if they are to continue to provide care without becoming ill themselves. Visiting nurses, home care, peer support programmes, rehabilitation services, assistive devices, respite care and adult day care are all important services that enable informal caregivers to continue to provide care to older people. Other forms of support include training, social security coverage, help with housing adjustments that enable families to look after older people who are disabled and disbursements to help cover caring costs.



Professional caregivers also need training and practice in enabling models of care that recognize older people's strengths and empower them to maintain even small measures of independence when they are ill or frail. Paternalistic attitudes by professionals can have a devastating effect on the self-esteem and independence of older people who require services.

Equity of access and *cost effectiveness* are key concerns for health systems. In many countries older people who are poor and who live in rural areas have limited or no access to needed health care. A decline in public support for primary health care services in many areas has put increased financial and intergenerational strain on older people and their families.

Major Chronic Conditions Affecting Older People Worldwide

- **Cardiovascular diseases** (such as coronary heart disease)
- **Hypertension**
- **Stroke**
- **Diabetes**
- **Cancer;**
- **Chronic obstructive pulmonary disease**
- **Musculoskeletal conditions** (such as arthritis and osteoporosis)
- **Mental health conditions** (mostly dementia and depression)
- **Blindness and visual impairment**

Note: The causes of disability in older age are similar for women and men although women are more likely to report musculoskeletal problems.

Source: WHO, 1998b

When health and social services are available and accessible, they are often fragmented and uncoordinated, leading to both duplication and gaps. These factors combined with inefficiencies in care delivery and the inappropriate use of high cost technologies are the main drivers of escalating health care costs, not the ageing of the population per se.

The majority of health care expenses in older age occur in the last few years of life; however, these costs taper off in the very oldest groups. If people live longer with fewer disabilities than originally projected, dire predictions of an "explosion in health care costs" are not likely to happen.

Economic Factors: Income, Work and Social Protection

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

Income

Many older people (especially women who live alone and older people who live in rural areas) do not have reliable nor sufficient incomes. This has a negative effect on their health and independence. The most vulnerable are those who have no assets, little or no savings, no pensions or social security payments or who are part of families with low or uncertain incomes. Those without children or family members run a risk of homelessness and destitution. Thus, active ageing policies need to intersect with broader schemes to reduce poverty and increase the involvement of older people in income-generating activities.

Work

In all parts of the world, there is an increasing recognition of the need to support the active and productive contribution that older people can and do make in paid, unpaid and voluntary work.

In developed countries, the potential gain of encouraging older people to work longer is not being fully realized. In less developed countries, older people are by necessity more likely to remain economically active into old age. However, industrialization and labour market mobility is threatening much of the traditional work of older people, particularly in rural areas. Development projects need to ensure that older people are eligible for credit schemes and full participation in income generating opportunities.

But concentrating only on paid work tends to ignore the valuable contribution that older people make in unpaid work in the informal sector (e.g., small scale, self-employed activities and domestic work) and in the home. In both developing and developed countries, older people often take prime responsibility for household management and for childcare so that younger adults can work outside the home.

In all countries, a number of skilled and experienced older people act as volunteers in schools, communities, religious institutions, businesses and health and political organizations. Such activities should be encouraged as voluntary work benefits older people by increasing social contacts and mental well-being while making a significant contribution to their communities and nations at the same time.

Social Protection

In all countries of the world, families provide the majority of support for older people who require help. However, as societies develop and the practice of co-residency among several generations begins to decline, countries are increasingly called on to develop mechanisms that provide social protection for older people who are unable to earn a living and are alone and vulnerable. In developing countries, older people who need assistance tend to rely on family support, informal service transfers and personal savings. Social insurance programmes are minimal and in some cases, redistribute income to elite segments of the population who are less in need. However, in some countries, such as in

Consider This...

- Studies have shown that older people with low incomes are one-third as likely to have high levels of functioning as those with high incomes (Guralnick and Kaplan, 1989).
- When unemployment is high, there is a tendency to see reducing the number of older workers as a way to create jobs for younger people. However, experience has shown that the use of early retirement to free up new jobs for the unemployed has not been an effective solution (OECD, 1998).
- In countries where voluntary work among all age groups has been empirically studied, the contribution is estimated to be between 8 and 14 percent of the Gross Domestic Product (United Nations Volunteers, 1999).



South Africa and Namibia, two poor countries that have a national old age pension, these benefits are a major source of income for the entire family, as well as for the older adults.

The money from these small pensions is used to purchase food for the household, to send children to school, to invest in farming technologies and to ensure survival for the entire family.

In developed countries, social protection measures can include old age pensions, in-kind services, occupational pension schemes, mandated contribution programmes, savings incentives programmes, compulsory savings funds and disability, health and unemployment insurance programmes. In recent years, policy reforms in developed countries have favoured a diverse system of pension schemes that mixes state and private support for old age security and encourages productivity, working longer and gradual retirement (OECD, 1998).

A balanced approach to the provision of social protection and economic goals suggests that societies who are willing to plan can afford to grow old. Sustained economic development and effective labour market policies have, in fact, a more dramatic impact on a nation's ability to provide social protection than demographic ageing per se. The goal must be to recognize and harness the skills and experience of older people and to ensure adequate living standards for them while encouraging harmonious intergenerational transfers.

Factors in the Physical Environment

Physical environments that are age friendly can make the difference between independence and dependence for some older people. For example, older people are more likely to be physically and socially active when they can safely walk to a neighbour's home, local transportation and parks. Older people who live in an unsafe or polluted area 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* because disease patterns are different and there are fewer support services available. Urbanization and the migration of younger people in search of jobs may leave older people isolated in rural areas with little means of support and little or no access to health and social services. Sometimes they are unable to continue agriculture work. Older farmers need support, access to credit schemes and training in new techniques to ensure that their livelihoods and food production remains viable.

Safe, adequate housing is especially important for the well-being of older adults. Location, including proximity to family members, services and transportation can mean the difference between positive social interaction and isolation.

World-wide, there is an increasing trend for older people (especially older women) to live alone. Older women are often poor, even in rich countries, and may be forced to live in

shelters that are inadequate and/or unsafe. In many developing countries, the proportion of older people living in slums and shanty towns is rising quickly due to the migration of older people to cities to live with younger family members. Older people living in these settlements are at high risk for social isolation and poor health.

In times of crisis and conflict, displaced older people are particularly vulnerable. Often, they are unable to walk to refugee camps. Even if they make it to camps, it may be hard to obtain shelter and food, especially for older widows, when the distribution of resources flows through a male-dominated system of distribution.

Consider this...

- Approximately 60% of the world's older people live in rural areas (UN, 1998).
- Injuries resulting from cars hitting pedestrians tend to be higher for older people than any other age group (Lilley et al, 1995).

In numerous developed countries, supportive housing for older people that includes support services but not nursing care has become an important policy option. Studies have shown that residents of supportive housing are likely to have the same level of disability as those in a nursing home, and the use of supportive housing is a cost-effective alternative for inappropriate nursing home placements (Gnaedinger, 1999).

Hazards in the physical environment can lead to debilitating and painful injuries among older people. Injuries from falls, fires and traffic collisions are most common. The consequences of injuries sustained in older age are more severe than among younger people. For injuries of the same severity, older people experience more disability, longer hospital stays, extended periods of rehabilitation, a higher risk of dying and a higher risk of subsequent dependency. The great majority of injuries are preventable; however, the traditional view of injuries as “accidents” has resulted in historical neglect of this area in public health.

Personal Factors

Biology, genetics and adaptability are three key personal factors in how well a person ages. The changes that accompany ageing progress gradually and individual differences are significant. For example, a fit 70-year old person's physical performance can be equal to the performance of an unfit 30-year-old person.

During the process of ageing, some intellectual capacities (such as reaction time, learning speed and memory) naturally decline. However, these losses can be compensated by gains in wisdom, knowledge and experience. Often, declines in cognitive functioning are triggered by disuse (lack of practice), behavioural factors (such as alcohol use) and psychosocial factors (such as lack of motivation, lack of confidence, isolation and depression), rather than ageing per se.



The influence of genetic factors on the development of chronic conditions such as diabetes, heart disease, Alzheimer's Disease and certain cancers varies greatly among individuals. For most people, living disease- and disability-free into old age depends as much on personal behaviours, coping skills and the physical, social and economic environment as on their heredity.

Successful adjustment to life after age 60 requires the ability to be flexible and adaptable. Most people remain resilient in old age and older people do not differ significantly from younger people in their ability to cope. Older people who adapt well to loss and change tend to have a sense of control, a positive attitude and a belief in their ability to succeed (self-efficacy).

Behavioural Factors

One of the myths of ageing is that it is too late to adopt healthy lifestyle behaviours in older age. On the contrary, engaging in appropriate physical activity, healthy eating, not smoking and using alcohol and medications wisely in older age can prevent disease and functional decline, extend longevity and enhance one's quality of life.

Physical Activity

Participation in regular, moderate physical activity can delay functional declines and reduce the risk of chronic diseases in both healthy and chronically ill older people. It improves mental health and often promotes social contacts. Being active can help older people maintain their activities of daily living as independently as possible for the longest period of time. There are also economic benefits when older people are physically

active. Medical costs are substantially lower for older people who are active (WHO, 1998a).

Despite all of these benefits, a high proportion of older people in most countries lead sedentary lives. Populations with low incomes, ethnic minorities and older people with disabilities are the most likely to be inactive. Policies and programmes should encourage sedentary older people to become more physically active and provide opportunities to do so. Providing safe areas for walking is particularly important as well as support for culturally appropriate community activities that are organized and led by older people themselves. Professional advice to "go from doing nothing to doing something" and physical rehabilitation programmes that help older people recover from mobility problems are both effective and cost-efficient.

In the least developed countries the opposite problem may occur. In these countries older people may be engaged in strenuous physical work and chores which may hasten disabilities and cause injuries. Health promotion efforts in these areas should be directed at providing relief from repetitive, strenuous tasks and making adjustments to unsafe physical movements at work that will decrease injuries and pain.

Healthy Eating

Malnutrition in older adults includes both under-nutrition (mostly in the least developed countries) and excess calorie consumption (mostly in developed countries, countries in transition and developing countries experiencing rapid urbanization and the transition

from communicable to non-communicable diseases). Malnutrition can be caused by limited access to food, tooth loss, socioeconomic hardships, emergency situations, a lack of nutritional knowledge and information, poor food choices (e.g., eating high fat foods), disease and the use of medications, social isolation, and cognitive or physical disabilities that inhibit one's ability to buy food and prepare it, and a lack of physical activity.

Excess calorie consumption greatly increases an older person's risk for chronic diseases and disabilities. Obesity and a high-fat diet are highly related to diabetes, cardiovascular disease, high blood pressure, arthritis and some cancers.

Insufficient calcium and Vitamin D is associated with a loss of bone density in older age and an increase in painful, costly and debilitating bone fractures, especially in older women.

Tobacco Use

Middle aged and older adults who smoke are more likely than non-smokers to have serious disabilities and to die prematurely of smoking-related diseases. Smoking may decrease the effect of needed medications. Exposure to second-hand smoke can also have a negative effect on older people's health, especially if they suffer from asthma or other respiratory problems.

Most smokers start young and are quickly addicted to the nicotine in tobacco. Therefore, efforts to prevent children and youth from starting to smoke must be a primary strategy

Consider This...

- Regular, moderate physical activity reduces the risk of cardiac death by 20 to 25 percent among people with established heart disease (Merz and Forrester, 1997). It can substantially reduce the severity of disabilities associated with heart disease and other chronic illnesses (U.S Preventive Services Task Force, 1996).
- With advancing age, certain nutrients are not as well absorbed and energy requirements are reduced due to a decline in the basal metabolic rate. Therefore, it is especially important for older people to eat a variety of nutrient-rich foods that are culturally acceptable and regionally available at affordable prices.
- Studies have shown that tobacco control is highly cost-effective in low- and middle-income countries. In China, for example, conservative estimates suggest that a 10 percent increase in tobacco taxes would reduce consumption by 5 percent and increase overall revenue by 5 percent. This increased revenue would be sufficient to finance a package of essential health care services for one-third of China's poorest citizens (World Bank, 1999).

in tobacco control. At the same time, it is important to reduce the demand for tobacco among adults (through comprehensive actions such as taxation and restrictions on advertising) and to help adults of all ages to quit.

It is never too late to quit smoking. Quitting in older age can substantially reduce one's risk for heart attack, stroke and lung cancer.



Alcohol

While older people tend to consume less alcohol than younger people, metabolism changes that accompany ageing increase their susceptibility to alcohol-related diseases, including malnutrition, liver disease and peptic ulcers. Older people also have greater risks for alcohol-related falls and injuries, as well as dementia and the potential hazards associated with mixing alcohol and medications. Treatment services for alcohol problems should be available to older people as well as younger people.

According to a recent WHO review of the literature, there is evidence that alcohol use at very low levels (up to one drink a day) may offer some degree of protection against coronary heart disease and stroke for people age 45 and over. However, in terms of overall excess mortality, the adverse effects of drinking outweigh any protection against coronary heart disease, even in high risk populations (Jernigan et al., 2000).

Medications

Because older people often have chronic health problems, they are more likely than younger people to need and use medications – traditional, over-the-counter and prescribed. In most countries, older people with low incomes have little or no access to insurance for medications. As a result, many go without or spend an inappropriately large part of their meager incomes on drugs.

In contrast, in wealthier countries medications are sometimes over-prescribed to older people (especially to older women). Adverse

drug-related illnesses and falls are significant causes of personal suffering and costly preventable hospital admissions (Gurwitz and Avorn, 1991).

As the population ages, the demand will continue to rise for medications that are used to delay and treat chronic diseases, alleviate pain and improve quality of life. This calls for a renewed effort to increase affordable access to essential, safe medications and to better ensure the appropriate, cost-effective use of current and new drugs. Partners in this effort should include governments, health workers, traditional healers, the pharmaceutical industry, employers and organizations representing older people.

Factors in the Social Environment

Social support, opportunities for education and lifelong learning, and protection from violence and abuse are key factors in the social environment that enhance health, independence and productivity in older age. Loneliness, social isolation, illiteracy and lack of education, elder abuse and exposure to conflict situations greatly increase older people's risks for disabilities and early death.

Social Support

Connecting with family members, friends, neighbours, work colleagues and community groups is essential to health at all ages. In older age it is particularly important, since older people are more likely to lose loved ones and friends and to be more vulnerable to loneliness, social isolation and the availability of a "smaller social pool". Social isolation in old age is linked to a decline in both physical and mental capacities and an increase in health damaging behaviours such

as excess alcohol consumption and physical inactivity. In most societies, older men are less likely than older women to have supportive social networks. However, in some cultures, older women who are widowed are systematically excluded from mainstream society or even rejected by their community.

Decision-makers, nongovernmental organizations, private industry and health and social service professionals can help foster social networks for older people by supporting traditional societies and community groups for older people, voluntarism, neighbourhood helping, peer mentoring and visiting, family caretakers, intergenerational programmes and comprehensive case management.

Education and Literacy

Low levels of education and illiteracy are associated with increased risks for disability and death among older people, as well as with higher rates of unemployment.

Education in early life combined with opportunities for lifelong learning can give older people the cognitive skills and confidence they need to adapt and stay independent.

Studies have also shown that employment problems of older workers are often rooted in their relatively low literacy skills, not in ageing per se. If older adults are to remain engaged in meaningful and productive activities, there is a need for continuous training in the workplace and lifelong learning opportunities in the community (OECD, 1998).

Like younger people, older citizens need training in new technologies in agriculture, electronic communication and other new technologies. Self-directed learning, increased practice and physical adjustments (such as the use of a larger computer screen) can compensate for reductions in visual acuity, hearing

Consider This...

- In Japan, older people who reported a lack of social contact were 1.5 times more likely to die in the next three years than were those with higher social support. In the U.S.A, studies have shown that older people with high levels of social support (especially from family members) were more likely to recover after hip surgery and to successfully adjust to the onset of chronic illness (WHO, forthcoming).
- Worldwide, striking disparities in literacy rates between men and women continue to exist. In 1995 in the least developed countries 31 percent of adult women were illiterate compared to 20 percent of adult men (WHO, 1998b).
- In many countries, older women and men tend to make up a large proportion of illiterate citizens and to have lower levels of education.
- Elder abuse occurs in families at all economic levels. It is likely to escalate in societies experiencing economic upheaval and social disorganization when overall crime and exploitation tends to increase.



and short-term memory. Older people can remain creative and flexible. Their experience and wisdom brings added advantages to group problem solving in a workplace or community.

Intergenerational learning bridges generations, enhances the transmission of cultural values and promotes the worth of all ages. Studies have shown that young people who learn with older people have more positive and realistic attitudes about the older generation.

Violence and Abuse

Older people are increasingly at risk for violence in times of war and conflict. In peacetime, older people who are frail or live alone may be particularly vulnerable to crimes committed by strangers such as theft, assault and break-and-enter. But the most common form of violence against older people (especially against older women) is “elder abuse” committed by family members or others (such as institutional caregivers) that are well known to the victims.

According to the International Network for the Prevention of Elder Abuse, elder abuse is “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 an older person”. It includes physical, sexual, psychological and financial abuse as well as neglect, and is notoriously under-reported in all cultures. It is a violation of human rights and a significant cause of injury, illness, lost productivity, isolation and despair.

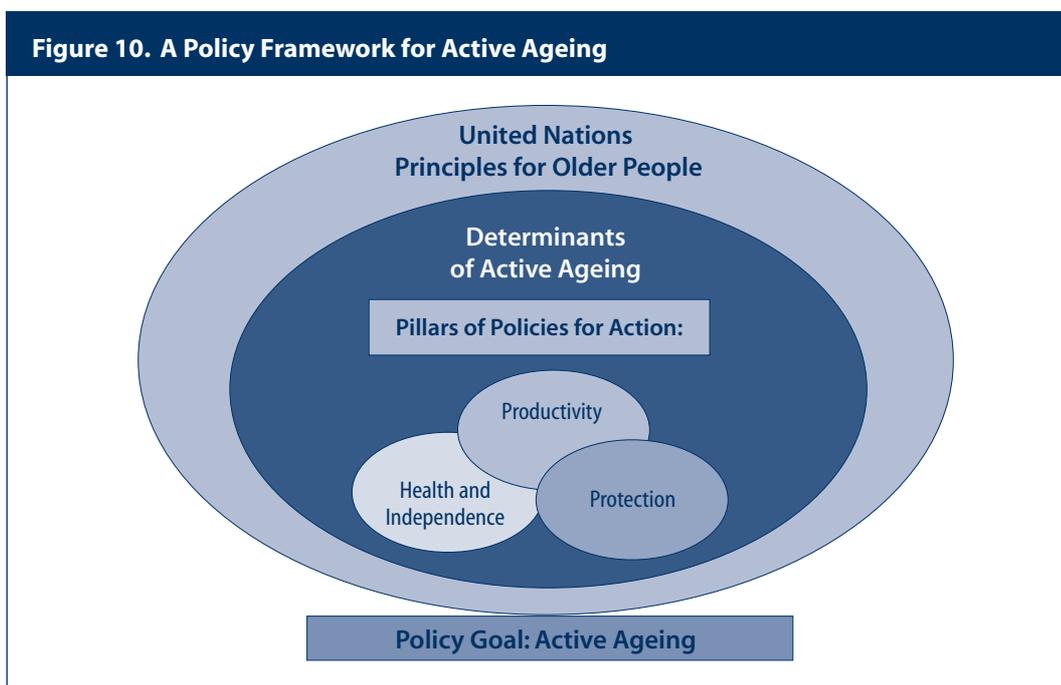
Domestic and societal violence against older people is an issue for justice, public health, labour and employment and social development. Confronting and reducing this violence requires a multisectoral, multidisciplinary approach involving justice officials, law enforcement officers, health and social service workers, labour leaders, spiritual leaders, faith institutions, advocacy organizations and older people themselves. Sustained efforts to increase public awareness of the problem and to shift values that perpetuate gender inequities and ageist attitudes are also required.

5. The Policy Response

The ageing of the population is a global phenomenon that demands international, national, regional and local action. In an increasingly connected world, failure to deal with the demographic imperative and rapid changes in disease patterns in a rational way in any part of the world will have socioeconomic and political consequences everywhere. On a personal level, each of us grows older with each passing day. Ultimately, a collective approach to ageing and older people will determine how we, our children and our grandchildren will experience life in later years.

The policy framework requires **action on three basic pillars:**

- *Health and independence.* When the risk factors (both environmental and behavioural) for chronic diseases and functional decline are kept low and the protective factors are kept high, people enjoy both a longer quantity and quality of life. Older people will remain healthy and able to manage their own lives. Fewer older adults will need costly medical treatment and care services.



A policy framework for active ageing is guided by the **United Nations Principles for Older People** (the outer circle). These are independence, participation, care, self-fulfillment and dignity. Decisions are based on an understanding of how the **determinants of active ageing** influence the way that individuals and populations age (see Figure 9, page 19). Policy action addressing these determinants is required in three areas: health and independence, productivity and protection.



- *Productivity.* Older people will continue to make a productive contribution to society in both paid and unpaid activities when labour market, employment, education, health and social policies and programmes support their full participation in socioeconomic, cultural and spiritual activities, according to their capacities, needs and preferences.

- *Protection.* When policies and programmes address the health, social, financial and physical security needs and rights of older people, older people are ensured of protection, dignity and care in the event that they are no longer able to support and protect themselves. Families are supported in their efforts to care for older loved ones.

Intersectoral Policy Objectives

Attaining the goal of active ageing will require action in a variety of sectors, including health, social services, education, employment and labour, finance, social security, housing, transportation, justice and rural and urban development. All policies need to support intergenerational solidarity and include specific targets to reduce inequities between women and men and among different subgroups within the older population. Particular attention needs to be paid to older people who are poor and marginalized, and those who live in rural areas.

Key Policy Proposals

1. *Reduce the prevalence of risk factors associated with major diseases and increase the prevalence of factors that protect health and well-being throughout the life course.*

- Develop culturally-appropriate, population-based guidelines for physical activity for older men and women. Provide accessible, pleasant and affordable opportunities to be physically active (e.g., safe walking areas and parks) and support peer leaders and groups that promote regular, moderate physical activity for older people.
- Develop culturally-appropriate, population-based guidelines for healthy eating for older men and women that can be used as education and policy tools. Support improved diets and healthy weights in older age through the provision of information (including information specific to the nutrition needs of older people), healthy food policies and interventions to improve oral health among older people.
- Take comprehensive action at local, national and international levels to control the marketing and use of tobacco products and provide older people with help to quit smoking.
- Determine the extent of misuse of alcohol, medications and other drugs by older people and put practices and policies in place to reduce misuse and inappropriate prescribing practices.

- Provide incentives and training for health and social service professionals to counsel and guide older people in positive self-care and healthy lifestyle practices.
 - Reduce risk for social isolation by supporting community empowerment and mutual aid groups, traditional societies, peer outreach, neighbourhood visiting and family caregivers.
 - Capitalize on the strengths and abilities of older people while helping them build self-efficacy and confidence, as well as coping and realistic goal-setting skills.
 - Recognize and support the importance of mental health and spirituality in older age.
 - Include older people in prevention and education efforts to reduce the spread of HIV/AIDS.
- 2. *Develop health and social service systems that emphasize health promotion, disease prevention and the provision of cost-effective, equitable and dignified long-term care.***
- Train health and social service workers in enabling models of primary health care and long-term care that recognize the strengths and contributions of older people.
 - Eliminate age discrimination in health and social service systems.
 - Reduce inequities in access to primary health care and long-term care in rural and isolated areas, through the use of both high-tech (e.g., telemedicine) and low-tech solutions (e.g., support to community-based outreach programmes).
 - Reduce inequities in access to care among older people who are poor by reducing or eliminating user fees and/or providing equitable insurance schemes for care.
 - Improve the coordination of primary health care and social services.
 - Provide a comprehensive approach to long-term care that stimulates collaboration between the public and private sectors and involves all levels of government, civil society and the not-for-profit sector. Support informal caregivers through initiatives such as training, respite care, pension credits, financial subsidies and home care nursing services.
 - Ensure high quality standards and stimulating environments in residential care facilities. Provide needed services to care for older people with dementia and other mental health problems as well as physical problems.
 - Ensure that all people have a right to death with dignity and one which respects their cultural values.
 - Endorse policies which enable people whenever possible to die in a place they themselves decide, surrounded by people of their own choosing and as free from distress and pain as possible.
 - Support older healers who are knowledgeable about traditional and complementary medicines and encourage their roles as teachers.



3. Prevent and reduce the burden of excess disabilities, especially in marginalized populations.

- Set gender specific targets for improvements in health status among older people and in the reduction of disabilities and premature mortality.
- Create “age-friendly” standards and environments that help prevent the onset or worsening of disabilities.
- Support the continuing independence of people with disabilities by assisting with changes in the environment, providing rehabilitation services and/or providing effective assistive devices (e.g., corrective eyeglasses).
- Prevent injuries by protecting older pedestrians in traffic, making walking safe, implementing fall prevention programmes, eliminating hazards in the home and providing safety advice.
- Make effective, cost-efficient treatments that reduce disabilities (such as cataract removal and hip replacements) more accessible to older people with low incomes.
- Increase affordable access to essential safe medications among older people who need them but cannot afford them.
- Encourage the development of a range of housing options for older people that eliminate barriers to independence and encourage full participation in community and family life.

4. Enable the active participation of older people in all aspects of society.

- Include older people in the planning, implementation and evaluation of social development initiatives, efforts to reduce poverty and in political processes that affect their rights. Ensure that older people have the same access to development grants, income-generation projects and credit as younger people do.
- Enact labour market and employment policies and programmes that enable the participation of older people in meaningful work at the same rate as other age groups, according to their individual needs, preferences and capacities (e.g., the elimination of age discrimination in the hiring and retention of older workers).
- Support pension reforms that encourage productivity, a diverse system of pension schemes and more flexible retirement options (e.g., gradual or partial retirement).
- Provide greater flexibility in periods devoted to education, work and caregiving responsibilities throughout the life course.
- Recognize the contribution that older women and men make in unpaid work in the informal sector and in caregiving in the home.
- Recognize the value of volunteering and expand opportunities for older people to participate in meaningful volunteer activities, especially those who want to volunteer but cannot because of health or transportation restrictions.

- Provide policies and programmes in education and training that support lifelong learning and skill development for older people, especially in information technologies and agriculture.
 - Provide intergenerational activities in schools and teach young people about active ageing.
 - Work with the media to provide realistic and positive images of active ageing, as well as educational information for older people.
- 5. *Improve health and increase independence by providing protection to older people, particularly in difficult times.***
- Recognize the relevance of HIV/AIDS to older people and provide necessary financial and caregiving support to older people who care for dying family members and orphaned grandchildren.
 - Enforce occupational safety standards that protect older workers from injury and the modification of formal and informal work environments so that older workers can continue to work productively and safely.
 - Uphold older people's right to maintain control over personal decision-making, even when they are frail.
 - Support the provision of a social safety net for older people who are poor and alone, as well as social protection initiatives that improve the quality of life.
 - Protect older consumers from unsafe medications and treatments.
 - Explicitly recognize older people's right to and need for secure, appropriate shelter, especially in times of conflict and crisis. Provide housing assistance for older people when required (paying special attention to the circumstances of those who live alone) through rent subsidies, cooperative housing initiatives, support for housing renovations, etc.
 - Specifically recognize and act on the need to protect older people in emergency situations (e.g., by providing transportation to relief centres to those who cannot walk there). Recognize the contribution that older people can make to recovery efforts in the aftermath of an emergency and include them in recovery initiatives.
 - Recognize crimes committed against older people during war and bring the perpetrators to trial.
 - Enact legislation that protects widows from the theft of property and possessions and from harmful practices such as health-threatening burial rituals and charges of witchcraft.
 - Recognize elder abuse (physical, psychological, financial and neglect) as a crime, and encourage the prosecution of offenders. Train law enforcement officers, health and social service providers, spiritual leaders, advocacy organizations and groups of older people to recognize and deal with elder abuse.



- Increase awareness of the injustice of elder abuse (especially domestic violence against older women and widows) through public information and awareness campaigns. Involve the media and young people, as well as older people in these efforts.

6. Stimulate research and share knowledge.

- Clarify and popularize the term “active ageing” through dialogue, discussion and debate in the political arena, public fora and media outlets such as radio and television programming.
- Assist developing countries in collecting and analyzing pertinent information for policy-making on population ageing.
- Publish more detailed analyses of the evidence related to the various determinants of active ageing and how they interact, the life course approach to understanding older age, and specific, successful policies and programmes that foster active ageing.
- Involve older people in efforts to develop research agendas on active ageing, both as advisors and as investigators.
- Disseminate the results of reliable research efforts on ageing in ways that can be easily understood and used by policy-makers, the media, seniors’ groups and the general public.

The Importance of International Dialogue

With the launch of the International Plan of Action on Ageing, the 1982 UN World Assembly on Ageing marked the turning point in awareness of the challenges posed by an ageing world. In April 2002, the Second UN World Assembly on Ageing will be held in Madrid, Spain. It will adopt a revised international plan of action on ageing.

WHO stands ready to assist in this process by providing a framework for discussion in the development of a global strategy on ageing and health.

It is hoped that the framework provided in this paper will stimulate the discussion of policy options for achieving health and independence, productivity and protection of older people. The framework is meant to further the exchange of experiences between countries, and to contribute towards the formulation of recommendations related to health and well-being in the revised plan of action. Suggestions and comments on this framework are welcome.

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WHO and ageing

In response to the global challenges of population ageing, WHO launched a new programme on ageing and health in 1995 designed to advance the state of knowledge about health care in old age and gerontology through special training and research efforts, information dissemination and policy development.

The programme's perspectives focus on the following:

- approaching ageing as part of the life course rather than compartmentalizing health promotion and health care for older people;
- focusing on the process of healthy ageing and the promotion of long-term health;
- respecting cultural contexts and influences;
- adopting community-based approaches by emphasizing the community as a key setting for interventions, taking into account that many health problems need to be dealt with outside the health sector;
- recognizing gender differences;
- strengthening intergenerational links;
- respecting and understanding ethical issues related to health and well-being in old age.

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