Policies on Ageing and Health
A selection of innovative models

MULTISECTORAL ACTION FOR A LIFE COURSE APPROACH TO HEALTHY AGEING

Dr. Mathias Bernhard Bonk

Bern, December 2016
Mandated by the Swiss Federal Office of Public Health (FOPH)
Division of International Affairs
Dear Reader,

The good news today is that life expectancies are rising and mortality rates are decreasing in almost every country. However, given decreasing birth rates, the world population is ageing fast. Increasing longevity should ideally be accompanied by an extended period of good health and wellbeing. It is time to prepare our societies for the challenges and opportunities triggered by these demographic shifts.

Switzerland supported the adoption of the Global Strategy and Action Plan on Ageing and Health by the 69th World Health Assembly in Geneva in May 2016 and co-sponsored the respective resolution. Multisectoral action is required to develop age-friendly environments and to transform our understanding of ageing and health. In order to respond efficiently and adequately to the needs of older populations, health systems need to be reformed to ensure sustainable long-term care and workforce capacities. More evidence on the successes or failures of all these measures need to be collected and analysed.

The Action Plan includes a detailed list of contributions to the objectives of the Global Strategy, which Member States, WHO and other UN bodies as well as national and international partners can use for reference. Each country will respond according to its priorities and settings taking into account national context. Switzerland is sharing this comparative study as a tool to initiate a national process to promote healthy ageing, and in the spirit of fostering an exchange of experiences, best practices and innovative models.

We hope you will find this document useful in our common endeavour to provide our citizens with the necessary environment for a long life in good health.

Bern, November 2016
Tania Dussey-Cavassini
Swiss Ambassador for Global Health
Vice-Director General of the Federal Office of Public Health
Population ageing is expected to become the next global public health challenge. The changes caused by this worldwide process are unprecedented and will have profound implications not only for the ageing individual, but also for the society as a whole. The extent of the challenges and opportunities arising from increased longevity will mainly depend on health as the key factor. Age-friendly environments need to be developed and health and long-term care systems should be aligned with the needs of the older population. Economic challenges and financial issues have to be targeted, research encouraged and political commitment ensured. Above all we all need to transform our own understanding of ageing and health, if all these challenges are going to be met.

Overarching national ageing frameworks, innovative policies and public services across multiple sectors and a broader evidence-base will be required. Enabling and supporting ageing populations to enjoy the additional years of life in good health is a crucial consideration in policy development. Therefore WHO’s Member States have been adopting the Global Strategy and Action Plan on Ageing and Health in 2016 to provide a framework for the development and implementation of national healthy ageing policies.

The overall aim of this study is to present public policies and programmes designed to promote healthy ageing. The study is based on national policies and initiatives of five countries, which have already been very active in this field (France, Japan, Netherlands, Norway and Switzerland). Additional policies and innovative approaches for healthy ageing from other countries are also being presented. WHO’s Global Strategy and Action Plan for Ageing and Health has been used as the underlying framework for the study’s structure.

The study demonstrates the complexity of challenges, the diversity of stakeholders involved, and the variety of measures and initiatives in the area of ageing and health. It also illustrates that a coordinated and harmonized approach at local, regional and national levels is beneficial to tackle the challenges. Countries need to identify evidence-based solutions suitable to their respective societal and cultural contexts. Setting measurable and achievable targets will be important for securing political commitment and for raising public awareness. The exchange of knowledge, experiences and good practices nationally and internationally will certainly be helpful for the development and implementation of policies and programmes for healthy ageing.

“Today, most people, even in the poorest countries, are living longer lives. But this is not enough. We need to ensure these extra years are healthy, meaningful and dignified. Achieving this will not just be good for older people, it will be good for society as a whole” (WHO, 2015d).
Margaret Chan, Director-General of WHO
This study has been carried out under the supportive guidance of the Swiss Federal Office of Public Health (FOPH) in Bern. I would like to express my sincere gratitude to Ms Tania Dussey-Cavassini, Vice-Director General of the Swiss Federal Office of Public Health and Ambassador for Global Health, for her advice and support for the analysis and writing. In addition I would especially like to thank Ms Céline Fürst, Swiss Federal Office of Public Health for her very valuable feedback throughout the study.

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# Table of Contents

- Executive summary ............................................. 3
- Acknowledgments .................................................. 4
- List of figures ....................................................... 6
- List of tables .......................................................... 7
- List of abbreviations .................................................. 8
- Study design .............................................................. 9
- Introduction .............................................................. 10
  - I. Demographic change ........................................ 10
  - II. Challenges for ageing societies ............................ 19
  - III. WHO and ageing ............................................. 20
  - IV. International organizations’ responses to ageing... 26

1. National policies for healthy ageing ............... 33
   - 1.1 France .................................................... 35
   - 1.2 Japan .................................................... 50
   - 1.3 Netherlands ............................................. 65
   - 1.4 Norway .................................................... 79
   - 1.5 Switzerland ............................................. 91

2. Innovative policies for healthy ageing ........... 107
   - 2.1. Commitment to action .................................. 110
   - 2.2. Developing age-friendly environments .............. 116
   - 2.3. Aligning health systems to older populations.... 130
   - 2.4. Developing sustainable long-term care systems 137
   - 2.5. Improving measurement, monitoring, research... 144

3. Conclusion ......................................................... 149

Bibliography ............................................................ 151
LIST OF FIGURES

Figure 01  Global population by broad age group 1980 – 2050
Figure 02  Young children and older people as a percentage of global population 1950 – 2050
Figure 03  Percentage of the population aged 60 years or over for the world and regions, 1980 – 2050
Figure 04  Maps of percentage of population aged 60 years or over in 2000, 2015, 2050
Figure 05  Percentage change in the population aged 60 years or over between 2000 and 2015 for the world and regions, by urban / rural area
Figure 06  Population age structure, 1950, 2015, 2050
Figure 07  Sex ratios of the population aged 60 years or over of the world and regions, 2015 and 2050
Figure 08  Life expectancy at birth, world and development regions, 1950 – 2050
Figure 09  Life expectancy at ages 60, world and development regions, 2010 – 2050
Figure 10  Total fertility rate: world and development regions, 1950 – 2050
Figure 11  Total dependency ratio for the world and regions, 1950 – 2050
Figure 12  Determinants of Active Ageing
Figure 13  A Public Health Framework for Healthy Ageing
Figure 14  Active Ageing Index
Figure 15  Global AgeWatch Index
Figure 16  Population by broad age group, France, 1980, 2015, 2030, 2050
Figure 17  Life expectancy at 60 years, France, 1980 – 2050
Figure 18  Population by broad age group, Japan, 1980, 2015, 2030, 2050
Figure 19  Life expectancy at 60 years, Japan, 1980 – 2050
Figure 20  Population by broad age group, Netherlands, 1980, 2015, 2030, 2050
Figure 21  Life expectancy at 60 years, Netherlands, 1980 – 2050
LIST OF FIGURES AND TABLES

Figure 22 Population by broad age group, Norway, 1980, 2015, 2030, 2050. 80
Figure 23 Life expectancy at 60 years, Norway, 1980 – 2050. 81
Figure 24 Population by broad age group, Switzerland, 1980, 2015, 2030, 2050. 92
Figure 25 Life expectancy at 60 years, Switzerland, 1980 – 2050. 93

List of Tables

Table 1 Population aged 60 years or over, by World Bank regions 2000, 2015, 2030, 2050. 12
Table 2 Population aged 60 years or over, by World Bank regions and income groups, 2000, 2015, 2030, 2050. 14
Table 3 Strategic objectives, Global Strategy and Action Plan, WHO 2016. 25
Table 4 Life expectancy, France, 2015. 37
Table 5 Key facts, France, 2015. 38
Table 6 Life expectancy, Japan, 2015. 52
Table 7 Key facts, Japan, 2015. 54
Table 8 Life expectancy, Netherlands, 2015. 67
Table 9 Key facts, Netherlands, 2015. 69
Table 10 Life expectancy, Norway, 2015. 81
Table 11 Key facts, Norway, 2015. 83
Table 12 Life expectancy, Switzerland, 2015. 93
Table 13 Key facts, Switzerland, 2015. 95
<table>
<thead>
<tr>
<th>Abbreviation</th>
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<tr>
<td>AALJP</td>
<td>Active and Assisted Living Joint Programme</td>
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<tr>
<td>AFRO</td>
<td>WHO Regional Office for Africa</td>
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<tr>
<td>DESA</td>
<td>United Nations Department of Economic and Social Affairs</td>
</tr>
<tr>
<td>EB</td>
<td>Executive Board</td>
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<tr>
<td>EC</td>
<td>European Commission</td>
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<td>WHO Regional Office for the Eastern Mediterranean</td>
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<td>IFRC</td>
<td>International Federation of the Red Cross and Red Crescent Societies</td>
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<td>IFA</td>
<td>International Federation of Ageing</td>
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<tr>
<td>LMIC</td>
<td>Low- and Middle-Income Countries</td>
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<tr>
<td>NCD</td>
<td>Non-Communicable Diseases</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>OECD</td>
<td>Organization for Economic Cooperation and Development</td>
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<tr>
<td>PAHO</td>
<td>Pan American Health Organization</td>
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<tr>
<td>SDG</td>
<td>Sustainable Development Goals</td>
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<tr>
<td>SEARO</td>
<td>WHO Regional Office for South East Asia</td>
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<tr>
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<td>Survey of Health, Ageing and Retirement in Europe</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WPRO</td>
<td>WHO Regional Office for the Western Pacific Region</td>
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Aim and Objectives

The overall aim of this study is to present public policies and programmes designed to promote healthy ageing.

The specific objectives are:
- To describe the current context in the area of healthy ageing
- To present the national policy initiatives and programmes of five selected countries
- To identify promising examples of national approaches to healthy ageing from additional countries
- To present examples of innovative policies in various policy fields at the national level aligned with the strategic objectives of the Global Strategy and Action Plan on Ageing and Health
- To provide an overview of useful web-based resources

A mix-methods study based on an extensive, web-based literature and document review and expert consultation has been carried out to address the objectives stated above. The national policies and programmes were identified and analysed by using the five strategic objectives of the Global Strategy and Action Plan as guiding principles.

The study is based on national policies and initiatives of five countries, which have already been very active in this policy field (France, Japan, Netherlands, Norway and Switzerland). Some policies and innovative approaches for healthy ageing from other countries will also be presented.

The focus of this study is on policies and programmes especially developed for people aged 60 years and over. This follows the United Nations standard definition of older people and is currently the most commonly used threshold for national ageing policies (WHO, 2016e).

This age definition might seem to be rather young when discussing the populations of some developed countries where the average retirement age is 65 and life expectancy is the longest. In addition life expectancy is also rising rapidly in the developing countries. However chronological age is not a precise indicator for the changes accompanying ageing populations and there are great variations in health status, social participation and independence levels of older people. These and many other factors, e.g. the cultural context, need to be taken into account by policymakers.

The research methods used in this study are subject to certain limitations. The choice of countries is certainly an important aspect when identifying innovative policy solutions. Another critical aspect is the actual implementation of political decisions. Some of the presented policies and programmes have not yet been completely implemented and many have not been evaluated so far. Thus results achieved may also be due to many other factors, especially in this very multifaceted field with its high number of different stakeholders.
General Introduction

Populations around the world are ageing rapidly, providing a significant human and social resource, but also leading to many challenges in areas such as health, long-term care, social security, pension, finances and economics among others. Countries need to create age-friendly environments to ensure their ageing citizens can enjoy active and healthy lives. The World Health Organization (WHO), other UN organizations, the European Commission and a great number of international and national non-governmental organizations (NGOs) support such activities. Some of these organizations have also developed indices, e.g. Active Ageing Index, to assist policy makers in their planning and evaluating undertakings.

I. Demographic change

The United Nations Department of Economic and Social Affairs (DESA) estimates that the current global population of 7.3 billion will increase to 8.5 billion in 2030 and 9.7 billion in 2050 (Figure 1). The proportion of the global population aged 60 years or over will increase from 12.3% in 2015 to 16.5% in 2030 and 21.5% in 2050 and is expected to reach even 32.8% in the developed world (UN, 2015a). Before long there will be more people globally aged 65 years or over than children under the age of 5 (Figure 2) (NIH, 2011).

Figure 1: Global population by broad age group 1980 – 2050

Source: United Nations, Department of Economic and Social Affairs, Population Division, 2015
The substantial increase in the size of the population aged 60 years or over will be observed in all world regions. While presently the percentage of people aged 60 years and over is highest in Europe and North America (Figure 3), the fastest growth rates in this age group during the next 15 years will be observed in Latin America and the Caribbean (+71%), Asia (+66%) and Africa (+64%).
Globally, the number of people in this age group will more than double from 900 million in 2015 to almost 2.1 billion in 2050. Asia will be home to 60% of the world’s older population with a projected 845 million older people in 2030 and almost 1.3 billion in 2050 (Table 1).

In many developing countries the pace of population ageing is considerably faster than this has been in the developed countries in recent decades. This will lead to additional challenges, e.g. rapid increase in incidence rates of NCDs like diabetes or dementia, and requires a quicker societal adaptation to the needs of ageing populations (UN, 2015b).

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*Source: United Nations, World Population Prospects: The 2015 Revision*
The number of countries in which more than 20% of people will be 60 years or over will increase significantly in the upcoming decades. In 2050 44% of the world population will live in such a relatively aged country (Figure 4).

*Figure 4: Maps of percentage of population aged 60 years or over in 2000, 2015, 2050*

*Source: United Nations, World Population Prospects: The 2015 Revision*
Between 2000 and 2015 the older population in urban areas has been growing faster (+68%) than in rural areas (+25%). This applies to almost all world regions and is due to the ongoing urbanization movement across all age groups, lower mortality risks and better access to healthcare and other services in urban areas (Figure 5) (UN, 2015b).

Substantial population ageing can be seen throughout all income groups. Between 2015 and 2030 the population aged 60 years or over will grow globally by 55.7%. The highest growth rates (+70.2%) will be seen in upper-middle-income countries (e.g. Brazil, China, South-Africa), while the older age group will also grow by 32.0% in high-income countries (UN, 2015b).

### Table 2: Population aged 60 years or over, by World Bank regions and income groups, 2000, 2015, 2030, 2050

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<td>48.4</td>
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**Source:** United Nations, World Population Prospects: The 2015 Revision

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**Figure 5:** Percentage change in the population aged 60 years or over between 2000 and 2015 for the world and regions, by urban / rural area.
The ageing process will lead to substantial changes in the national population age structures of all income groups. While low fertility rates and higher median ages are the main reasons for relatively stable or only slow growing population sizes in developed (e.g. Germany) and emerging economies (e.g. Brazil), a low median age and high fertility rates will lead to substantial population growth in many developing countries like Tanzania (Figure 6) (UN, 2015b).

Figure 6: Population age structure 1950 – 2015 – 2050
Figure 7: Sex ratios of the population aged 60 years or over of the world and regions, 2015 and 2050


In 2015 women still outlived men by 4.5 years and therefore accounted for 54% of the global population aged 60 years or over. The average survival rate of males is expected to further improve in the coming years in most regions of the world (Figure 7).

Figure 8: Life expectancy at birth, world and development regions, 1950–2050


Life expectancies have increased worldwide in an unprecedented way within the past decades. Between 2000 and 2015 the average life expectancy at birth increased by 5 years (Figure 8), in the WHO African Region even by 9.4 years. The latter has especially resulted from the successful achievement of some of the Millennium Development Goals (MDG) such as improving child survival, malaria control measures and expanded access to HIV treatments. Despite all these gains, health inequalities between and within countries persist (WHO, 2016).
Figure 9: Life expectancy at age 60, world and development regions, 2010 – 2050

Healthy life expectancy, the number of years in good health that a newborn in 2015 can expect, stands at 63.1 years globally (64.6 years for females and 61.5 years for males) (WHO, 2016h).

People who survive to age 60 can expect to live 20 additional years. Life expectancy at age 60 will slightly increase in all development regions within the upcoming decades (Figure 9) (UN, 2013b).


In 2015 life expectancy was 71.4 years globally. Women live longer than men in every country of the world. Female life expectancy is 73.8 years, ranging from 50.8 years in Sierra Leone to 86.8 years in Japan. Male life expectancy is 69.1 years, ranging from 49.8 years in Sierra Leone to 81.3 years in Switzerland (WHO, 2016).
Main factors for population ageing in most regions of the world are the falling fertility rates. The total fertility rate has fallen from 5.0 children per woman in 1950 to 2.5 children per woman in 2010. Many developed countries already have fertility rates below the replacement level (2.1 children per woman) (UN, 2013b).

The total dependency ratio is the ratio of the number of young people (0-19 years) plus the number of older people (aged 65+ years), to the number of persons in the working age group (20-64 years). At the global level this has fallen to a historical minimum (74/100) and will only increase gradually in the coming years (Figure 11).


The total dependency ratio is expected to rise rapidly for regions, which already have a higher proportion of older persons and low fertility rates, such as Europe or Northern America. In Africa, despite having a constantly growing percentage of older people, the total dependency ratio will decrease. This is mainly due to a fast growing proportion of the population entering the working age group in the upcoming decades (UN, 2015b).

II. Challenges for ageing societies

Population ageing is expected to become the next global public health challenge (Suzman et al., 2014). The changes caused by this worldwide process are unprecedented and will have profound implications not only for the ageing individual, but also for the society as a whole. The extent of the challenges and opportunities arising from increased longevity will mainly depend on health as the key factor (Beard et al., 2016). Age-friendly environments need to be developed and health and long-term care systems should be aligned with the needs of the older population. Economic challenges and financial issues have to be targeted, research encouraged and political commitment ensured. Above all we all need to transform our own understanding of ageing and health, if all these challenges are going to be met.

Multisectoral action needs to be stimulated to create age-friendly environments, to foster older people’s autonomy and to enable older people’s engagement. Housing solutions, transportation infrastructure and assistive technologies need to be developed to support the older persons keeping their varying functional capacities in mind. Policies to combat ageism, e.g. by eliminating age-related discrimination, promoting and protecting the rights and dignity of older persons and facilitating their social participation are needed (UN, 2015b). Older people’s working capacities need to be supported to increase their livelihood security and social protection through empowerment, improved confidence and reduced social isolation (HelpAge, 2015).

Health systems face a great number of challenges: the national burden of disease range will shift towards non-communicable (e.g. stroke or diabetes) and neurodegenerative diseases (e.g. dementia); there will be an increasing number of patients with multiple morbidities, including hearing and visual impairments as well as increasing physical disabilities; costs for medicines will rise and there will be a lack of specialized geriatric healthcare workers (OECD, 2011). Life course interventions promoting health and preventing diseases at all ages might also help to keep older adults in good health for much longer (Suzman et al., 2014).

Health systems and long-term care systems need to be prepared for a significant increase in the absolute number of older people who are care-dependent. More multidisciplinary teams composed of physicians, nurses, care coordinators, community workers, occupational therapists, physiotherapists and social workers will be required. In addition family caregivers and other volunteers will need to be supported (WHO, 2015e). Improving and monitoring the quality of health and long-term care services are also important to ensure their cost-effectiveness. There is also an extensive knowledge gap hindering evidence-based policy development in this field. Assessing the impact of population ageing on national health budgets, pension systems and other macroeconomic aspects are likewise difficult (Beard et al., 2016; EIUS, 2016).
Overarching national ageing frameworks, innovative policies and public services across multiple sectors and a broader evidence-base will be required. Enabling and supporting ageing populations to enjoy the additional years of life in good health is a crucial consideration for policy development (WHO, 2015e). Therefore WHO has been supporting its Member States e.g. by developing the Global Strategy and Action Plan on Ageing and Health in 2016, a key element for the development and implementation of national healthy ageing policies (WHO, 2016g).

III. WHO and ageing

1999

Active Ageing makes the difference was WHO’s theme for its annual World Health Day during the United Nations (UN) International Year of Older Persons (WHO, 2001).

2002

At the Second World Assembly on Ageing hosted by the UN in Madrid, Spain, the 159 attending UN Member States adopted a political declaration and the Madrid International Plan of Action on Ageing. The Plan focuses on three priority areas: older persons and development; advancing health and well being into old age; and ensuring enabling and supporting environments (UN, 2002a).

The Madrid Plan stresses the crucial role of governments in “promoting, providing and ensuring access to basic social services, bearing in mind specific needs of older persons”. It fully recognises the rights and contributions of older persons themselves and draws attention to the urgent need for action on ageing worldwide (UNFPA, 2012b).

WHO’s Ageing and Life Course Programme presented the Active Ageing Policy Framework to the Assembly as a basis for policy discussion and the development of multisectoral active ageing policies promoting healthy and active ageing (WHO, 2002).
“Active Ageing” is the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age. It applies to both individuals and population groups. Active ageing allows people to realize their potential for physical, social, and mental well-being throughout the life course and to participate in society, while providing them with adequate protection, security and care when needed.

The word active refers to continuing participation in social, economic, cultural, spiritual and civic affairs, not just the ability to be physically active or to participate in the labour force. Older people who retire from work, who are ill or live with disabilities can remain active contributors to their families, peers, communities and nations. Active ageing aims to extend healthy life expectancy and quality of life for all people as they age.

Health refers to physical, mental and social well being as expressed in the WHO definition of health. Maintaining autonomy and independence for the older people is a key goal in the policy framework for active ageing. Ageing takes place within the context of friends, work associates, neighbours and family members. This is why interdependence as well as intergenerational solidarity are important tenets of active ageing.

Source: Adapted from WHO, Active Ageing Policy Framework, 2002
2005
The 58th World Health Assembly adopted a resolution on **Strengthening active and healthy ageing**, urging Member States to develop, implement and evaluate policies and programmes for their older citizens (WHO, 2005).

2006

2009
The Pan American Health Organization (PAHO) presented the **Plan of Action on the Health of Older Persons, including Active and Healthy Ageing**, setting regional priorities for the period 2009-2018 (PAHO, 2009a; PAHO, 2009b).

2012
“Good health adds life to years” was the theme of WHO’s annual World Health Day. The campaign highlighted the positive influences of maintaining good health throughout life to help older people lead full and productive lives as well as being a resource for their families and communities (WHO, 2012b).

Aligned with the **European Union’s European Year for Active Ageing and Solidarity between Generations** WHO Regional Office for Europe presented a **Strategy and action plan for healthy ageing in Europe 2012 – 2020**. The vision of the strategy is to create an age-friendly region where population ageing is seen as an opportunity rather than a burden for society (EURO, 2012).

Acknowledging that healthy ageing is a major public health challenge, health ministers from 11 Southeast Asian countries adopted the **Yogyakarta Declaration on Ageing and Health**, and the WHO Regional Office for South-East Asia **Regional strategy for healthy ageing** (2013-2018) (SEARO, 2012a; SEARO, 2012b).

2013
WHO established the **Global Forum on Innovation for Ageing Populations** as a platform for information exchange between all stakeholders. The WHO Centre for Health Development in Kobe, Japan, hosted the first Global Forum in December 2013 (WHO, 2013).

During its 63rd Session the Regional Committee for Africa adopted a resolution on **Healthy Ageing in the African Region: Situation analysis and way forward**, proposing the development of a regional implementation framework for active and healthy ageing (AFRO, 2013).

2014
WHO Regional Office for the Western Pacific Region (WPRO) presented the **Regional Framework for Action on Ageing and Health in the Western Pacific (2014-2019)** to support Member States in identifying options for strengthening the health sector response to ageing (WPRO, 2014).

2015
The 2nd WHO Global Forum on Innovation for Ageing Populations was held in Kobe, Japan, with the theme “Imagine tomorrow”. Ideas for transforming communities, systems, and technologies for ageing populations were discussed in the context of universal health coverage (UHC) and the new
Sustainable Development Goals (SDG) (WHO, 2015c).

On October 1, the International Day of Older Persons, WHO launched its first World Report on Ageing and Health. The authors emphasize that there was “very little evidence that the added years of life are being experienced in better health than was the case for previous generations at the same age” (WHO, 2015e). The report highlights three key areas for action requiring a fundamental shift in the way society thinks about ageing and older people: creating age-friendly environments; aligning health systems to the need of older people shifting towards an integrated health care system; and building sustainable and equitable systems for long-term care.

The report stresses that governments must ensure policies enabling older people to continue participating in society and reducing inequities, which often lead to poor health in older age. It is calling for comprehensive public health action on population ageing and outlines a Public Health Framework for Healthy Ageing built around the two concepts of intrinsic capacity and functional ability. Intrinsic capacity is referring to the composite of all physical and mental capacities an individual can draw on. Functional ability is defined as the combination of individuals and their environments and the interaction between them (Figure 13) (WHO, 2015e).

Based on these two concepts, WHO defines Healthy Ageing as “the process of developing and maintaining the functional ability that enables well-being in older age”.

Within this overall concept it is important to understand that the trajectory of each individual will be especially dependent on life choices or interventions, while intrinsic capacity and functional ability will change constantly over time.

Figure 13: Public Health Framework for Healthy Ageing: opportunities for public health action across the life course

WHO and its Member States are now working on the Identification of quantifiable progress indicators for each strategic objective in the strategy. In addition an agreement on metrics and methods to assess Healthy Ageing is anticipated for June 2017. WHO will also contribute to the 15-year review of the Madrid International Plan of Action on Ageing. The implementation of the strategy will be evaluated and the direction refined accordingly. Furthermore the proposal for a Decade for Healthy Ageing (2020 – 2030) will be discussed in open consultations with Member States, entities representing older people, bodies of UN system and other key partners and stakeholders (WHO, 2016d).
Multisectoral action for a life course approach to healthy ageing: Global Strategy and Action Plan on Ageing and Health

Following a 2014 World Health Assembly resolution and an extensive consultation process, a comprehensive Global Strategy and Action Plan on Ageing and Health (A69/17) has been adopted by the Member States during the 69th World Health Assembly in May 2016 (WHO, 2014a) (WHO, 2016g). The strategy is aiming at guiding Member States, the WHO Secretariat and other national and international partners to contribute to the vision of “a world in which everyone can live a long and healthy life”. Using a multisectoral approach it is based on the regional strategies of five of WHO’s regions and is aligned with the UN SDG agenda, especially SDG 3 (Ensure healthy lives and promote well-being for all at all ages) (WHO, 2016a).

The guiding principles are:
- Human rights
- Gender equality
- Equality and non-discrimination
- Equity
- Intergenerational solidarity

Two goals have been set:
1. Five years of evidence-based action to maximize functional ability that reaches every person; and
2. By 2020, establish evidence and partnerships necessary to support a Decade of Healthy Ageing from 2020 to 2030.

The strategy focuses on five strategic objectives (Table 3).
IV. International organizations’ responses to ageing

International organizations, e.g. UNFPA, European Commission, the G7 group and non-governmental organizations such as the International Committee of the Red Cross or HelpAge International have also included responses to ageing populations into their working agendas.

UN

In 1982 the United Nations held its first World Assembly on Ageing in Vienna, Austria, adopting the Vienna International Plan of Action and Ageing, which was later endorsed by the UN General Assembly. This also included recommendations in the areas of health, nutrition, environment and social welfare for the elderly (UN, 1982).

In 1990 the UN designated October 1 as the annual International Day of Older Persons, and the UN General Assembly also adopted a resolution on United Nations Principles for Older Persons in 1991 (UN, 1990).

To highlight the necessity for action in the field of population ageing the UN declared 1999 as the International Year of Older Persons (UN, 1998).

During the second World Assembly on Ageing in 2002, the Political Declaration and the Madrid International Plan of Action on Ageing were endorsed (UN, 2002b).

In 2010 the UN General Assembly established the Open-Ended Working Group on Ageing, to discuss the human rights of older people and how best to address or improve them, including the participation of about 40 NGOs in this field (UN, 2014; UN, 2010).

The Population Division of the UN Department of Economic and Social Affairs is monitoring the global, regional and national trends in ageing and its major socio-economic implications. It publishes reports, data sets, briefings and other information and analytical material and organizes expert consultations. A key publication is the Report on World Population Ageing (UN, 2016a; UN, 2013b).

The United Nations Population Fund (UNFPA) has been working to raise awareness about population ageing and the need to address the challenges and to harness its opportunities. UNFPA has been focusing on five key areas: policy dialogue, capacity building, data collection, research and advocacy (UNFPA, 2016). Together with HelpAge International UNFPA is also publishing policy reports, e.g. Ageing in the 21st century and Policy, research and institutional arrangements relating to older persons (UNFPA, 2012b; UNFPA, 2012a).

The International Labour Organization (ILO) and the World Bank have also been providing assistance to Member States in the field of ageing populations (ILO, 2016; WB, 2016).
Active Ageing Index

The **Active Ageing Index (AAI)** is an analytical tool to support policy making for active and healthy ageing. Its aim is to point to the untapped potential of older people for more active participation in employment, in social life and for independent living.


To reflect the multidimensional concept of ageing, the AAI is constructed from **four different domains**. Each domain presents a different aspect of active and healthy ageing. The first three domains refer to the actual experiences of active ageing (employment, unpaid work/social participation, independent living), while the fourth domain captures the capacity for active ageing as determined by individual characteristics and environmental factors.

“**Active ageing** refers to the situation where people continue to participate in the formal labour market, as well as engage in other unpaid productive activities (such as care provision to family members and volunteering), and live healthy, independent and secure lives as they age.” (UNECE, 2016)

<table>
<thead>
<tr>
<th><strong>Active Ageing Domains</strong></th>
<th><strong>Employment</strong></th>
<th><strong>Participation in Society</strong></th>
<th><strong>Independent, Healthy and Secure Living</strong></th>
<th><strong>Capacity and Enabling Environment for Active Ageing</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment Rate 55-59</td>
<td>Voluntary activities</td>
<td>Physical exercise</td>
<td>Remaining life expectancy at age 55</td>
<td></td>
</tr>
<tr>
<td>Employment Rate 60-64</td>
<td>Care to children and grandchildren</td>
<td>Access to health service</td>
<td>Share of healthy life expectancy at age 55</td>
<td></td>
</tr>
<tr>
<td>Employment Rate 65-69</td>
<td>Care to other adults</td>
<td>Independent living</td>
<td>Mental well-being</td>
<td></td>
</tr>
<tr>
<td>Employment Rate 70-74</td>
<td>Political participation</td>
<td>Financial security (three indicators)</td>
<td>Use of ICT</td>
<td></td>
</tr>
</tbody>
</table>

**Figure 14a: Active Ageing Index**

**Source:** Adapted from UNECE, 2016
**Figure 14b**: Active Ageing Index
*Source*: Adapted from UNECE, 2016

- **High index value**
- **Middle index value**
- **Lower index value**
The European Commission has also been intensifying its work in the area of active and healthy ageing. The European Union (EU) promoted active ageing during the European Year 2012 for Active Ageing and Solidarity between Generations (EC, 2012b). One of the key objectives was “to raise general awareness of the value of active ageing and its various dimensions and to ensure that it is accorded a prominent position on the political agendas of stakeholders at all levels” (EP, 2011).

Guiding principles for active ageing were prepared by the Social Protection Committee and the Employment Committee and agreed on by the members of the Council of the European Union (EU, 2012). An Active Ageing Index has been developed to assess the potential of seniors in the EU (UNECE, 2016).

In 2012 the EC published a comprehensive report about Healthy Ageing – a challenge for Europe resulting from a joint project involving other key partners including 10 member states, WHO, the European Older People’s platform (AGE) and the EuroHealth-Net. It includes data, good practice examples and more information on policies and strategies for healthy ageing (EC, 2012c).

The European Innovation Partnership on Active and Healthy Ageing was established in 2011, bringing together all relevant actors at EU, national and regional levels from various sectors to foster research and innovation in this field. The objectives of this partnership are to improve health and quality of life of Europeans with a focus on older people, to support the long-term sustainability and efficiency of health and social care systems and to enhance the competitiveness of EU industry through business and expansion in new markets. Action Groups within this partnership have been working on different areas related to ageing and health, e.g. fall prevention, independent living solutions or the adherence to prescriptions. In addition a repository of innovative policies is being provided (EC, 2012a).

G7 / G8

The G8 group presented their Turin Charter Towards Active Ageing in 2000, recognizing that ageing societies will create new opportunities as well as challenges and that older people represent a great reservoir of resources for economies and societies. The G8 called for concerted efforts, coherent strategies and enhanced partnerships with all stakeholders involved (G8, 2000).

At the G7 Ise-Shima Summit in Japan in May 2016, the G7 leaders made the commitment to take action towards promoting healthy and active ageing. Acknowledging the wide-reaching effects of population ageing in the health sector and beyond, the G7 group called for multisectoral action in the field of active ageing, including more programs for disease prevention and health promotion. The G7 group has supported WHO’s efforts to implement the Global Strategy and Action Plan on Ageing and Health and has been encouraging developing and transitional countries to develop national and regional action plans accordingly (G7, 2016).
Non-Governmental Organizations & Networks
A multisectoral approach is necessary to provide an age-friendly environment and health and long-term care systems that are aligned with the needs of the ageing populations. In many cases Non-Governmental Organizations (NGOs) and stakeholder networks are at the forefront of the activities in this field. Their work and experiences can be beneficial for policy and other decision makers. Many of these NGOs and networks have also enabled older people to engage actively in the development and implementation of initiatives and programmes (e.g. as volunteers or policy advisors). Some examples:

The **International Federation of the Red Cross and Red Crescent Societies** (IFRC) works with and advocates on behalf of older people and has called upon governments, national societies and other partners to prepare for the societal transformation by recognizing older people as an important resource in society, promoting active ageing and strengthening inter-generational solidarity. The IFRC has also been delivering a range of services to older people, e.g. through community-based home care programmes. In addition it has encouraged older people to volunteer, contributing their knowledge, experience and skills to help others (IFRC, 2013).

**HelpAge International** is a global network of organisations working with and for older people. Its vision is to create a world in which all older people can lead dignified, active, healthy and secure lives. The network members are committed to helping older people to claim their rights, challenging discrimination and overcoming poverty. HelpAge International has developed the **Global AgeWatch Index** (page 36) (HelpAge, 2016c; HelpAge, 2016b).

The **International Federation on Ageing** (IFA) is an international NGO with members from governments, industry, academia, other NGOs and individuals from 70 countries. Their goal is to be a global connecting center with a network of experts shaping age-related policies that improve the lives of older people (IFA, 2016).

Another multinational consortium consisting of member organizations is the **International Longevity Centre Global Alliance** (ILC Global Alliance). Its mission is to help societies to address longevity and population ageing, using a lifecourse approach. ILC Global Alliance members have been carrying out this mission by developing ideas, conducting research projects or organizing discussion fora, always including older people as key stakeholders (ILC, 2016).

**AGE Platform Europe** was set up in 2001 to strengthen the cooperation between organizations of older people and organizations for older people at EU level (all non-profit). The work is focusing on many ageing-related policy areas like anti-discrimination, employment, social protection, health or elder abuse among others (AGE, 2016).

The **NGO Committee on Ageing**, founded in 1977, is based at the UN Headquarters in New York, USA. It is a membership organization promoting and supporting the development of a UN Convention for the Rights of Older Persons. Its members have actively participated in the national and regional implementation of the Madrid International Plan of Action on Ageing (NGOCA, 2016).
### Global AgeWatch Index

The Global AgeWatch Index has been developed and constructed by HelpAge International from international data sets drawn from the UN Department of Economic and Social Affairs, the World Bank, WHO, ILO, UNESCO and the Gallup World Poll.

The index makes international comparisons of quality of life in older age possible. It is a tool to measure progress and it aims to improve the impact of policy and practice on ageing populations. The index brings together a set of internationally comparable data based on older people’s income status, health status, capability, and enabling environment.

The aim of the index is to capture the multidimensional nature of the quality of life and wellbeing of older people, and to provide a means by which to measure performance and to promote improvements (HelpAge, 2016b).

#### Figure 15a: Global AgeWatch Index

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Pension income coverage</td>
<td>2.1 Life expectancy at 60</td>
<td>3.1 Employment of older people</td>
<td>4.1 Social connections</td>
</tr>
<tr>
<td>1.2 Poverty rate in old age</td>
<td>2.2 Healthy life expectancy at 60</td>
<td>3.2 Educational status of older people</td>
<td>4.2 Physical safety</td>
</tr>
<tr>
<td>1.3 Relative welfare of older people</td>
<td>2.3 Psychological wellbeing</td>
<td>3.3 Civic freedom</td>
<td>4.3 Civic freedom</td>
</tr>
<tr>
<td>1.4 GDP per capita</td>
<td></td>
<td></td>
<td>4.4 Access to public transport</td>
</tr>
</tbody>
</table>

**Source:** Adapted from Global AgeWatch, 2015
Figure 15b: Global AgeWatch Index

Source: Adapted from Global AgeWatch, 2015
In the following chapters the national policy initiatives and programmes to promote healthy ageing of five selected countries are presented (France, Japan, Netherlands, Norway and Switzerland). These national policies and programmes were identified and analysed by using the five strategic objectives of the Global Strategy and Action Plan as guiding principles:

1. Commitment to action on Healthy Ageing in every country
2. Developing age-friendly environments
3. Aligning health systems to the needs of older populations
4. Developing sustainable and equitable systems for providing long-term care (home, communities, institutions)
5. Improving measurement, monitoring, research on Healthy Ageing

A number of subcategories of actions, aligned with the respective strategic objectives, have been selected. These subcategories obviously overlap in some cases (e.g. employment, healthcare workforce), but duplication has been avoided. Despite the availability of 2016 data from some countries, data from 2015 or previous years using the same source have been included to allow better comparability.
Key facts

The UN estimates that the French population of 64.4 million will increase to 68.0 million by 2030 and to 71.1 million by 2050.

The population of France is ageing fast and has one of the highest proportions of older people in the world. More than 25.2% of the population is 60 years or older. This percentage is likely to increase to 29.9% in 2030 and 31.8% in 2050 (Figure 16).

Despite the increasing aging population the median age will increase only slightly from 41.2 years in 2015 to 43.0 years in 2030 and 43.9 years in 2050 (UN, 2015a).

France’s total fertility rate (births per woman) is 2.0, which is the 2nd highest in the EU and nearly as high as the replacement level for industrialized countries of about 2.1. In addition older people remain in better health than in most other European countries. Therefore the ageing process in France is mainly driven by the increasing life expectancy rather than by low fertility rates as in other developed countries (WB, 2014; EUOBS, 2015).

Figure 16: Population by broad age group, France, 1980, 2015, 2030, 2050

Source: UN DESA, Profiles of Ageing, France, 2015
Life expectancy

Like in most OECD countries life expectancy in France has been rising over the past decades due to improvements in living conditions, public health interventions and progress in the healthcare sector (OECD, 2016h).

France now has some of the highest life expectancies worldwide. Girls born in 2015 can expect to live 84.9 years and boys 78.8 years. The gender gap, which can be seen in many other European countries as well, is likely to be reduced in the future (UN, 2015a; UNDATA, 2016; WHO, 2016o).

Life expectancies for people 60 years of age are also considerably high in France and will be further growing in the next decades.

<table>
<thead>
<tr>
<th>2015</th>
<th>Both sexes</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth</td>
<td>81.9</td>
<td>84.9</td>
<td>78.8</td>
</tr>
<tr>
<td>Healthy life expectancy at birth (2012)</td>
<td>72</td>
<td>74</td>
<td>69</td>
</tr>
<tr>
<td>Life expectancy at 60</td>
<td>25.7</td>
<td>27.7</td>
<td>23.5</td>
</tr>
</tbody>
</table>

Table 4: Life expectancy, France, 2015

Sources: UN DESA, Profiles of Ageing, France, 2015; UN DATA, 2016; WHO, World Health Statistics, 2016;
Health system

The French health system consists of a diverse group of institutional and individual actors from both the public and private sectors. At the national level the Ministry of Social Affairs, Health and Women’s rights is responsible for defining the country’s health strategy, including the planning, regulating and budgeting of the system. Regional Health Agencies are in charge of the administration of health and social affairs. They are responsible for population health (health promotion and disease prevention) and health care. Local governments (General Councils) are responsible for health and social care of the elderly and disabled people (CF, 2015).

Since the implementation of the Universal Health Coverage Act in 1999 all residents in France have been covered by a statutory health insurance system. The health insurance is based on a redistributive funding model, including a specific system to allow free access to care for the very poor. Through this model the French system nearly reaches universal health coverage of the population (Nay et al., 2016). The health insurance is financed by employer and employee (64%), a national earmarked income tax (16%), taxes on tobacco and alcohol, the pharmaceutical industry, voluntary health insurance companies (12%), state subsidies (2%) and other social security branches (6%). France also has a universal mandatory long-term care insurance scheme, the Allocation Personnalisée Autonomie (APA) (Robertson et al., 2014).

Health expenditure accounted for 11.0% of the GDP in 2015 (OECD avg. 8.9%). Public spending on long-term care in 2014 was 1.3% of the GDP, which has slowly increased in the last decade (OECD avg. 1.4%) (OECD, 2016c).

Pension system

The French pension system for the private sector is based on two public mandatory levels: a defined-benefit pension and occupational schemes. A minimum contributory pension is included in the benefit scheme and a minimum income for the elderly is also guaranteed (OECD, 2015b).

The current statutory retirement age in France has long been 60 years with workers retire at the age of 59 years on average, which is relatively low in comparison to most other OECD countries. Labour force participation of people 65 years and over is therefore also comparatively low. The government has been introducing a number of reform acts in recent years. It is now gradually increasing the minimum retirement age from 60 to 62 years and the contributing time required for full pension eligibility from 165 to 172 quarters. Both are calculated in relation to the birth year of the individual (OECD, 2015b; Cleiss, 2016). The total dependency ratio is going to increase mainly due to a growing number of people aged 65 or over (Table 5) (UN, 2015a).

<table>
<thead>
<tr>
<th>Key facts</th>
<th>2015</th>
<th>2030</th>
<th>2050</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pension coverage (65+)</td>
<td>100%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Statutory retirement age (years)</td>
<td>60 -&gt; 62</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Labour force participation 65+ (%)</td>
<td>2.9</td>
<td>5.8</td>
<td>-</td>
</tr>
<tr>
<td>Total dependency ratio (Per 100 persons aged 15-64)</td>
<td>60.3</td>
<td>69.5</td>
<td>75.9</td>
</tr>
</tbody>
</table>

Table 5: Key facts, France, (2015)

Source: UN DESA, Profiles of Ageing, France, 2015
National Policies related to Healthy Ageing

Since the 1990s demographic change and its impacts on society and individuals has been on the political agenda in France. At that time a medico-social approach to old age was being used. A special allowance for elderly people was introduced in 1997, followed by the creation of a personal autonomy allowance (APA) in 2002 to finance home care services and residential care. Further reforms of the traditional policies and initiatives were triggered especially by the devastating outcome of the summer 2003 heat wave, when more than 15,000 elderly people died of dehydration and as a result of the slow response by the social and health care sectors (EUOBS, 2015).

The French government developed a national action plan Bien Vieillir (Good Ageing) using a holistic approach, which was adopted by several ministries in 2007. The plan had a strong focus on health promotion and other health-related issues concerning older people, including creating age-friendly environments, encouraging social participation and promoting intergenerational solidarity (FRA, 2007). An annual La Semaine Bleu (Blue Week) is held to provide information about the contributions of pensioners to the social, cultural and economic sectors and about the concerns and challenges they face (FRA, 2016p). A new French public health law was enacted in January 2016, emphasizing the importance of access to healthcare and prevention. This law foresees a wide-range of prevention measures through the life course, planning to reduce financial and other barriers in access to healthcare, especially for the poorest population and to ensure patient rights (FRA, 2016h).

Promoting healthy ageing is also a key objective of the Act on adapting society to an ageing population, which came into force on January 1, 2016 (FRA, 2016a). The Act has been developed through an interministerial process led by the Ministry of Social Affairs and Health. This act is considered to be as “ambitious” and as “marking a turning point in long-term care policies in France”, but adequate financing remains to be a great challenge (ESPN, 2016).
Vision

The French government is envisioning a society in which the ageing population can live an independent and healthy life in their own homes as long as they wish.

Approach

The French government envisions to strengthen the coordination of health and social care services and various other stakeholders involved in ageing issues (institutional, professional and political). The aim is to give more elderly people the option of staying at home by increasing benefits, investing in new technologies and training social care workers. In addition measures to support informal carers are being planned (FRA, 2016b).

Focus

The new act is using a comprehensive, crosscutting approach to promote independent living for the elderly. It is based on three key areas (FRA, 2016a):

- **Anticipating loss of autonomy**
  By e.g. meeting the demands for housing, transport, social and civic life, preventing and combating isolation

- **Adapting society to ageing**
  By e.g. adjusting private housing, renovating residence accommodation or encouraging volunteering activities

- **Support of the older people facing loss of autonomy**
  To support the elderly to live in their own homes
Commitment to action on Healthy Ageing

Ageism
According to the results of the European Social Survey 68% of French citizens thought age discrimination was a very or quite serious problem in their country (EURAGE, 2011). In 2010 7% of French workers 50 years or older complained of discrimination at their workplace (vs. 4-5% as the European average) (OECD, 2014e). The French discrimination law is constructed on the basis of the principle of equality and freedom included in a number of constitutional and international texts. France has implemented laws aligned with the EU anti-discrimination directives in 2001 and 2008. Since 2006 a government policy, supported by an inter-industry collective agreement, is aiming at increasing the level of employment of older workers. Since 2010 companies can be penalised for not providing measures in favour of seniors’ employment (CAPSTAN, 2016).

Gender
Gender inequality remains an issue in France. Employment and pension policies still lead to gender inequalities, gender occupational segregation and the marginalization of women, especially at the end of their working life. The French government has nominated a Minister for Women’s rights in 2012, initiated new laws to promote gender equality and included this aim in all domains of its public policy. While age differences are included in these policies, inequalities linked to migration, ethnicity or geographic location still require more consideration (EP, 2015a).

As part of the new ageing act, the French government has been offering French citizenship to foreign-born people aged 65 and over, who have been living in France for 25 years and who have French children. This would give them a number of additional rights in comparison to their current status (FRA, 2016a).

Poverty
Poverty rates in the older population are relatively low in France. While 3.4% of the people aged 60 to 74 years are poor (and 3.2% of those >75 years), 8.1% of the French population is categorized as poor (INSEE, 2013). The French government is using a multi-year plan against poverty and to support social inclusion and a new law has been introduced in 2016 to support workers receiving only small incomes (“Prime d’activité”) (FRA, 2016o; FRA, 2016k).

Employment
The period of transition from employment to retirement starts earlier and poses additional challenges for workers in France. Many older people experience longer periods of unemployment at the end of their careers, despite the fact that French workers retire at about 60 years on average, compared to an average of 64.7 years in the OECD area. The OECD has recommended strengthening incentives to continue working, removing obstacles to hiring older workers and improving their employability. The French government has been providing financial assistance and preferential access to government contracts for employers hiring unemployed people aged 50 years and over (OECD, 2014b). “Fifti – New Professional Dynamics after 45” is another initiative promoting career development in older age groups supported by the French government (FIFTI, 2016) In addition a special “Silver economy” committee has been set up to assess the economic challenges and opportunities arising from an ageing society (FRA, 2016e).
Developing age-friendly environments

**Rights and assistance**
The Ministry of Social Affairs and Health is responsible for protecting the rights of the elderly and for providing them with assistance to live an active and healthy life. A minimum income for people from the age of 65 is being ensured through a “solidarity allowance for the elderly” (FRA, 2016f).

**Elder Abuse**
A 2011 study using data from the French national elder abuse helpline suggests that about 5% of persons 65 years and older and 15% of persons aged 75 years and older might be affected by abuse (UNECE, 2013). The Ministry of Social Affairs and Health has been supporting the “3977” project, a network of telephone helplines for older people who are victims of abuse. Trained volunteers have been supporting the victims, developing a knowledge base and raising awareness about the issue in France (FRA, 2016l).

**Prevention of falls**
The French institute for prevention and health education (INPES) estimates that a third of the elderly population aged 65 years or more who live at home will experience a fall each year. INPES has therefore published information and guidelines on fall prevention in the elderly (INPES, 2010). The French National Pension Insurance Fund (CNAV) has set up a national prevention policy based on data on frailty from the national health insurance and the pension insurance fund. At-risk territories have been identified, fields for social prevention programmes selected and an overall needs assessment conducted. Personalised social action plans (PAP) are being used to preserve the autonomous well-being of the elderly (Hughes, 2016).

**Mobility**
An analysis by the EC on “Mobility Patterns in the Ageing Populations” shows that the car remains the primary form of transportation for older age groups in France. Older people living in urban areas, having a higher education level and / or are living in single households appear to be more mobile (Bell et al., 2013). Public transport in France is organized at the regional and local level. A number of mobility solutions for the elderly population have been implemented such as reduced fares, better access or a special rickshaw service in Lyon (Lyon, 2012).

**Cities and communities**
A number of cities and communities in France have joined the WHO Global Network of Age-friendly Cities and Communities (Dijon, 2009). Dijon, for example, has been working on an age-friendly city project since 2010. Following an inclusive and comprehensive process about 100 actions and improvements have been selected and four pillars for the cities’ active ageing policy using the principal of intergenerational solidarity have been identified. These include an “Office for Dijon Seniors”, a “Guide for Seniors”, a one-stop facilitation centre (“Center for seniors”), and the creation of an “Observatory on Age” consisting of a multisectoral participation and aiming at promoting innovation and at monitoring policies in the area of ageing (Dijon, 2016). In response to a suggestion by the WHO Regional Office for Europe, the French Network of Healthy Cities has been formally established in 1990. More than 80 cities have joined this network to exchange information, experiences and best practice solutions (Villes-Santé, 2016).
Housing
One of the main goals of the French government’s new ageing Act is to support independent living at home for which a National Adaptation Plan is currently under development. Within this plan the National Housing Agency (ANAH) and the National Pension Insurance (CNAV) will be responsible for renovating more than 80,000 private accommodations with public support by 2017 (FRA, 2015b). A special information campaign on the new policies, solutions and funding opportunities focusing on the adaptation of houses and flats for the elderly is being conducted through the national information portal (FRA, 2016m). The Ministry of Environment, Energy and the Sea, has also published a comprehensive guide on the adaptation of housing to people with disabilities and the elderly, including available funding opportunities (FRA, 2015a).

The French government is also working closely with Caisse des Dépôts, a financial institution under parliamentary control. This cooperation has been focusing on structuring the silver economy sector, contributing to the adaptation of social housing stock to changing needs, financing the construction and renovation of special residences for the elderly, supporting local authorities as they develop their strategy for the silver economy and proposing new ways for seniors to mobilise their assets. Demographic transition has also become one of the strategic priorities of Caisse des Dépôts (CDD, 2015).

Active and Assistive Living
Caisse des Dépôts is also one of the multisectoral partners of the Autonom@Dom project, which is led by the Department of Isère in partnership with the National Health Insurance Fund, regional health authorities and other public and private stakeholders. This project uses telecare, telehealth and telemedicine as well as personal and household services and medical assistance through a 24/7 telephone helpline. The aim is to identify innovative solutions to enable older people to live independently and to increase their social participation despite an increasing need for care (ISERE, 2015).

The Bretagne and Limousin regions are involved in the Coral project, a European network of regions collaborating in the field of assisted living and healthy ageing. An open innovation process is used to overcome barriers for implementing assisted living solutions and services and to develop regional policies in these areas (CORAL, 2015).

Social participation
One of the key objectives of the French government’s new ageing Act is to enhance the participation of older people in the development of public policies, especially in relation to the challenges of an ageing society (FRA, 2016e). The French National Pension Fund and Public Health France have launched a comprehensive web-portal covering a wide-range of information and opportunities for older people to stay healthy and socially active (“Bien Vieillir”) (PBV, 2016).
The French organization “Petits Frères des Pauvres” (Little brothers of the poor), founded in 1946 provides assistance to frail and isolated older people living in poverty. Besides emotional support and building human relationships, the organization has been engaged in developing innovative housing solutions and raising awareness on the political level (PF, 2016).

**Voluntary work**
In France the participation rates for voluntary activity increases with age, reaching a maximum of about 37% in the age group between 60 and 74 years (EFILWC, 2011). Since the 2007 National Plan on Successful Ageing, the French government has been encouraging older people to get involved in volunteer activities. In addition it supports national volunteer organizations such as “France Bénévolat” or “Passerelle et compétences”, which are linking applicants, including older people, and associations (FB, 2016; PC, 2016).

**Lifelong learning**
France has a relatively high participation rate in lifelong learning activities in Europe. 18.6% of survey participants aged 25 to 64 had participated in educational or training activities for work or leisure during a 4-week period before the survey in 2015 (European average 10.9%) (EUROSTAT, 2016). According to the World Economic Forum’s Human Capital Index, France is among the world leading countries in relation to using and supporting the skills and competencies of its citizens (WEF, 2015a). The French government has encouraged older people to continue learning and to strengthen their cognitive functions. The French Ministry of Health, for example, supports the network of “Universities for all ages”(UFUTA, 2016).

**Nutrition**
The French National Programme for Food is aiming at guaranteeing quality food for all citizens, especially for the elderly. The Ministry of Social Affairs and Health has published special guides for local authorities (e.g. to set up home delivery services) and for facilities housing elderly people (e.g. to improve the provision and quality of food) (MB, 2016; FRA, 2016c).
Aligning health systems to the needs of the elderly

The French government presented a new national health strategy in 2013 aiming at restructuring the health system in order to combat inequities and inequalities, to provide access to everyone, to make it more people-centred and to adapt it to current and future challenges such as the ageing population and the rising burden of chronic diseases (FRA, 2016g). This strategy and public consultations, including 150 public forums involving 23,000 participants, were used as the basis for a new National Health Law, which was adopted by the parliament in 2015. The law has a strong focus on developing prevention measures, defining patient care pathways and improving geographical and financial access to care (Touraine) (EUOBS, 2015).

Health promotion

As part of the national health strategy, a new national public health agency, Public Health France, has been created in 2016. The agency is taking over the responsibilities of three existing agencies in the areas of health observation, risk assessment, health promotion and disease prevention as well as health education (INPES, 2016a). One of the key areas of work is healthy ageing, including the protection of autonomy and prevention of disabilities in the older age groups. The work includes conducting surveys, providing patient information, raising awareness through campaigns or supporting health care and social professionals, who are working with elderly people (INPES, 2016b).

Prevention

The Ministry of Social Affairs and Health presented a National Action Plan for the prevention of loss of autonomy in 2015. This comprehensive plan is covering a wide range of areas, including primary, secondary and tertiary prevention, reducing health inequalities, training professionals and developing research and evaluation strategies (FRA, 2015c).

The former National Institute for prevention and health education, INPES, which is now part of Public Health France, had launched a special “To get older in good health” campaign in 2013. This campaign targeted young people and future retirees and included information on prevention, healthy lifestyles, nutrition, physical activity as well as emotional and mental health (EuroHealthNet, 2016). The French branch of the International Longevity Centre and the Pension Fund Klesia have launched an online prevention tool for all ages, offering individualized lifestyle and medical advice and recommendations for preventative measures (ILC, 2015; CPS, 2016).

Vaccinations

Besides the basic immunizations, which should be checked regularly, an annual influenza vaccination for people 65 years and over is recommended in France. In addition, a vaccination against shingles is recommended for people aged 65 to 74 (FRA, 2016d).
Non-communicable diseases
The French government has recently presented a number of plans and strategies to prevent and treat NCDs, e.g. the National Cancer Plan (2014), a Neurodegenerative Diseases Plan (formerly covering Alzheimer only) and a National Health and Environment Plan. Other programmes and initiatives are targeting alcohol and tobacco consumption, physical activity and nutrition (FRA, 2014b; FRA, 2014a; FRA, 2016; FRA, 2016n).

Health workforce
The geographical distribution of the health workforce in France is uneven. Several projects are aimed at reducing these disparities, including incentives for health professionals to move to underserved areas or shifting of tasks from physicians to nurses (FRA, 2016i).

The Ministry of Social Affairs and Health has been using a projection model for physicians, including scenarios on the development of medical education, specialist training, retirement patterns and other aspects. The results have shown that the postponement of retirement of physicians and nurses might have the biggest impact on the projected decline of the physician to population ratio in France, which is especially caused by the ageing of the population (OECD, 2016f; FRA, 2009).
Developing sustainable and equitable long-term care systems

Long-term care for the elderly and disabled is integrated into the “third sector” of the social system, which combines the health and social care elements in France. Care is being provided at home or as residential care in collective housing facilities, retirement homes and intermediate or long-term care units (EUOBS, 2015). While the medical costs for long-term care are covered by the statutory health insurance, patients and their families are responsible for the housing costs in long-term care facilities and hospices (CF, 2015).

Since the reform of the social care system in 2002 a universal mandatory long-term care insurance scheme has been introduced. Citizens, older than 60 years, with care needs can apply for a personal autonomy allowance (APA) to cover the costs of social care services and of additional support costs (e.g. for technical devices). The APA is funded through general taxation at central and regional level (Robertson et al., 2014).

Local political levels have the main responsibilities for providing long-term care facilities and for supervising the quality of the services. They are supported by two national agencies in charge of policy supervision (CNSA) and of quality control and practice guidelines in the area of long-term care (ANESM) (Interlinks, 2011).

In 2014 the French public spending on long-term care was 1.3% of the GDP, which is slightly lower than in many other OECD countries (OECD avg. 1.4%) (OECD, 2016c).

The new act on adapting society to an ageing population is re-emphasizing the principle of “ageing at home” (Maintien à domicile), the APA will be re-evaluated, the rights of seniors, especially those living in retirement homes, will be strengthened and living conditions for the elderly will be improved, e.g. by investing in the adaptation of houses and the modernization of retirement homes (FRA, 2015b).

Improving the coordination of health and social care services, especially for older people and those with chronic diseases, is of high priority for the French government. Since 2013 the Ministry of Social Affairs and Health has launched nine regional pilot projects aiming at optimizing care pathways for frail people over 75 years of age. These are conducted and adapted to local circumstances by the regional health authorities. In addition a common set of tools is being used, including a personalized health plan, an information-sharing platform and a messaging tool for exchanging patient information between health professionals (EUOBS, 2015). Following these pilot projects, the program will now be expanded and implemented at the national level (“Personnes Agées En Risque de Perte d’Autonomie”, PAERPA) (FRA, 2016i). To improve coordination in the palliative care field a National Centre for Palliative Care was established in 2016 as part of the National Palliative Care plan (2015 – 2018) (FRA, 2016q).
The French government has been emphasizing the importance of supporting family caregivers, for example, by giving them the opportunity to be employed by the patient through APA funding, but spouses remain excluded from this (EUOBS, 2015). The importance of non-family carers (e.g. neighbours or friends) is also being increasingly recognized, e.g. in the law on adapting society to an ageing population. An allowance to pay for day care centres is also included within this law, supporting the “right to respite” for carers (FRA, 2016a). A national information portal to promote the autonomy of the elderly and to support their relatives, including a wide-range of information, links and contact numbers has also been launched (FRA, 2016m).

Long-term care workforce
Similar to the situation of the increasing need for physicians in France, there will be an increasing need for nurses and other caregivers in the upcoming years to care for the ageing population. Projection models show that a gradual two-year postponement of the retirement of nurses would have a substantial impact in responding to these challenges (Ono, 2013).
Measurement, Monitoring and Research

As part of its 2015 Health Law, the French government has been planning to introduce a national health data system bringing together the major medical administrative databases (e.g. reimbursement for medical expenses, duration of hospital stays, risk factors for premature deaths etc.). The government is also planning to make this data available for NGOs, associations, research centres and the private sector (FRA, 2016h).

Most of the research on issues related to ageing and health has been conducted or supported by the state in France. The French Institute for Demographic Studies (INED) has conducted research in the area of Healthy Ageing. The National Institute of Statistics and Economic studies (INSEE) has provided census and socioeconomic survey data and the National Institute for Health and Medical Research (INSERM) has mainly been working on health-related research (Béland and Durandal, 2012).

Public Health France has conducted general population surveys and other research activities within its lifecourse and healthy ageing programs (INPES, 2016b). French E3N cohort study, initiated in 1990, comprising 100,000 women between 40-65 years of age, has been investigating risk factors for cancer and other non-communicable diseases. There has been a recent increase in investigations related to age-related diseases and conditions. A new E4N cohort, comprising the children and grandchildren of the women included in the E3N study as well as the fathers of these children, has now been started, enabling research using a transgenerational approach (Clavel-Chapelon and Group, 2015).

Research on ageing and health is also being conducted in France by independent social insurance agencies. The National Retirement Fund of Public Social Security, (CNAV) is publishing a special journal presenting retirement and pension research (“Retraite et Société”). A trust fund agency for long-term care, CNSA, also supports research and its dissemination in the field of ageing and health (Béland and Durandal, 2012).

French agencies, institutions and researchers have been involved in a number of European age-related research projects, e.g. in the Survey of Health, Ageing and Retirement in Europe (SHARE) or the FUTURAGE project, funded by the European Commission, to identify the main research priorities for ageing and health from a multi-disciplinary perspective (SHARE, 2016; FUTURAGE, 2011).

The French Geriatric and Gerontological Association (SFGG) and the National Gerontological Foundation (FNG) have been involved in research projects and networks and key resources for research related to ageing and health in France (SFGG, 2016) (FNG, 2016).

The French Ministry of Social Affairs and Health and the Ministry of Economy have been promoting the “Silver economy” to enable and encourage innovations supporting the elderly and promoting their autonomy (FRA, 2016e). France is also an active member of the European Innovation Partnership on Active and Healthy Ageing (EC, 2012a).
1.2 JAPAN
Key facts

It is estimated that the Japanese population will substantially decline from 126.6 million to 120.1 million by 2030 and to 107.4 million by 2050.

The population of Japan is ageing fast and has the highest proportions of older people in the world. More than 33.1% of the population is 60 years or older. This percentage is going to increase to 37.3% in 2030 and 42.5% in 2050 (Figure 18) (UN, 2015a). A significant increase is especially being predicted for the 80+ age group. Japan is therefore often described as a “super-ageing” society (McCurry, 2015).

The median age in Japan will increase further from 46.5 years in 2015 to 51.5 years in 2030 and 53.3 years in 2050 (UN, 2015a).

Japan’s total fertility rate is 1.4, which is among the lowest in the world and far below the replacement level for industrialized countries of about 2.1. Older people in Japan remain in better health than in most other countries. Therefore the ageing process in Japan is especially driven by the low fertility rates in the past decades and the increasing life expectancy (WB, 2014; WPRO, 2011).

Figure 18: Population by age group, Japan, 1980, 2015, 2030, 2050

Source: UN DESA, Profiles of Ageing, Japan, 2015
Life expectancy

The health situation in Japan remains one of the best in the world and health disparities within the country are comparatively small (WPRO, 2011). Like most OECD countries life expectancy in Japan has been rising over the past decades due to public health interventions, progress in the healthcare sector and improvements in living conditions and especially also in the education sector (OECD, 2016b). Japan has some of the highest life expectancies worldwide. Girls born in 2015 can expect to live 86.5 years and boys 80.0 years. The gender gap is likely to remain in the future (UN, 2015a; UNDATA, 2016; WHO, 2016o).

Life expectancies for people 60 years of age are also considerable in Japan and will be further growing in the next decades.

<table>
<thead>
<tr>
<th>2015</th>
<th>Both sexes</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth</td>
<td>83.3</td>
<td>86.5</td>
<td>80.0</td>
</tr>
<tr>
<td>Healthy life expectancy at birth (2012)</td>
<td>75</td>
<td>77</td>
<td>72</td>
</tr>
<tr>
<td>Life expectancy at 60</td>
<td>25.8</td>
<td>28.4</td>
<td>23.0</td>
</tr>
</tbody>
</table>

*Table 8: Life expectancy, Japan, 2015
Sources: UN DESA, Profiles of Ageing, Japan, 2015; UN DATA, 2016; WHO, World Health Statistics, 2016*

*Figure 19: Japan, Life expectancy at age 60 years
Sources: UN DESA, Profiles of Ageing, Japan, 2015*
Health system

The Ministry of Health, Labour and Welfare (MHLW) is responsible for the national health strategy, the “National Strategic Plan for Medical Care”, to ensure a health system of high quality and to provide appropriate medical care. At the regional level, each of the 47 prefectural governments has been setting up prefectural health care plans catering to the local needs based on the respective national plans (e.g. “Medical Care Plan”, “Health Promotion Plan”, “Insured Long-Term Care Insurance Project Plan”). The municipalities are in charge of public health services and health promotion activities for their residents. The private sector and many non-governmental organizations provide a large part of the Japanese health services (WPRO, 2012; CF, 2015).

The Japanese government regulates the universal public health insurance system. Japan’s medical insurance system has been in place since 1922 and universal health coverage was already achieved in 1961. This is considered to have contributed greatly to the rapid extension of the average life expectancy during this period of economic growth. Citizens are covered either by their employer (in large firms), the Japan Health Insurance Association or by a government run plan. More than 70% of adults also have an additional private health insurance linked to a life insurance policy (Robertson et al., 2014; JP, 2014b).

Free access and high quality of the Japanese health care system have led to an overusage of the services and supported the “social hospitalization” trend, where elderly people stay in hospitals for unnecessarily long periods in order to temporarily their caretakers.

The average length of a hospital stay in Japan is about five weeks, while most other developed countries observe average stays of less than 2.5 weeks (WPRO, 2011). The overusage of the health system, the ageing society and a declining workforce are threatening the financial sustainability of the Japanese health insurance system (WPRO, 2012).

Health expenditure in Japan, which is predominantly funded through the social health insurance contributions, has been constantly rising from 7.4% in 2000 and 9.5% in 2010 to 11.2% of the GDP in 2015 (OECD avg. 8.9%). Public spending on long-term care has also been rising, especially since the introduction of the long-term care insurance in 2000, from 0.6% of the GDP in 2000 to 2.1% in 2013 (OECD avg. 1.4%). (OECD, 2016c; WPRO, 2012)
Pension system

The Japanese public pension system is based on a basic flat-rate scheme and an earnings-related employees’ pension scheme. The basic old-age pension is paid from age 65 and requires a minimum of 10 years’ contributions. To be eligible for a full basic pension 40 years of contributions are necessary. If a pensioner is eligible to the basic pension and has contributed at least one month to the employee’s pension scheme, he is eligible to receive an employees’ pension, which is earnings-related, in addition to his basic pension. In both pension schemes early retirement at a reduced rate and late retirement with increased rates is possible. Since 2006 pensioners of 65 years and over are allowed to combine work and pension within certain income limits. Parents taking care of children can be credited up to 3 contribution-free years per child in the earning’s related scheme (OECD, 2013a).

The public pension system is continuing to face financial difficulties due to the rapidly ageing population and the declining workforce. About 20% of the Japanese workforce is now 60 years or older. Contribution rates have therefore gradually been increased from 13.6% in 2004 to 18.3% in 2017 and benefits have been cut. Despite this and the fact that Japan has the longest working life periods, public spending on pensions have more than doubled between 1990 and 2010 (from 4.8% to 11.2% of the GDP) (OECD, 2015g).

The total dependency ratio, which is already very high, will further increase due to the growing number of people aged 65 or over (Table 9). In 2015 three people from the working age group (15-64) had to maintain for two dependents (children or pensioners). It is estimated that by 2050 the ratio will be almost 1:1 (UN, 2015a).

<table>
<thead>
<tr>
<th>Key facts</th>
<th>2015</th>
<th>2030</th>
<th>2050</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pension coverage (65+)</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statutory retirement age (years)</td>
<td>65</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labour force participation 65+ (%)</td>
<td>21.0</td>
<td>26.4</td>
<td></td>
</tr>
<tr>
<td>Total dependency ratio</td>
<td>64.5</td>
<td>74.4</td>
<td>95.1</td>
</tr>
<tr>
<td>(Per 100 persons aged 15-64)</td>
<td></td>
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</table>

Table 7: Key facts, Japan, (2015)

Source: UN DESA, Profiles of Ageing, Japan, 2015
National Policies related to Healthy Ageing

The Japanese government has a long history in responding to the health needs of its ageing population. Following the implementation of universal health care and the enactment of the Act on Social Welfare for the Elderly in 1963, Free Medical Care for the Elderly was introduced in 1973. An Elderly Care Act, introducing co-payment rates, was enacted in 1983 because of the rising costs of the rapidly ageing population. The long-term hospitalization of elderly people with limited needs, often described as “social hospitalization”, continued to be a major problem leading to high costs. In 1989 the government developed a 10-year strategy to promote health care and welfare for the elderly, the “Gold Plan”, reducing the costs and improving the Japanese long-term care infrastructure (JP, 2014b).

Apart from reducing the high costs, the aim of the “Gold Plan” was to build a national infrastructure for care of the ageing population, shifting the system from long-term institutionalized care in hospitals and nursing homes to home programmes and community-based rehabilitation facilities.

Despite all efforts of the Japanese government the demand for care was rising rapidly and the “New Gold Plan”, including raised targets, was put in place in 1994. The new plan included, for example, the training of 170,000 additional caregivers and the establishment of 5,000 home-care service stations. In 1999 the “Gold Plan 21” was introduced aiming at vitalizing the image of the elderly, ensuring and supporting their independent living with dignity, developing mutually supportive local communities and establishing trustworthy long-term care services of high quality (Ihara, 2000) (JP, 2016b). To support the objectives of the “Gold Plan 21” and to cover the growing expenses of long-term care the Japanese government introduced the public Long-Term Care Insurance (LTCI) in 2000, which also supports independent living of the elderly and reduces the burden of family caregivers (Tamiya et al.). In 2012 the government revised the Long-Term Care Insurance Act establishing a community-based integrated care system to support the elderly in their local communities (JP, 2014b). In 2002 the Movement to Strengthen Citizen’s Health in the 21st century (Healthy Japan 21) was initiated in alignment with WHO’s Active Ageing concept. This will now be continued until 2023 (JP, 2016d).
Vision
The Japanese government aims at making its super-aged society “a society where all people can live a healthy life comfortably with peace in mind” with the elderly population playing an active role by sharing their experiences (JP, 2016c).

Approach
Japan has been using a multisectoral, community based approach to promote healthy ageing. Since 1995 all national measures concerning the ageing society have been based on the Aged Society Basic Law. Based on this law the Ageing Society Policy Council was established, which is chaired by the Prime Minister and includes all Cabinet Ministers as members. An annual report on the ageing society has been published since 2002 (JP, 2015b; JP, 2016a). The Japanese government has also emphasized its commitment to healthy ageing by including it into the discussions and the declaration of the G7 Ise-Shima Summit in 2016 (G7, 2016).

The Ministry of Health, Labour and Welfare with its Health and Welfare Bureau for the Elderly leads the Japanese policies in the area of healthy ageing (JP, 2013). Previously the responsibility of health and welfare plans for the elderly had been primarily with the central government, a revision of several laws in 1990 (e.g. Act on Social Welfare for the Elderly) shifted this to local governments (JP, 2014b). All municipalities in Japan have developed a Health and Welfare Plan for the Elderly and a Long-term Care Insurance Project Plan in a unified manner (JP, 2013).

Focus
The Japanese government has not published a comprehensive healthy ageing strategy, but as stated in the “Annual Report on the Ageing Society” policies related to ageing and health have been based on the following principles of the Basic Law on Measures for the Ageing Society (JP, 2016a; JP, 1995):

1. Revising the basic understanding and awareness of ‘elderly’
2. Establishing a social security system to ensure the peace of mind of the elderly
3. Utilizing the motivations and capabilities of the elderly
4. Realization of stable local society and strengthening of local community
5. Realization of safe and comfortable lifestyle environment
6. Promoting ageing policies by advocating to people to prepare from an early age for the ‘90 years of life’ and by adopting the 6 basic ideas for realizing a circulation of generations

September 15 is the Japanese Senior Citizen Day, which is followed by the Senior Citizen Week (September 15-21). These are held annually with government agencies, prefectures, communities and non-governmental organization running national campaigns all over Japan to promote a healthy and active lifestyle. The third Monday in September is the Respect for the Aged Day, which has become a national holiday in 1966. Initially this was an initiative launched by a single village in 1947 aiming at fostering respect for the elderly and promoting their welfare (ILC, 2008b).
Commitment to action on Healthy Ageing

Ageism
As in many other countries age discrimination remains a common problem in Japan, especially in the employment sector. This is mainly due to the fact that Japanese companies prefer to employ young people as wages are linked to the length of employment. The Japanese government has introduced several laws to combat age discrimination, e.g. the Law Concerning Stabilization of Employment of Older Ages (Kodoma, 2015).

Gender
The Japanese government has been supporting gender equality through its 1986 Equal Employment Opportunity Law. Maternity leave and childcare time (up to 3 years / child) is credited for the pension scheme without payments. In its “White Paper on Gender Equality 2015” the government emphasized the importance of promoting the active role of women in revitalizing Japan’s regions. It is also actively supporting the establishment of small businesses run by aged females in rural areas. But in spite of these efforts, large gaps in the economic participation between women and men remain (JP, 2015c; Lee, 2016).

Poverty
The poverty rate among Japanese elderly has fallen from 22% in 2007 to 19% in 2011, but remains well above the OECD average of 12%. More than 50% of those dependent on public welfare programmes in Japan are now 65 years and older. Despite the basic universal public pension coverage, benefit cuts in recent years and increasing living expenses have been contributing to this problem. Therefore the Japanese government has been encouraging older people to continue working beyond the retirement age of 65 years (OECD, 2015g; Japan Times, 2016).

Employment
Japan already has a very high labour force participation of people aged 65 years and older (29.8% in men, 14.5% in women). The Japanese workforce has been declining due to the low fertility rates in decades and the rapidly ageing population. The total dependency ratio has also been rising dramatically, almost reaching equilibrium (UN, 2015a). Unlike older people in many other developed countries, the older people in Japan often wish to work as long as they can to contribute to their community and the society as a whole. The Japanese government has been encouraging older people to continue working e.g. by sponsoring self-help-organizations like the Silver Human Resources Centres, offering part-time employments and other opportunities for the elderly to stay actively involved in their local communities (EIU, 2012).
Rights and assistance

To protect the human rights of older citizens the Japanese Ministry of Justice has created special counselling offices at social welfare facilities and has been cooperating with welfare workers working closely with elderly people (JP, 2014a).

**Elder Abuse**


The Act made it a requirement for anyone discovering the abuse of a person aged 65 or over (including physical, sexual and emotional abuse, neglect or financial exploitation) to report the incident to the municipal government. The municipal government is responsible for the protection and provision of shelter for the abused older person. In addition they are required to provide consultations, guidance, advice, and other necessary support to the elderly and their caregivers (ILC, 2008a).

**Falls prevention**

Epidemiological studies in Japan have shown that 10-30% of people aged 65 years and over will experience a fall every year. The incidence is higher in women, increases with age and appears to be similar in most regions in Japan. Especially since the implementation of the long-term care insurance in 2000 a number of fall prevention programmes have been initiated mainly at the municipal level (Yasumura and Hasegawa, 2009).

Mobility

For the Japanese government a good public transportation system is essential to encourage the elderly’s social participation. Substantial improvements have been observed since the introduction of the Public Transportation Accessibility Act in 2000, e.g. almost all buses in downtown Tokyo are now wheelchair-accessible. In 2006 this act and the Building Accessibility Act were combined into the Barrier-Free Act. Through this new act the Japanese government has been implementing the principle of universal design in public transportation, sidewalks, building entrances, and interiors. While public transportation for the elderly has improved in urban areas, transport options for older people living in rural areas remain limited, especially as many younger family members have moved to urban areas (Kawauchi, 2011).

Traffic safety programmes for older adults have been introduced as the number of accidents involving elderly people has been rising in recent decades. Many municipalities have been encouraging drivers aged 65 and older to give up their driving permits voluntarily. Drivers aged 70-74 are required to attend seminars to extend their driving license. Driver retesting and a health check at the age of 75 are also mandatory now. In addition a labelling system has been introduced for drivers aged 75 and over by the Public Safety Commission and the National Police Agency (Sekhar Somenahalli, 2016).
Cities and communities
A number of cities in Japan have joined the WHO Global Network of Age-friendly Cities and Communities. The Japanese government has also initiated the Future Cities initiative, including 11 cities and regions, to create sustainable economic and social systems in response to the challenges of ageing and the environment (City, 2016). The 2014 amendment of the Act on Special Measures concerning Urban Reconstruction has been encouraging cities to apply the compact urban form concept. The city of Toyama, in which 26% of residents are already older than 65 years, has been following this concept. Its comprehensive plan for 2007-2016 has been promoting a high population density in the city with universal public transport solutions as well as encouraging walking and cycling (OECD, 2014d).

Housing
As traditional family structures have been breaking down in Japan over the past decades the percentage of people 65 years and older living alone (16%) or only with a spouse (37%) has been increasing substantially (Muramatsu and Akiyama, 2011). A revision of the Act on Securement of Stable Supply of Elderly Persons’ Housing in 2011 aimed at increasing the supply of serviced housing with monitoring and consulting services for the elderly (JP, 2014b).

After the 2011 earthquake the Japanese government incorporated a number of community-building efforts into its rebuilding plans. Special elements such as an inviting area for social interaction with neighbours (“engawa”) or a traditional neighbourhood information paper on events and emergency plans (“kairan-ban”) have been used. In 1994, the Building Accessibility Act had been passed with the goal of encouraging and enabling older adults to participate more fully in society. However, although the act advised building owners to make efforts to increase accessibility, its provisions were not mandatory, so its impact was quite limited (Muramatsu and Akiyama, 2011).

Active and Assistive Living
Japan has a long history of developing technical solutions to support active and assisted living for the elderly. A “Welfare Techno House” has been built with automatic monitor health indicators such as measuring devices for body and excrement weight in the lavatory and an ECG measuring apparatus without electrodes in the bathtub or bed (Tamura et al., 2007). Another example is the “Ubiquitous Home”, a special facility to test technological solutions for elderly people at home using devices, sensors and appliances (Yamazaki, 2007). More recently the government has been focusing on the development of user-friendly nursing robots and similar technologies. The establishment of 10 development centres throughout Japan with active involvement of nursing care workers and elderly people has enhanced research and innovation in this area (Robotics-Trends, 2015). A therapeutic, socially assistive pet robot (PARO), which looks like a baby seal, has been used for improving the mood and stimulating social interaction for people with dementia (Yu et al., 2015).

Social participation
Senior citizen’s clubs and other organizations for older people are very common and these are actively engaged in the communities. In Shinagawa City, for example, there are more than 700 registered voluntary senior citizen’s groups including a “Silver University”, supported by the local authorities under the Act on Social Welfare Service for Elderly. New approaches involving social participation of the elderly have been developed in recent years, for example,
with older people developing their own business ideas or working towards the solutions of local problems (JR, 2014b; Kondo, 2011). To promote their social participation and physical activity the Ministry of Health, Labour and Welfare is organizing the National Health and Welfare Festival for the Elderly (Nenlympics = Tree-Ring Olympics) (JP, 2016c).

Voluntary work
Japan has a long tradition of voluntary work. Volunteers are especially important for providing elderly care service. The government is therefore encouraging and supporting a number of initiatives in this field. One of the largest is the “Ninchisho Supporter Caravan”, a nationwide campaign organized by a non-governmental organization, aiming at training up to six million dementia supporters. These volunteers will be able to understand the disability and to provide support to patients and their families affected by dementia (ADI, 2016).

Another initiative targeting especially older people and pensioners is “Fureia Kippu” (“Ticket for a caring relationship”). This initiative has been established in 1991 by the Sawayaka Welfare Foundation, an NGO now acting as the umbrella organization for a large number of local time-banking schemes. By providing care for elderly or disabled people, the caregiver can earn time-credits for personal use if required. These can also be transferred to relatives or friends in need of care (Hayashi, 2012).

Lifelong learning
The Japanese government is providing lifelong learning opportunities for its citizens through various activities and is stimulating the interest in these by e.g. holding national lifelong learning festivals. In addition a National Lifelong Learning Network Forum has been held, including a wide range of stakeholders. The Ministry of Education, Culture, Sports, Science and Technology has also implemented a nationwide project for promoting educational activities on Saturdays, in which residents, especially elderly people are encouraged to share their experiences and skills to improve the educational activities of children at weekends (JP, 2016f).

Health literacy
Recent surveys suggest that health literacy levels in Japan are lower than in many European countries. The authors believe that this might be caused by inefficiencies in the Japanese primary care system and that access to reliable and understandable health information in Japan has been difficult. The researchers suggest focusing policy interventions to improve the health literacy on deprived sociodemographic groups (Nakayama et al., 2015; Furuya et al., 2013).

Nutrition
Since 1945 the Ministry of Health, Labour and Welfare has carried out an annual National Health and Nutrition Survey. Dietary recommendations and guidelines for the population have been revised (WPRO, 2011). A prospective cohort study in Japan with almost 80,000 healthy participants aged 45-75 years showed that closer adherence to the Japanese dietary guidelines has reduced the risk of total mortality and of cardiovascular disease mortality in Japanese adults (Kurotani et al., 2016). The prevalence of obesity among adults in Japan in 2010 was 3.5%, which is extremely low in comparison to the other OECD countries with an average of 22.2% (WPRO, 2012).
Aligning health systems to the needs of elderly

In 1963 the “Act on Social Welfare for the Elderly” strengthened the principle of social welfare and obligated the central and local governments to take action on this, e.g. by establishing special elderly nursing homes. In 1973 an act on the Free Medical Care for the Elderly (70+ years) was introduced, leading to a great increase in medical expenses. As the national health insurance system could not cope with this situation the 1983 “Health and Medical Service Act for the Elderly” using an out-of-pocket payment system with a fixed amount and a medical care financing system for the elderly were introduced. Despite these changes and due to the rapidly ageing society the financial burden for the employees’ medical insurance increased. In 2008 the independent “Medical care system for the elderly” (75+) was established (JP, 2014b).

In response to the demographic transition and increasing financial constraints the Japanese government has been introducing structural reforms of the health system in recent years. The 2015 Health Care Reform Act transferred the responsibility of community-based health insurance plans to the regional authorities (CF, 2015).

The Ministry of Health, Labour and Social Welfare launched “Healthy Japan 21”, a national health promotion programme, in 2000, emphasizing primary prevention and aiming at early detection and treatment of diseases. Within this programme priority areas have been selected, targets have been set and evaluations have been conducted (WPRO, 2011). The Japanese government has set up a “Cost-Containment Plan for Health Care” aiming at promoting healthy behaviour, shortening hospital stays, improving care coordination and developing new home care solutions (CF, 2015).

Health promotion

The 2002 Health Promotion Act highlighted the importance of creating an environment promoting healthy lifestyles as a key strategy for an ageing society. A national health promotion programme was initiated as part of the “Healthy Japan 21” strategy, aiming at reducing NCDs and at promoting physical activities and exercise. In addition evidence-based “Exercise Criteria for Health Promotion” have been developed in 2006 (WPRO, 2011; WPRO, 2012).

Prevention

Based on the national policies, each prefecture has been developing a Prefectural Health Promotion Plan adapted to the local needs (JP, 2016e). Health awareness is very common in Japan and healthcare and screening tests are seen as part of daily life. Annual health screenings are organized by employers or by the municipal governments (EIU, 2012).

Vaccinations

Besides the basic immunizations an annual influenza vaccination for people 65 years and over is recommended in Japan.

Health workforce

Japan has fewer physicians per capita than many other countries in the OECD region (2.2/1000 population vs. 3.4/1000 on OECD avg.). Stable numbers have been observed for most other health professions (WPRO, 2012). An increase in the number of physicians is expected in the coming years following an increase in admission rates to medical schools in Japan in 2008 (OECD, 2015e).
Developing sustainable and equitable long-term care systems

Until 2000 the long-term care system in Japan had been a tax-funded system, organized at the municipality level and servicing mainly low-income groups. Traditionally care for the elderly was the responsibility of the wife of the oldest son, but this is not the case anymore. Since 2000 the long-term care system in Japan has seen a significant policy shift due to the introduction of a premium-based National Long-Term Care Insurance under the slogan “from care by family to care by society (Muramatsu and Akiyama, 2011).

Before 2000 long-term care has been provided mainly by hospitals in Japan, resulting in high costs and an inefficient use of the system. Residential care institutions, which are not allowed to make profits, are now increasingly being used. Since the introduction of the compulsory Long-Term Care Insurance, the number of home care service providers, including private for-profit and non-profit as well as some public agencies, has almost tripled within a decade. Integrated care services, providing both health and social care, are offered by some of these providers. Persons eligible to receive care can choose a care manager to coordinate the services they require (McCurry, 2015; Robertson et al., 2014).

The national, compulsory long-term care insurance covers people aged 65 years and over and some disabled people between 40 and 65 years of age. This includes home care, respite care, domiciliary care, special equipment and assistive devices as well as home modifications. Medical care, palliative and hospice care are covered by the medical insurance system. About 50% of the long-term care is financed through taxation and 50% through income-related premiums, paid by citizens over 40 (CF, 2015).

The uptake of services from the Long-Term Care Insurance scheme was much higher than expected and led to some entitlement restrictions and an increase of co-payments depending on the wealth of the individual (Robertson et al., 2014).

The 2012 revision of the Long-Term Care Insurance Act established a community-based integrated care system. More than 4000 Community Comprehensive Support Centers have been set up, in which care managers, social workers and other specialists provide support for patients with long-term conditions. This system enables older people to receive medical and long-term care jointly in their local environment. Regional and city authorities are also responsible for setting up special councils to promote the integration of care and support (CF, 2015; JP, 2014b).

The Japanese government has also introduced financial incentives for hospitals and clinics using post-discharge protocols and providing effective follow-up services, especially in the areas of cancer, stroke, cardiac and palliative care (CF, 2015).
The Ministry of Health, Labour and Welfare’s Social Security Council is responsible for national strategies on quality, safety and cost control and for publishing guidelines to determine provider fees. The Japan Council for Quality Health Care is a non-governmental organization working to improve quality throughout the health system and publishing clinical guidelines in this field (CF, 2015).

In 2013 public spending on long-term care in Japan was 2.1% of the GDP, which is much higher than in many other OECD countries (OECD avg. 1.4%) (OECD, 2016c). Some alterations to the LTC system, especially regarding the community-based integrated care system, have been made in recent years, but empirical assessments of the effectiveness of these measures are needed (Morikawa, 2014).

Dementia

The Ministry of Health, Labour and Social Welfare is expecting a sharp increase in the number of people suffering from dementia in Japan from about 5.2 million in 2015 to about 7.3 million in 2025. Almost 20% of people aged 65 and over will be affected. In 2005 the government published a 10-year plan to understand dementia and to build community networks. In 2012 the “Orange Plan”, a five-year plan to promote policy measures on dementia was developed in close cooperation with local governments, who are primarily responsible for implementing these measures. These include achieving an early diagnosis, creating a clear clinical pathway and providing an appropriate treatment and care for the elderly with dementia in their own living environments (JP, 2014b). In 2015 the government launched a national dementia strategy, the “New Orange Plan”. Key objectives of this strategy are to strengthen dementia-friendly communities, to support family carers, to use a whole-of-government approach and to emphasize the inclusion of people with dementia in planning processes (Hayashi, 2015).

Long-term care workforce

Japanese projections have shown that between 2007 and 2025 about 500,000 additional nurses and 1 million additional other long-term care workers would be needed, especially to be able to provide for the integrated community care system and additional home-based services (Ono et al., 2013).

In recent years a small number of foreign nurses and other caregivers have been coming to Japan, especially from the Philippines, but especially language barriers remain a great challenge (Ballescas, 2009).

The Japanese long-term care system continues to rely on the support of family caregivers, but many of these people themselves are becoming old. As part of the national employment insurance, family care leave benefits are paid for up to three months. Some financial support for family caregivers is also provided by some of the municipalities (CF, 2015).
Measurement, Monitoring and Research

The Japanese government has conducted a range of surveys, longitudinal and other studies in the area of ageing and health and has provided the data for secondary analysis. The Ministry of Health, Labour and Welfare and the Ministry of Education, Culture, Sports, Science and Technology are also supporting scientific research on ageing and health (Muramatsu and Akiyama, 2011).

Some examples:

• The Ministry of Health, Labour and Social Welfare has conducted an annual Longitudinal Survey of Middle-Aged and Elderly Persons. Information on family, employment status and social activities from about 20,000 participants who were aged between 50 and 59 in 2005 are being collected. The information is being used to formulate health, labour and welfare measures for supporting senior citizens (JP, 2015a).

• The Nihon University - Japanese Longitudinal Study of Ageing (NUJLSOA) was a longitudinal survey of a representative sample of people aged 65 years and over. The study investigates the health status, the use of the long-term care system, intergenerational exchange, living arrangements, caregiving and workforce participation of the elderly (NIH, 2016b).

• The Japanese Study of Ageing and Retirement (JSTAR) used a combination of interviews, anthropometric, physical performance measures and blood samples to follow up on middle-age and elderly citizens. It is very similar to the European SHARE study (Ichimura et al., 2009).

• The Japan Gerontological Evaluation Study (JAGES) is a population-based survey initiated in 2003, focusing on the social determinants of health and the social environment. About 140,000 older people from all over Japan responded to the fourth survey in 2013 (JAGES, 2016).

At the national level indicators have been used to monitor and evaluate the degree of independence in the everyday life of elderly citizens. In addition a Care Needs Certification System has been implemented as part of the long-term care insurance scheme in since 2000. Data is being collected for planning evidence-informed policies (JP, 2014b).
1.3 NETHERLANDS
Key facts

The United Nations Department of Economic and Social Affairs estimates that the Netherlands’ population will grow slightly from 16.92 million in 2015 to 17.60 million in 2030 and 2050. The population of the Netherlands is ageing fast and has one of the highest proportions of older people in the world. More than 24.5% of the population is 60 years or older. This percentage will continue to increase to 32.0% in 2030 and 33.2% in 2050 (Figure 20) (UN, 2015a).

The median age will increase from 42.7 years in 2015 to 44.7 years in 2030 and 46.2 years in 2050 (UN, 2015a).

The total fertility rate in the Netherlands is 1.7 births per woman, which is below the replacement level for industrialized countries of about 2.1. The ageing process in the Netherlands is mainly driven by the increasing life expectancy as older people remain in better health than in most other countries (WB, 2014).

Figure 20: Population by age group, Netherlands, 1980, 2015, 2030, 2050
Source: UN DESA, Profiles of Ageing, Netherlands, 2015
Life expectancy

The Dutch population enjoys good health and has some of the highest life expectancies worldwide. Girls born in 2015 can expect to live 83.6 years and boys 80.0 years. It is expected that the gender gap will be reduced in the future. Life expectancies for people 60 years of age are also high in the Netherlands and will be growing further in the next decades (UN, 2015a; UNDATA, 2016; WHO, 2016o).

<table>
<thead>
<tr>
<th></th>
<th>Both sexes</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy</td>
<td>81.9</td>
<td>83.6</td>
<td>80.0</td>
</tr>
<tr>
<td>at birth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy life expectancy at birth (2012)</td>
<td>71</td>
<td>72</td>
<td>70</td>
</tr>
<tr>
<td>Life expectancy</td>
<td>23.8</td>
<td>25.4</td>
<td>22.0</td>
</tr>
<tr>
<td>at 60</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 8: Life expectancy, Netherlands, 2015

Sources: UN DESA, Profiles of Ageing, Netherlands, 2015; UN DATA, 2016; WHO, World Health Statistics, 2016;

Source: UN DESA, Profiles of Ageing, Netherlands, 2015
Health system

In 2006 the Netherlands implemented a structural health care reform, introducing a single compulsory insurance scheme with multiple private health insurers competing for insured persons. The healthcare and social service system in the Netherlands has become more decentralised and municipalities, who are responsible for public health and health promotion, are now also responsible for providing services to elderly people and patients with chronic diseases. The Ministry of Health is in charge of the regulation and supervision of the health system, while the management is mainly organized on the regional and local levels (Kroneman et al., 2016).

The Dutch health care system is based mainly on four basic health-care related acts:

- Health Insurance Act
- Long-Term Care Act
- Social Support Act
- Youth Act

All residents of the Netherlands are now entitled to a comprehensive basic health insurance package, offered by private health insurers and providers, which are almost exclusively non-profit cooperatives (NL, 2016d). The statutory health insurance system is publicly funded achieving almost universal health coverage. In addition to this about 84% of the population purchases a voluntary insurance covering benefits like dental care, alternative medicine, physiotherapy and others (CF, 2015).

Health expenditure accounted for 10.8% of the GDP in 2015 (OECD avg. 9.3%) and public spending on long-term care was 3.0% of the GDP, the latter being the highest in all OECD countries (OECD avg. 1.4%) (OECD, 2016c). The government has introduced several reforms in recent years because of the high public expenditure for health and long-term care and the expected growth of recipients in the ageing population. The 2006 Health Insurance Act made the system more demand-driven and the 2015 Long-Term Care Act has been introduced to secure affordable care for an ageing population and for those who are mentally or physically handicapped (NL, 2016d; OECD, 2016e).
Pension system

The older population in the Netherlands has a high level of income security due to the country’s universal pension coverage (100 % of people over 65) and additional benefits. Before 2014 the retirement age was 65 years and it is now increasing by one month per year up to 67 years in 2021. Following this, the standard retirement age will be linked to gains in life expectancy. Supplementary pension schemes can start paying at the age of 65. It is expected that these schemes will increase the age of retirement as well (OECD, 2015i).

The Dutch pension system is built on three pillars.
- Flat-rate state pension (AOW; related to minimum wages)
- Supplementary, occupational pension schemes
- Private saving schemes for retirement

Through the General Old Age Pensions Act (AOW) basic state pensions for people aged 65 and over are provided. Pension rights are collected during working life (NL, 2009).

In recent years legal obstacles for postponing retirement have been removed. Thus higher pension benefits can be accumulated, making later retirement especially interesting for those with a low basic pension (Pension-Federatie, 2010).

The total dependency ratio is going to increase substantially due to a high median age, a low fertility rate and the high life expectancies in the Netherlands (Table 9) (UN, 2015a).

<table>
<thead>
<tr>
<th>Key facts</th>
<th>2015</th>
<th>2030</th>
<th>2050</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pension coverage (65+)</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statutory retirement age (years)</td>
<td>65 -&gt; 67</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labour force participation 65+ (%)</td>
<td>7.3</td>
<td>9.8</td>
<td></td>
</tr>
<tr>
<td>Total dependency ratio (Per 100 persons aged 15-64)</td>
<td>53.3</td>
<td>68.2</td>
<td>74.2</td>
</tr>
</tbody>
</table>

Table 9: Key facts, Netherlands, (2015)
Source: UN DESA, Profiles of Ageing, Netherlands, 2015
National Policies related to Healthy Ageing

The Dutch government has been responding to the increasing proportion of its older population with reforms in the health, long-term care and pension sectors. Although there is no comprehensive, overall ageing policy or healthy ageing strategy, an inclusive approach is being used covering various policy areas (e.g. health, environment, housing, public transport).

The Ministry of Health, Welfare and Sport has a Directorate for Long-Term Care, which is also responsible for social support and health insurance of the population, as far as long-term care is concerned. Its Directorate of Cure is responsible for the health care insurance act (NL, 2016a).

The National Institute for Public Health and the Environment (RIVM) is very active in the field of healthy ageing and has presented a comprehensive report of the situation in the Netherlands (“Gezond ouder worden in Nederland”). The data included has provided useful information for municipalities for the development and implementation of preventative health care services for the older population. The report emphasized the necessity to provide effective measures for maintaining health and autonomy of the elderly. These should be especially targeted at people aged 75 years and over, single women, people with low educational level, ethnic minorities and elderly caregivers (Zantinge et al., 2011).

The National Care for the Elderly Programme was set up in 2008 focusing on the specific needs of every individual, improving the quality of the care and the coordination between different health and care providers by setting up and strengthening regional networks. In addition the programme was intended to promote research to develop new care solutions (Beter-Oud, 2016).
Vision
The Dutch government has been supporting older people to help them stay healthy and live independently for as long as they wish.

Approach
The government is aiming at integrating healthy ageing in its overall health policies and programmes taking a life-course approach.

Focus
The Dutch healthcare system has been adapted to cover the needs of the older population using an integrative approach, e.g. by providing care services especially for older people with chronic diseases and disabilities, promoting self-management and functional autonomy and supporting older informal carers. The 2016 Long-term care Act and policies stimulating economic and voluntary participation in society and self-reliance are also key areas of Dutch policies related to healthy ageing (NL, 2016a, RIVM, 2015a).
Commitment to action on Healthy Ageing

**Ageism**
Discrimination is prohibited in the Netherlands as described in Article 1 of the Dutch constitution and the Equal Treatment Act (NL, 2016c). A survey showed that only 4% of the Dutch population aged 62 or over has experienced discrimination due to their age (European average 11%) (van den Heuvel and van Santvoort, 2011). But age discrimination is of concern especially in the employment sector. 57% of all long-term unemployed people in the Netherlands are aged 55 and over (Ran, 2015).

In May 2004 the Netherlands implemented the EU Framework Directive through its Equal Treatment in Employment (Age Discrimination) Act (Bronsgeest-Deur, 2016). A 2014 OECD report on Dutch ageing and employment policies recommended that more action in this field using innovative models and initiatives to support the employability especially of older age groups was needed (OECD, 2014a).

**Gender**
The Dutch government has been aiming at strengthening the economic independence of women and at raising the percentage of women in employment through its gender equality policies. The Ministry of Education, Culture and Research is responsible in this area and has published the Dutch gender and LGBT-equality policy (2013 – 2016). Gender inequalities in older age groups are not specifically mentioned here. Although a gender gap in pensions persists with women’s average pensions being about 40% lower, poverty rates among older people remain low in the Netherlands due to its pension system and other benefits (EP, 2015b).

**Employment**
The Dutch Ministry of Social Affairs and Employment has been assessing the employment policies in regard to the ageing population in cooperation with OECD. Key recommendations from the resulting 2014 report “Working better with age – Netherlands” were a concerted approach towards age-neutrality, the encouragement of and incentives for longer working lives, further efforts to improve the employability of older workers and tackling employment barriers on the employers side (OECD, 2014a).
Develop age-friendly environments

**Elder Abuse**
The Netherlands Institute for Social Research presented a comprehensive report on abuse of the elderly in the Netherlands in 2014, but as in many other countries there is a considerable knowledge gap in this area (Plaisier and de Klerk, 2015). The Dutch government published its “The Elderly in Safe Hands” action plan in 2011, aiming at encouraging the reporting of abuse, at improving general prevention measures and at developing mechanism for early risk identification. Additional objectives were the prevention of elder abuse in professional settings and the strengthening of victim support. The action plan also includes public information campaigns, a guidebook for volunteers, an e-learning module and other tools and activities (Rijksoverheid, 2015).

**Falls prevention**
In 2008 the Regional Fall prevention Network Nijmegen was initiated, funded by the Netherlands Organization for Health Research and Development. The network’s integrative approach encompasses the entire chain around falls prevention, including a wide range of stakeholders involved in this area (e.g. prevention, housing, health care, welfare services, rehabilitation). It was also involved in the “Senior-Step Study: how elderly people optimally move forward”, which was initiated in 2010 through the National Care for the Elderly Programme. In a number of phases, covering all living situations (home, community care, long-term care facilities) and by actively involving elderly people the researchers are trying to identify best practices to reduce the incidence of falls (Netwerk100, 2016).

**Transport**
The Dutch government has implemented a number of regulations in the public transport sector to improve the accessibility and suitability for all people, especially those with limited movement or physical impairments (e.g. audio-visual) (NL, 2016b). There have been several initiatives in different regions of the Netherlands to encourage older people to use public transport such as the improvement of waiting facilities, courses or guides. Dutch Railways have introduced a travel card for a 40% reduction of the price for an off-peak ticket, which supposed to have had a significant impact on travel behaviour especially of older people. Various cities offer free travel in buses and trams after 9 a.m. for people from 65 and older (NL, 2010).

**Cities**
The Hague and Amsterdam have joined the WHO Global Network of Age-friendly Cities and Communities. The Hague has initiated a 2-stage research project, including a survey of the older population and an assessment of the current situation of the city in relation to its age-friendliness. The city has also initiated a Vitality Award, rewarding a variety of community projects and initiatives encouraging senior residents to stay active and involved in the city (Den Haag, 2016a; Den Haag, 2016b).
Communities

“Stadsdorp Zuid” is a city village project initiated in 2010 in Amsterdam with the aim of enabling senior citizens to live in their own homes in an active, healthy and safe way. Members receive information on care and other services and a variety of activities for the elderly are offered especially in combatting loneliness and improving social networks within their own neighbourhood. There are now 21 similar projects in Amsterdam and their success has led to visions of further projects in other cities and communities throughout the Netherlands. All of these cooperatives would work independently and be adapted to the characteristics of the individual neighbourhood and its citizens (StadsdorpZuid, 2016).

Housing

The Dutch government has been supporting older people to live independently on their own for as long as possible, e.g. by providing housing benefits and by providing grants for home adjustments through the 2015 Social Support Act or Chronic Care Act if they have disabilities or chronic illnesses. In addition, since November 2014, planning permission is no longer needed to build a house extension for people who provide or receive informal care. The government is also encouraging municipalities and housing associations to ensure that 44,000 additional houses will be made suitable for older people within the next 5 years (NL, 2016e).

Active and Assistive Living Joint Programme

The Ministry of Health, Welfare and Sport gives financial support to the implementation of the Active and Assisted Living Joint Programme (AAL JP) in the Netherlands together with the European Commission and participating organizations and companies. ZonMw is responsible for the implementation of the programme, which has two main objectives: to improve the quality of life of elderly people enabling them to live their lives independently in their own homes; and to support the European economic and industrial base in this area. Projects within this programme need to include the older population, families and other caregivers throughout the project and are usually developed by small and medium-sized enterprises with a short time-to-market period (2-3 years) (ZonMw, 2016a).

Social participation

The Dutch Government encourages the social participation of the ageing population by e.g. supporting local volunteer organizations to offer activities for older people. There is a wide range of such activities in the Netherlands, e.g.

- Green care farms (Zorgboerderijen), combining agricultural activities with care services, which are paid by the Social Support Act (Zorgboeren, 2016)
- “Golden Sports” – Fit for Life 65+, facilitating sports and exercise activities for seniors within a broad social context (Golden-Sports, 2016)
- “Seniorweb”, providing online courses and personal computer help (SeniorWeb, 2016)
Voluntary work
Volunteering is very common in the Netherlands. According to data from the Survey of Health, Ageing and Retirement in Europe (SHARE) 39% of people in the Netherlands aged 50 and over participated in volunteering activities in 2011 (vs. 16% on average in the other countries included in the study) (van de Maat et al., 2015). One example in this field is “Gilde Nederland”, an umbrella organization of about 65 guilds located throughout the Netherlands, offering consulting services by pensioners on a voluntary basis e.g. as language trainers, city guides, project advisors or coaches. In this way pensioners can share their knowledge and experience, contribute to society while remaining active and being socially involved (Gilde-Nederland, 2016).

Lifelong learning
The Netherlands has some of the highest participation rates in lifelong learning activities in Europe. Almost 19% of survey participants aged 25 to 64 have participated in educational or training activities for work or leisure in 2015 (EU average 10.9%) (CBS, 2016) (EUROSTAT, 2016). Like in most other countries the Dutch governmental policies in this field aim at people aged below 65 years (CBS, 2015).

Health literacy
Data from the European Health Literacy Survey, which was led by the University of Maastricht and co-financed by the Dutch Ministry of Health, Welfare and Sports, showed that health literacy among Dutch adults is especially dependent on the socio-economic status and the domain in which health information is provided (van der Heide et al., 2013). As part of its equity in health approach the Ministry supports health literacy activities. In addition the health sector is part of the Dutch National Literacy Programme. The implementation of activities is conducted by a number of stakeholders, e.g. the National Alliance for Health Literacy (AGV, 2016; Koot, 2013).

Nutrition
A national survey of independently living individuals over the age of 70 (conducted between 2010 and 2012) showed that many did not have a balanced dietary intake and that 20% were overweight. Another study showed that 32% of women and 10% of men over the age of 75 had an insufficient calorie intake. The Netherlands Nutrition Centre, the Dutch national authority in the field of healthy, safe and sustainable food, has published special guidelines and information material on nutrition for the elderly (NNC, 2016).
Aligning health systems to the needs of elderly

The Dutch healthcare system has been reformed significantly since the introduction of the 2006 Health Insurance Act, changing the underlying model of health service financing and entitling all residents of the Netherlands to a comprehensive basic health insurance package (Robertson et al., 2014). In addition three new acts (Long-term care, youth health services and social support) were introduced in 2015 to promote an integrated approach, to improve the quality of care and to “keep healthcare available and affordable in times of an ageing population” (NL, 2016d). The Dutch government initiated a program aiming at identifying areas of “waste” in which resources are not used adequately. To involve the population actively in this process a special virtual reporting point as part of an online survey has been set up. The results of the programme, which will terminate at the end of 2016, will be used to initiate policies and programmes addressing waste in curative care, long-term care, for medicines and medical devices (Lafeber and Jeurissen, 2013).

The Dutch authorities are preparing a central health information technology network to enable exchange of information between providers within the health care system. The objectives are to standardize electronic records on the national level and to make these interoperable between the different domains of care. A “Union of Providers for Health Care Communication” is responsible for the exchange of data via the IT infrastructure “AORTA”. (CF, 2015)

Health promotion

The Dutch National Prevention Programme “All about health” (2014 – 2016), a joint effort of six ministries, municipalities, businesses and civil society organizations, has been highlighting the significant increase in the numbers of patients with chronic conditions and an increase of patients with multiple morbidities. This is partially been due to the ageing society, but also to unhealthy lifestyles in younger age groups and therefore the programme has been taking a life course and whole-of-society approach (RIVM, 2015a).

Vaccinations

The Dutch Institute for Public Health and the Environment (RIVM), responsible for the National Immunization Programme, recommends seasonal influenza vaccination to people aged 60 years and over (RIVM, 2015b). A study by the Netherlands Institute for Health Services Research has shown a decreasing vaccine coverage in this age group (60.1% in 2014) (Sloot et al., 2014).

Chronic diseases

RIVM is also participating in the European Joint Action on Chronic Diseases and Promoting Healthy Ageing across the life cycle” (CHRODIS) and has published a comprehensive overview, including the Dutch policies and programmes as well as good practice examples in this area (RIVM, 2016).

Health workforce

In a recent OECD survey the Netherlands was the only country indicating no particular concern about the national supply of physicians. The Advisory Committee on Medical Manpower Planning frequently conducts scenario-based projection exercises to advise the government and other stakeholders (OECD, 2016).
Developing sustainable and equitable long-term care systems

The Netherlands’ public spending on long-term care was 3.0% of the GDP, being the highest in all OECD countries (OECD avg. 1.4%) (OECD, 2016c). The government introduced several policies to control costs and to improve the quality of long-term care in January 2015. The Long-term Care Act, aiming at establishing a community-based, people-centred healthcare system, has replaced the Exceptional Medical Expenses Act (NL, 2016d).

Further objectives of the new act are to improve the balance between formal and informal care and to focus on enabling the elderly to live independently at home rather than in institutions. Municipalities are responsible for offering assistance at home under the 2015 Social Support Act. Additional support for home care can be provided e.g. by district nurses, under the Health Insurance Act (NL, 2016f). Overall the reforms and newly introduced acts, using an integrated and holistic approach, have led to a decentralisation of the system, giving local authorities a predominant role in providing community-based long-term care. The Dutch government believes that the provision of a broad coverage for health care and long-term care will lead to many benefits and will contribute to social solidarity (WHO, 2015e).

The National Care for the Elderly Programme, launched in 2008, is combining research and practice in the fields of nursing care, dementia and palliative care. The programme aims at improving the quality of care by developing a coherent approach better suited for the individual needs of the elderly people. The elderly are involved in the development and implementation of the programme and the activities, regional cooperation is strengthened and innovative projects and experiments are supported (Beter-Oud, 2016). In February 2015 the Dutch government presented a plan on “Dignity and Pride, loving care for our elderly”, aiming at improving the quality of people-centred care, supporting caregivers, healthcare providers and nursing homes (Waardigheid-en-trots, 2016).

Dementia

The Dutch National Institute for Public Health and the Environment has estimated that dementia will be the number one cause of death by 2030 (RIVM, 2014). The Ministry of Health, Welfare and Sport is therefore prioritising dementia in its work. The development of a dementia-friendly society, the establishment of local networks surrounding the client and the carer (including case managers), structural improvements (e.g. by improving the national Dementia Care Standard) and creating room for dementia care provided by the municipalities are the core areas of this work (NL, 2015b).

In addition the Dutch government has initiated the Delta Plan on Dementia network cooperative, a multi-stakeholder, not-for-profit organization in charge of implementing this plan. Its three main focus areas are: the implementation of day programmes, the adaption of living facilities to patient needs and the improvement of knowledge and skills of family members and other caregivers supported by information and educational campaigns for the general public (NL, 2015a). Dementia had also been the theme of an international conference hosted by the Netherlands EU Presidency in 2016 (NL, 2016g).

Palliative care

The Dutch government has also given special attention to palliative care by launching a National Palliative Care Programme in 2014 (ZonMw, 2016b).
Measurement, Monitoring and Research

The Dutch National Institute for Public Health and the Environment has been collecting data on ageing and health and has published the report “Public health forecasts” (VTV) every four years, providing an overview of the current state and describing trends, including those in the ageing population (RIVM, 2014).

Several research projects have been or are being conducted on ageing and health in the Netherlands. The Longitudinal Aging Study Amsterdam (LASA) was designed to study the determinants of the autonomy and well being of older people (LASA, 2016). Maastricht University has conducted a 12-year longitudinal study focusing on age-related cognitive changes (MHeNS, 2016). The Rotterdam Study, a prospective cohort study, is investigating the prevalence and incidence of risk factors for chronic diseases in elderly people (Erasmus, 2016). Since 2006 the University Medical Center in Groningen has been working on a large cohort study on healthy ageing (“Lifelines study”), including 165.000 children, parents and grandparents, who will be followed up for 30 years, focusing on (epi)-genetics, psychological and social factors as well as health care use (Lifelines, 2016).

The Netherlands Organization for Health Research and Development (ZonMw) in The Hague is hosting the Secretariat of the Joint Programming Initiative “More Years, Better Lives – The Potential and Challenges of Demographic Change”. This European initiative aims at enhancing the coordination and collaboration between national research programmes related to demographic change in 15 European countries, Canada and Israel (JPIMYBL, 2016).

The Netherlands is a leading contributor to the European Innovation Partnership on Active and Healthy Ageing (EC, 2012a). Several projects and networks, in part supported by the government, the EC and / or regional authorities are involved in research and innovation in the field of healthy ageing, e.g.:

- The Healthy Ageing Campus in Groningen, located on and around the University Medical Center, is a multisectoral ecosystem working on innovative medical technology, devices, materials and pharmaceuticals (HACG, 2016).

- The Healthy Ageing Network Northern Netherlands (HANNN) has become a reference site, recognized by the EC, sharing knowledge and expertise to allow cross-border innovation, bringing together researchers, entrepreneurs, government authorities and other experts to exchange best practices (products, services, concepts) (HANNN, 2016).

- Medical Delta, a network of life sciences, health and technology partners, is also a reference site recognized by the EC, focusing on digitally-enabled services in digital health and connected care for the elderly (MD, 2016).
Key facts

The United Nations Department of Economic and Social Affairs estimates that the Norwegian population will grow, especially due to ongoing migration trends, from 5.21 million in 2015 to 5.94 million in 2030 and 6.66 million in 2050.

The population of Norway is ageing rapidly and has one of the highest proportions of older people in the world. More than 21.8% of the population is 60 years or older. This percentage is likely to increase to 26.2% in 2030 and 29.5% in 2050 (Figure 22) (UN, 2015a).

Despite the increasing ageing population the median age will increase only slightly from 39.1 years in 2015 to 40.9 years in 2030 and 42.8 years in 2050 (UN, 2015a).

Norway’s total fertility rate is 1.8 births per woman, which is nearly as high as the replacement fertility rate for industrialized countries of about 2.1. In addition, older people remain in better health than in most other European countries. Therefore, the ageing process in Norway is mainly driven by the increasing life expectancy rather than by low fertility rates as in other developed countries (WB, 2014).

Figure 22: Population by age group, Norway, 1980, 2015, 2030, 2050

Source: UN DESA, Profiles of Ageing, Norway, 2015
Life expectancy

The Norwegian population has a good health status and has some of the highest life expectancies worldwide. Girls born in 2015 can expect to live 83.7 years and boys 79.8 years.

Life expectancy at age 60 is 25 years for women and 22 years for men. These will continue to increase and the gender gap will narrow within the next decades.

<table>
<thead>
<tr>
<th>2015</th>
<th>Both sexes</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth</td>
<td>81.8</td>
<td>83.7</td>
<td>79.8</td>
</tr>
<tr>
<td>Healthy life expectancy at birth (2012)</td>
<td>72</td>
<td>72</td>
<td>70</td>
</tr>
<tr>
<td>Life expectancy at 60</td>
<td>24</td>
<td>25</td>
<td>22</td>
</tr>
</tbody>
</table>

Table 10: Life expectancy, Norway, 2015

Sources: UN DESA, Profiles of Ageing, Norway, 2015; UN DATA, 2016; WHO, World Health Statistics, 2016;
Health system

The organizational structure of the Norwegian healthcare system is built on the principle of equal access to services for all inhabitants regardless of their social or economic status and geographic location. Norway’s healthcare system is semi-decentralised, the state and its four regional health authorities being responsible for specialist care and the municipalities being responsible for primary care.

Healthcare expenditure in 2015 was 9.9% of Norway’s GDP. Due to its very high value of GDP per capita, its health expenditure per head is higher than in most countries. Public sources account for 85% of this. The majority of private health financing comes from household’s out-of-pocket payments. Dental care is provided for free for children, adolescents and older people in nursing and long-term care institutions as well as for disabled persons.

Over recent years there have been structural changes in the delivery and organization of health-care intended to empower patients and users. In addition the focus of the reforms has been on improving coordination between health care providers, to increase attention towards the quality of care and to safety issues.

The Norwegian health-care system will experience a growing need for care from an ageing population leading to a greater demand for skilled health-care personnel and for strengthening of community care (OECD, 2016d). Due to the fact that Norway is one of the most sparsely populated countries in Europe, it continuously faces challenges to ensure geographical and social equity in access to health-care. This is likely to worsen as the number and proportion of people aged over 67 is continuously increasing in rural areas with many young people moving to the cities (Ringard et al., 2013; NOR, 2016c).
Pension system

Older Norwegians have a high level of income security due to Norway’s universal pension coverage and additional benefits. The retirement age is flexible between 62 and 75 years (HelpAge, 2013).

The Norwegian pension system is built on three pillars. The National Insurance Scheme is the main source of income for most of the elderly population. An occupational pension scheme is covering all public sector employees and about 50% of private sector employees. All civil servants and some private sector employees are entitled to a contractual early retirement pension (AFP pension). The employees, the employers and the state finance the respective scheme (Midtsundstad, 2014).

The Government Pension Fund-Norway and the Government Pension Fund Global (also known as the “Oil Fund”) are the backbone of the Norwegian social welfare system supporting especially the older population (NOR, 2016c; Norges-Bank, 2016).

In 2011 a comprehensive reform of the Norwegian pension system led to major changes aimed at increasing the labour force participation of older workers. Individuals can now claim their pensions anytime between the ages of 62 and 75. While the government had hoped that this would increase the labour force participation among older workers, first results show that a lot of people are now retiring at an earlier age instead (Brinch et al., 2015).

The total dependency ratio is going to increase substantially due to a high median age and the increasing life expectancies in Norway (Table 11) (UN, 2015a).

<table>
<thead>
<tr>
<th>Key facts</th>
<th>2015</th>
<th>2030</th>
<th>2050</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pension coverage (65+)</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labour force participation 65+ (%)</td>
<td>12.0</td>
<td>15.6</td>
<td></td>
</tr>
<tr>
<td>Statutory retirement age (years)</td>
<td>67</td>
<td>(62-75)</td>
<td></td>
</tr>
<tr>
<td>Total dependency ratio (Per 100 persons aged 15-64)</td>
<td>52.2</td>
<td>60.9</td>
<td>68.0</td>
</tr>
</tbody>
</table>

Table 11: Key facts, Norway, (2015)
Source: UN DESA, Profiles of Ageing, Norway, 2015

National Policies related to Healthy Ageing

The Norwegian government published its comprehensive strategy “More years – more opportunities” for an age-friendly society in May 2016. The strategy covers a multi-disciplinary policy field including transport, planning for local communities, strengthening voluntary organisations, inclusiveness in working life and safety in local communities. All ministries will be responsible to promote an age-friendly society (NOR, 2016c).
Vision

The government’s vision is that all Norwegians must be able to lead long and meaningful lives, and experience active and healthy ageing.

Approach

The main goal is to create an age-friendly society by using the resources offered by older people in terms of participation and contribution and by making a longer worklife possible. The Norwegian government believes that work and activity are essential for securing the existing welfare system for future generations as well. Previous policies on ageing mainly focused on pension, health and care reforms to prepare the welfare services for the demographic shift. Recognizing the decreasing number of economically active people and a shortage of personnel in several sectors in the future, the Norwegian government is now placing greater attention on the growing number of older people in good health to retain them at work for more years. The strategy is based on two main principals:

1. Promoting and strengthening the perspective on ageing in ongoing cross-sectoral work
2. Developing this policy through further research and development in order to achieve an age-friendly society

Focus

The focus of the Norwegian strategy is especially on the following areas:

- **Longer working life** – This includes professional development, attitude changes, HR-policy for all ages, a higher retirement age, and further work on the pension policy.
- **Age-friendly local communities** – Key components are social development, housing policy, local culture and transport.
- **The voluntary sector and civil society** – These acquire a more important role in making older people more active and increasing their participation in civil society.
- **Innovation and technology** – This covers how technology and new solutions can be used and developed to stimulate business and “the silver economy” whilst increasing the autonomy and participation of the older population.
- **The health and care sector** – Using a life-course approach while promoting healthy ageing.
- **Research on ageing** and on conditions for active ageing must be improved.

Source: NOR, 2016c
Commitment to action on Healthy Ageing

Ageism
A survey in 28 European countries has shown that only 3% of the Norwegian population aged 62 or over has experienced age discrimination (European average 11%) (van den Heuvel and van Santvoort, 2011). The Norwegian Anti-Discrimination Act focuses on ethnicity, national origin, descent, skin colour, language, religion or belief. Discrimination due to age is not explicitly mentioned (NOR, 2005).

Gender
As stated in the Norwegian Gender Equality Act discrimination on the basis of gender is prohibited (NOR, 2007). However gender equality has still not been achieved. Women’s income level is 60% of men’s and the treatment for illnesses, which women are prone to have not been prioritised and are comparatively under-resourced (Gender, 2016).

Employment
The Norwegian government is emphasizing the importance of a high labour force participation of older people for welfare and sustainability in the future. The Working Environment Act gives everyone the right to continue working up to the age of 72 before the employer can decide on the continuation of the contract (NOR, 2016a). The government will also prioritize the health and care sector as a good workplace for older workers. This is also being emphasized in response to the growing needs for personnel due to demographic changes (NOR, 2016c). Norway’s Centre for Senior Policy has been raising awareness of the importance of addressing the issues of demographic change and the important contribution of older workers in the Norwegian labour market (Seniorpolitikk, 2016).
Developing age-friendly environments

Elder Abuse
“Vern for Eldre” (Protective Services for the Elderly) is a government-funded service established in 2002 for persons above 62 years of age, who suffer or are at risk of suffering from abuse. They themselves or their relatives and caregivers can contact the service anonymously to receive advice, counselling and assistance. The program is part of the municipal health and social service system. It is also raising awareness, spreading knowledge and enhancing cooperation between the assistance services (UNECE, 2013; Vern, 2016).

Falls prevention
Norway has among the highest incidence of fractures in the older population worldwide, climatic conditions explaining this only in part (Solbakken et al., 2014). The Norwegian Directorate of Health and the municipalities have therefore been developing fall prevention strategies (Helsedirektoratet, 2013).

Transport
Through its National Transport Plan (2014-2023) the Norwegian government is aiming to make the public transport system accessible to people of all age groups and with different abilities (NOR, 2012). Norway is one of the first countries worldwide to publish a National Walking Strategy called “Walking for life”. The main objectives have been to make walking more attractive to everyone and to motivate people to walk more. This has been supported by local strategies to promote walking, faster construction of footpaths and cycle paths designed to accommodate the needs of the older people, by e.g. railings, good lighting, benches for resting and better winter maintenance (Berge, 2012).

Cities
Oslo, projected to have twice as many citizens aged over 67 by 2040, joined the WHO Global Network of Age-friendly Cities and Communities in May 2014 as the first city in Norway. To meet the upcoming opportunities and challenges, the city government developed a policy report, “Independent, Active and Safe Older Residents in Oslo” in 2014, in which five main areas are emphasised:

- Active and healthy ageing
- New forms of housing for seniors
- Networks and voluntariness
- Welfare technology
- Innovation in care

The main aim is to enable seniors to live independent, active and safe lives and stay healthy for as long as possible. For this purpose the well-established senior centers will be expanded to include services for senior citizens relating to health, training and empowerment as well as information services on areas like the adaptation of housing, support equipment, public services and welfare technology (WHO, 2014c).

Communities
The Norwegian government’s vision is to build “a society that enables everyone to participate” and the development of age-friendly communities is one of the main goals of the national strategy (NOR, 2016c).
Accessibility standards
The Norwegian national Action Plan for universal design and increased accessibility was launched in 2005 aiming at making Norway accessible for everyone by 2025 following a universal design concept. This was to be applied to all public services with regard to transport, buildings, outdoor environments, communication and information services. Local and regional authorities have been using their own strategies aligned with the national plan (NOR, 2009).

Housing
The Norwegian government adapted the Technical Building Regulations in 2010 to increase the number of homes suitable for older generations. The aim was that 40% of buildings would meet these special requirements. Municipalities have been encouraged to plan adequately and to implement smart housing technologies in homes together with private developers and housing associations.

Social participation and volunteering
The National Council for Senior Citizens is appointed by the government to give advise on policies for senior citizens. The council is appointed for a four-year parliamentary term and is mandated to work independently to raise issues relating to senior citizens’ activities and social participation (Statens-Seniorrad, 2010).

The Norwegian government has been contributing to voluntary organizations and civil society to promote active ageing activities and to mobilise against loneliness among older people. At present more than 50% of people over 60 years volunteer, although the frequency varies (NOR, 2016c). The Association of NGOs in Norway and the City of Oslo have launched an internet portal for voluntary work in 2015 to support the identification of suitable opportunities including those for the older population (Frivillig, 2016). To increase the knowledge about this sector in Norway, several ministries are jointly conducting a research programme on “Research on Civil Society and the Voluntary Sector 2013 - 2017” (CRCSVS, 2016).

Lifelong learning
The average level of educational attainment among seniors in Norway is high compared with other countries in the OECD region. 27.3% of people aged 55-64 had tertiary-level education in 2010 (OECD average: 22.9%) (OECD, 2014f). The Norwegian government is currently developing a new white paper on “Lifelong learning and exclusion” aiming at giving every adult opportunities to acquire skills forming the basis for a stable and lasting labour market attachment (NOR, 2014c).

Nutrition
The Norwegian government is currently working on an action plan for nutrition, including policies and programs targeting people during their older years (to be published in 2017).
Aligning health systems to the needs of the elderly

Norwegian people are generally very healthy and at 60 years of age can expect to live for more than 17 years on average in good health. The Norwegian government has been promoting healthy diets, daily physical activity, reduced tobacco and alcohol consumption and social support for all to promote health throughout the life course.

In 2015 several White Papers were presented aimed at adapting the Norwegian health and care system to the needs of the ageing population. The Public Health Report (Folkehelsemeldingen) and the Primary Health Service of the Future report (Fremtidens primærhelsetjeneste) show how the municipalities can be better equipped to prevent, limit and treat disease (NOR, 2014a; NOR, 2014b).

The National Health and Hospital Plan forms the basis for the development of the specialist health service providing safe hospitals and improved health services for all, including those living in the rural areas. The municipalities have been establishing primary health teams to provide more comprehensive and coordinated services to users with long-term and chronic conditions, including close monitoring, preventive measures and psychosocial measures in case of illness (NOR, 2015b).

The Ministry of Health and Care Services has also initiated the “Health & Care 21” strategy, Norway’s first national research and innovation strategy for health and care services. The aim is to generate new forms of collaboration and cooperation between health and care sectors, academic institutions, patient organizations and the industry (RCN, 2015).

The Norwegian Institute for Public Health established a Department for Ageing and Health in 2016. The institute has also been emphasizing the importance of preventing invasive bacterial infections in the population, 65 years and older, and has therefore recommended that this age group should be protected of pneumococcal and influenza vaccine (NIPH, 2014b).

The Norwegian National Advisory Unit on Ageing and Health is responsible for securing national competency building and for the distribution of such competencies on dementia, intellectual disability and ageing, physical disability and ageing and old age psychiatry. The unit provides competency building and guidance for the entire health service, both the municipal health care services and the specialist health services, for other service providers, patients, families and other caretakers and the population in general. It operates several research and development projects, offers courses and training programmes and has been publishing and communicating knowledge and information through various channels (AOH, 2016).

Health workforce

The Norwegian Directorate of Health publishes a tri-annual report on the Labour market for Healthcare personnel (Helsemod) forecasting healthcare supply and demand in all sectors for the next 25 years. This forecast shows that there will be a significant increase in demand for 20 different groups of healthcare personnel and that a deficit of about 76,000 man-years is to be expected until 2035 (Roksvaag and Texmon, 2012).
Developing sustainable and equitable long-term care systems

The Norwegian Government’s Care Plan 2020 (Omsorg 2020), its Dementia plan 2020 (Demensplan 2020), and its work on e-health, quality and patient safety, follow up on the challenges set out in the coordination reform for integrated health care.

The organisation and provision of long-term care is the responsibility of municipalities and is administratively integrated with health and social services at the local level. Long-term care is provided in three settings: patients’ homes, nursing homes and sheltered houses, which are run by the municipalities. While the work performed in municipalities amounts to 130,000 person-years, care provided by family and other close caregivers is estimated to 100,000 person-years.

The measures of the Care Plan 2020 are designed to promote new solutions for enabling users to have greater influence over their own daily lives through more freedom of choice and a wide range of high-quality services. The Government will assume a greater financial responsibility for ensuring that the municipalities develop sufficient capacity and quality in the health and care services, building long-term care alternatives away from inpatient settings.

The government has been formulating an informal care policy to ensure that family members providing care are valued and supported (NOR, 2015a)

Dementia

The Dementia Plan 2020 emphasizes three main focus areas: the implementation of day programmes, the adaption of living facilities to patient needs and the improvement of knowledge and skills of family members and other caregivers, supported by information and educational campaigns for the general public (NOR, 2016b).

Palliative care

To improve palliative care a number of measures have been implemented in the municipalities and specialist health care services, including competence-building measures. In addition the government is planning to establish a framework for greater involvement of family members and develop a training programme for care services employees.

Long-term care workforce

The Norwegian government published a comprehensive Care Plan 2020, describing measures for enhancing quality and expertise in the care services. These include a closer cooperation with family caregivers, who will receive financial support, and restructuring the professional long-term care workforce aiming at a higher level and at different kinds of expertise (NOR, 2015a).
Measurement, Monitoring and Research

The Norwegian government will ensure a systematic follow-up of its comprehensive ageing strategy, using a public health policy monitoring system. It will also engage in a continuous dialogue on ageing policies with professional communities, public administration, voluntary organizations and others. In connection with the International Day of Older People (October 1) meetings and seminars will be held on the political level to raise awareness, to receive feedback and to review policies (NOR, 2016c).

The Norwegian study on life course, ageing and gender (NorLAG) is a multidisciplinary and longitudinal study conducted by Norwegian Social Research (NOVA) and co-funded by the Research Council of Norway, the Norwegian government and Statistics Norway. It has three main objectives:

1. To explore the conditions for vital ageing and quality of life in old age
2. To study these conditions in different areas and types of communities, and under different care regimes
3. To provide knowledge to support a sustainable welfare policy in an ageing society.

The research has been focusing on changes in behaviour and transitions in four key domains: (1) Work and retirement, (2) Family and generations, (3) Mental health and quality of life, and (4) Health and care (NORLAG, 2016).

Active ageing is also a main priority of the Research Council of Norway’s initiative, “More active and healthy years (FASE)” (NIPH, 2014a).

The older population should participate in the development process of technological solutions, products and services for the elderly. Needs-driven innovation is part of the Norwegian governments 10-year innovation programme, which has been initiated by the Ministry of Health and Care Services and the Ministry of Trade and Fisheries in 2007. The Norwegian Directorate of Health, Innovation Norway, local governments and regional health authorities are all involved in a national joint-venture agreement regarding needs-driven innovation. InnoMed promotes innovation through a national network, which is rooted in the health care sector (InnoMed, 2016).

A National Programme for Supplier Development has been initiated to encourage the development of technology suited to the needs of an ageing population in terms of design and user-friendliness (NPL, 2016).
1.5 SWITZERLAND
Key facts

The United Nations Department of Economic and Social Affairs estimates that the Swiss population will grow from 8.30 million in 2015 to 9.22 million in 2030 and 10.02 million in 2050.

The population of Switzerland is ageing rapidly and the country has one of the highest proportions of older people in the world. In 2015 23.6% of the population was 60 years or older. This percentage will continue to increase to 30.6% in 2030 and 34.5% in 2050. Growth rates will be particularly high in the population age group 80 years and older (Figure 24) (UN, 2015a).

The median age will increase from 42.3 years in 2015 to 45.1 years in 2030 and 46.9 years in 2050.

The total fertility rate in Switzerland is 1.5 births per woman, which is below the replacement fertility rate for industrialized countries of about 2.1. The ageing process in Switzerland is mainly due to the increase in life expectancy as older people remain in better health than in most other countries (WB, 2014).

Figure 24: Population by age group, Switzerland, 1980, 2015, 2030, 2050

Source: UN DESA, Profiles of Ageing, Switzerland, 2015
Life expectancy

Results from the SHARE study show that the Swiss population in the age group 65 years and over have the highest rates for cognitive and physical functioning in Europe. More than 90% report having no disability (vs. 83.7% on avg. in the study population) and about 60% say that they do not have a major disease (42.6% on avg.) (Hank, 2011). An international survey of older adults (55+) demonstrated a high level of satisfaction in Switzerland in regard to the health system and the access and quality of the primary care services (Osborn et al., 2014).

Swiss men have the longest life expectancy in the world (2016). Boys born in 2016 can expect to live up to 81.3 years on average, which is more than a decade longer than the world average of 69.1 years. The life expectancy of Swiss women is 85.3 years. Only women in Singapore, South Korea, France and Japan can expect to live slightly longer (WHO, 2016o).

Life expectancies for people 60 years of age are also considerably high in Switzerland and will be further growing in the next decades.

<table>
<thead>
<tr>
<th>2015</th>
<th>Both sexes</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth</td>
<td>83.4</td>
<td>85.3</td>
<td>81.3</td>
</tr>
<tr>
<td>Healthy life expectancy at birth (2012)</td>
<td>73</td>
<td>74</td>
<td>71</td>
</tr>
<tr>
<td>Life expectancy at 60</td>
<td>25.0</td>
<td>26.6</td>
<td>23.2</td>
</tr>
</tbody>
</table>

Table 12: Life expectancy, Switzerland, 2015

Sources: UN DESA, Profiles of Ageing, Switzerland, 2015; UN DATA, 2016; WHO, World Health Statistics, 2016;
Health system

The Swiss health system is well developed, offering a high degree of choices and immediate access to all levels of care for all. Public satisfaction with the system is high and the quality of the services offered is viewed as good or very good. Improving financial protection and fairness of financing, especially for households with lower and middle incomes, are challenges to be considered for the next years (De Pietro C, 2015).

The Swiss healthcare system is highly decentralized and duties and responsibilities are divided between the federal, cantonal and communal levels of government. Each of the 26 Swiss cantons (incl. six half-cantons) has its own constitution with an elected Cantonal Minister of Public Health. These cantons are responsible for coordinating health services, institutions and organizations, licensing providers and promoting health and preventing diseases. The Federal Office of Public Health (FOPH) is the main coordinating and supervising authority for health at the national level.

The health insurance system is publicly financed and all residents are legally required to purchase a statutory health insurance (SHI) premium, leading to almost universal health coverage. Complementary voluntary health insurance for services not covered by the SHI is often purchased privately (CF, 2015).

Health expenditure accounted for 11.5% of the GDP in 2015 (OECD avg. 9.3%). Public spending on long-term care was 2.2% of the GDP in 2014, and has only marginally increased in the last decade (OECD avg. 1.4%) (OECD, 2016c).
Pension system

The current statutory retirement age in Switzerland is 65 years for men and 64 years for women. The Swiss pension system has a three-fold basis: the public scheme is earnings-related with a progressive formula, an income-tested supplementary benefit and a mandatory occupational person regime. The latter can be supplemented on a voluntary basis. A bonus for taking care of close relatives during caring periods is credited (OECD, 2015h). In Switzerland 1% of all value-added tax (VAT) collected is used for the state-run retirement fund. Both employers and employees contribute 4.2% of the wage each towards the employee’s personal retirement fund. The future of the Swiss old age insurance scheme is currently under discussion and a reform as part of the Retirement 2020 plan is expected by the end of 2016. Raising the general retirement age for women to 65 years and offering more flexibility in respect to early or late retirement are key issues in this context. In addition a public vote will be conducted in response to a people’s initiative requesting an increase in pensions by 10%. Another proposal under discussion is linking the retirement age to the average life expectancy (Wurz, 2014). The total dependency ratio is going to increase significantly mainly due to a growing number of people aged 65 or over (UN, 2015a).

<table>
<thead>
<tr>
<th>Key facts</th>
<th>2015</th>
<th>2030</th>
<th>2050</th>
</tr>
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<tbody>
<tr>
<td>Pension coverage (65+)</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statutory retirement age (years)</td>
<td>65 (m)</td>
<td>64 (w)</td>
<td></td>
</tr>
<tr>
<td>Labour force participation 65+ (%)</td>
<td>10.6</td>
<td>11.6</td>
<td></td>
</tr>
<tr>
<td>Total dependency ratio</td>
<td>48.8</td>
<td>63.2</td>
<td>75.4</td>
</tr>
</tbody>
</table>

(Per 100 persons aged 15-64)

*Table 13: Key facts, Switzerland, 2015*

*Sources: UN DESA, Profiles of Ageing, Switzerland, 2015*
National Policies related to Healthy Ageing

Since 2016 Switzerland ranks first in the Global AgeWatch Index, achieving high ratings in all domains (Enabling environments, income security, health status, capability), but there are still some remaining challenges such as a relatively high poverty rate among the older population (HelpAge, 2016a).

Fostering healthy ageing is a key objective in the Swiss Federal Council’s national “Health2020” strategy. This strategy covers a wide range of measures across the health care sector aiming at maintaining the quality of life, reducing inequalities, raising the quality of care and improving transparency (CH, 2013a; SAGW, 2016).

A number of ministries, public authorities, regional and local governments as well as NGOs are involved in ageing policies and programmes in Switzerland. The central government is in charge of the pension and social security system (Federal Social Insurance Office) as well as the health care insurance and of financing long-term care (Federal Office of Public Health). Cantons and communities are responsible for providing outpatient care through SPITEX and inpatient care in homes for the elderly and care facilities (CH, 2016c).

Health Promotion Switzerland, a non-profit organization financed by the national health insurance system, is responsible for disease prevention and health promotion programmes and for informing the public on health issues. Through its “Via – Healthy Ageing” project the organization is focusing on health promotion of people aged 65 and over. The project has been implemented by more than 10 cantons and includes activities in the areas of physical activity, fall prevention, nutrition, and social participation (GFS, 2016b).
Vision

The aim of the Swiss government is to help its elderly people to live long, independent and healthy lives in their own homes.

Approach

In 2007 the Swiss government presented a “Strategy for Swiss ageing policies”, including guidelines covering various age-related areas such as health and care, social security, employment, mobility, economic situation of pensioners, social participation and engagement (SFC, 2007). The approach used focussed on resources and potentials of older people (e.g. autonomy, participation, contribution) and on their needs (e.g. access to health and social care). In line with the Swiss federal principles, the ageing guidelines were adapted to regional and local requirements, e.g. by developing “Cantonal Guidelines” (Rodrigues et al., 2013). Switzerland has also been exchanging experiences and ideas in various age-related areas internationally, e.g. Ageing Dialog Switzerland – Japan (CH, 2014a).

Focus

The Swiss government has been supporting the development and adoption of the WHO Global Strategy and Action Plan on Ageing and Health and is now aligning its activities with this framework. Focus areas for Switzerland are (among others):

- 80+ generation
- Non-communicable diseases and multimorbidity
- Coordination of long-term care
- Dementia
- Palliative care
- Reducing health inequalities, esp. in older migrants
- Support of caring relatives
Commitment to action on Healthy Ageing

Ageism
Age discrimination is still legal in Switzerland and can often be seen in recruitment advertising. Therefore the OECD has pointed out that this is “the biggest gap to fill” in Switzerland (OECD, 2014g; ADI, 2014). A number of recent national and cantonal programmes and initiatives have been targeting this issue, e.g. the “Potential 50plus” campaign in Kanton Aargau (Canton-Aargau, 2016).

Health inequalities do not seem to be a matter of great concern in Switzerland in comparison to other OECD countries. This may be deceptive as they could be less visible due to the strong decentralisation of the healthcare system. However the Swiss Federal Council has included the improvement of health opportunities for vulnerable populations, including elderly people and immigrants, into its national “Health2020” strategy (CF, 2015; CH, 2013a).

Due to the lack of a coherent integration policy older migrants often had limited educational opportunities and were recruited mainly for labour intensive and low paid work. These are also the main factors for the lower health status and the higher poverty rates within this population group. A National Forum on Age and Migration has been initiated in 2003 to support the health and social situation of older migrants in Switzerland (NFAM, 2016).

Gender
The Federal Constitution and the Gender Equality Act protect gender equality in Switzerland. The Swiss Federal Office for Gender Equality (FOGE) has been focussing in particular on both direct and indirect gender-related discrimination in the workplace (CH, 2016e). In 2003 the Swiss Federal Office of Public Health initiated the Gender Health Research Network to promote intersectoral and interdisciplinary research in this field. It is a national open forum including an alliance of researchers, lecturers and professors in health sciences (CH, 2016f; Gender-Campus, 2016).

Employment
The Swiss Directorate for Employment, Labour and Social Affairs has been assessing the employment policies in regard to the ageing population in cooperation with OECD in 2012. 70.5% of the Swiss population aged 55-64 years were in work, which was well above the OECD average of 54.0%. Rates are higher for men and university graduates and much lower for women, especially those without a university degree (49%) (OECD, 2014c). In the 2014 OECD report “Working better with age – Switzerland” a comprehensive strategy was recommended, especially to support the long-term unemployed of 55 years and over.

The Swiss government has been implementing special programmes for the unemployed people aged 50 years and over and gives this group special attention in its strategy to tackle the shortage of specialists (CH, 2016b). A national conference on age-related employment is held annually to discuss the current and future situation and the development of national and regional policies and programmes in this area (SFC, 2016).
Develop age-friendly environments

**Elder Abuse**
It is estimated that 3 - 6 % of elderly people in Switzerland are victims of abuse. Due to a common underreporting and the lack of systematic research in this field, these numbers cannot be verified. Several NGOs, partially supported by the cantons and communities, are working on prevention of elder abuse and support for victims (O’Dea, 2011; AE, 2016).

**Falls prevention**
The independent Swiss Council for Accident Prevention (BFU) has been conducting research, publishing information material and raising awareness through public campaigns in the field of accident prevention. Falls prevention in the elderly, particularly for those living in care institutions is also one of the key areas of work of Health Promotion Switzerland (BFU, 2016; GFS, 2016b).

**Mobility**
The implementation of the Federal Act on the Elimination of Discrimination against People with Disabilities (DDA) is an important step towards the age-friendliness of the public transport system in Switzerland (CH, 2016d). The Swiss Federal Office of Transport (FOT), other national ministries, cantons, cities and communities are involved in these activities and are partners of “Rundum Mobil”, an independent company, offering mobility training courses throughout Switzerland for people aged 50 years and older (Rundum-Mobil, 2016; Aeneas, 2016). As one of a number of NGOs Pro Senectute is offering special senior taxis (e.g. for trips to doctors, hospitals, shopping) and courses to introduce public transport solutions and their usage to improve mobility among older people (Pro-Senectute, 2016b).

**Cities**
Swiss cities and communities have been involved in research and projects to create more age-friendly environments. Lugano and Uster participated in the study “UrbAging: planning and designing the urban space for an ageing society”. This is part of the National Research Program 54, “Sustainable development of the build environment”. The researchers recommend that a participatory process would be very valuable and that more interdisciplinary research and cooperation are essential to develop and implement age-friendly solutions in the urban environment (Acebillo, 2009).

Geneva, Bern and Lausanne have joined the WHO Global Network of Age-friendly Cities and Communities. The City of Bern, for example, has published the “Age Concept 2020” including strategic goals in eight action areas, e.g. livelihood security, potential and capabilities in old age and intergenerational relations (Bern, 2015). In 2012 Bern was also a founding member of a network of age-friendly cities in Switzerland, aiming at supporting the integration of the elderly in urban areas and at disseminating WHO’s concept of an age-friendly environment throughout Switzerland (Altersfreundlich, 2016).
Housing
The Swiss Federal Law on the Promotion of Inexpensive Housing (Housing Act) has particularly focussed on the needs of families, people with disabilities and elderly people. The Federal Office for Housing (FOH) is involved in several age-related housing projects and initiatives and is cooperating with a number of stakeholders in this field, e.g. Living Switzerland, Age Foundation, Spitex or Pro Senectute (CH, 2016). Pro Senectute, a Swiss-wide NGO supporting older people, has started a number of projects to encourage intergenerational social links. In one initiative in Zurich, “Housing for Help”, older people offer empty rooms in their homes to younger people in exchange for services and help (Pro-Senectute, 2016a).

Active and Assistive Living Joint Programme
The Swiss State Secretariat for Education, Research and Innovation (SBFI) is supporting the implementation of the Active and Assisted Living Joint Programme (AAL JP) in Switzerland together with the European Commission and participating organizations and companies (CH, 2016a). The Lucerne University of Applied Sciences and Arts is working on various projects in the field of Ambient Assisted Living, e.g. personal assistance systems for people with dementia (HSLU, 2016).

Poverty
Despite having 100% pension coverage, Switzerland has a relatively high poverty rate of people aged 65 and over (16.1% vs. 12.6% OECD country average) (OECD, 2015h). The Swiss government has started a national program against poverty in 2010, supporting people affected by poverty through increasing their educational and employment opportunities, improving their living situation and by informing and consulting them on various issues (CH, 2016h).

Social participation
The Swiss Senior Citizens Council represents the interests of the older generation towards the National Council, federal authorities and the public. Similar councils can also be found in many cantons and communities (SSR, 2016). The Swiss Government, regional and local governments have been encouraging programs and initiatives to increase the social participation of the ageing population. These have been mainly organized by non-governmental organizations (SFC, 2007).

Some examples are listed here:
- “Seniorweb”, an interactive internet platform creating networks, organizing events and sharing information (Senior-Web, 2016)
- “Rent a rentner”, a platform offering short-term work in a wide range of areas by pensioners (RAR, 2016)

Pro Senectute, the largest organization representing the needs of the elderly in Switzerland, has been campaigning to raise awareness and to change the way of thinking about the elderly, who should not be viewed as financial burdens, but as valuable and contributing members of the Swiss society. In addition Pro Senectute has been offering a wide range of activities and volunteering opportunities for elderly people (AHSZ, 2016).
Voluntary work
Voluntary work, especially by relatives and friends caring for the elderly and physically impaired people, is of great importance in Switzerland and needs to be further encouraged. One example is a special programme launched by the city of St. Gallen in which senior citizens can actively earn “care time” for themselves by caring for other senior citizens. The project is run by a foundation and supported by the city, regional authorities and other partners (Zeitvorsorge, 2016). Many cities and communities also run “Seniors in schools” projects, where senior citizens can support teachers on a voluntary basis, fostering intergenerational dialogue as well.

Lifelong learning
Switzerland has the highest participation rate in lifelong learning activities in Europe. 32.1% of survey participants aged 25 to 64 had participated in educational or training activities for work or leisure during a 4-week period before the survey in 2015 (European average 10.9%) (EUROSTAT, 2016). According to the World Economic Forum’s Human Capital Index, Switzerland is one of the world leading countries in relation to using and supporting the skills and competencies of its citizens (WEF, 2015b).

Health literacy
A 2015 representative survey commissioned by the Federal Office of Public Health showed that health literacy levels in Switzerland were similar to those in other European countries, but 54% of the study participants were categorized as having problematic or insufficient levels. Educational and financial backgrounds appear more important than the age in this context (CAREUM, 2016). In 2010 Public Health Switzerland, Health Promotion Switzerland, the Careum Foundation, the Swiss doctor’s association and a pharmaceutical company established the Swiss Alliance for Health Literacy to improve health literacy levels in the Swiss population (AGK, 2016). The new National Strategy for the Prevention of non-communicable diseases (2017-2024) also supports this goal (CH, 2016i).

Nutrition
The Switzerland Nutrition Report 2020, published by the Federal Office of Public Health, has shown that the risk to be malnourished is rising constantly with age, especially for those living in care institutions. It is expected that the number of malnourished people in Switzerland will further rise due to the ageing of the population and the rising incidence of NCDs, e.g. diabetes (CH, 2012a). The prevention of NCDs is a core objective of the Swiss Nutrition Policy (2013 – 2016) (CH, 2016k).
Aligning health systems to the needs of the elderly

In its Health 2020 strategy the Swiss Federal Council responds to the upcoming challenges in the health care sector caused by the ageing population and the increasing incidence of chronic diseases. Health promotion and disease prevention will be intensified, equality of opportunity and individual responsibility reinforced, the quality of healthcare further increased and transparency, better control and coordination of the system created. The Swiss Council emphasizes the importance of keeping the ageing population as healthy as possible and of keeping older employees in the work process, as this will have a positive impact for the health, social and economic sectors alike (CH, 2013a).

As part of the Health2020 strategy a project for coordinated care has been initiated to improve the care especially for those groups requiring multiple and varying health and care services. A needs assessment for elderly people with multiple diseases has already been undertaken and an action plan for this group will now be implemented (CH, 2016g).

Health promotion

Overall senior citizens in Switzerland appear to be healthier and report fewer difficulties in their daily activities (e.g. taking medications, shopping, managing money). Only 5% of those aged 65-74 years and about 17% of those aged 75 years and older are in need of assistance. This is considerably less than in many other European countries (WHO, 2016o).

Health Promotion Switzerland, a non-profit organization working in close collaboration with the Federal Office of Public Health, is responsible for disease prevention and health promotion and is actively involved in various programs for the elderly, especially in the area of nutrition and physical activity (GFS, 2016a). The organization coordinates the “Project Via” aiming to foster health of the older people to ensure their autonomy and to improve their well-being. This is being implemented at the cantonal and community levels and focuses on interventions leading to behavioural change as well as preventive and structural measures (GFS, 2016c).

A proposed Federal Prevention Law, aiming at clearly defining the roles between the federal level and the cantons, at improving coordination and the introduction of a Swiss Institute for Disease Prevention and Health Promotion was rejected by the Parliament in 2012. Smaller cantons feared too much federal influence and businesses and insurers also lobbied against the law (De Pietro C, 2015).

Vaccinations

Besides the basic immunizations, which should be checked regularly, an annual influenza vaccination for people 65 years and over are recommended by the Federal Office of Public Health. Since 2014 the vaccination against pneumococcus is no longer recommended for this age group, but a new vaccine is currently tested for its efficacy (CH, 2016j).
Non-communicable diseases
NCDs are the leading cause of morbidity and mortality in Switzerland and are responsible for 80% of health expenses in the country. As the incidences of NCDs will further rise due to the fast ageing population, the Swiss government has prepared a “National Strategy for the Prevention of non-communicable diseases” (2017-2024), which is contributing to its overall Health2020 policy (CH, 2016i).

Migrants
About 20% of the Swiss population are foreigners and studies have shown that their health is not as good as in the rest of the population. This applies particularly to the older age groups. To tackle this problem the National Programme “Migration and Health” (2014-2017) has been implemented. This includes a number of health promotion and prevention measures also targeting the elderly population. One innovative approach is a free national telephone interpreting service specialized for health care purposes and covering 15 languages (CH, 2014c).

Health workforce
The ageing population will lead to an increasing demand for physicians in Switzerland. Urgent action is needed as the average age of a physician in Switzerland is 49 and a relatively high proportion of primary care physicians will reach the retirement age within the next decade (De Pietro C, 2015; FMH, 2015). The Swiss Health Observatory estimated that to maintain the current level of healthcare approximately 155,000 additional healthcare professionals would be needed by 2030 (OBSAN, 2009a). In 2011 the Swiss government set up a strategy to reduce the shortage of doctors and to promote family medicine. As 37.5% of all physicians in Switzerland are foreigners an incentive-based programme has been set up to reduce the dependency on foreign doctors by increasing the training capacity in medical schools by almost 40% between 2017 and 2020 (CH, 2011; FMH, 2015).
Developing sustainable and equitable long-term care systems

Long-term care services are provided by the cantons for inpatient care (e.g., in nursing homes or institutions for the disabled or chronically ill persons). Outpatient care is provided through Spitex, a Swiss-wide care organization financed by healthcare insurances, regional authorities and a small patient contribution (SPITEX, 2016).

High priority has been given to improving the coordination of care. A special task force, the “Dialogue on National Health Policy” discusses current and future approaches to care and the national Health 2020 strategy addresses care coordination and emphasizes the importance of an integrated care approach (CF, 2015; CH, 2013a).

In 2014 the Swiss public spending on long-term care was 3.0% of the GDP, which is the highest rate in all OECD countries (OECD avg. 1.4%) (OECD, 2016c). The government has introduced several policies to control costs and improve the quality of long-term care. These include policies to improve the coordination and quality of care, especially for very old patients and those with multiple morbidities. A national long-term care strategy is currently under development (CH, 2015b; CH, 2016g).

Dementia
The number of dementia sufferers in Switzerland is predicted to almost double until 2030 (from 110,000 to 200,000) and almost triple until 2050 (to 300,000). Responding to these developments the Federal Office of Public Health has launched the National Dementia Strategy 2014-2017. The aim is to support the people affected by dementia and to promote the quality of their lives always taking their individual circumstances into account. The strategy defines four key areas for action: health awareness, information and participation; needs-appropriate services; quality and professional skills; and data and knowledge transfer (CH, 2014b; Ochsenbein, 2014).

Palliative care
A national strategy for Palliative Care (2010 – 2012) was prolonged to 2015 and has now been transformed into a Platform for Palliative Care, offering suitable services and information of high quality for all citizens (Palliative, 2016). National guidelines and a framework for palliative care have also been developed (CH, 2013b).
**Long-term care workforce**

A study by the Swiss Health Observatory predicts an increasing demand for healthcare workers by 13-25% between 2010 and 2020 due to the ageing population. In addition almost 30% of healthcare workers will reach the retirement age in this time period. New estimates are going to be published in 2016 (OBSAN, 2009b). As part of the Health2020 strategy the government plans to increase the number of healthcare workers and to implement a new law adapting the health workforce to the integrated care approach (CH, 2013a). Informal carers, including family members, friends or migrant workers, the latter often not officially being registered, play an important role for the long-term care system in Switzerland. In 2014 the Federal Council adopted the “Action plan for support and respite of relatives providing care” as part of the Health2020 strategy (CH, 2014d). Several cantons and municipalities offer small daily or monthly payments usually linked to certain conditions to caring relatives. Other cantons have even formalized informal care arrangements by hiring caring relatives through Spitex providers (De Pietro C, 2015).
Measurement, Monitoring and Research

The Swiss Health Observatory (Obsan) is monitoring the situation of the Swiss health care system, which has been confronted with many challenges due to a large increase of chronically ill patients, mainly from within the elderly population. Its 2015 National Health Report includes a special section focusing on the health status of the older generation (OBSAN, 2015). The Swiss Federal Statistical Office has published data on the health of older people on its website and conducts a national health survey every five years (CH, 2012b). In addition the office has created an integrated health information system to measure and monitor ambulatory care in Switzerland (MARS) (FMH, 2016).

In 2011 The Swiss National Centre of Competence in Research “LIVES” was established to conduct a longitudinal study to learn more about the effects of a changing society and economy. This study uses an innovative, interdisciplinary and comprehensive approach to investigate the life trajectories of 25,000 people covering several aspects such as health, family and work (LIVES, 2016).

Switzerland has also been fostering research and innovation in the field of healthy ageing internationally, e.g. by hosting a Japanese-Swiss Joint Workshop on Ageing, Health and Technology, involving a number of Swiss and Japanese universities, academies and policy makers (CH, 2015a). The Swiss State Secretariat for Education, Research and Innovation (SERI) also co-hosted a Swiss-Dutch Innovation Matchmaking event focusing on health and care solutions for an ageing society (UOF, 2015).

Academic institutions in Switzerland are also involved in a number of research projects in the field of healthy ageing. For example, the University of Zurich is part of an international, interdisciplinary collaboration working on an integrative analysis of longitudinal studies of ageing (IALSA). An integrative life course development framework is used to study health-related changes due to ageing. As part of IALSA the university has been conducting the Zurich Longitudinal Study of Cognitive Ageing (ZULU) (IALSA, 2016).

Novartis, the largest pharmaceutical company in Switzerland and TopPharm, one of the biggest pharmacy groups in Northern Switzerland, have launched a “Health Ageing Forum Switzerland” to engage in a dialogue with all stakeholders involved in this area and to foster innovative ideas and approaches (HFS, 2016). Several Swiss insurance companies, healthcare providers, pharmaceutical companies and other organizations have organized the World Demographic and Ageing Forum (WDA) in St. Gallen. The WDA Forum has been particularly focusing on finding innovative solutions for the challenges of the employment sector caused by an ageing society (WDA, 2016).
2. INNOVATIVE POLICIES RELATED TO HEALTHY AGEING

National policies and programmes for healthy ageing will always have to take the cultural, social and economic context into account. A comprehensive strategic approach requires the identification of suitable frameworks and cost-effective policy options. The Global Strategy and Action Plan on Ageing and Health provides policy makers with a public health framework for action, based on five strategic objectives. Each of these is further divided into three subcategories. This well balanced approach has been used as a basic guideline for the following presentation of selected innovative policies.

<table>
<thead>
<tr>
<th>Table 3: Strategic objectives, Global Strategy and Action Plan, WHO 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Commitment to action on Healthy Ageing in every country</strong></td>
</tr>
<tr>
<td>1.1 Establish national frameworks for action on healthy ageing</td>
</tr>
<tr>
<td>1.2 Strengthen national capacities to formulate evidence-based policy</td>
</tr>
<tr>
<td>1.3 Combat ageism and transform understanding of ageing and health</td>
</tr>
<tr>
<td>2. <strong>Developing age-friendly environments</strong></td>
</tr>
<tr>
<td>2.1 Foster older people’s autonomy</td>
</tr>
<tr>
<td>2.2 Enable older people’s engagement</td>
</tr>
<tr>
<td>2.3 Promote multisectoral action</td>
</tr>
<tr>
<td>3. <strong>Aligning health systems to the needs of older populations</strong></td>
</tr>
<tr>
<td>3.1 Orient health systems around intrinsic capacity and functional ability</td>
</tr>
<tr>
<td>3.2 Develop and ensure affordable access to quality older person-centred and integrated clinical care</td>
</tr>
<tr>
<td>3.3 Ensure a sustainable and appropriately trained, deployed and managed workforce</td>
</tr>
<tr>
<td>4. <strong>Developing sustainable and equitable systems for providing long-term care (home, communities, institutions)</strong></td>
</tr>
<tr>
<td>4.1 Establish and continually improve a sustainable and equitable long-term care system</td>
</tr>
<tr>
<td>4.2 Build workforce capacity and support caregivers</td>
</tr>
<tr>
<td>4.3 Ensure the quality of person-centred and integrated long-term care</td>
</tr>
<tr>
<td>5. <strong>Improving measurement, monitoring, research on Healthy Ageing</strong></td>
</tr>
<tr>
<td>5.1 Agree on ways to measure, analyse, describe and monitor healthy ageing</td>
</tr>
<tr>
<td>5.2 Strengthen research capacities and incentives for innovation</td>
</tr>
<tr>
<td>5.3 Research and synthesize evidence on healthy ageing</td>
</tr>
</tbody>
</table>
Healthy Ageing

Transform our understanding of ageing and health

1. Commitment
   - Frameworks for action
   - Evidence-based policy
   - Evidence
   - Research & Innovation
   - Measure, Analyse, Describe, Monitor

2. Age-friendly Environments
   - Autonomy
   - Engagement
   - Multisectoral action
   - Intrinsic capacity and functional ability
   - Person-centred and integrated clinical care

3. Health Systems aligned to older populations
   - Health workforce
   - Person-centred and integrated clinical care
   - Long-term care workforce
   - Sustainable and equitable long-term care system

4. Long-term care systems
   - Person-centred and integrated long-term care

5. Measurement, Monitoring & Research
   - Combat ageism
STRATEGIC OBJECTIVE 1

1. Commitment
   - Frameworks for action
   - Evidence-based policy
   - Combat ageism

2. Age-friendly Environments
   - Autonomy
   - Engagement
   - Multisectoral action

3. Health Systems aligned to older populations
   - Intrinsic capacity and functional ability
   - Person-centred and integrated clinical care
   - Health workforce

4. Long-term care systems
   - Sustainable and equitable long-term care system
   - Person-centred and integrated long-term care
   - Long-term care workforce

5. Measurement, Monitoring & Research
   - Evidence
   - Research & Innovation
   - Measure, Analyse, Describe, Monitor

Healthy Ageing
Transform our understanding of ageing and health
2.1 Commitment to action on healthy ageing

Transforming societies to provide a basis for healthy ageing requires leadership and commitment and the involvement of different levels of government as well as a multisectoral approach. The key to the success of ageing policies is collaboration with non-governmental organizations, academics, service providers, product developers and especially with the older people themselves. Investment in the well-being of older people will lead both directly and indirectly to significant economic and social returns. A fundamental step in fostering healthy ageing is combating ageism and adapting the concept and understanding of ageing and health to the challenges and opportunities of the 21st century.

Strategic objective 1 of the Global Strategy and Action Plan on Ageing and Health is divided in three subcategories:

- 1.1 Establish national frameworks for action on Healthy Ageing
- 1.2 Strengthen national capacities to formulate evidence-based policy
- 1.3 Combat ageism and transform understanding of ageing and health.

2.1.1 National frameworks for action

Governments are called upon to develop evidence-informed national and regional plans fostering healthy ageing and systematically involving older people in the development, implementation, monitoring and evaluation of age-specific laws and plans. The identification of a government focal point for healthy ageing, the establishment of clear lines of responsibility and of coordination mechanisms across all sectors as well as the allocation of adequate resources have been strongly recommended.

WHO and other bodies within the UN system are including healthy ageing throughout the life course in the agendas of governing body meetings and in other social, health and economic fora. They are supporting policy dialogues, strengthen intersectoral collaboration and engage older people in policy-making at international, regional and national levels.

National and international partners have been encouraged to include healthy ageing in all dialogues on health, human rights and development.

Examples for national frameworks:

- The Government of Australia released a “National Strategy for an Ageing Australia” in 2001. A whole-of government approach to population ageing has been used to promote positive images of older people and to encourage healthy and productive ageing. The Minister for Health and Aged Care has led the national programmes in the area of population ageing and health. (AUS, 2001).
Healthy Ageing has also been given high priority by the German government for some time. In 2006 a comprehensive framework on this “National Health Goal” was published. The Federal Ministry of Health presented an updated revised version in 2012. This framework was developed in close cooperation with more than 120 organizations, including academic institutions, NGOs, insurance and other private sector companies (GER, 2012).

Ireland published a “National Positive Ageing Strategy” in 2013. This over-arching cross-departmental policy is used as the basis for planning all age related policies and services. As part of the strategy the “Healthy and Positive Ageing Initiative” is monitoring changes in older people’s health and wellbeing. A liaison group of national NGOs and a public consultation process have supported the development of the strategy (IRE, 2013b).

A “National Policy on the Health of Older Persons” has been enacted in Brazil in 2006, emphasizing the objective of restoring, maintaining and promoting older people’s autonomy. The government renewed this commitment with the National Health Plan (2012) and the “Presidential Decree National Commitment for Active Ageing” (2013) (ILC, 2013).

Singapore has a long tradition in the field of active and healthy ageing and a new “Action Plan for Successful Ageing” has been presented in 2016. The Government aims at re-defining ageing and at building a “Nation for All Ages” (SIN, 2016a).
2.1.2 National capacities for evidence-based policy

Despite the existence of adequate evidence of the need for action, there are still some major knowledge gaps concerning policy and programme selection in the field of healthy ageing. Further research needs to be undertaken and the transfer from evidence to policy needs improving, e.g. by policy dialogues, the involvement of civil society organisations and by surveying social expectations in this field.

Policy makers and researchers should work closely together to identify research gaps, create mechanisms to improve knowledge translation and communication flows. WHO has been providing technical support towards these activities, facilitating international exchanges on innovations and good practices and publishing the 2012 “Knowledge Translation Framework for Ageing and Health” (WHO, 2012c).

National and international partners have been encouraged to facilitate relationships among all stakeholders in the area of healthy ageing, including older people, their families and caregivers.

Examples:

- In its “Positive Ageing Strategy”, the Government of Ireland emphasized its evidence-informed approach by promoting the development of a comprehensive framework for collecting data in all areas of ageing, including health and care. The government has also set up a multi-stakeholder National Health and Wellbeing Council using a life-course approach. The Department of Health has also organized an annual forum, including older people and NGOs, to assess and discuss progress of the national strategy and programmes. (IRE, 2014b).

- The Norwegian strategy for an age-friendly society is based on a whole-of-government approach. The implementation is linked to creating new knowledge for evidence-based policy making. The Norwegian Institute for Public Health established a Department for Ageing and Health in 2016 (NIPH, 2014b). In addition the Norwegian National Advisory Unit on Ageing and Health is responsible for securing national competency building in this field (AOH, 2016).

- In the UK the Department of Work and Pensions and the Department of Health are co-chairing the UK Advisory Forum in Ageing, a multistakeholder forum including policymakers, older people, regional representatives and NGOs. The Government has also been working closely with the independent Age Action Alliance of more than 500 organisations from all sectors (UK, 2015b).

- In 2012 the Government of Ghana requested WHO’s technical support in reviewing its existing policy and implementation plan on ageing and health. A comprehensive approach including epidemiologic evidence, reviews of policy documents, site visits and interviews have been used to conduct a nation-wide assessment. The results were discussed in a multi-stakeholder workshop, identifying challenges and policy options (Araujo de Carvalho et al., 2015).

- In 2015 the US Department of Health and Human Services co-organized a Healthy Ageing Summit in Washington, DC, USA, bringing together policymakers, researchers, clinicians, educators and public health practitioners to discuss and exchange ideas on a wide range of issues (USA, 2015).
2.1.3 Ageism and a new understanding of ageing and health

Ageism is the stereotyping or discrimination of a person or group of people because of their age (Butler, 1969). Combating this has to be an essential part of any public health response to population ageing. It not only requires adopting or modifying laws, but also requires a new way of understanding ageing and health. There is the need for more informed views of the ageing population, emphasizing not only the challenges, but also the opportunities that will evolve for the older person, their families, communities and the whole of society.

Governments should adopt legislation against age-based discrimination together with enforcement mechanisms. Policies and programmes need to be modified accordingly, especially in the area of health, employment and life-long learning. Evidence-based communication campaigns should be undertaken to combat ageism increasing public knowledge and understanding.

WHO and other UN bodies are to synthesize available evidence and provide guidance for policy makers in this field. The development of improved economic models has been envisioned to assess the contributions of older people and the costs and benefits of investments in healthy ageing. National and international organizations, especially NGOs, have been encouraged to share their knowledge and experience to help combat ageism and to encourage changes in public attitudes to lead towards a more positive view of the role and contribution of older people for societies and economies.

The International Federation of Red Cross and Red Crescent Societies, HelpAge International and the International Federation on Ageing have been very active in combating ageism to achieve healthy ageing (IFRC, 2016).

Ageism

- Combating ageism has been an important crosscutting element of Ireland’s “National Positive Ageing Strategy”. Measures have been introduced to raise awareness, to encourage the media and opinion-makers to present an age-balanced image of society, and to promote intergenerational solidarity and initiatives (IRE, 2013b).

- It is estimated that about 20% of the working population in Germany has been discriminated due to age (young and old) during working life. The enactment of the General Equal Treatment Act led to the establishment of the Federal Anti-Discrimination Agency in 2006. This agency offers counselling and support for affected people in cooperation with regional and local authorities as well as NGOs. (GER, 2011).

- In 2009 Sweden passed a new Discrimination Act establishing the Equality Ombudsman, a new agency to monitor compliance with the act. This act now includes age and transgender as additional fields. In addition a Board against Discrimination has been established to examine applications for financial penalties (SWE, 2009).

- In Australia the Age Discrimination Act was introduced in 2004, aiming to ensure equal treatment and equal opportunities for all. This Act applies to many areas of public life and focuses on the areas of employment, education, housing and access to services. (AHRC, 2016).
Gender
In 2012 UN Women published a report on the situation of the world’s older women to raise awareness about gender issues related to ageing. Worldwide women make up a significantly larger proportion of the older population (aged 50 years or older). Average literacy levels for older women remain very low in many countries. Older women also suffer significantly from health inequities as health care is often less accessible and affordable for them. As women’s participation in the labour market is lower than men’s and with the gender gap in the employment sector even widening in later stages of life, older women are often financially worse of than men. In addition women are more vulnerable to age discrimination. Inequalities in education, employment and income throughout the lifecourse lead to higher risks of age-related poverty for women. UN Women has therefore prepared overarching and specific recommendations for policymakers (UNWOMEN, 2012; UNWOMEN, 2016).

Employment
Higher life expectancies require new concepts and ideas in relation to work, careers and professional development. Age limits, pension systems and human resource policies have to be adapted to reflect the different abilities and preferences in relation to work of the older population. For many national welfare systems it will be important to give the older generation the possibility to continue working as long as they desire. This would not only help to make welfare systems sustainable, but would also increase the activity level of older people, stimulating their self-reliance, quality of life and increasing opportunities.

- OECD has published a number of reviews and reports on ageing and employment policies, including examples of how countries have been responding to age discrimination in the employment sector. In addition various country responses to population ageing have been described (OECD, 2016a).

- Denmark has implemented a number of policies and initiatives encouraging work even beyond the retirement age and tackling age discrimination in the labour market. These include, e.g. raising awareness of age-discrimination legislation, linking public pensions to improvements in life expectancies, adapting unemployment benefits to prevent early retirement and extending early activation measures for the older unemployed (OECD, 2015a).

- In New Zealand older people play an increasingly important role in the workforce. In 2015 75% of 55-64 year-olds were employed, which is the second highest percentage in the OECD region. The Department of Labour has been supporting older unemployed people. In addition a non-governmental organization called “Older workers” has been linking older job seekers with age-friendly employers (CareersNZ, 2016; OECD, 2016a; OlderWorkers, 2016).

- The Gerontological Society of America has published a comprehensive, global literature review on the effects of work on health in later life. The authors give policy recommendations on the areas of social protection, human resources and employability of older employees (Staudinger et al., 2016).
STRATEGIC OBJECTIVE 2

1. Commitment
   - Frameworks for action
   - Evidence-based policy

2. Age-friendly Environments
   - Autonomy
   - Engagement
   - Multisectoral action

3. Health Systems aligned to older populations
   - Intrinsic capacity and functional ability
   - Person-centred and integrated clinical care
   - Health workforce

4. Long-term care systems
   - Sustainable and equitable long-term care system
   - Person-centred and integrated long-term care
   - Long-term care workforce

5. Measurement, Monitoring & Research
   - Measure, Analyse, Describe, Monitor
   - Evidence
   - Research & Innovation

Healthy Ageing
Transform our understanding of ageing and health
2.2 Developing age-friendly environments

Age-friendly environments need to be developed to foster older people’s autonomy and facilitate the active participation of older people in society. Great societal benefits can be created by adapting the use of public areas, adopting innovative housing solutions, developing accessible and user-friendly transport systems and by implementing new technological solutions targeting the needs of the elderly. Multisectoral action needs to be promoted at all levels (local, regional, national) taking different cultural and socio-economic contexts into account.

Strategic objective 2 of the Global Strategy and Action Plan on Ageing and Health is divided into three subcategories:

- 2.1 Foster older people’s autonomy
- 2.2 Enable older people’s engagement
- 2.3 Promote multisectoral action

2.2.1 Older people’s autonomy

Older people are highly concerned about the protection of their human rights and autonomy to live their lives in dignity and good health. Autonomy is influenced by many factors including personal capacity and resources, relationships and networks, available opportunities (e.g. for lifelong learning) and access to services (e.g. public transport). The key threats to autonomy are elder abuse and injuries caused by falls (WHO, 2015e).

Governments have been encouraged to raise awareness about the rights of older people and to establish mechanisms to protect these rights. They should provide mechanisms for advanced care planning, support assistive technologies and enable older people to retain the maximum level of control of their own lives.

WHO and other UN bodies have been promoting awareness and understanding of the rights of older people, including designating June 15 as “World Elder Abuse Awareness Day”. In addition technical guidance for policy makers is being developed covering key issues in this area like food security, prevention of falls and violence against older women (WHO, 2016n).

National and international organizations have also been asked to raise awareness of the human rights of older people, to support the provision of assistive technologies and to create and support platforms for sharing information on successful programs and initiatives in fostering older people’s autonomy.
Human rights
“A human rights approach can help to address the legal, social and structural barriers to good health for older persons, clarifying the legal obligations of state and non-state actors to uphold and respect these rights.” (Baer et al., 2016)

Policies, approaches and innovative models
In 2012 the Australian Human Rights Commission presented a position paper “Respect and choice” outlining a human rights approach for the implementation of aged care reforms of the Federal Government (AHRC, 2012).

The British Institute of Human Rights has been working closely with the National Health System’s (NHS) healthcare services on embedding human rights in healthcare. “The difference it makes: putting human rights at the heart of health and social care” gives a comprehensive overview of this decade-long collaboration, offering some best practice examples (BIHR, 2016).

AGE Platform Europe published a special policy briefing on “Human rights of older persons in need of care” in 2014 following a high-level seminar and expert workshop together with the Council of Europe and the EC’s Directorate General for Employment, Social Affairs and Inclusion (AGE, 2014).

Elder abuse
Elder abuse has cultural, ethnic, religious and other dimensions. WHO defines elder abuse as “a single or repeated act, or lack of appropriate action, occurring within the relationship where there is an expectation of trust causes harm or distress to an older person” (UN, 2016b). It is estimated that about 10% of older people experience some sort of abuse every month and that only 4% of cases are actually reported. These can be physical, psychological, sexual or financial abuse or abuse through neglect (WHO, 2015a).

• The Division for Social Policy and Development in the Department of Economic and Social Affairs of the United Nations Secretariat has provided an overview of the state of knowledge about the neglect, abuse and violence against older women. A selection of preventative and interventional policy responses from various countries was also provided (UN, 2013a).

• The UN Economic Commission for Europe published a comprehensive policy brief on the “Abuse of Older Persons”, presenting good practice examples for the prevention of abuse and for assistance in case of abuse in a number of countries (UNECE, 2013).

• WHO Regional Office for Europe presented the “European report on preventing elder maltreatment” in 2011, including examples for policies, programmes and interventions (EURO, 2011a).
The National Institute for the Care of the Elderly (NICE) in Canada has conducted the “National Survey on the Mistreatment of Older Canadians” to provide insights for service provision and policy development. This is a prevalence study to provide data on the prevalence, risk factors, and causes of abuse in older Canadians (NICE, 2015).

There is growing concern in Germany about the abuse of older persons, especially women, although the scale of the problem remains unclear. The independent German Institute for Human Rights has published a comprehensive report and recommendations for the government and local authorities. The Federal Ministry of Family Affairs, Senior Citizens, Women and Youth has been raising awareness, offering information material and supporting local telephone helplines for victims of abuse, their families and caregivers (Mahler, 2015) (GER, 2016b).

In Ireland the Health Service Executive’s Elder Abuse Service has been working throughout the country. It is responsible for oversight mechanisms, unified data collection, awareness campaigns and other activities. In addition it has been funding the National Centre for the Protection of Older People, which offers a wide range of research and training programmes, reviews, best practice examples and policy briefs on the management of elder abuse (NCPOP, 2016).

South Africa implemented the Older Persons Act in 2006, prohibiting abuse of older people and providing a framework for reporting and prosecuting the abuse of older people (SA, 2006).

Falls prevention
The reasons for falls are complex. The most common risk factors are previous falls, advancing age, poor balance and mobility, poor vision, cognitive impairment, diseases (e.g. stroke) and the use of multiple drugs (Bergland 2012).

WHO published the 2007 “Global Report on Falls Prevention in Older Age”. The report included examples of effective policies and interventions and a Falls Prevention Model within the Active Ageing Framework describing a cohesive, multisectoral approach to fall prevention (WHO, 2007). Falls prevention was also highlighted as one of the priority interventions in the “Strategy and action plan for healthy ageing in Europe 2012-2020” of the WHO Regional Office for Europe. A number of actions were suggested to reduce the burden of disease and disability from accidental falls among older persons (EURO, 2012).

The European Innovation Partnership on Active and Healthy Ageing has created an action group for personalized health management and prevention of falls. This group consists of more than 100 organizations, public authorities, administrations and other stakeholders from multiple sectors at the regional, national and local level from across the EU. The aim is to reduce falls by promoting the development and market introduction of new technologies and by supporting the establishment of regional programmes (EC, 2012a).
• Each year more than 30% of adults aged 65 years and over in the United States fall. It is estimated that falls among adults are responsible for more than 25,000 deaths (esp. through traumatic brain injury or following a hip fracture), 2.5 million emergency department visits and more than 700,000 hospitalizations. Treatment costs increase with age and have accounted for more than $34 billion in 2013. The Center for Disease Control and Prevention has therefore developed a fall prevention toolkit for healthcare providers. Risk assessments, training programmes, support for home modifications and facilitating better medication management have also been used (NCSL, 2016).

• The Australian Commission on Safety and Quality in Health Care has developed best practice guidelines, a guidebook for preventing falls and harm from falls, and additional resources for hospitals and residential care facilities (AUS, 2009).

• The Irish Department of Health estimated costs of approximately € 500 million annually caused, directly or indirectly, by falls and fractures in older people. A “Strategy to Prevent Falls and Fractures in Ireland’s Ageing Population” was published in 2008. (IRE, 2008).

• A comprehensive study on fall prevention in the elderly population was conducted on behalf of the German Federal Ministry of Health in 2012. The researchers concluded that due to the complexity of the field no clear evidence-base on prophylactic measures, possible indicators and risk factors could be generated (Balzer et al., 2012).
Mobility
As older people are often not able to drive their own cars anymore, good, accessible public transport is a prerequisite for leading an active and healthy life. Transport planners and providers need to cooperate and develop travel chains offering good accessibility and easy usability for older people. Some technological approaches, e.g. digital ticket solutions using smartphones, could be helpful if they are specially designed for use by older people.

- **AgeUK** and the [International Longevity Centre UK](https://www.ageuk.org.uk) published a comprehensive report on the “Future of Transport in an Ageing Society” in 2015. The report presented gaps and challenges that have to be addressed and emphasized the urgency of responding to the needs of people aged 80 years and over, poor people and those living in rural areas. Opportunities, especially through technology, local decision-making and volunteering concepts are also described (Holley-Moore and Creighton, 2015).

- The **EU** funded research project “Growing older, staying mobile” (GOAL), presented an action plan for innovative solutions responding to the transport needs of an ageing society. Areas for action were identified, including the identification of motivators for walking and cycling, the assessment of accessibility measures in the public transport system and the investigation on social media solutions for travel information suitable for older people (GOAL, 2013).

- The **US** Department of Transportation has developed a “Traffic Safety for Older People 5-Year Plan” aiming at identifying and providing evidence-based measures to reduce risk for all road users, especially the elderly. The four key areas of work focus on data collection, vehicle safety, driver behaviour and pedestrian safety (USA, 2013).

- **Singapore’s** new “Action Plan for Successful Ageing” has emphasized the need of enhancing the age-friendliness of its public transport system. The Ministry of Transport has been implementing measures to improve the accessibility and user-friendliness of the system, e.g. the “Barrier Free Accessibility Programme” or a “Green Man Plus” scheme to provide additional time for elderly and disabled at pedestrian crossings (SIN, 2016a; SIN, 2016b).

- As part of the Government’s Equality strategy the **UK** Department for Transport developed an information resource package on transport solutions for older people for use by local authorities. This package included a wide-range of topics regarding the affordability, availability, accessibility and acceptability of local travel options for the elderly (UK, 2012).
The 2003 Brazilian Elderly Statute allows people over 65 to have free access to public transport in urban and suburban areas. Additionally, older people with lower incomes equal to or less than twice the minimum wage have a right to discounted travel or free interstate transport passes (BRA, 2007).

42% of people in Ireland aged 65 and older live in rural areas. A study on public and community transport for older people in rural Ireland emphasized the need for a joint effort between government departments, local authorities, transport providers, NGOs, senior citizens’ groups and other stakeholders (Breen, 2014).
2.2.2 Older people’s engagement

Enabling the participation and engagement of older people should be a central goal of socio-economic development. Older people make a wide range of contributions to their families, communities and societies, for example as mentors, consumers, workers and volunteers. Their participation in decision-making on policies, programmes and services concerning them and the development of older people’s organizations should be encouraged.

National and international organizations (e.g. HelpAge International) have been providing information, training, peer support and long-term care. In addition many of these build platforms and networks for sharing the voices of older people.

WHO and other UN bodies are raising awareness and promoting understanding of the contributions of older people to their societies. Several NGOs working in the field of healthy ageing and representing older people’s voices have been actively involved in the development of the WHO Global Strategy and Action Plan on Ageing and Health (WHO, 2016g).

The Irish Senior Citizens Parliament, established in 1994, is an NGO promoting the views of older people in policy development and decision-making in Ireland. This parliament has 400 affiliated organizations with a combined total of more than 100000 individual members (ISCP, 2016).

One of the main goals of the German national healthy ageing framework is supporting the engagement and social participation of elderly people. A number of sub-goals, possible measures and other recommendations for a wide range of stakeholders have been identified. Most of these activities are to be developed and implemented by authorities, NGOs and senior citizen organizations at the regional and local level (GER, 2012).

The Canadian National Seniors Council has been advising the Government on current and emerging, age-related issues like health, well-being and the quality of life of seniors. The Council has been working with seniors, stakeholders and experts and has also received input and advice from a large number of organisations representing the interests of older people (GOV, 2016).

Social and political participation of senior citizens is one of the main goals of the 2012 “Federal Plan on Ageing and the Future”, which the Government of Austria developed in close cooperation with the Senior Citizens Council and the Austrian Interdisciplinary Platform on Ageing (AUT, 2012).
2.2.3 Multisectoral action

Promoting multisectoral action is essential for fostering the functional ability of older people. Many programmes and initiatives require cross-sector involvement. For example, stakeholders from the fields of transportation, urban planning, housing, health and social welfare among others are required for promoting the mobility of older people.

Therefore governments need to encourage and support cities and communities to take multisectoral approaches when developing their age-related policies and programmes. Such approaches should also include providing protection from poverty, the expansion of housing options, ensuring accessibility in buildings, transport and other services, the creation of community meeting places and the provision of social and lifelong learning opportunities for older people. The establishment of task forces at the local level linked to regional and national coordination mechanisms would ensure the effective implementation and monitoring of these activities.

WHO has been expanding and further developing its Global Network of Age-friendly Cities and Communities and has provided an interactive platform for exchange. WHO has also developed indicators to inform policy-makers on the progress in the development of age-friendly environments (WHO, 2016k; WHO, 2015b).

National and international organizations are important for promoting the concept and for supporting the development of age-friendly cities and communities. For example, the European Commission’s European Innovation Partnership on Active and Healthy Ageing has a special action group aimed at bringing together partners from multiple sectors from all over Europe to develop and discuss innovative approaches for age-friendly buildings, cities and environments (EC, 2016c).

WHO Global Network of Age-friendly Cities and Communities

The network has been established to foster the exchange of experience and mutual learning between cities and communities worldwide. Its members have the desire and commitment to promote healthy and active ageing and a good quality of life for their older residents (WHO, 2016k).

Cities and communities share their ideas and experiences in a Global database of age-friendly practices (WHO, 2016f). Additional resources including senior strategies, community action plans and progress reports can be found on the Age-friendly world website (WHO, 2016b).

These activities are supported by WHO’s Regional Offices, e.g. the WHO Regional Office for Europe, which heads the Age-friendly environments in Europe (AFEE) project in collaboration with the European Commission (EURO, 2016b).
Cities and communities

The German Healthy Cities network was established in 1989 based on WHO’s age-friendly cities concept. About 160 cities and communities have already joined this network, which has developed into a platform for exchange between its members. The network proved to be especially useful in 2015, when more than 1 million refugees and migrants arrived in Germany (GSN, 2016).

Launched in 2012 the “UK Network of Age-friendly Cities” has been aiming at new ways of thinking about the challenges and opportunities of an ageing population. It also intends to be a national platform for exchange and a collaborative voice to influence policy and practice. The network members are actively involved in the development of a research and evaluation framework for age-friendly cities (MICRA, 2016).

In Ireland the “Age-friendly Counties Programme” has been aiming at creating communities in which all age groups can participate fully. The Irish government has also encouraged the establishment of Older People Councils by local authorities. These are to be involved in the development, implementation and monitoring of the national ageing strategy (IRE, 2013b) (AFI, 2016).

A recent study on the development of age-friendly cities and communities in Australia suggests that initiatives in a number of cities have been promising, but that political commitment and austerity measures have often limited their implementation and success (Lowen et al., 2015).

HelpAge International has published a comparative overview of selected European cities and urban environments and their responses to an ageing society. The publication “Shaping Ageing Cities: 10 European Case Studies” examines the complexities cities experience and describes local solutions (IFA, 2015).

The Office of the Mayor, the New York City Council and the New York Academy of Medicine have established the Age-friendly NYC initiative. The aim is to encourage all sectors in the city to rethink their attitudes towards ageing, to align their services to the needs of the elderly population and to consider how to benefit from this growing part of the city’s population (AFNYC, 2016).

In Poland, 26% of the population in the city of Poznan are 60 years or older. The city has joined WHO’s age-friendly cities network in 2016 and an increasing number of age-related policies and programmes have now been included into the “City Development Strategy”. Poznan’s City Senior Council has established a Senior Initiatives Centre to improve the quality of life of seniors and to encourage them to participate in the social, cultural and political life of the city (WHO, 2016c).

Since 2013 the second largest district in Sri Lanka, the District of Moneragala, has been following WHO’s age-friendly city concept and has been implementing the age-friendly primary health care concept. The district has also been emphasizing the inclusion of the needs of the disabled into their programmes (WHO, 2014b).
Poverty

- Ensuring protection against old-age poverty remains one of the main goals of Canada’s “National Senior Strategy” despite the fact that poverty rates have fallen substantially in recent decades and are now among the lowest in the OECD region. This has been mainly due to specific income supports for individuals over 65 years, which have been federally administered and publicly funded (Old Age Security; Guaranteed Income Supplement) (CAN, 2016a).

- In Ireland the percentage of older people at risk of poverty was reduced significantly from 27.1% in 2004 to 9.6% in 2010. This reduction has been attributed to generous social welfare transfers within the period. The government’s “National Action Plan for Social Inclusion 2007-2016” has been aiming at securing a sufficient income for older people and at further reducing the risk of poverty in all age groups (IRE, 2016c).

- In 2015 the German old-age poverty rate (65+) was 9.4%. This was lower than the OECD average of 12.6%, but much higher than in other European countries. (OECD, 2015f). The current government emphasized the need to tackle old-age poverty in its 2013 coalition treaty. A solidarity pension for lifetime achievement and a reform of company pensions are currently being prepared (KAS, 2014).

- Chile introduced a minimum guaranteed pension and has reduced its old-age poverty rate from 23% in 2008 to 18.4% in 2012. The Chilean government has also subsidised gaps in the pension contributions of women and low-income workers. In addition self-employed workers, who have a higher risk of old-age poverty, are now required to contribute to individual pension accounts (OECD, 2016i).

- Many EU member states have been becoming increasingly active in the prevention of old-age poverty and social exclusion and the provision of adequate welfare for the elderly. A well-designed minimum income scheme appears to be a good solution for supporting the most vulnerable populations groups. In addition measures need to be identified for tackling challenges related to the labour market, like-gender segregation and part-time working. The recognition of periods of time used for caring of children or elderly relatives without paid work could be beneficial in relation to older women’s poverty (EC, 2007; Bontout, 2008).

- The Belgium Government has taken a number of measures to tackle old-age poverty especially in women, for example by enabling part-time workers to receive a minimum pension. Since the implementation of these measures in 2006 the old-age poverty rate has fallen from 13.8% to 7.3% in 2013 (OECD, 2016g; OECD, 2013b).

- AgeUK ran the “End Pensioner Poverty” campaign to raise awareness and has presented a campaign report including a number of recommendations for politicians and local decision-makers (AgeUK, 2016).
Housing

- **German** estimations show the need for an additional 1.5 million apartments for older people by 2030. The government has been supporting age-friendly housing solutions with financial contributions for the adaptation of private accommodation including burglary prevention measures. In addition the government has been offering low-interest rates for construction companies and others investing in age-friendly accommodation. A 2014 study has shown that substantial cost-savings would be achieved in the social and long-term care systems, if elderly people could live safely in their own housing instead of a nursing home (GER, 2016a).

- **Ireland** the majority of older people live in their privately owned houses. The lack of modern insulation and other energy efficiency measures, low-income levels and high fuel prices has often led to “fuel poverty”. Older people are unable to heat their homes enough and an increase of cardiovascular and respiratory morbidity and mortality has been observed during periods of cold temperatures. The Irish government has published the “National Housing Strategy for People with Disabilities 2011-2016” with the aim of helping older people to live in well-maintained, safe and secure homes (IRE, 2011).

- **Canada’s** “National Senior Strategy” emphasizes the government’s aim to ensure older Canadians have access to appropriate, secure and affordable housing and transportation. The government has been combining its efforts concerning housing and transportation for the elderly because private cars remain the main form of transport for most older people in Canada as less than 10% of older Canadians use public transport services (CAN, 2016b).

- The key principle of “ageing-in-place” is the basis of a number of measures that have been implemented by the Government of **Singapore** adapting homes to the needs of the elderly and providing more housing choices for older people. For example, the government has been offering home improvement programmes, including the “Essential, Optional and Enhancement for Active Seniors (EASE)” programme. Another example is the “Silver Housing Bonus scheme”, in which the government has been giving financial support to senior citizens moving to smaller apartments (SIN, 2016d). The Housing Development Board has customised housing options for the elderly since 1998. In addition seniors have been encouraged to share their stories and memories by becoming tour-guides (“Heartland Ambassador Programme for Seniors”) and intergenerational neighbourhood interaction has been supported with the help of schools and student volunteers (“Project SPHERE”) (SIN, 2016c).
Active and Assistive Living

- WHO’s Centre for Health Development in Kobe, Japan, has hosted two Global Forums on Innovation for Ageing Populations exploring and promoting ideas for transforming communities, systems and technologies. The focus of the second Forum in 2015 was on innovations to enable ageing in place and to ensure the accessibility of health and care services for everyone (WHO, 2015d).

- The European Innovation Partnership on Active and Healthy Ageing has brought together all relevant actors from various sectors to foster research and innovation in this field. One action group within this partnership has been working on the development of interoperable independent living solutions (EC, 2012a; EC, 2016a). The European Commission also supports the Active and Assisted Living Programme (AAL) aiming at fostering information and communication technology solutions for older people (AAL, 2016).

- The Coral project is a European network of regions collaborating in the field of assisted living and healthy ageing. An open innovation process has been used to overcome barriers for implementing assisted living solutions and services and to develop regional policies in these areas (CORAL, 2015).

- The Healthy Ageing Network of Competence (HANC) is a regional, cross-border network in Northern Germany and Southern Denmark. It focuses on preventative measures to maintain mobility and independence of older adults (HANC, 2016).

Social Participation

- Estimations show that up to 20% of older adults in Canada experience some degree of social isolation (CAN, 2014). In the 2014 National Seniors Council’s Report on the Social Isolation of Seniors a number of risk factors were determined. The Canadian government has been organizing general awareness campaigns and has been funding projects to identify populations at risk to address the complex cultural and societal issues related to social isolation and elder abuse (CAN, 2016b).

- As part of its new “Action Plan for Successful Ageing” the Government of Singapore has introduced 70 initiatives to enable citizens to age confidently. The aim is to provide more opportunities for all age groups in a cohesive community, strengthening intergenerational harmony (SIN, 2016a).

- The German Ministry for Family, Seniors, Women and Adolescents supports the German National Association of Senior Citizen’s Organisations (BAGSO), which has been promoting the social integration and participation of older people (BAGSO, 2016).

- A comprehensive study on social exclusion and loneliness in the elderly in Ireland identified risk factors (e.g. income level, family relations) and regional differences and also emphasized the need for more research in this area (CARDI, 2013). Cultural and social participation as well as volunteering have been key priorities in the Irish government’s “National Positive Ageing Strategy” (IRE, 2013b).
Volunteering

- The International Federation of the Red Cross and Red Crescent Societies (IFRC) has recommend governments to promote volunteering activities for older people. By volunteering they can contribute their skills and experience while being actively engaged in their community. The IFRC has also involved older volunteers in its wide range of services and activities (IFRC, 2013).

- A 2009 survey on volunteer work in Germany showed that the participation rate of older people in voluntary activities had risen to about 28% of the people aged 65 and over. The rate is higher for men than for women, is depending on the level of education and is decreasing with age. The German Government has supported a number of projects and initiatives to promote volunteering in older age groups and to prevent social isolation and loneliness (GER, 2012).

- In the United Kingdom older people account for a large part of volunteering services throughout the country (RVS, 2016). In its “Building the Big Society” programme the UK government has encouraged citizens to get actively involved in their communities and has been supporting charities and social enterprises (UK, 2010).

- The European Foundation for the Improvement of Living and Working Conditions published a comprehensive report on “Volunteering by older people in the EU” in 2011, including country reports, case studies and policy recommendations (EFILWC, 2011).

Lifelong Learning

- To respond to the needs and demands of ageing populations, new initiatives and innovative projects combining lifelong learning and civic engagement are important. In the US, for example, Lifelong Learning Institutes, educational communities with peer-to-peer courses often linked to universities and colleges, have proven to be very successful (Henessy, 2010).

- In Austria policies and programmes for lifelong learning and education in old age are based on the 2011 Federal Senior Citizens’ Plan and the Lifelong Learning Strategy 2020. The aim is to improve the quality of life in the post-employment phase, including the provision of high-quality programmes, low-threshold educational offers and intergenerational projects (AUT, 2016a).

- Promoting access to a wide range of opportunities for continued learning and education for older people is one of the key objectives of Ireland’s “National Positive Ageing Strategy”. The government published “Ireland’s National Skills Strategy 2025” in 2016, emphasizing the need for continuous education, especially for older workers to improve their employability (IRE, 2016b).

- A study by the University of Malta on “Lifelong learning towards healthy ageing in primary care” shows that lifelong learning programmes for older adults focusing on their personal health needs can lead to maintaining autonomy and healthier lifestyles (Cutaja, 2015).
STRATEGIC OBJECTIVE 3

1. Commitment
   - Frameworks for action
   - Evidence-based policy

2. Age-friendly Environments
   - Engagement
   - Multisectoral action

3. Health Systems aligned to older populations
   - Intrinsic capacity and functional ability
   - Person-centred and integrated clinical care
   - Health workforce

4. Long-term care systems
   - Sustainable and equitable long-term care system
   - Person-centred and integrated long-term care
   - Long-term care workforce

5. Measurement, Monitoring & Research
   - Measure, Analyse, Describe, Monitor

Healthy Ageing
Transform our understanding of ageing and health
2.3 Aligning health systems to older populations

Health systems need to be prepared for the more chronic and complex health needs of the ageing population. Availability, accessibility and affordability of health care services often need to be improved. More staff trained in recognizing and managing age-related impairments and geriatric syndromes is required. In addition new approaches and clinical intervention models especially at the primary care level are needed to prevent care dependence and to maintain intrinsic capacity in the older population. More health promotion and disease prevention programmes and initiatives (e.g. vaccination campaigns) must be implemented to build and maintain the functional ability of the elderly. Overall coordination between the different healthcare services and between the health and social sectors is imperative.

_**Strategic objective 3** of the Global Strategy and Action Plan on Ageing and Health is divided in three subcategories:

- 3.1 Orient health systems around intrinsic capacity and functional ability
- 3.2 Develop and ensure affordable access to quality older person-centred and integrated clinical care
- 3.3 Ensure a sustainable and appropriately trained, deployed and managed workforce

2.3.1 Health systems promoting intrinsic capacity and functional ability

Health systems and services need to be adapted in many ways to optimize older people’s intrinsic capacities and functional abilities. Access to care, medical products, vaccines and assistive devices has to be ensured, health information systems improved, and technological innovations in these and other fields (e.g. E-health, mHealth) need to be supported. Furthermore there is the need for new strategies and models of health promotion and disease prevention throughout the life-course.

WHO has been providing technical assistance and guidance on setting up national healthy ageing strategies and on adapting health systems to the needs of ageing populations. Regional and national assessments of these health system alignments have also been supported.

National partners are encouraged to support the engagement of older people, their families and communities with health systems and their planning processes. In addition more health systems research is needed in the area of healthy ageing to gain critical evidence for policy makers.
Health systems

- The German Government emphasized the need to strengthen health resources and resilience of older adults and to protect them against health risks. A wide range of programmes and campaigns focusing on health literacy, disease prevention, health promotion, nutrition or fall prevention have been conducted with national authorities, NGOs and the insurance companies (GER, 2012).

- In 2012 the Irish government published its strategic framework for reforming the health system, “Future Health” to respond to the changing needs of an ageing population and other challenges. The development and implementation of a new integrated model of care and a reform of the primary care sector, including new models for the management of chronic diseases, were emphasized (IRE, 2012).

- The Government of Australia has implemented a number of health sector reforms in recent years and is currently discussing a reform of primary health care to support the growing number of patients with chronic and complex illnesses as well as mental health conditions (AUS, 2016b).

- The Government of South Australia published a “Health Service Framework for Older People 2009 – 2016”, aiming at improving the health service model, addressing the needs of specific populations and strengthening partnerships with other stakeholders at the regional level (SouthAus, 2009).

Health Promotion

- A study on the epidemiological evidence, prevalence and interventions to promote active ageing has shown that innovative population-level efforts are necessary to address physical inactivity in order to prevent loss of muscle strength and to maintain balance in older adults. (Bauman et al., 2016). NGOs, like the Age Action Alliance have been promoting public health and active lifestyles for older people in many countries (AAA, 2016).

- WHO and its Regional Offices offer a wide range of programmes, initiatives and networks in the field of health promotion and disease prevention throughout the life-course. For example, the WHO Regional Office for Europe published a “European Physical Activity Strategy 2016 – 2025” and has been hosting the European network for the promotion of health-enhancing physical activity (HEPA) (EURO, 2016a; EURO, 2014).

- In Ireland, the Health Promotion and Improvement Offices organize the national “Go for Life” programme promoting sport and physical activity for older people in Ireland. This programme includes a leadership programme, targeted initiatives to increase participation, a national grant scheme as well as a physical activity awareness programme (IRE, 2016a).

- In Brazil the Ministry of Sport initiated the “The Healthy Living Program” in 2012 aiming at increasing older people’s physical activity and at encouraging their social interaction through the establishment of recreation and sports centres throughout the country (BRA, 2012).
Prevention

- The German Government enacted the 2015 Preventive Healthcare act aimed at reducing the risk of diseases and disabilities in the older population. This act focuses on improving preventative measures on the primary care level in addition to health check-ups, screening tests, vaccination campaigns and rehabilitation programmes. Special attention has also been given to prevention programmes for older adults from socio-economically disadvantaged groups (GER, 2012).

- “Healthy Ireland” is a national framework for action to improve health and wellbeing in Ireland between 2013 and 2025. It has been using a whole-of-government and whole-of-society approach, promoting a life-course approach, aiming at reducing health inequalities. A special focus has been on the support of older people in maintaining, improving and managing their physical and mental well-being (IRE, 2013a).

- The EU “Joint Action on Chronic Diseases and Promoting Healthy Ageing across the Life-Cycle” (CHRODIS) is a funding instrument and network within the EU Health Programme 2014 – 2020. The aim is to support Member States to reduce the burden of chronic diseases, for example by providing a knowledge exchange platform (CHRODIS, 2016).

- In addition to the basic vaccinations, WHO has recommended an annual influenza vaccination for older people (EURO, 2012). The importance of vaccinations throughout the life-course of ageing populations also needs to be taken into consideration (Gusmano and Michel, 2009).

Health literacy

- In its report on “Improving Health Literacy in Older Adults” the US Centre for Diseases Control emphasizes the critical importance of health literacy for the effectiveness of preventive measures and public health programmes. Health literacy is seen as a key factor for securing older people’s autonomy. The provision of health information using age-friendly communication tools, considering vision, hearing and cognitive impairments and including internet-based solutions were key recommendations in this area (USA, 2009).

- The Health Literacy Centre Europe (“where healthy ageing begins”), is a portal funded by the EU and coordinated by the University of Groningen, Netherlands. The centre has provided a wide range of information relating to health literacy and published a comprehensive overview on national health literacy policies (HLCE, 2015b). A policy brief on health literacy in the older population and its contribution to sustainable health systems is also available (HLCE, 2015a).

- The Health Promotion Board of the Government of Singapore published the 2010 “Singapore Action Plan to Improve Health Literacy”. The plan was based on an integrated approach by creating health literacy initiatives, targeting individuals, providers and systems (SiN, 2010).
Nutrition

- In 2014 the **European Commission** presented a report on “The role of nutrition in active and healthy ageing” with up-to-date evidence for the prevention and treatment of age-related diseases. The authors have concluded that undernutrition and lack of micronutrients, both common in the elderly population, need to be tackled to reduce and delay age-related functional decline and disability. An overall approach to promote healthy nutrition has been recommended instead of single measures such as nutrient supplementation. Further research was recommended to gain more knowledge, for example, about the positive effects of a “Mediterranean diet” (EC, 2014).

- The **US** National Academies of Sciences, Engineering and Medicine have held a workshop on “Meeting the Dietary Needs of Older Adults, Exploring the Impact of the Physical, Social, and Cultural Environment”. Their report also describes the USDA nutrition programmes and pilot projects for the older population (Brown-Rodgers and Oria, 2016).

- In **Germany** a national health survey showed that many older people have an unhealthy diet leading to high obesity rates in the age group 65 and older (51% in men, 39% in women, 2008). Therefore the Government has been conducting public awareness campaigns, giving specialist training to healthcare workers and carrying out measures to ensure the quality of food provided in healthcare settings (GER, 2012).

Non-Communicable Diseases (NCDs)

- The **New Zealand** Ministry of Health published a background paper on “Food and Nutrition Guidelines for Healthy Older People” in 2013. These guidelines about healthy diet and lifestyle were designed to help practitioners, educators and caregivers supporting older people and their families (NZ, 2013).

- The **Pan American Health Organization** (PAHO) has been supporting its Member States in responding to the increasing challenges caused by NCDs in their ageing populations. Healthy lifestyles and interventions to reduce risk factors for NCDs (e.g. tobacco, alcohol, unhealthy diet) can reduce the NCD prevalence by up to 70% and PAHO has been offering technical support, providing guidelines and additional information material in this field (PAHO, 2016).

- A major goal of the **German** healthy ageing policies has been to improve the treatment of older patients with multiple, especially non-communicable diseases. The government, recognizing the lack of evidence in this multifaceted area, has supported research programmes to adapt the health and care infrastructure, services and guidelines to the complex needs of patients with multiple illnesses (GER, 2012).

- Several **NGOs** have been working to ensure that the special needs of older people are included in national NCD strategies and policies. Rising healthcare costs caused by rapidly ageing populations could substantially be reduced by supporting the prevention, promotion, management and care strategies related to NCDs in this age group (HelpAge, 2016d).
2.3.2 Person-centred and integrated clinical care

The starting point for an older person-centred and integrated clinical care system must be a strong case management system to assess individual needs and to set up personalized care plans. Fostering older people’s self-management through peer support, training, information and advice to older people and their caregivers should be encouraged.

Governments need to identify and implement evidence-based models of integrated care and establish age-friendly health care infrastructures, services designs and processes. In addition the continuum of care and the availability of acute care, rehabilitation and palliative care need to be ensured. The provision of universal health coverage, including mechanisms ensuring that older people can use the health system without financial burden, will be crucial.

In May 2016 the World Health Assembly adopted the resolution on “Strengthening integrated people-centred health services” supporting the “Framework on integrated people-centred health services”. Member states have been encouraged to use this framework to adapt their health systems to the changing needs of an ageing population, including treating more chronic conditions often requiring multiple complex interventions. (WHO, 2016)

- The European Innovation Partnership on Active and Healthy Ageing has a special working group for integrated care especially for chronic diseases. More than 120 stakeholders from multiple sectors have been working together aiming at reducing avoidable hospitalisations of older people with chronic conditions through the development of community-based integrated care service models (EC, 2016b).

- In the United Kingdom the National Health Service (NHS) is a key partner in the National Collaboration for Integrated care and support. The collaborating organizations have been using a holistic approach while working towards a person-centred, coordinated system responsive to the needs of the individual, families and caregivers (NHS, 2016). The UK government has been supporting the development and implementation of integrated care services (UK, 2015a).

- The Scottish Parliament’s information centre published an international comparison of integrated health and social care models (Burgess, 2012).

- The Gothenburg University Centre for Person-centred Care has been conducting more than 40 multisectoral studies to identify practice-oriented solutions and to contribute to evidence-based, sustainable change in health care (GPCC, 2016).

- WHO’s Collaborating Centre for Integrated Health Services based on Primary Care in Granada, Spain, has been supporting WHO Member States in adapting their health services. Emerging, promising and leading practices from different countries have been presented and a comprehensive lists of resources, including scientific publications, implementation reports, toolkits and multimedia have been provided (CC, 2016).
2.3.3 Health workforce

A multidisciplinary approach, covering a range of competencies, e.g. gerontological and geriatric skills, is required to address older people’s needs and to provide integrated care. In addition new professions like care coordinators and self-management counsellors need to be included in an overall workforce development strategy to ensure a workforce, which is adequately trained, appropriately deployed and well managed.

Training institutions need to expand their capacities to increase the number of physicians, nurses and other caregivers with specialized geriatric skills. Opportunities for extending the roles of existing staff for delivering special care for older people should be provided. WHO has been guiding its Member States in the development of evidence-informed strategies for their health workforce, and supporting the development of training programmes to improve skills and knowledge of health professionals in the area of ageing and health.

National and international organizations can provide technical support and expertise to conduct training activities especially in countries with a lack of healthcare professionals and a weak training infrastructure.

- The WHO “Global Strategy on human resources for health: Workforce 2030” was adopted at the 69th World Health Assembly in May 2016. One of the key objectives has been to align national human resources for health with the current and future needs of populations, taking labour market dynamics, existing shortages, unequal geographical distributions and additional aspects into account (WHO, 2016h).

- WHO has also been providing guidance and supporting training activities in geriatrics and gerontology for Member States adapting their health workforce to an ageing population (WHO, 2016m).

- The 2016 study on “Health Workforce Policies in OECD countries” shows that many countries already lack health workers and that the upcoming retirement of many physicians and nurses from the “baby-boom” generation will make the overall workforce situation even more critical. Some governments have responded to this by increasing training capacities for medical students and nurses and by raising retirement ages. In addition to these measures the authors recommend that national health workforce policies should be more focussed on identifying the right mix and skill sets as well as on the development of new roles beyond the traditional professional boundaries, e.g. by training case managers for patients with chronic diseases (OECD, 2016f).

- The Swedish Government has set up training programmes to increase the number of multi-professional teams capable of working with elderly people and their families (SWE, 2016). In addition the Swedish Research Council is funding the Swedish National Graduate School for Competitive Science on Ageing and Health at Lund University (LU, 2016).

- The Australian Department of Health and Ageing published a comprehensive review of its workforce programmes analysing the overall situation as well as specific areas such as rural recruitment and retention strategies or policies to increase the number of health care workers for vulnerable groups (AUS, 2013).
STRATEGIC OBJECTIVE 4

1. Commitment
   - Frameworks for action
   - Evidence-based policy

2. Age-friendly Environments
   - Autonomy
   - Engagement
   - Multisectoral action

3. Health Systems aligned to older populations
   - Intrinsic capacity and functional ability
   - Person-centred and integrated clinical care
   - Health workforce

4. Long-term care systems
   - Sustainable and equitable long-term care system
   - Long-term care workforce
   - Person-centred and integrated long-term care

5. Measurement, Monitoring & Research
   - Measure, Analyse, Describe, Monitor

Healthy Ageing
Transform our understanding of ageing and health
2.4 Developing sustainable long-term care systems

Older people have the right to receive care and support to maintain the highest level of functional ability. WHO defines long-term care as “the activities undertaken by others to ensure that people with or at risk of a significant ongoing loss of intrinsic capacity can maintain a level of functional ability consistent with their basic rights, fundamental freedoms and human dignity” (WHO, 2016g).

As family structures are changing and traditional caregivers within families are choosing other social and economic roles, countries need to develop comprehensive long-term care systems, involving all levels of care (home, communities, institutions). The economic and cultural contexts and existing health and social care delivery systems need to be taken into account while ensuring intergenerational equity. Governments need to secure an adequate workforce capacity and to support caregivers, especially the often unpaid family caregivers. Implementing accreditation and monitoring systems could safeguard the quality of person-centred and integrated long-term care.

Strategic objective 4 of the Global Strategy and Action Plan on Ageing and Health is divided in three subcategories:

- 4.1 Establish and continually improve a sustainable and equitable long-term care system
- 4.2 Build workforce capacity and support caregivers
- 4.3 Ensure the quality of person-centred and integrated long-term care

2.4.1 Sustainable and equitable long-term care system

Long-term care will become an important public health priority for most countries. To establish a long-term care system aligned with the needs of the ageing population, especially regarding the location of care services, roles and responsibilities of all stakeholders involved need to be clearly defined and challenges and barriers to be identified.

As part of the universal health coverage concept, access to care must be ensured and prioritized for those with the greatest health and financial needs. The development of sustainable and equitable financing mechanisms is essential. To achieve this, governments need to foster the collaboration between key stakeholders, including care-dependent people, caregivers, NGOs, the public and private sectors.

WHO provides guidance and technical support to its Member States to identify suitable solutions for different resource settings. Many national and international organizations (e.g. IFRC, HelpAge International) are key stakeholders in the field of care, not only in low- and middle-income countries. Their contribution, often based on a voluntary basis, should not be underestimated when planning a sustainable and equitable long-term care system. Special attention also needs to be given to the rapidly growing numbers of dementia patients and to person-centred palliative care models.
• **Germany** already introduced a statutory long-term care insurance system covering almost the whole population in 1994. Insurance members and their employers contribute 0.975% of the monthly income each, pensioners pay 1.95% from their pensions and childless members pay an increased contribution rate of 2.2% (Busse and Blümel, 2014). The German system has received international recognition, but it faces financial constraints and new challenges due to the rapidly ageing population. The parliament has adopted a new law to support family caregivers taking time off from work to care for their relatives (WHO, 2012a).

• **In Canada** access to appropriate, high quality home and community care, long-term and palliative care is one of the main objectives of the government’s National Seniors Strategy. Policies and measures have also been developed to improve the access to care providers (e.g. geriatricians) and to develop standardized metrics and accountability standards for the care sector (CAN, 2016b).

• **The Australian** Government has been progressively implementing a number of reforms of its aged care system (three phases in 10 years), moving towards consumer-directed care and investing in home support and home care packages. In addition a national contact centre, “My Aged Care”, has been introduced as the main entry point to the aged care system in Australia, providing information and support for older people, their families and carers (AUS, 2016a).

• **Dementia**
  - **WHO and Alzheimer’s Disease International** published a joint report on “Dementia: a public health priority” in 2012, highlighting the global prevalence of dementia and the impact on families, societies and economies. The authors encourage countries to develop and implement policies and programmes in response to the growing challenges related to dementia and to improve the quality of life for people with dementia and their caregivers (WHO, 2012b).

  - **Alzheimer Europe** has published the status of national dementia strategies of 29 countries in Europe, providing a comprehensive overview on current policies and programmes (Alzheimer-Europe, 2016).

  - **Austria** launched its first National Dementia Strategy in 2015 based on the “Austrian Dementia Report 2014”. The provision of high quality care to people with dementia, irrespective of their place of residence, has been one of the general objectives of the strategy (AUT, 2015; AUT, 2014).

  - **The Irish** National Dementia Strategy was published in 2014 to raise awareness and improve diagnosis, treatment, care and support services for people with dementia and their families. (IRE, 2014a).

  - **The Pan-London Dementia Action Alliance**, including a range of NGOs, public authorities and companies, has been aiming at making London the first dementia-friendly city (DAA, 2016). (UK, 2008)
Palliative care

- WHO estimates that only 14% of the 40 million people worldwide currently in need of palliative care have access to this care. Therefore the World Health Assembly has adopted a resolution on palliative care in 2016 (WHO, 2015c). Together with the Worldwide Palliative Care Alliance WHO already published the “Global atlas of palliative care at the end of life” in 2014 (WHO, 2014d).

- The Worldwide Hospice Palliative Care Alliance is an international network of NGOs envisioning a world with universal access to hospice and palliative care. The Alliance has been fostering, promoting and influencing the delivery of affordable, quality palliative care (WHPCA, 2016).

- The WHO Regional Office for Europe published a comprehensive overview on “Palliative Care for Older People, Better Practices” in 2011 (EURO, 2011b).

- The United Kingdom published the “End of Life Care Strategy: promoting high quality care for adults at the end of their life” in 2008 and reviewed its policies regularly (UK, 2008).

- The German Parliament adopted the “Improving Hospice and Palliative Care Act” in 2015, including palliative care in the national health insurance system and supporting home- and community-based models of end-of-life care (GER, 2015).

2.4.2 Workforce capacity and caregivers support

The large number of family members, volunteers, community members and other untrained workers providing essential care need to be taken into consideration when planning a sustainable long-term care system. To ensure the best possible care for older people all these caregivers need to be well informed, adequately trained and, if required, financially supported.

This also applies to the existing health care workforce, who often does not get the appreciation and support it deserves. Improving working conditions, remuneration and career opportunities are important factors in retaining paid caregivers. Greater use of men, younger people and older volunteers in this field can also be of great value as many examples in low- and middle-income countries have shown.

The inclusion of national and international organizations, especially NGOs, in the development and implementation of training, continuing education and supervision of the long-term care workforce can be of great importance. Organizations involved in delivering care must ensure pay, benefits and working conditions for their workers. They should be encouraged to support governments in identifying cost-effective interventions to build up and retain the necessary workforce capacities in this field.
Long-term care workforce

- According to OECD more than 90% of long-term care workers are women, many of them working part-time. Foreign-born workers play an important role for the provision of long-term care in many OECD countries. In the US, for example, almost 25% of workers are foreign born. An increasing demand for long-term care services and a reduced availability of family caregivers will lead to an increasing need for professionally trained long-term care workers (OECD, 2015d). OECD presented a comprehensive review on “Providing and Paying for Long-term Care” in 2011, focusing on policies and programmes to support both the formal workforce and the informal workforce, mainly consisting of unpaid family caregivers (OECD, 2011b).

- The Centre for Policy and Ageing published a review on “The care and support of older people – an international perspective” in 2014, presenting a wide range of issues related to planning the national long-term care workforce. The authors highlighted the crucial role of family and informal carers and provided an extensive overview of different caring models and of country responses to the growing need for healthcare workers (CPA, 2014).

- A 2014 report, commissioned by the Swedish Ministry of Health and Social Affairs, reviewed the different options of delivering long-term care, either by public providers or by contracting public and non-public providers. The authors presented a wide range of subjects to be considered, resources to be allocated and knowledge gaps to be filled when designing and setting up long-term care services, including the required workforce mix (Rodrigues et al., 2014).

- Like many other countries the UK has been focusing more on care and support at home rather than in residential care facilities. “Skills for Care”, the employer-led strategic body for workforce development in England, has provided a wide-range of briefings, reports and research evidence for policymakers (Skills-for-Care, 2015). The authors of a UK study on “Workforce planning in the NHS” have suggested building a flexible and adaptable long-term care workforce, trained with additional skills and competencies to work in multidisciplinary teams able to respond to the increasingly complex patient needs (Addicott et al., 2015).

- The UK Government has been implementing a programme to transform the primary care system, including new training, recruitment and retention initiatives. Health Education England, has been working with employers, professional bodies and education providers to ensure the availability of a sufficient number of adequately trained long-term care workers (UK, 2015c).

- Ireland remains reliant on international nurse recruitment and has been actively recruiting nurses internationally since 2000. Of the approximately 14,500 foreign nurses, who have joined the Irish Health System between 2000 and 2010, 35% came from non-EU countries. During the same period about 17,300 nurses were trained in Ireland (Humphries et al., 2012).
The Government of Australia has conducted an audit of government-funded aged care workforce programmes to assess the needs and identify gaps and opportunities in the aged care and disability workforces. A special Aged Care Sector Workforce Advisory Committee has been set up to support this initiative. In addition the Aged and Care Community Services Australia (ACSA) and NGO’s have been contributing to the development of a new workforce strategy for aged care in Australia (AAAG, 2015).

A growing number of countries have recognized the importance of supporting unpaid caregivers. Canada ensures that unpaid caregivers are not financially penalized for taking caregiving roles through enhanced job protection measures, tax credits and enhanced contribution allowances (CAN, 2016b).

In Austria a number of options of direct and indirect financial assistance (e.g. social insurance contributions, provision of stand-in carers) are offered to caregiving and supporting relatives (AUT, 2016b).

Ireland has been leading a EU-wide project creating an online tool kit for caregivers. The “Digital Inclusion Skills for Carers bringing Opportunities, Value and Excellence” (“DISCOVER”) project provides information, guidance and training to support caregivers throughout Europe (DISCOVER, 2016).

Ensuring the quality and effectiveness of long-term care systems requires appropriate national guidelines, protocols and standards as well as accreditation and monitoring mechanisms. Quality management systems, case management procedures and close coordination across and between sectors are also required. These tasks can be further supported by innovative assistive health technologies or the use of existing technologies in innovative ways.

WHO provides technical support for ability-oriented, person-centred, and integrated long-term care provision. In addition guidance is offered to ensure the quality and appropriateness of long-term care in different resource settings. As many non-governmental and private sector stakeholders are involved in the delivery of long-term care, they need to be encouraged to follow national care standards, guidelines and protocols, and should also adhere to accreditation and monitoring mechanisms.

OECD and the European Commission jointly published a comprehensive report on monitoring and improving long-term care quality in 2012. Delivering high-quality care services has become a policy priority in most OECD countries, but the quality measurement of long-term care services needs to be further developed and data collection should be harmonized at both the national and international levels. Standardised tools and scales to guide care decisions and resource allocation as well as to develop quality indicators have increasingly been available. However these have
not been widely adopted so far, often due to administrative challenges. In addition the importance of quality measurement in informal long-term care settings (e.g. home-based care) remains difficult (OECD/EC, 2013).

- In 1995 long-term care insurance based on a market-oriented model was introduced in Germany emphasizing quality assurance of professional nursing services and care facilities. Mandatory internal quality assurance has been complemented by inspections and since the 2008 long-term care reform by “transparency criteria”. Annual inspections are carried out without prior notice, and the results are publicly reported on a dedicated website. The Medical Service of the German Health Insurance (MDK) has been improving the scheme on an ongoing basis (Rodrigues et al., 2014).

- In the UK self-assessments and remote control mechanisms to monitor the quality of long-term care have increasingly been used since 2010 following the enactment of the 2009 Health and Social Care Bill and the creation of the Care Quality Commission (CQC). Inspection of services are now based more on risks rather than routine schedules. To add an additional perspective to the inspection, service users or informal carers can accompany CQC inspectors. As the CQC guidance has not been using specific outcome indicators, data collections haven’t been standardized and therefore the comparability of data and information has been limited (Leichsenring et al., 2014).

2.5 Improving Measurement, Monitoring and Research

Further research and evidence for informed policy-making is required on issues related to ageing and health and on opportunities to promote the concept of healthy ageing throughout the life-course. Many knowledge gaps need to be addressed, multidisciplinary and multicountry research projects encouraged and knowledge translation supported. Longitudinal, cohort studies need to be more inclusive of older age groups and adapted to their special contexts to gain more knowledge about their experiences and health outcomes.

To monitor progress accountability frameworks and mechanisms will be needed, incorporating e.g. the values and targets of the Global Strategy, health system performance evaluations and commitments to age-friendly cities among others. Appropriate information systems sharing data on health of older people between the various care providers and levels of care will improve effective monitoring of older people’s health.

Strategic objective 5 of the Global Strategy and Action Plan on Ageing and Health is divided in three subcategories:

- 5.1 Agree on ways to measure, analyse, describe and monitor Healthy Ageing
- 5.2 Strengthen research capacities and incentives for innovation
- 5.3 Research and synthesize evidence on Healthy Ageing

2.5.1 Measure, analyse, describe and monitor Healthy Ageing

Operational definitions, indicators and data collection and reporting methods need to be discussed to improve the understanding of older people’s health issues and to assess the appropriateness and effectiveness of policies and programmes. These new approaches need to measure trajectories of intrinsic capacity and functional ability throughout the life-course. There are also a number of important determinants, which need to be taken into account such as environmental factors, cultural attitudes, individual choices, problems caused by multimorbidity and polypharmacy.

Population-based monitoring of older people, including those receiving long-term care, should be conducted regularly. Data sharing and linkages across sectors (e.g. health, social welfare, labour, transportation etc.) should be encouraged and monitoring of healthy ageing metrics should be linked to other national and international policies and programmes or international efforts like the UN Sustainability Goals.

WHO, other UN bodies and specialized agencies have been liaising with additional development partners to find a consensus on metrics and methods to measure and analyze the process in this field. A global situation report on healthy ageing is being envisaged for 2020.

National and international organizations are encouraged to empower older people to become actively involved in these research and surveillance activities and to support policy development by reporting on trends and emerging issues.
WHO and its Regional Offices have been working with a large number of health indicators, providing analysis and reports, some of which could be used for national planning and international comparisons in the field of ageing and health (WHO, 2016a).

The US Centre for Disease Control and Prevention has developed “Healthy People 2020”, a set of national objectives for a 10-year period for improving health of all Americans. A wide range of indicators, some linked to specific targets, have been selected. While some indicators are more relevant to older age-groups, most indicators can be used throughout the lifecourse (CDC, 2016).

As part of the Irish ageing strategy the “Healthy and Positive Ageing Initiative” has been monitoring changes in older people’s health and wellbeing on a regular basis. Performance indicators have been defined and a comprehensive model for measurement and evaluation has been implemented (IRE, 2014b).

OECD has been collecting and analysing a wide range of health systems and related indicators from its member states and additional countries. These include health systems performance indicators, indicators on health workforce migration and on quality of healthcare services (OECD, 2015c).

AgeWatch International has advocated the improvement of data systems in relation to age-related indicators. The organization has also provided a number of recommendations for countries in this area (HelpAge, 2014).
2.5.2 Research capacities and incentives for innovation

National research capacities at system, institutional and individual levels need to be strengthened to address the determinants of healthy ageing and to evaluate related interventions. Collaboration across disciplines, organizations and countries as well as multidisciplinary research projects need to be supported. Many of the age-related health challenges also require the promotion of innovation, knowledge exchange and technology transfer, e.g. by improving home-based or community-based services or developing medical devices and drugs meeting the specific needs of older populations.

Clinical research involving older people is necessary to find preventative, diagnostic and therapeutic approaches for the growing complexity due to multimorbidity and polypharmacy as well as specific physiological differences in the older population.

WHO has been supporting international research activities especially through its network of WHO collaborating centres on ageing and health (e.g. in Kobe, Japan) and by supporting international cooperation to promote technological innovation, e.g. for assistive devices, information and communication technology. WHO and its partners have been developing a global research agenda on healthy ageing.

National and international organizations are encouraged to support the participation of older people in the development, design and evaluation of services, assistive technologies, medical devices and other products. In addition they play an important role for building research capacity, strengthening academic networks and conducting trainings especially in low- and middle-income countries.

- The European Commission has been emphasizing the need for acquiring more valid, comparable, longitudinal data on the health of its older populations to develop evidence-based policies. The Commission has therefore been involved in a number of projects in this field, e.g. “COURAGE in Europe”. In this project, researchers from Spain, Finland and Poland collaborated to measure health and health-related outcomes for an ageing population to develop a valid and reliable evidence-base on ageing comparable throughout Europe (EC, 2012c). The European Commission has also organized the “European Summit on Innovation for Active and Healthy Ageing” in Brussels, Belgium, in 2015 (EC, 2015).

- The US National Institute on Ageing funds the National Archive of Computerized Data on Ageing (NACDA), aiming at advancing research on ageing by providing a broad range of datasets especially for gerontological researchers (NACDA, 2016).

- The UK Medical Research Council developed a “Strategy for collaborative ageing research in the UK” within its “Lifelong Health and Wellbeing programme” in 2011 (MRC, 2011)

- The Federal Ministry of Science and Research in Austria has been funding “ÖPIA”, the official, national platform on age-related interdisciplinary research, created by Austrian scientists in 2009 (ÖPIA, 2016).
2.5.3 Evidence for Healthy Ageing

More research and a comprehensive analysis of the already existing evidence are required for an effective and sustainable public health response to population ageing. To shape political, social and environmental policies for healthy ageing results from longitudinal cohort studies, including older people at home, in communities and long-term care institutions, could help in addition to information gained from surveys and evaluations on the needs and expectations of older people and by multisectoral analysis. Critical periods for action can be identified using a lifecourse approach.

- **WHO** has been coordinating multicountry research and evaluation efforts e.g. through the Study on global AGEing and adult health (SAGE), a longitudinal study mainly collecting data from adults aged 50 and over, supported by the US National Institute on Ageing and national governments (WHO, 2016). WHO has also been raising awareness of research priorities by organizing and participating in international forums and by encouraging national and international partners to engage in a dialogue within communities and the media to convey the concept of healthy ageing. In addition WHO has been working closely with scientific organizations like the Gerontological Society of America, an interdisciplinary organization involved in research, education and practice in the field of ageing and health.

- The **European Commission** funds the “Survey of Health, Ageing and Retirement in Europe” (SHARE) to examine the different ways people aged 50 years and over live in 20 European countries and Israel. It includes a multidisciplinary and cross-national database of data on health, socio-economic status and social and family networks, which can be accessed free of charge (SHARE, 2016).

- The **US** National Institute on Ageing has been in charge of a wide range of scientific activities aimed at understanding the nature of ageing and gaining more knowledge on ways to extend the healthy, active years of life. The Federal agency also supports and conducts Alzheimer’s disease research. In addition it provides information on various ageing-related topics for the general public and health professionals (NIH, 2016a).
• In **India** the International Institute for Population Sciences together with the Harvard School of Public Health and the RAND Corporation launched the “Longitudinal Ageing Study in India (LASI)” in 2010. This study has been focussing on health, economic and social well-being of the older population in India. The study design was specifically chosen to be similar to comparable studies in other countries, e.g. the US Health and Retirement Study (HRS) or the Chinese Health and Retirement Longitudinal Study (CHARLS). 45000 age-qualifying individuals, representative of all India, its 29 states and two union territories have been followed to improve evidence-based decision making on the national and state levels (IIPS, 2016).

• The Max Planck Institute's Centre for Demographic Research has been conducting various research projects related to ageing and health in **Germany** using a life-course approach (MPG, 2016).
Population ageing is expected to become the next global public health challenge. WHO’s “Global Strategy and Action Plan on Ageing and Health” and the “Public Health Framework for Healthy Ageing” can be used as guiding principles for the development and implementation of national policies and strategies in this field. Societies need to develop a new understanding of ageing and health and decision makers need to show their strong commitment.

A number of countries have already been active in the field of healthy ageing, focusing their policies and programmes mainly on the older population. While this could be seen as a necessary response, the results will only be temporary. Demographic estimations clearly show that greater challenges are still to be expected by most countries in the upcoming decades and that a life-course approach to healthy ageing will be necessary.

Japan has already become a model of a super-ageing society and of healthy ageing, showing that longevity has many social and economic implications that need to be addressed in addition to medical concerns. Existing societal strengths and intergenerational solidarity were clearly demonstrated in Japan during the aftermath of the 2011 earthquake and tsunami catastrophe. These aspects as well as the incorporation of local customs and traditional wisdoms into healthy ageing policies and programmes should not be neglected.

New technologies and the digitalization of many sectors offer enormous opportunities for increasing the independence of older people, who will soon be more comfortable with using technology than today’s older generations. Healthy and active older people will also play an important role as consumers and the “Silver Economy” will become an interesting area for investments.

Age-friendly environments to foster older people’s autonomy and enable their engagement need to be developed. This is at the centre of many national ageing strategies and policies such as the new ageing act in France or Norway’s “More years, more opportunities” strategy for an age-friendly society.

Many aspects need to be considered to develop sustainable health and long-term care systems and to be prepared for the upcoming challenges. These include the great diversity among older people, their varying intrinsic capacities and functional abilities. Health promotion and disease prevention programmes throughout the life-course as well as policies and initiatives for dementia and palliative care will become even more relevant as many governments such as the Netherlands or Switzerland aim at enabling people to live healthily and independently in their own homes. In addition social participation, volunteering activities and lifelong learning opportunities should be encouraged as these have proven to be of great benefit for all.

3. CONCLUSION
Many ageing societies will only be able to maintain their high living and health standards, if they manage to compensate the lack of supportive younger generations. Birth rates remain low in many developed countries and they are declining in many low- and middle-income countries. International migration could have a substantial impact not only on the health and care sectors, but also on whole societies and economies.

Education levels have reached historic highs in most countries and older generations have already become enormously influential, as the “BREXIT” vote in the UK has clearly shown. Policymakers will find it more and more difficult in the future to deal with pension systems, health insurance benefits and related issues, as these will have a direct effect on a large share of their voters. Higher education levels, especially among women, will also have an impact on several other aspects like finances, labour force participation, values, lifestyles and health. Furthermore this trend could be beneficial for health promotion and vaccination campaigns, health literacy levels and societal participation.

While many of the policies, programmes and initiatives described in this study are from high-income countries, many mid- and low-income countries will soon be facing similar health, societal and economic challenges caused by ageing societies. This study has shown that the perfect approach in response to the needs of rapidly ageing societies has yet to be identified. However many lessons can be learned through the exchange of experiences and good practices at both the national and international levels. Various examples in this study have also illustrated that older people and non-governmental organizations working with and for them need to be involved in the development, implementation and evaluation of healthy ageing polices and programmes.

All these aspects clearly show that policy makers should take action now. The most effective overall strategy would be to keep the older population healthy and actively contributing to society as long as possible. A more positive image of older people has to be created to support this aim. The contributions of older people to their families, communities, societies and economies need to be highlighted. More respect should be shown towards older generations and their choices and decisions have to be valued. Indeed healthy ageing begins even before conception and therefore the overall concept of healthy ageing needs to be promoted and supported throughout the whole life-course.


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