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Promoting well-being into older age:
A situation analysis of the Western Pacific Region
Annex
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### Abbreviations

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<th>Abbreviation</th>
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<tr>
<td>NCD</td>
<td>noncommunicable disease</td>
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<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
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<td>PHC</td>
<td>primary health care</td>
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<td>SDG</td>
<td>Sustainable Development Goal</td>
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<td>UHC</td>
<td>universal health coverage</td>
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<td>WHO</td>
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Executive summary

Populations are ageing rapidly across the world, as most people live longer and have fewer children. Adults over the age of 65 years are now the fastest-growing age group in the Western Pacific Region. While a few countries in the Region are global leaders in providing health services and other necessities for their older citizens, others are not prepared or are struggling to meet the unique needs of this population. Currently, the populations in the countries in the Region are at different stages of ageing (aged, ageing or will experience ageing). Regardless of their stage of population ageing, all countries are required to take early action to address this demographic shift to yield better results.

All countries will inevitably experience ageing populations as a result of improvements in life expectancy. The rate at which this transition is occurring is fast increasing, so countries will have a narrow window of opportunity to take action. Ageing requires a transformation of all of society, not just health systems. Similar to the challenge of achieving the Sustainable Development Goals (SDGs), preparations for ageing populations involve collaboration across sectors, from city planning to financing and more. In addition, preventing noncommunicable diseases and age-related diseases at earlier ages improves health outcomes, quality of life and productivity, thus ensuring sustainable development. Early engagement of the community builds greater community ownership and empowerment.

Ensuring the best possible health and well-being of older populations is part of the commitment of the SDGs to leave no one behind. Furthermore, the Regional Committee for the Western Pacific in 2013 endorsed the Regional Framework for Action on Ageing and Health in the Western Pacific (2014–2019), and the World Health Assembly in 2016 endorsed the Global Strategy and Action Plan on Ageing and Health. Since then, Member States in the Western Pacific Region have made concerted efforts to increase available evidence and strengthen country capacity with the support of the Regional Office. As the Regional Framework comes to a close, reviewing regional progress, successes and lessons learnt is timely and necessary. Many lessons have been learnt as health systems continue to adapt to this transition. Rather than relying on fragmented specialized services, evidence suggests that health systems should integrate care for older people and ensure that all health services are age friendly, by guaranteeing that providers are knowledgeable about the needs and preferences of this population. In addition, declines in functional abilities whether mental or physical can be best supported by an age-friendly environment.

This report first presents the current regional situation of this rapidly growing population and its impact, followed by reasons all countries, regardless of their ageing status, should prepare for early action for ageing. Last, it describes country successes aligned with the current Regional Framework in preparing for this demographic change.
1. Introduction

1.1 Current situation

Across the Western Pacific Region, population demographics vary greatly. In 2015, 26.6% of Japan’s population was 65 years and over (1). The same year, people aged 65 years or older in Cambodia made up 5% of the population and in the Philippines only 4.35%, with many nations situated between these extremes (2). Regardless of where a country currently lies along this demographic spectrum, most will inevitably become aged societies and face the health system challenges that this change poses. However, this transition is happening at differing rates across both the Region and the world. The size of the older population in France and Sweden doubled from 7% to 14% of the total population over approximately 115 and 85 years, respectively (3). Yet, this same transition occurred over only 50 years in Australia and New Zealand (3–5). Even more remarkable, the population aged over 60 years in China is expected to double over a mere 30 years from 12.4% in 2010 to 28% by 2040 (3,4). Among countries with similar demographic proportions, the more populated a country, the more enormous the number of older people who will require provision of health services. By 2050 in China alone, the projected number of people over the age of 65 years is estimated to be 358 million and over the age of 80 years to be 90 million (6). Many countries in the Region will face the complex challenges of an ageing population as they are still developing economically, with less time to prepare or to adjust and react as problems arise. As shown in Fig. 1, the pace and time period of this demographic transition varies across the Region.

Fig. 1. Time period for population aged 60 years or older to double, select countries and areas of the Western Pacific Region


A population is defined as aged when more than 14% of the people are 65 or older and as ageing when more than 7% of the people are 65 years or older (7). Countries and areas in the Western Pacific Region are at one of three stages of population ageing (as of 2015):

1) Four countries or areas met the criterion for an aged population: Australia, Hong Kong SAR (China), Japan and New Zealand.

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1 Throughout this report, definitions for older populations fluctuate from those 60 or older and those 65 or older in other scenarios. Different sources and countries use varying parameters; this is often a result of country context including cultural, social, health and economic norms as well as increasing lifespans.
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2) Five countries or areas in the Region have already met the criterion for an *ageing* population: China, the Pitcairn Islands, the Republic of Korea, Singapore and Viet Nam.

3) All other countries and areas will *experience an ageing society*, meaning currently less than 7% of the population is above 65 years old.

In Japan, more than 7% of the population was already 80 years and older by 2014 (2). People aged 65 years and older are the fastest-growing age group in the Western Pacific Region, due to a combination of decreasing fertility rates and increasing life expectancies (8). For future projections of the proportion of populations aged 60 years and older in select countries of the Western Pacific Region, see Appendix 1.

Consequently, healthy ageing has become a pressing issue for numerous nations, with many more soon confronting the same challenges. While ageing in itself is not a disease or disability, and for a multitude can mean added years enjoyed in health, ageing for some may signify a decline in physical or mental function. Of note, such decreases in functional capacity due to ageing are only loosely associated with the actual age of a person, and evidence indicates these losses are neither consistent nor linear (9).

In the WHO *Regional Framework for Action on Ageing and Health in the Western Pacific* (2014–2019), four pillars for action were identified: (1) foster age-friendly environments through action across sectors, (2) promote healthy ageing across the life course and prevent functional decline and disease among older people, (3) reorient health systems to respond to the needs of older people, and (4) strengthen the evidence base on ageing and health (see Appendix 2 for diagram).

### 2. Calling for early action

Ageing populations are a global trend, calling for an early response – and the earlier the better.

#### 2.1 Population ageing is a global trend

All countries will inevitably experience ageing populations as a result of improvements in life expectancy. In many countries in the Region, populations are ageing faster due to declining fertility rates. The rate of change for some countries in the Region will be faster than for those countries that experienced the transitioned sooner. This will lead to competing investment priorities, such as infrastructure and poverty reduction, allowing less time and resources to prepare for the changes.

#### 2.2 Ageing requires significant changes in health care and beyond

As the implications of demographic composition changes continue to occur, governments need to revise policies accordingly. At present, policies in many countries do not demonstrate the valuable contributions that older people can continue to provide for a nation. Further, policies pertaining to ageing often reflect the context, culture and perspective of a country on how and where ageing has traditionally occurred. Yet cultural practices are changing throughout the Region, which will have implications if policies are not revised. In China, where various generations of larger families traditionally lived together, the number of multigenerational families living together is decreasing, with single-generation living on the rise – and evidence suggests this phenomenon is occurring in other nations in the Region as well (3,12,15–17). This is likely due to a number of factors, including internal urban migration, an increase in women’s employment, educational advancement and decreases in
family size (3). Consequently, these societal and cultural changes impact who provides care for older people, how care is accessed, who can afford care and the social support system for older people. All these factors contribute to the challenges that countries in the Region face or will face in the near future. Therefore, it is imperative to rethink health systems and the cost, methods, services and quality of providing care to rapidly ageing populations.

Comprehensively preparing for an ageing society requires a whole-of-systems approach. Creating a society prepared for this demographic transition will require collaboration and teamwork from many sectors, including public and private entities, and involve various government ministries. Examples of this may include transportation services to ensure public transport is available (nearby), accessible (wheelchair accessible, ease of use for those with auditory or visual impairments) and affordable. Community members and urban planners should be involved in creating age-friendly communities that promote walkability through pathways, available benches and public toilets, and so forth.

Departments of housing may wish to coordinate with community planners to ensure that housing for older populations is near specific shops and health centres, can help ensure housing affordability to older individuals living on their own, and can promote accessibility within housing complexes (elevators, wheelchair-accessible toilets and so forth). Social sectors can help in increasing support within communities or assisting in the dispersal of information. Departments of labour should be consulted for policies that would provide older people to remain employed past the traditional retirement age. Ministries of finance would be integral in securing funding for the transformation of society at large and the health sector.

In summary, preparing for this rapidly occurring demographic transition will require a massive paradigm shift in the way society operates over a historically short period of time. It will require addressing the different social implications of ageing populations (see Appendix 3), examples of which are briefly discussed in the following sections.

2.2.1 Older people have different health needs

Across the Western Pacific Region, the burden of disease for individuals aged 60 years or older by 2004 was already predominantly noncommunicable diseases (NCDs), as the risk of chronic disease increases with age (10). In 20 countries and areas across the Region, NCDs comprised 79% or more of the disease burden in those aged 60 years and older by 2004, ranging from Cambodia at 79% to New Zealand at 97% (10). The top causes both of years of life lost and estimated mortality globally for individuals aged 60 years or older in 2010 were ischaemic heart disease followed by stroke and chronic obstructive pulmonary disease. When grouped by level of economic development, the pattern for top causes of estimated mortality holds for lower-middle-income countries, but the pattern changes for high-income countries with Alzheimer’s disease and other dementias replacing the third spot (11,12).

By 2016, the burden of disease for those aged 60 years and over had already shifted. The top three overall causes of mortality in the Western Pacific Region are still ischaemic heart disease, stroke and chronic obstructive pulmonary disease. This ranking reflects the reality of lower- and middle-income countries in the Region. In high-income countries, the top overall causes of mortality rank differently, with ischaemic heart disease followed by Alzheimer’s disease and other dementias, stroke and then chronic obstructive pulmonary disease (13). These rankings demonstrate that Alzheimer’s disease and
other dementias are relationally a higher burden in high-income countries. Notably, in upper-middle-income countries, Alzheimer’s disease and other dementias constitute the fourth leading cause of mortality, but the 2016 estimated deaths from this cause are actually higher in upper-middle-income countries than high-income countries, where it is the second leading cause of mortality.

When calculated globally, the diseases causing the most loss of years of healthy life due to disability (combining severity, duration and incidence) for individuals over the age of 60 years are hearing loss, back and neck pain, depressive disorders, uncorrected refractive errors, Alzheimer’s disease and other dementias, stroke, and osteoarthritis, followed by falls (14). Additionally, there are a set of conditions unique to ageing with interrelated factors and causes that can occur due to older age including, but not limited to, frailty, urinary incontinence and delirium (12). While endeavouring to extend quality of life into later years, it is important to remember that not every disease or condition has the same impact on health and daily activities, and even in older age the presence of a condition does not necessarily signify disability.

This shift requires the significant reorienting of health systems.

**Changing health needs call for different health services**

The sheer number of individuals that will enter the older population age group, combined with the higher risk for chronic diseases and the unique diseases that can occur as a result of ageing or specific lifetime exposures, creates a high patient volume, often involving co-morbidities that span various medical specialties (12). This leads to fragmented care. One 2014 cross-country analysis of 11 high-income countries found that of the adults aged 65 years or older surveyed, 26% experienced a problem with coordination of care, and between 4% and 31% of older adults of varying countries reported that their primary doctor appeared uninformed about hospital care following discharge in the previous two years (18). This lack of coordination can lead to frustration, missed follow-ups, avoidable systemic and personal costs from duplication, and ultimately inadequate care (18,19).

Despite lower-middle-income countries carrying a disproportionate share of the disease burden, the WHO World Health Survey found that, unlike in high-income countries, there is no clear increase in self-reported utilization of care by the older people surveyed (20). Leading reasons reported among older adults in lower-middle-income countries of the barriers to accessing these services were cost of both the service and/or transportation or no transportation available. Meanwhile, leading responses as barriers among the high-income countries were bad treatment by prior health-care providers and the respondent’s perception that they were not sick enough to seek care (20). As a result, improvements can be made not only in services (including pricing and locations) offered but also in the way health-care providers offer them.

Therefore, it is important that health-care services be available in close proximity to where older people reside to increase accessibility and decrease indirect costs, whether urban or rural, and with minimal out-of-pocket fees. Furthermore, these services need to be provided in an age-friendly manner, both in the treatment and respect of the patient and of the quality and scope of services offered, such as a provider’s comprehensive knowledge of the health risks of ageing, complex disease processes and co-morbidities, as well as shared care goals that are based on an individual’s functional and intrinsic abilities and that are distributed to all care providers for a patient. Such an approach will enable patients to integrate what once would have required many visits into a minimal number of well-coordinated visits.
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Life expectancy at the age of 60 in 2015 in the Western Pacific Region ranged from 15.04 to an astounding 26.13 years, and health promotion integrated in all health services is of the utmost importance to optimize health and quality of these added years (2). Integrated age-friendly primary health care (PHC) services offered in all settings where older populations reside are thus vital to ensuring that the health-care needs and preferences of older people are met in a sustainable manner for the health system. In addition to a strengthened PHC system, three other important aspects of health-care integration include active case-finding and management, community-based care and home-based interventions (21). These aspects aim to help with coordination of services and link patients across sectors to enable support and resources near the home and to increase skills and knowledge. The combination of these aspects of integrated care will minimize complications, optimize quality of life and empower individuals to age in place. Presently, the strength of PHC differs across systems in the Region. Depending on this strength, a country may only require transforming care services into age-competent and age-friendly services, whereas another country may still wish to work extensively in strengthening the PHC system at the same time as adapting services.

Different health services require different skills

Reorienting health systems to provide care that is no longer focused on acute diseases to chronic and geriatric disease management and health promotion for older people will be a challenge. Health systems will need to have a sufficient number of providers knowledgeable and competent in performing functional assessments of older people and screening and diagnosing conditions associated with ageing and common NCDs. Moreover, training providers on the signs and symptoms of neglect and abuse of older people will be important. Such training will require revising or adding to current in-service and pre-service training to ensure competent health-care providers. One potential solution to strengthening pre-service training might include clinical training in older person-centred primary care (22).

Reorienting the workforce towards a system centred on age-friendly PHC will require countries to evaluate if the current distribution of providers meets the needs of older populations in the settings where they reside. This may lead to findings that providers are unevenly distributed, which may require incentives or policies to redistribute the workforce. Furthermore, for care to truly become coordinated, interdisciplinary teams must train on communication practices (whether information is shared in person or through shared electronic health systems) and define appropriate roles for each team member. Key roles to consider in any setting for an age-friendly multidisciplinary team may include a general practitioner, a nurse, a social worker, a community health worker, a pharmacist and a geriatric specialist (12). The inclusion of a nurse on this team has been associated with improvements in patient satisfaction, use of health services, and health status among the general population with respect to screening and treatment of chronic conditions (23–25). Utilizing team members such as nurses, social workers and community health workers can enable task shifting and complement physicians’ role to better serve large patient populations. Formal policies and guidelines should be in place to determine the scope of each role, and supervision regulations should ensure that the quality of care is always met.

Geriatricians will be essential members of any multidisciplinary team for referrals from a primary care provider. It may also be useful to have them play a key role in providing training and increasing the competency of age-friendly care provided by other team members in an effort to decrease unnecessary referrals. However, a gap in demand already exists between the current ageing population in many
countries and the number of geriatricians (12). Globally, many countries struggle to attract future providers to specialize in geriatrics, yet without a drastic increase in providers entering this specialty soon, this gap will widen (12). A systematic review found that one approach that increased interest was exposure to geriatric care, both preclinical and clinical. Thus, it is important to ensure that school curricula are tailored appropriately and that a pre-service training rotation in a geriatric facility is included (26).

### 2.2.2 Some older people experience social vulnerability and health inequity

Just as the populations among the countries and areas of the Western Pacific Region are incredibly diverse, so are older populations across the Region. There are differences in the disease burden across levels of economic development. For example, there is a higher burden of disease resulting from sensory impairments and chronic obstructive pulmonary disease globally in lower-middle-income countries than found in high-income countries, most likely due to increased environmental risks such as pollution, sun or noise (12). In addition to variations among countries, ageing inequities persist within countries. In China, men aged 55 years or older who have higher incomes, received tertiary education or only engage in light strenuous activity (in comparison to heavy) have life expectancies that are 20–37% longer than those without those advantages (3). This gap only widens by the time men reach the age of 80 years or older, when individuals with a higher socioeconomic status have a 40–52% increase in life expectancy over those with a low socioeconomic status (3). Often, marginalized or impoverished older individuals face increased exposure to health risks and have more health problems (15). Across the Region, women have a longer life expectancy than men both at birth and at the age of 60 years. While this gap narrows when comparing healthy life expectancy at birth for many countries, that for women still exceeds that for men (10).

Social protection schemes and UHC should aid in decreasing disparities due to socioeconomic differences by increasing access to services and basic living needs. Health promotion activities and stronger integrated services may aid in increasing the years that older women in the Region spend healthy instead of in disability. Further, health promotion, active ageing, and coordinated care targeting men and their earlier mortality largely due to cardiovascular diseases may help decrease inequities in life expectancies (5). Disparities in older populations may result from exposure to risk factors or unhealthy behaviours throughout life that are difficult to reverse, but acknowledging these differences and targeting specific screening or promotion may help increase years of healthy life.

Throughout the Western Pacific Region, countries employ different methods in attempting to ensure funding for health services for older people. Regardless of the mechanism, all funding policies should align with the common regional goal of universal health coverage (UHC), which ensures that all people have access to the health services needed without financial hardship.

Social protection schemes, such as pensions, offer a guaranteed income for people above a specified age (age varies by country for those that employ this mechanism). This helps older people afford basic living expenses such as food and housing and cover out-of-pocket medical expenses. With increasing numbers of older people advancing in age with less family to help provide care in the home, pensions may be the only reliable source of income for many older people (3,15,17). More broadly, pensions could take the form of mandatory contributions (paid throughout life until an individual reaches the age to collect), a voluntary occupational pension programme, a private pension programme or a non-contribution public pension programme (27). In any of these types of programmes, the government can
set the minimum standards for collecting a pension, such as age, citizenship status, medical conditions, contribution status and so forth. However, a social pension promoting well-being of all older people would not require an individual to have worked for a specific employer or met a specific contribution scheme (28).

While not representing a direct form of financing, UHC seeks to ensure that no one faces financial hardship in accessing needed health services. Hence, countries working towards UHC should be on the path to ensuring all older people have access to necessary medical services at an affordable cost. Removing financial barriers would likely increase demand for care. These barriers may help explain why there appears to be less demand for health services in older age, despite increased disease burden.

Long-term care has become a staple of health-care provisions for the older population. Though not an indiscriminate recommendation, long-term care may be necessary once the functional and intrinsic abilities of an individual prohibit activities of daily living. Long-term care may be privately or publicly funded and may take place in an institution or in the home. Private financing for long-term care requires an individual or family to pay out of pocket or use private insurance for such services, whether they are provided by family, informal caregivers or an institution. This can create a massive financial obstacle for those of lower economic status or individuals without a family member to provide care. Additionally, institution-based long-term care often does not align with ageing in place.

Among public funding for long-term care, countries may opt for a tax-based system, insurance-based system or a mix. Despite the consistent use of tax revenues among five high-income countries in the Western Pacific Region across public funding types, the precise mixture of public and private funding for long-term care varies widely with out-of-pocket expenditures accounting for 10% of funding in Japan, 26% in the Republic of Korea and 40% in Singapore (29). While the Republic of Korea maintains the higher end of out-of-pocket fees, the country is the only one of the five to ensure universal long-term care. Other countries utilize means- and needs-based assessments for eligibility. Furthermore, once a government chooses a funding mechanism, a decision must then be made on whether both private and public service providers will be used. Due to the vulnerable status of older people with functional limitations, strict quality measurements should be in place for these services.

2.2.3 Older people have more opportunities and motivation to contribute and be productive

As life expectancies increase, the traditional life-course roles (school, employment, retirement) and ages at which those roles transition are changing. Many older people can continue to contribute to society well after what was the traditional retirement age. These contributions not only are important to society, but also extend purpose and value into the years of able older adults. As nations grapple with demographic changes and shrinking populations of working age, a reconsideration of national retirement ages must occur. However, this is not a uniform suggestion. Not all older adults are physically capable or wish to continue working, especially if the work entails intense manual labour. Other valuable contributions may include volunteer work, caring for other family members, or participating in the creation of groups comprised of older people to ensure their perspectives and preferences are met when reorienting a health system or creating age-friendly communities. All these opportunities demonstrate how older individuals can become a significant resource in the coming years if enabled.
Accurate and timely diagnosis and the quality of treatment both for symptoms and underlying causes require age-friendly services where health-care providers can deliver comprehensive skilled services for older people, rather than relying on specialized care providers for each of these differing issues. Presently, health systems for older people are fragmented between PHC and a plethora of specialists, depending on single health needs rather than comprehensive integrated age-friendly services coordinated by an interdisciplinary team led by a PHC provider. Additionally, societies and environments are often not constructed in an age-friendly manner to support older people and prevent or mitigate declines in function.

2.2.4 Older people thrive in community environments

Ageing in place – a key aspect of healthy ageing – enables older individuals to remain where they live as they age in a safe and comfortable manner, regardless of age, ability or income. The option of ageing in place can be promoted by locating support and care services within their communities, shifting a community’s perspectives on ageing to create inclusive societies free of ageism and building age-friendly environments that promote the safety and independence of older individuals.

Age-friendly environments enable older people to maximize their participation and independence in society, decrease or mitigate declines in functional ability and maximize opportunities for ageing in place. Five domains of age-friendly environments promote autonomy, safely ageing in place and continued contributions to society (12). At present, many cities and communities have not been designed with older people in mind and are a barrier to ageing in place. For example, one domain of an age-friendly community is allowing older populations to stay mobile. This means ensuring public transportation, housing and pedestrian crossways are accessible, that there are benches along walking paths and sidewalks for older individuals to rest, that there are public toilets, and that the design of neighbourhoods and communities ensures both walkability and minimal distance to locations such as markets and health centres. Furthermore, older populations should be able to build and maintain relationships (the second domain). This may include accessible community centres, senior centres and religious buildings that host social activities or community-sponsored organizations to aid older people participating in such activities.

As mentioned, older populations can still contribute greatly to society (the third domain). An age-friendly community should ensure that accessible transportation and/or walkways to employment or volunteer work locations are available. The fourth domain of age-friendly communities ensures that an individual’s basic needs are met (accessible and adequate housing, safe transportation options to basic needs, financial security, retraining as needed). The last domain (to learn, grow and decide) entails that the older populations have access to information on housing and available Internet (accessible library computers, for example), that infrastructure uses a universal design for ease of use, and that public workers interacting with older populations are trained in non-discriminatory practices and the needs of older populations. Non-discriminatory work practices may involve communication campaigns to combat ageism or end fixed retirement policies.

2.3 Early action yields greater benefits

Prevention of NCDs at earlier ages will yield greater benefits for countries as their populations age. WHO recently estimated the benefits of the most cost-effective and feasible interventions to prevent and control NCDs (“best buys”) in low-income and lower-middle-income countries (xx). These best buys include: (1) reduce tobacco use, (2) reduce the harmful use of alcohol, (3) reduce unhealthy diet,
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(4) reduce physical inactivity, (5) manage cardiovascular disease and diabetes, and (6) manage cancer. It was estimated that countries only need an additional US$ 1.27 per person per year to implement these interventions and reduce premature mortality by 15% by 2030. These benefits extend beyond health gains and towards other impacts such as economic, environmental and social returns. The best NCD policies can provide returns in all of these domains. For example, every US$ 1 invested in these WHO best buys will yield a return of at least US$ 7 by 2030. By investing in these interventions, countries can reduce the health and economic impact of NCDs, while also maximizing the benefits for other areas of development.

Early engagement and support of the community and family builds greater community ownership and empowerment. This is especially important as communities and families are at risk of losing their ability to support older people due to growing urbanization and smaller family size. In Japan, nearly 70% of people aged 65 and over used to live with their children in 1980, but the share had decreased to 39% in 2015. Meanwhile, the percentage of older people living alone or with their spouse increased from 30% in 1980 to 56.9% in 2015.

In addition, anticipating future needs enables more efficient design and planning of health systems to avoid the potential “pitfalls” of more significant and costly changes later, such as overutilization of health-care services due to free or heavily subsidized care for older people, inadequate community engagement and/or home-care support resulting in heavy reliance on public support for long-term care.

3. Regional successes and lessons learnt

Following the approaches to address ageing populations laid out in the Regional Framework for Action on Ageing and Health in the Western Pacific (2014–2019), countries in the Region have made significant progress. In reviewing country progress as the Regional Framework comes to a close, a number of experiences stand out.

3.1 Regional examples of reorienting health care

Reorienting health systems is a complex task, yet countries in the Western Pacific Region have had great successes over the years. Japan enacted a long-term care insurance system in 2000, separate from medical care insurance, to provide a comprehensive range of services from home visits to inpatient care to individuals aged 65 years and older (30). Japan is now implementing a community-based integrated care system to provide health care, nursing care, prevention, housing and livelihood support (31). To ensure that this coordinated support is accessible to all older people, the goal is for such systems to exist at the municipal level (31). This example demonstrates coordination between sectors (health and housing) to promote ageing in place. Australia utilizes a team approach to protect older people from unsafe or ineffective medicine use by referring high-risk patients to a home medicines review, in which a pharmacist evaluates an individual’s medication profile and shares all recommendations with the referring provider, who can then work with the patient to tailor medication plans accordingly as a team (12). An independent study of this programme indicated that this form of teamwork identified a minimum of one inappropriate rating in 99% of patients reviewed and that the index score of medication appropriateness was significantly lower (improved) after review in the programme (32).
In Tonga, a community-based NCD nurse programme began a pilot project in 2012 and has shown great success (33). With pre-service and in-service training on age-friendly care and ageing conditions, these nurses could provide competent age-appropriate care at the community level. Although specifics differ, Cambodia, China and Viet Nam utilize older people’s associations to mobilize, engage and support older populations. Benefits provided may include home visits or health services and cash assistance or non-cash loans (rice, unmilled rice, or cows, for example) (34). In Cambodia, older people’s associations mobilized advocates urging the Government to expand the Identification of Poor Households or IDPoor Programme, which uses a database of poor households to target services (35). In countries where formal support is limited for older populations, these associations fill a much-needed gap. Many associations acknowledge the range of needs of older people across sectors, demonstrated by the benefits ranging from finance to health to social. These examples show only a few ways in which countries can begin and how many in the Region are already reorienting health systems, regardless of their current state.

Looking towards the future, numerous country strategies and action plans seek to advance progress in reorienting health care. Singapore’s action plan outlines piloting a multidisciplinary community-based geriatric health services programme while increasing the nation’s home care capacity by 50% and community care capacity by 100% by 2020 (36). Simultaneously, the plan emphasizes the importance of transitioning the health system from a fragmented care model into a holistic approach. Innovative practices should be considered to help nations reorient health systems in an efficient manner. In order to better enable ageing in place, Singapore’s action plan notes the potential to utilize technology such as telehealth through video consultations, telerehab or virtual monitoring to reduce human resource needs while increasing the ability for seniors to remain in their own community (36). This type of care and services may be consequential to other countries that lack such service provision due to impractical geography and isolated populations such as vast rural areas or a multitude of islands. New Zealand’s Healthy Ageing Strategy emphasizes the potential of technology through initiatives that improve the transmission of health information between older populations and health workers, from smartphone apps that inform on health status and more that could enable the population to learn and stay informed about health information to make appropriate care decisions (37). Whether helping reorient a health system or promoting information sharing, technology with accessible interfaces can enable older populations to stay educated about their health or easily contact a provider from the comfort of their own home.

### 3.2 Policies and environments to promote contributions of older people

Preparing for ageing populations at the national level is complex. Nevertheless, many countries in the Western Pacific Region have begun implementing policies to promote and support the contributions of older people with great success. These efforts began early in Japan. The Government revised the Act concerning Stabilization of Employment of Older Persons in 1994 to set the retirement age to 60 years (Article 8); this Act was then amended (2004 and 2012) to ensure workers who wish to stay employed between the ages of 60 and 65 years can do so through one of three options chosen by companies (38). Japan also instituted the Silver Human Resource Center to support older people in finding part-time low-skilled employment (39). In Singapore, depending on individual eligibility, employees have the option to remain employed after the retirement age of 62 years until the age of 67 years through re-employment guidelines (this age was increased from 65 years in 2017) (40). Singapore also instituted a tax incentive (3%) to promote the hiring and re-employment of people aged 65 years and older (40). As healthy life expectancies continue to increase across the Region, policies in place should
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both enable those who wish or need to retire due to ill health while limiting age discrimination for those individuals who wish to remain employed as they age. Cook Islands notes the potential for enabling valuable contributions from older people through offering adjunct teaching positions in schools for classes ranging from crafts to the Maori language or creating a database of interested older people accompanied by qualifications to facilitate consulting employment opportunities or a mentoring programme (41).

Instituting age-friendly environments is also paramount. To date, cities and communities from five countries (Australia, China, Japan, New Zealand and the Republic of Korea) in the Region have joined the WHO Global Network for Age-friendly Cities and Communities (42). Examples of city actions taken to promote inclusivity in Seoul, Republic of Korea, include adding elevators and automatic gates and introducing larger screens with train times to make all subway stations accessible (43). Subways also offer priority seating for older people (43). Salisbury, Australia, implemented computer classes and a forum on digital literacy for older people to promote the availability and accessibility of information (44). Hong Kong SAR (China) enacted a government public transport fare concession scheme that provides reduced public transport fares for those aged 65 years or older and people with disabilities (45). These are just a few of the communities and mechanisms in the Region already enabling accessibility for older populations. Coupling enabling policies and environments affords older populations the ability and freedom of decision-making and ageing in place. Cambodia’s national ageing policy includes five strategies aimed at improving the mobility domain for age-friendly communities including instituting priority lanes or public buildings free of barriers and seven strategies to promote ageing in place (46). Ageing in place can pose challenges without an age-friendly home; consequently, the Cook Islands Ministry of Internal Affairs has been implementing home visits to older people’s homes, starting in 2012, to determine if bathrooms require renovations (41).

Further to the aforementioned examples of actions, many nations have committed to continued progress through national plans and strategies on ageing. The national action plan for Singapore (2016) includes elements supporting contributions from older populations through promoting education and employment to volunteering for seniors with specific targets to achieve these in the coming 10–15 years (36). The plan also highlights adaptations to be made by the Land Transport Authority such as increasing accessibility by only using wheelchair accessible buses by 2020, increasing the number of elevators located at pedestrian bridges, and installing more age-friendly traffic lights (36). Fiji’s National Policy on Ageing emphasizes increased participation in decision-making through a national council, increased labour force participation and volunteering as well as offering education or training opportunities (47). The Philippine Plan of Action for Senior Citizens outlines actions such as organizing a volunteer programme and creating an Office for the Senior Citizens Affairs in cities and municipalities to serve as a channel of communication and providers of information and to serve and represent older people in their respective communities (48).

3.3 Country solutions to social support

Social support and cohesion can take many forms depending on the context. As the number of years in older age increases, so do financial requirements to ensure basic living and health necessities. Social support in the form of pensions, as numerous countries in the Region have initiated, is vital to enable ageing in place. As family structures change, various types of social support in the form of groups, organizations, centres or one-on-one volunteering are important to decrease social isolation. China began the New Rural Pension Scheme in 2009, initiated a pension scheme for urban residents in 2012
and merged the two schemes in 2014 with a goal of providing a universal pension by 2020 \((49,50)\). In 2010, the Philippines initiated pensions for those eligible under the Expanded Senior Citizens Act, targeting poor adults over the age of 60 years \((51)\). Singapore created the Community Befriending Programme to combat loneliness and isolation in older people and to provide support to help older people continue safely ageing in place \((52)\). In addition to providing health benefits for members, some older people’s associations offer social leisure activities and a network for socialization. In the aforementioned home visits in Cook Islands, eligibility assessments for allowances can be performed or in addition to monetary support, countries may follow the Cook Islands example of operating a Meals on Wheels programme seeking to ensure older populations have access to food regardless of financial stability \((41)\). Viet Nam implements a combination of social protection methods with differing eligibility for each kind, depending on age, means, disability status and prior employment status in an attempt to ensure wide coverage across the country \((53)\).

Across the Region, countries are acknowledging social support preparations are essential aspects to ensuring well-being into older age and are incorporating relevant goals and objectives in national action plans and strategies. Mongolia’s strategy \((2009)\) incorporates activities such as initiating a type of pension for herdsmen and self-employed individuals while gradually instituting a universal pension with equal pension for all citizens \((54)\). The Philippine Plan of Action for Senior Citizens established a percentage target for expanding pension coverage \((48)\). Cambodia’s policy suggests exploring the potential for creating a social protection floor to prevent impoverished older populations \((46)\).

### 4. Wrap-up

This report described the impact of the current rapid demographic transition occurring in the Western Pacific Region and how Member States have responded with success across the Region to better prepare for the future. In order to comprehensively meet the needs and preferences of the rapidly ageing population, all countries should take early action, reorienting the way health-care services are delivered and ensuring these services are affordable to all older people, modifying the communities we live in, and providing adequate opportunities for the older population to continue contributing and interacting with society.
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Appendices

Appendix 1. Projected percentage of population by aged 60 years and older, select countries of the Western Pacific Region, medium fertility variant

Fig. A1.1. Projected percentage of population aged 60 years and older, 2030, select countries of the Western Pacific Region (medium fertility variant)

<table>
<thead>
<tr>
<th>Country</th>
<th>Population 60+ (%)</th>
<th>Population under 60 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>China</td>
<td>25%</td>
<td>75%</td>
</tr>
<tr>
<td>Fiji</td>
<td>14%</td>
<td>86%</td>
</tr>
<tr>
<td>Japan</td>
<td>37%</td>
<td>63%</td>
</tr>
<tr>
<td>Mongolia</td>
<td>11%</td>
<td>89%</td>
</tr>
<tr>
<td>Republic of Korea</td>
<td>32%</td>
<td>68%</td>
</tr>
<tr>
<td>Singapore</td>
<td>31%</td>
<td>69%</td>
</tr>
<tr>
<td>Vanuatu</td>
<td>9%</td>
<td>91%</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>18%</td>
<td>82%</td>
</tr>
</tbody>
</table>

Fig. A1.2. Projected percentage of population aged 60 years and older, 2050, select countries of the Western Pacific Region (medium fertility variant)

- **China**: 35% population 60+ (%), 65% population under 60 (%)
- **Fiji**: 19% population 60+ (%), 81% population under 60 (%)
- **Japan**: 58% population 60+ (%), 42% population under 60 (%)
- **Mongolia**: 19% population 60+ (%), 81% population under 60 (%)
- **Republic of Korea**: 42% population 60+ (%), 58% population under 60 (%)
- **Singapore**: 40% population 60+ (%), 60% population under 60 (%)
- **Vanuatu**: 14% population 60+ (%), 86% population under 60 (%)
- **Viet Nam**: 28% population 60+ (%), 72% population under 60 (%)

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The Regional Framework has four pillars of action, one for each of the four strategic priorities identified for the Region. The four pillars are:

1. foster an age-friendly environment through action across sectors;
2. promote healthy ageing across the life-course and prevent functional decline and disease among older people;
3. reorient health systems to respond to the needs of older people; and
4. strengthen the evidence base on ageing and health.

Issues of gender, equity and human rights are integrated across the Regional Framework (see Fig. A2.1).

Fig. A2.1. Overview of the Regional Framework
Appendix 3. Implications of ageing populations for society

<table>
<thead>
<tr>
<th>Significant demographic shift</th>
<th>Key changes at individual level</th>
<th>Implications to society (examples)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elderly population becomes largest demographic group</td>
<td>Elderly people have different health needs (e.g. NCDs and age-specific diseases)</td>
<td>Need to anticipate and accommodate needs of care in future (e.g. financing, facilities, referral systems, HR)</td>
</tr>
<tr>
<td>Significant changes in population’s health, social and living conditions</td>
<td>Some elderly people experience social vulnerability and health inequity</td>
<td>Address the social, financial and physical security needs and rights of people as they age</td>
</tr>
<tr>
<td></td>
<td>Elderly people have more opportunities and motivation to contribute/be productive</td>
<td>Need to allow elderly to work, study and participate in the community, including reconsideration of biological age criteria in the social systems (e.g. retirement, welfare)</td>
</tr>
<tr>
<td></td>
<td>Elderly people thrive best in community environments</td>
<td>Need to empower the community to provide more tailored and mutual support to elderly and serve as a place for belonging including supporting elderly with dementia</td>
</tr>
</tbody>
</table>