SIXTY-SEVENTH WORLD HEALTH ASSEMBLY
Provisional agenda item 14.4

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Multisectoral action for a life course approach to healthy ageing

1. The attached document EB134/19 was considered and noted by the Executive Board at its 134th session.[1]

ACTION BY THE HEALTH ASSEMBLY

2. The Health Assembly is requested to note the report.

[1] See the summary record of the Executive Board at its 134th session, seventh meeting.

World Health Organization

EXECUTIVE BOARD
134th session
Provisional agenda item 8.2

EB134/19
13 December 2013

Multisectoral action for a life course approach to healthy ageing

Report by the Secretariat

1. The proportion of older people in the population is increasing in almost every country. By 2050, around 2000 million people in the world will be aged 60 years or over, with 400 million aged 80 years or over. Of them, 80% will be living in what are now low- or middle-income countries.

2. The transition to older populations will challenge society in many ways. Demand for health care, long-term care, social care and pensions is likely to increase, while the proportion of the population in traditional working ages will fall. But population ageing also presents many opportunities. Older people make important social contributions as family members, volunteers and active participants in the workforce. Indeed, older populations represent a substantial, but as yet underutilized, human and social resource.

3. Health in older age will be a crucial determinant of where the balance will lie between the costs and benefits associated with population ageing. Poor health undermines the ability of older people to remain actively engaged in society, limits their contribution and increases the costs of population ageing. Investing in health across the life course lessens the disease burden in older age, fosters the ongoing social engagement of older people (helping to prevent isolation) and has broader benefits for society by enabling the multiple contributions of older people.

4. Poor health in older age is a burden not just for the individual but also for his or her family and for society as a whole. The poorer the family or the setting, the greater the potential impact. Loss of good health can mean that an older person who was previously a family resource may no longer be able to contribute and may, instead, require significant support. This care is often provided by women who may need to give up other career aspirations to deliver it. The cost of health care for an older person can impoverish the whole family. These burdens are spread inequitably. Those with the least resources, or who live in the poorest areas, are most at risk.

5. Health in older age is determined by pathways or "trajectories" that develop across the life course. These trajectories are influenced by an integrated continuum of exposures, experiences and interactions. The impact of many factors is greatest at specific critical or sensitive periods of development. These can start very early in life, with experiences that can "program" an individual's

future health and development. Subsequently, risk and protective factors across life have a cumulative effect on health trajectories.

6. Because of the cumulative nature of these influences, one of the hallmarks of ageing is diversity. Many older people will be healthy and well educated and will want to continue to play an active role in society. Others of the same age may be poor, illiterate and have no financial security. Policies to enable older people to maximize their capabilities must address the broad spectrum of needs in these diverse populations.

CHALLENGES AND RESPONSES

Health systems

7. Current health systems, particularly in low- and middle-income countries, are not adequately designed to meet the chronic care needs that arise from this complex burden of disease. These needs span the life course and the care continuum: from prevention to detection, early diagnosis, treatment, rehabilitation, long-term care and palliative care. In many places, health systems will need to move from focusing on the delivery of curative interventions for single acute problems to a more comprehensive continuum of care that links all stages of life and deals with multiple morbidities in an integrated manner.

8. Towards the end of life, many people will eventually require assistance beyond that habitually required by a healthy adult. Most of these individuals prefer this "long-term care" to be provided in their home, and this is often delivered by family members. For those with severe functional decline, institutional care may be required. There are few standards or guidelines on the most appropriate care, family carers often lack an understanding of the challenges they face, and care may be disconnected from health services. This can leave the needs of the older person inadequately addressed, with carers facing a greater burden than is necessary and acute care services being inappropriately used to fill gaps in chronic care. Furthermore, changing social patterns mean that it may not be sustainable to rely on families alone to meet many of these needs. The relative number of older family members is dramatically increasing; older people are less likely to live with younger generations and are more likely to express a desire to continue living in their own home; and women, the traditional family carers, may have changing career expectations. New systems of long-term care are therefore urgently required, to provide a continuum of care that is tailored to a continuum of need. These should be focused on the individual, closely linked to health systems and designed to maintain the best possible function, well-being and social participation.

Workforce

9. Health system limitations are compounded by major workforce gaps. Few members of either the formal or the informal workforce are adequately trained to meet the specific needs of older people, and demographic change means that as the number of older people rises, the relative number of people in traditional working ages will fall.

New social models

10. Rigid ideas about the life course and ageist stereotypes limit our ability to find innovative solutions. For example, social systems often artificially categorize people into life stages based on chronological age (such as student, adult, retired). These concepts have little biological basis. With people living 10 or 20 years longer, a range of life options that would only rarely have been achievable

in the past become possible. A life course approach to healthy ageing views life as a continuum, recognizes and enables the valuable contributions of people at all ages, strengthens links between generations and develops strategies to build capabilities across all stages of life.

11. Ageing is interrelated with other major global trends, including migration, changing roles of women, urbanization, technological change and globalization. These and other aspects of the physical and social environment can strongly influence both the health of an older person and his or her capacity to participate actively in society. Innovation will be a crucial component of successful strategies to address the challenges of population ageing.

Gender

12. Gender exerts a powerful influence on health and ageing across the life course and in older age. Traditionally, women have provided most of the unpaid care for family members across the life course (from child care to elder care). This is often to the detriment of their own participation in the paid workforce and has many consequences in older age. These include a greater risk of poverty, more limited access to quality health and social care services, a higher risk of abuse, poor health in later life and reduced access to pensions.

Knowledge

13. There are major knowledge gaps that prevent us from taking appropriate and effective action on ageing and health. Even basic questions such as "are people living longer healthy lives, or are the additional years gained experienced in poor health?" cannot yet be answered. Other major gaps include understanding the causes and management of key conditions such as dementia. Even where strong evidence exists, barriers remain to its translation into policy and practice.

14. Current approaches to the development of policies and health interventions often exclude older people, even though they may be the main users or targets. Older people and those with comorbidities are routinely excluded from clinical trials, so our understanding of which treatment options are best in older ages is limited. Much routine data collection either excludes older people or aggregates all people over a certain age (such as 70 years and above), so we often cannot accurately assess health need or whether this is being met.

Leadership

15. While global attention on population ageing and health is rapidly increasing, existing responses are disjointed and outdated. There is no global strategy and no global action plan. Both the Madrid International Plan of Action on Ageing,[1] and the WHO contribution *Active ageing: a policy framework*,[2] are over 10 years old, and Member States need more up-to-date guidance to help them to prioritize their actions in a rapidly changing world. To ensure that this guidance is grounded in the best available evidence, there is an urgent need for a platform that brings together key experts to advise decision-makers on global action priorities. There is also an urgent need to coordinate global responses on ageing and health between key agencies.

[1] Political Declaration and Madrid International Plan of Action on Ageing. New York: United Nations; 2002 (http://undesadspd.org/Ageing/Resources/MadridInternationalPlanofActiononAgeing.aspx, accessed 4 December 2013).

[2] Active ageing: a policy framework. Geneva: World Health Organization; 2002.

RECOMMENDATIONS

Advocacy

16. Population ageing is one of the biggest demographic transitions the world has ever faced. Good health is central to ensuring that social and economic benefits are fully realized, and the development of sustainable health and social care systems is crucial if costs are to be controlled. There is a need for powerful international and national advocacy to ensure that the centrality of health is understood and that the opportunities arising from it are fully appreciated. As a step towards this goal, World Health Day 2012 had the theme "Good health adds life to years", to bring global attention to bear on issues related to ageing and health. The Secretariat continues to convey these messages in many forums, but these perspectives need to be given even greater prominence in global development and research agendas.

Convening and coordinating

17. The Secretariat partners with many other organizations, including the International Association of Gerontology and Geriatrics and the International Federation on Ageing, to link experts and decision-makers in this field. But a more formal expert advisory mechanism is needed, to inform the Director-General and other stakeholders about key knowledge gaps and priorities for research and action in the field of ageing and health.

18. A comprehensive global strategy on ageing and health, followed by a global ageing and health action plan with measurable outcomes, is needed to shape future global priorities in this area.

Support to Member States

19. The Secretariat currently supports Member States by providing guidance on key issues and promoting uptake of this evidence into policy and action at country level. This work is carried out by all levels of the Organization. The project on "Knowledge translation on ageing and health" supports Member States in identifying priorities for action and developing evidence-based policy options. The approach was piloted in Ghana in 2013 and will be applied in China in 2014. The Secretariat is also working to support the development of physical and social environments that foster active and healthy ageing through the WHO Global Network of Age-friendly Cities and Communities. This network encourages the exchange of experience and mutual learning between cities and communities that are creating inclusive and accessible "age-friendly" environments. It currently has over 150 member cities and communities in 21 countries worldwide, as well as 10 affiliated country programmes.

20. However, more support is needed. This includes:

- defining the best steps that countries at different levels of development can take to build an integrated continuum of care spanning primary health care, inpatient care, long-term care and end-of-life care;
- identifying evidence-based strategies to create environments that foster healthy and active ageing and enable intergenerational collaboration;
- developing models and standards for monitoring and quantifying the health of older people;

- elaborating strategies for capacity-building and workforce development to address the health needs of older people;

- identifying sustainable financing models to ensure access to services.

Knowledge generation and management

21. WHO will release the first global report on ageing and health in 2015. This will constitute a crucial resource for Member States, defining what is currently known, outlining case studies of innovative responses and making clear the gaps in our knowledge. Nonetheless, there is an urgent need to ensure that these knowledge gaps are included in global research agendas.

22. As a first step, data gathered by the Organization need to be collected across the whole life course and disaggregated by sex and age, to distinguish between different stages of ageing. The standards and practices recommended by WHO for data collection by Member States should also promote disaggregation by sex and age across the whole life course. Furthermore, objective indicators are urgently needed for monitoring the health of older adults, including determinants and consequences, and encouragement should be given to research that identifies the most cost-effective interventions.

ACTION BY THE EXECUTIVE BOARD

23. The Board is invited to note this report and provide further guidance.

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