Global Aging Report

Threats to Longevity
A Call to Action

United States of America

Japan

France

United Kingdom

Dominican Republic

India

South Africa

Argentina

The Netherlands

Israel

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The International Longevity Center Global Alliance

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2009

The International Longevity Center Global Alliance

Preface

The International Longevity Center Global Alliance comprises ten centers – the United States of America, Japan, France, the United Kingdom, the Dominican Republic, India, South Africa, Argentina, The Netherlands, and Israel. Together, we are engaged in an effort to understand and address the profound consequences of population aging and advancing longevity.

This report is a collaborative effort of all ten centers, presenting a detailed portrait of the realities of population aging around the world and articulating a call to action from an intergenerational and lifespan perspective.

A Call to Action

Geography of Longevity

a. Population aging

One of the dramatic events of the 20th century has been the unprecedented aging of populations around the world in both the developing and developed countries. In less than a century and particularly in the developed world there has been an average 30-year gain of life expectancy. Nearly 20 percent of that gain was from a base age 65, in addition to the sharp reduction in maternal, childhood and infant mortality rates. By the year 2020 one fourth of the population in many nations will be over 60, and by 2050, every fifth person on the planet will be over 60. At the same time, many developing countries are experiencing a significant downturn in their birth rates, increasing the percentage of older persons in these countries.

In contrast to the developed world, which grew rich before it grew old[1], the developing world, where 81 percent of the world's population lives, will grow old before it grows rich, with older persons among the poorest and most vulnerable. On average, men and women in the developed world live 75 years, although this could change in the event of an epidemic or pandemic or because of poor health habits that result in obesity.* In the developing world, however, life expectancy is substantially less, averaging 53 years for least developed countries and 64 years for less developed regions,** with enormous economic, social and personal consequences that include significant trade disadvantages. Currently, in 18 nations, (17 nations in Africa, and Afghanistan) life expectancies are less than 50 years and disability-free life expectancies or active life expectancies are less than 46 years.

b. Shortgevity

The populations of many poor nations suffer from shortgevity, and indeed, poverty and shortgevity move in the same direction. Sierra Leone, for example, has an average life expectancy of 40 years and a disability-free life expectancy of only 29 years. In addition, although it is unusual for a nation to reverse a longevity trend several nations of the former Soviet Union (FSU) have indeed lost life expectancy, largely resulting from the AIDS epidemic, and an increase in the incidence of alcoholism caused by the despair and loss of purpose that befell these societies at the breakup of the Soviet Union. Mozambique is another nation that has lost previously gained years of life.

Nations experiencing shortgevity have lower productivity and are at a disadvantage in

* Alex Kalachi, World Health Organization
** Source; UN Population Division

Male life expectancy in the Russian Federation is now 60.
It is the lowest of any nation in the developed world.

the global economy because they are limited in their ability to produce, exchange, buy and sell products and services to the developed world.

Threats to Longevity

a. Diseases of Developed Nations

With the advent of mass vaccinations and advances in public health, developed nations have in large mea sure overcome acute diseases. Chronic diseases, the so-called diseases of affluence, have replaced diseases like polio, diphtheria, and smallpox. They include obesity, coronary heart disease, diabetes and smoking-related diseases. The World Health Organization reports that tobacco is the leading cause of death worldwide.

David J.P. Barker theorized[2] that chronic diseases in later years have their origins in fetal life and early infancy. Low birth weight, which is a function of poor nutrition as well as other adverse prenatal environments, and conditions during infancy, have a direct bearing on the development of risk factors for adulthood diseases. Childhood infections may have a long-term effect on adult mortality, and there is a strong correlation between childhood diseases and later health problems.

In fact, many diseases generally considered "geriatric" did not suddenly emerge in old age but have a long history. It might be more appropriate to refer to them as "disorders of longevity", and to intervene early in life. Osteoporosis, for example, may be seen as a pediatric disease that originates in pubescence and adolescence, when, ideally, bone density is achieved and "banked." In part, the disease is the cumulative outcome of a lack of anti-gravity exercise, calcium and vitamin D. Heart disease and even type II diabetes, particularly when associated with obesity, may take root in infancy and later childhood culminating in death.

b. Diseases of Developing Nations

Not long ago public health experts optimistically predicted the end of infectious diseases. But in the developing world pulmonary and diarrheal diseases (especially in children), tuberculosis (including the extremely resistant form), malaria and acquired immune deficiency

syndrome (AIDS) remain common, debilitating and deadly.

It unfortunately remains true that only 10 percent of disease-related drug research in the developed world focuses upon diseases that affect 90 percent of the world population. For example, hepatitis B vaccine was developed in 1981 but 2 decades passed before it was introduced in the poor nations. Indeed, despite the progress that has been made in bringing vaccine inoculations to poor and remote areas, 20% of the world's children are not vaccinated against vaccine-preventable diseases: measles, polio, tuberculosis, diphtheria, whooping cough, and tetanus.

700,000 children die of pneumococcal disease annually in developing countries.

AIDS

More than 15 million children under the age of 18 have lost one or more parents to AIDS, with the greatest burdens being borne by Sub-Saharan Africa and parts of Asia. In Sub-Saharan Africa the cumulative number of AIDS orphans is estimated to be 12.1 million.[3]

HelpAge International reports that in Sub-Saharan Africa 60 percent of AIDS orphans have a grandparent as a principal guardian.

In many locations orphanages do no exist at all, and in addition to caring for their terminally ill adult children, older persons are the best and often only realistic solution to meeting the needs of their grandchildren and other orphans in the community.

The consequences of the erroneous assumption that older persons are not sexually active can have tragic consequences because they do not receive policy attention, and are not targeted for HIV prevention messages. Older persons are also excluded from many statistics on HIV/AIDS that typically does not include anyone over age 50, such as data from UNAIDS and WHO 2006. Not only are older persons often sexually active, they are also at risk of infection through their role as caregivers. In affected developing countries the impact of HIV/AIDS on older people has been particularly severe. When adults in the prime of their lives die of AIDS-associated illness, they leave behind two vulnerable populations, their children and their aging parents. During the time older persons care for their ill adult children, the physical demands

and emotional strain can seriously affect their health.

In the future, expanding access to antiretroviral therapy that prolong lives and delay serious illness may alter the important role older persons play. Instead of providing care for their grandchildren and terminally ill adult children, older persons in these countries may help ensure compliance to medication regimens by encouraging treatment and monitoring adherence.[4]

Diseases of "affluence" in poor nations

In the 21st century chronic diseases like obesity, coronary heart disease, diabetes and smoking-related diseases — the so-called diseases of affluence (or lifestyle) that afflict the developed world — have overtaken acute infectious diseases to become the predominant causes of disability and death in developing nations, placing an increased economic burden upon already fragile economies.

In just 20 years, the number of people suffering from diabetes increased from 30 million to more than 177 million. By 2030, as many as 366 million people worldwide will be diabetics. The fastest growth will be in developing countries.[5]

Many chronic diseases are also related to the amount (or intensity) and the duration of exposure to one or more pathogens, including infectious agents,[6] toxins, carcinogens, and mutations. Infectious diseases and malnutrition as well as other type of medical and socioeconomic stressors often set the stage in childhood.

Further, a World Health Organization (WHO) report states that slow growth and lack of emotional support in prenatal life and early childhood reduce physical, cognitive and emotional functioning in later years. But poor lifestyles affect rich and poor alike, and unhealthy parental behaviors, such as smoking and alcohol consumption are also implicated.

Aging itself is a risk factor for a variety of chronic diseases[7] with the accumulation of normal aging characteristics creating a threshold beyond which a person becomes increasingly susceptible to an array of pathological outcomes. Disorders like Alzheimer's disease, spinal

stenosis, and temporal arthritis are age-related, but a variety of diseases such as atherosclerosis may hasten the aging process.

Tobacco is the leading cause of death globally.[8]

Pandemics and epidemics

The WHO defines a pandemic as the emergence of an easily spread disease that infects humans and causes serious illness, and one that is new to the population. For example, in a pandemic in 1918 an estimated 40-50 million people perished worldwide as a result of an influenza strain known as the "Spanish Influenza". Pandemics as well as epidemics require international support, including early warning alert and response systems; international training programs to maintain preparedness; development of standardized approaches for readiness and response to major epidemic-prone diseases as determined by the WHO (e.g., meningitis, yellow fever, plague); strengthening of biosafety, biosecurity and readiness for outbreaks of dangerous and emerging pathogens outbreaks, such as Severe Acute Respiratory Syndrome (SARS).

The avian flu presents a new threat worldwide. Scientists fear that the virus will mutate and spread to humans. Indeed, the first case of human infection was reported in May 2008 in Bangladesh, where a 16-month-old child who had been exposed to fowl in his home was infected. Should avian flu spread, the nations of the world are not prepared. They lack the means to rapidly manufacture large quantities of vaccine; they lack veterinarians and laboratories to test for the virus; and they lack the means with which to protect poultry farmers by providing economic incentives if they must cull their flocks to stem spreading the disease.

Feeding the world

Although there is more food in the aggregate in the world than needed, nearly one billion are underfed and starving. Nigerian families spend 73 percent of their budgets on food, Vietnamese 65 percent, Indonesians half. In 2008 the president of the World Bank[9] warned that nations are at risk of social unrest because of the rising prices of food, and noted that over the long term, agricultural productivity must increase in the developing world. He suggested rich countries could help finance another "green revolution" to increase farm productivity and raise crop yields in Africa.

The first Green Revolution was started in the 1940s when the Rockefeller Foundation began a research project to develop a high-yield, disease resistant dwarf wheat crop to improve agricultural yields in Mexico. Under the direction of Norman Borlaug, who won a Nobel Prize for his work, a wheat plant was developed that yielded more grain than traditional varieties. With the development of the Green Revolution, food productivity rose while using less land.

Subsequently, in response to concern about the potential of famine in Southeast Asia, Asia and Latin America, the Rockefeller and Ford Foundations funded a major scientific research effort to improve agricultural productivity. In addition to seeds, over the years the Green Revolution provided farm technology, better irrigation and chemical fertilizers to developing nations, and was highly successful at increasing crop yields, as well as augmenting food supplies.

Global warming and the world's food

Global warming and rising food prices are inextricably bound. In order to meet the growing fuel demand, developed nations have supported the production of biofuels, such as corn ethanol, raising the price of corn and soybeans. The International Monetary Fund estimates that corn ethanol production in the United States accounted for at least half the rise in world corn demand in each of the past three years, which has elevated corn prices and resulted in an increase in the price of animal feed. In order to help millions of victims of hunger around the world, the World Food Program reported that rising grain costs increased expenditures by more than $500 million. It is ironic that although scientists hoped that biofuels would reduce greenhouse gases, at best, corn ethanol delivers only a small reduction when compared with gasoline.

Global warming and pollution affect the water supply, which in turn endangers the world's food supply. Water shortages, particularly in Asia, impair the production of rice. Sea life, a major source of protein in many nations, is clearly in short supply.

- **In 2007, the food import bill of developing countries rose by 25 percent, and food prices rose to levels not seen in a generation.**
- **Since 2006 the price of corn doubled, and wheat reached its highest price in 28 years.**

- **The United Nations Food and Agriculture Organization reports that world cereal stocks this year will be the lowest since 1982.**
- **Between 2006 and 2008 overseas aid by rich countries fell 8.4 percent.**[10]

Health Creates Wealth

Both micro and macro data, including research done by economists at the University of Chicago[11], Harvard[12], Yale[13], UCLA[14], and the University of Belfast[15] offer a perspective that links health and longevity. Their work suggests that most discretionary funds are accumulated by populations 50 and above; healthy individuals have accumulated more savings and investments by their old age than individuals beset by illness; most *private* intergenerational transfers go from old to young, not from young to old. Their studies indicate that healthy older persons are more apt to remain productively engaged in society in their old age through continuing work or voluntary activity and that they require fewer health services. Finally, the healthcare and pharmaceutical industries, financial services and the like all profit by the realities of people living longer, as do other industries known as "mature markets".

Bloom and Canning's work demonstrate that nations that have a five-year advantage in life expectancy show significant increases in gross domestic product, for example, from 0.3% to 0.5% GDP faster per year. Currently, conventional measures of national income and output exclude the value of improvements in the health status of the population.

Economist William Nordhaus of Yale University developed a methodology and preliminary estimates of how standard economic measures would change if they adequately reflected improvements in health status. He discusses how *health income* fits into existing theories for measuring and valuing consumption and health status, and concludes that the "value of increase in longevity in the last 100 years is about as large as the value of growth in

"The benefits from just lower infant mortality and better treatment of heart attacks have been sufficiently great that they alone are about equal to the entire cost of insurance for medical care over time."

David Cutler and Mark McClelland[17]

non-health goods and services"[16]. Nordhaus measures "real output" of the health care industry and estimates the dollar value of the prevention of a fatality to range between $0.6 and 13.5 million. He settles on $3 million as a reasonable figure.

Financing Longevity

Old people are among the poorest of the poor. Nonetheless, the so-called welfare states of Europe have demonstrated that it is possible to sustain basic core public pension and health care systems for all their peoples including old people. The European system has been modestly modified but firmly secured over the last several decades despite economic, political and ideological pressures. The International Monetary Fund and the World Bank have assisted the poor nations to some degree but their requirements emphasized a free market. Free-trading globalization often resulted in the institution of severe and onerous austerity requirements for indebted nations. These have been especially punishing to marginal groups such as old people who are most in need of social protections. The World Bank has been severely criticized for its neglect of agriculture in Sub-Saharan Africa and for inadequately dealing with corruption. The U.N. Convention Against Corruption makes an effort to make it harder for political leaders to park money in overseas banks.

With globalization of the economy the free movement of capital has focused upon cheap labor. Both to protect workers in developing and developed world's foreign policy agreements should foster a minimum and living wages, wage and employment insurance, training and retraining benefits, safety and health as well as the right to collective bargaining. Forced and child labor should obviously be forbidden.

In 2007, U.S. trade legislation began to move in these directions. However, we fear the extent of poverty and the lack of worker's rights will remain problematic for sometime to come without truly transformative changes in the foreign policy of the developed nations. It should be stressed that the protection of workers of the developing world also helps preserve the social protections in the developed world since cheap labor undermines developed world economies and their tax base that supports such protections.

Government policies that provide public pensions and health care need to be supplemented by the civil society, the for-profit sector, and by individuals themselves, who must be cognizant of the importance of working to maintain their own financial security and health.

Health Care

As noted in the follow-up to the Madrid International Plan of Action on Ageing which was adopted in 2002, the aging of the population entails a shift from a predominance of infectious diseases and high maternal and child mortality to that of non-communicable diseases at older ages, particularly chronic diseases. As a result, as the population ages there is an increasing need to deal with diseases that are more costly to treat, degenerative and difficult to control.

Health and well-being in old age varies widely among regions, and within them. In developed countries, demographic and epidemiological transitions have taken place over a longer period of time than in developing countries. Dramatic increases in longevity occurred after a reduction in social and economic disparities and an increase in access to health care. In developing countries, the transitions are taking place in the context of fragile socio-economic conditions, a high poverty rate and increasing inequalities in health coverage.

A New Paradigm

There is only a modest investment in research on aging in the world. In the United States, for example, the annual budget of the National Institute on Aging approximates $1 billion far less than 1 percent of the budget of Medicare, which is the public health financing system for older and disabled people. Only about $200 million is spent on the basic biology of aging. If only one percent of Medicare expenditures were set aside for research and development, this would triple the investment in biomedical, social-behavioral and especially the biology of aging and age-related diseases.

We know that age-related diseases are profoundly influenced by basic biological changes that occur in our bodies as we grow older. For example, 80 percent of all cancer occurs after age 60. It is important to devote resources to target specific diseases but it is also important to complement the disease-by-disease approach by better understanding the underlying biology that predisposes us to disease and death.

Inequalities of Longevity

Inequalities in longevity around the world are the consequences of many factors that include social-economic and geographic disparities. Globalization continues to favor the rich

nations over the poor. Europe and the U.S., for example, sustain agricultural subsidies, to the disadvantage of the poor countries.

. New imaginative steps are underway to assist the developing world. Note the Nobelist economist Mohammed Yunis who created microcredit, which helps poor women. Sovereignty in Bosnia and Kosovo was affected by military actions, international courts and conventions. The world is increasingly interconnected. Many multinational corporations are wealthier and more powerful than many individual nations. It is time to find new ways to eliminate poverty and advance the general welfare of all nations and peoples.

The prospects of personal health and economic prosperity remain constrained by tariffs and other trade policies and inadequate donations and investments to improve the lives of those living in the developing world. The U.S., for example, has not been in the lead in contributing to the developing world compared to the Scandinavian countries and the Netherlands.

Debt relief should be extended and grants rather than loans made to developing countries.

Human Rights

2008 marks the 60th anniversary of the Universal Declaration of Human Rights, which has roots in the U.S. Bill of Rights and the French Declaration of the Rights of Man and the Citizen. Notwithstanding these documents, the codification of basic human rights have not been widely adopted. But as we move forward in the 21st century it seems clear that political pressures will intensify. Concern for social, economic and cultural rights, such as worker's rights and trade agreements, property rights for the dispossessed who may be encouraged to lay claims to the land they work, the rights of women and the rights of minorities which while destabilizing will hopefully lead to the improvement of the daily lives of people who need economic security and jobs. Such progress is opposed to inequality in general, and to inequality in longevity.

What Can We Do? An Agenda for Action

Up to now no nation has fully embraced the challenges posed by population aging and advancing longevity with the possible exception of Japan. Yet, we need all fields of scholarship, policy, the civil society and government – and individuals – to respond to the

economic, social, cultural, health and personal issues resulting from population aging.

Nations can learn so much from each other, comparing policy and cooperating in scientific and scholarly activities. Sovereignty has been valuable for the development of individual states, and it is not easy to imagine a nation giving up individual sovereign power, although the European community is moving slowly in that direction. Yet it is hard to imagine the easy entry by nations into necessary treaties and agreements on a worldwide scale to resolve issues relating to climate change, energy sources, air and water quality, not to mention such issues as human rights – without giving up a piece of sovereignty. It is essential that nations enter into agreements, which could take the form of a sophisticated balance between national sovereignty on the one hand and international sovereignty on the other.

It is likely that there will be further additions to longevity in the 21st century as a result of genomics and regenerative medicine and other unanticipated innovations in health, for example, from the pursuit of research into the basic biology of aging. Those scholars involved with gerontology, population and longevity should extend their reach and undertake comparative international studies.

We should continue to pursue the recommendations of the Vienna (1982) and Madrid (2002) World Assemblies on Aging.

Those in medicine, specifically geriatrics, must help lay the foundations for health and education in medicine throughout the world.

Those in epidemiology must share their growing knowledge.

Those in politics and policy must emphasize health in foreign policies and create effective global strategies to address global challenges such as global warming. A carbon tax should be widely adopted. For example, we need a global health strategy and a global water strategy. We have much to do. These efforts must be lifespan in perspective and application.

A few specifics that have commonly been recommended:

1. Save the 20 percent of children who are unprotected through immunization against 6 vaccine preventable conditions. Realize nutritional goals for children by fortifying food staples like salt and sugar with important dietary minerals. These include vitamin A, without which 250,000 – 500,000 children become blind annually, and iodine, which is important for normal brain development[18].

2. Make widely available medicated mosquito nets against malaria and rehydration kits to save children with diarrhea.
3. Support the creation and expansion of educational systems that are culturally sensitive but at the same time promote gender equality and improve human resources in developing nations.
4. Promote the U.N. Millennium Development Goals, which has not specifically mentioned older persons: to eradicate extreme poverty and hunger; achieve universal primary education; promote gender equality and empower women; reduce child mortality; improve maternal health; combat HIV/AIDS, malaria and other diseases; ensure environmental sustainability; and develop a global partnership for development. The Goals were established in 2000 and have a target date of 2015.
5. Support the movement for health and longevity equity exemplified in the work of Sir Michael Marmot who heads the WHO Commission on the Social Determinants of Health. Among the determinants are social-economic status (poverty) and race.
6. Create nonprofit pharmaceutical companies and fair agreements regarding intellectual property of pharmaceutical companies. The aim is to make attractive to both the for-profit and nonprofit pharmaceutical companies widely available effective medications against both infectious and chronic diseases. The Institute for World Health, which was created by Victoria Hale and is supported by the Bill and Melinda Gates Foundation, is the first nonprofit U.S. drug company designed to create drugs that can be offered cheaply in developing countries.
7. Create systems of delivery of preventive and therapeutic services based on research into the means of effective implementation.
8. Catalyze a major international movement by the civil society through the strengthening of Non-Governmental Organizations (NGOs) movement. An exemplar is the International Campaign to Ban Landmines, a coalition of *non-governmental organizations* founded by Jody Williams, who won the Nobel Peace Prize for her efforts. The coalition has worked tirelessly to abolish the production and use of *anti-personnel mines*. Other examples: HelpAge International and Doctors without Borders.
9. Support the World Health Organization Framework Convention on Tobacco Control, which, since 2003, has been signed by 168 nations. Its aim is to enforce international

standards on tobacco price, advertising and sponsorship, labeling, illicit trade and second-hand smoke. Ultimately, its mission is to reverse World Health Organization statistics showing that tobacco is the leading cause of death globally.

10. Establish both a Declaration and a Convention for the human rights of older persons.
11. Seek universal ratification of The International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights.
12. Work to strengthen the United Nations and its agencies, including the U.N. Population Fund, the WHO and the U.N. International Institute on Ageing in Malta.
13. Support a life-cycle approach to women's health, including access to affordable quality health care; information and appropriate services relating to their reproductive lives and sexually-transmitted diseases.
14. Support universal social security programs, promoted by the International Social Security Association.
15. Support efforts to confront climate changes. Tropical diseases such as chikungunya are spreading to temperate zones (e.g., Italy).
16. Create educational institutions to establish well-trained health care workforces of which there are critical shortages in the world.
17. Make available a special stove for the poor. About 14 million people a year die in fires caused by paraffin stoves and by the effects of toxins in the air.
18. Phase out agricultural subsidies in Europe and the U.S.
19. Advance science and technology to promote sustainable well-being.
20. Call upon older persons to take major roles in mobilizing societal changes. Former South African President Nelson Mandela has assembled "Council of Elders" made up of leading statesmen and Nobel laureates such as former President Jimmy Carter, Bishop Desmond Tutu, former U.N. Secretary General Kofi Annan, former Norwegian Prime Minister Gro Harlem Brundtland, former Irish President Mary Robinson and the Nobelist in economics Mohammed Yunis from Bangladesh.

We must exploit the model of Doctors without Borders by creating organizations of educators, scientists and scholars who cross borders to work among nations to promote effective change.

Conclusion

In conclusion, why should the developed nations care at all? Because we face common challenges, such as the threat of a flu epidemic, economic issues of globalization, climate change, energy shortages and poverty, all of which profoundly affect us as well as longevity.

The ten nations whose representatives constitute the ILC Global Alliance believe that the challenges can be effectively met, that nations can afford old age, that old age will not bring about economic stagnation but rather will contribute to the wealth of nations, that intergenerational conflicts need not occur and gerontocracies will not develop. But we cannot afford to delay.

We must grow weary of pessimism, cynicism and skepticism, and we must keep in mind that developed nations were once very poor. We must act not only for humanitarian reasons or even with the goal of international economic development but also because what happens in the developing world can profoundly affect our health and economic security and our national security for good and bad.

Idealism is perhaps the only practical course left to us. And it has been said, "Crisis is a terrible thing to waste."

Postscript

Hugo Grotius wrote *The Law of War & Peace* in 1625. His legal masterpiece laid the foundation of international law. It is fair to say that his aspirations have not yet been reached. So, too, the aspirations described above – the call to action – by the ILC Global Alliance – are not likely to be immediately met. But it is important to stress now the urgent need to respond to the challenge of population aging and advancing longevity.

Endnotes

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Coda

As this publication goes to press, we are confronted with issues that affect the viability of the world's populations, irrespective of age. They include food and water shortages, soaring energy costs, planet deterioration and global warming. It is in the interest of all nations to work together to promote a better understanding of our common goals.

Organized humanitarian efforts are relatively new in human history. Natural and manmade disasters especially affect older persons. It is fitting that we, the undersigned, should speak up and call for actions that will benefit people of all ages and all generations.

Robert N. Butler, M.D.
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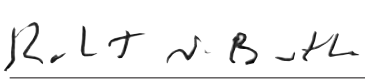

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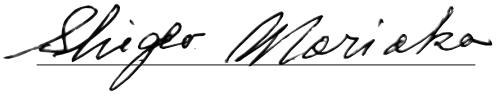

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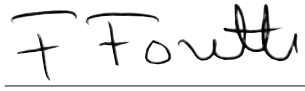

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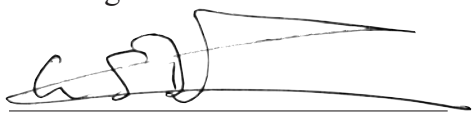

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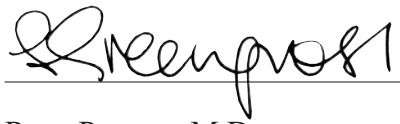

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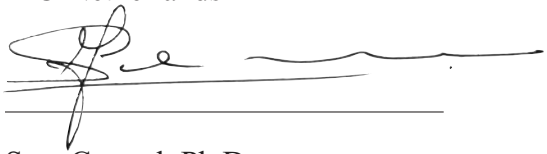
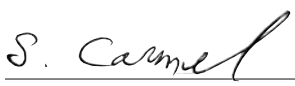


Rosy Pereyra, M.D.
ILC-Dominican Republic

Sara Carmel, Ph.D.
ILC-Israel



APPENDIX I

APPENDIX I

TABLE 1
Life Expectancy in 50 Locations, Both Sexes

COUNTRY	YEARS
Japan	83
Andorra	82
Australia	82
Monaco	82
San Marino	82
Switzerland	82
Canada	81
France	81
Iceland	81
Israel	81
Italy	81
Spain	81
Sweden	81
Austria	80
Cyprus	80
Germany	80
Greece	80
Ireland	80
Luxembourg	80
Netherlands	80
New Zealand	80
Norway	80
Singapore	80
Belgium	79
Denmark	79

COUNTRY	YEARS
Finland	79
Malta	79
Portugal	79
Republic of Korea	79
United Kingdom	79
Chile	78
Costa Rica	78
Cuba	78
Kuwait	78
Slovenia	78
United Arab Emirates	78
United States of America	78
Brunei Darussalam	77
Czech Republic	77
Qatar	77
Croatia	76
Panama	76
Argentina	75
Bahrain	75
Barbados	75
Bosnia and Herzegovina	75
Paraguay	75
Poland	75
Saint Lucia	75
Uruguay	75

Source: World Health Organization, Statistical Information System, 2006.

TABLE 2
Population of Countries with At Least 10 Percent of Their Population Age 65 and Over

Region or country	Number		Percent
	Total	65 and over	
Italy	57,998,353	10,893,973	18.8
Japan	127,214,499	23,720,030	18.6
Greece	10,625,945	1,947,336	18.3
Germany	82,398,326	14,643,067	17.8
Spain	40,217,413	7,075,743	17.6
Sweden	8,970,306	1,545,515	17.2
Belgium	10,330,824	1,777,398	17.2
Bulgaria	7,588,399	1,293,949	17.1
Portugal	10,479,955	1,749,225	16.7
France	60,180,529	9,801,524	16.3
Croatia	4,497,779	723,788	16.1
Estonia	1,350,722	217,199	16.1
Austria	8,162,656	1,282,955	15.7
United Kingdom	60,094,648	9,429,087	15.7
Finland	5,204,405	805,215	15.5
Latvia	2,322,943	358,400	15.4
Switzerland	7,408,319	1,131,164	15.3
Ukraine	48,055,439	7,212,722	15.0
Georgia	4,710,921	706,380	15.0
Denmark	5,394,138	802,456	14.9
Norway	4,555,400	676,160	14.8
Hungary	10,057,745	1,492,216	14.8
Slovenia	2,011,604	298,344	14.8
Serbia and Montenegro	10,823,280	1,592,794	14.7
Lithuania	3,620,094	530,425	14.7

TABLE 2 (continued)

Region or country	Number		Percent
	Total	65 and over	
Luxembourg	456,764	65,985	14.4
Belarus	10,322,151	1,478,835	14.3
Romania	22,380,273	3,169,849	14.2
Czech Republic	10,251,087	1,432,188	14.0
Netherlands	16,223,248	2,241,317	13.8
Russia	144,457,596	19,203,848	13.3
Malta	395,178	51,969	13.2
Uruguay	3,381,606	442,733	13.1
Canada	32,207,113	4,167,291	12.9
Poland	38,622,660	4,924,081	12.7
Australia	19,731,984	2,502,665	12.7
United States	290,342,554	35,878,341	12.4
Hong Kong S.A.R.	6,809,738	836,153	12.3
Puerto Rico	3,878,679	461,501	11.9
Iceland	291,064	34,055	11.7
Slovakia	5,416,406	630,190	11.6
New Zealand	3,951,307	457,805	11.6
Ireland	3,924,023	447,070	11.4
Cyprus	771,657	85,629	11.1
Macedonia	2,063,122	217,965	10.6
Argentina	38,740,807	4,042,311	10.4
Martinique	425,966	43,818	10.3
Armenia	3,001,712	306,182	10.2
Moldova	4,439,502	452,797	10.2
Bosnia and Herzegovina	3,989,018	401,929	10.1

Source: U.S. Census Bureau, International Data Base, 2004.

TABLE 3
The New Longevity: Life Expectancy from Age 60

Male			Female		
Rank	Country	Additional Years	Rank	Country	Additional Years
1	Iceland	22.48	1	Japan	27.76
2	China, Hong Kong	22.39	2	China, Hong Kong, SAR 4	26.78
3	Switzerland	22.24	3	France	26.18
4	Japan	22.13	4	Switzerland	26.12
5	Australia	22.01	5	South Africa	25.97
6	Israel	21.89	6	United States, Virgin Islands	25.67
7	Canada	21.70	7	Australia	25.65
8	Costa Rica	21.61	8	Italy	25.49
9	Sweden	21.38	9	Puerto Rico	25.40
10	New Zealand	21.33	10	Martinique	25.24
11	South Africa	21.28	11	Canada	25.20
12	China, Macao	21.27	12	Guadeloupe	25.08
13	Ecuador	21.17	13	Iceland	25.05
14	Martinique	21.07	14	China, Macao SAR5	24.98
15	Italy	21.06	15	Sweden	24.83
15	France	21.06	16	Israel	24.65
17	Norway	21.04	17	New Zealand	24.63
18	Sierra Leone	20.99	18	Austria	24.60
19	Guadeloupe	20.87	19	Norway	24.52
20	Cuba	20.78	20	Belgium	24.50
21	Greece	20.77	21	Chile	24.46
22	Chile	20.72	22	Finland	24.45
23	Austria	20.69	23	Costa Rica	24.38
24	Mexico	20.65	24	Germany	24.33
24	Netherlands	20.65	25	Republic of Korea	24.25
26	United Kingdom	20.42	26	United States of America	24.21
27	Belize	20.36	26	Netherlands	24.21
28	Malta	20.35	28	Luxembourg	24.03
29	Panama	20.32	29	United Kingdom	24.00
30	United States of America	20.30	30	Greece	23.99
31	Belgium	20.28	31	Sierra Leone	23.93
32	Dominican Republic	20.25	32	United Arab Emirates	23.91
33	United Arab Emirates	20.19	33	Slovakia	23.87
34	Cyprus	20.08	34	Malta	23.67

Source: United Nations Statistics Division, Statistics and Indicators on Women and Men, 2007.

TABLE 4
Ten Nations with Largest Populations: Selected Demographic Characteristics

Country	Total Number of Persons (in thousands)	% 60 and over	Life Expectancy at Age 60		Life Expectancy at Birth	
			Male	Female	Male	Female
China	1,328,474	11.0	N/A	N/A	72.0	75.0
India	1,151,751	8.0	16.4	18.7	62.0	64.0
USA	302,841	17.0	20.8	24.0	75.0	80.0
Indonesia	228,864	8.0	N/A	N/A	66.0	69.0
Brazil	189,323	9.0	19.2	22.3	68.0	75.0
Pakistan	160,943	6.0	18.5	18.5	62.0	63.0
Bangladesh	155,991	6.0	N/A	N/A	63.0	63.0
Nigeria	144,720	5.0	N/A	N/A	48.0	49.0
Russian Federaition	143,221	17.0	13.8	19.4	60.0	73.0
Japan	127,953	27.0	22.4	27.9	79.0	86.0

Source: "Life Expectancy at Age 60" figures are obstained from United Nations, Demographic Yearbook 2006,Table 22 last updated as of 21 July 2008. All other figures are from World Health Organization Health Indicators last updated as of May 2008.

TABLE 5
Healthy Life Expectancy (HALE) at Birth, Both Sexes, in Selected WHO Member States

COUNTRY	YEARS
Japan	75
Australia	73
Iceland	73
Italy	73
Monaco	73
Sweden	73
Switzerland	73
Andorra	72
Canada	72
France	72
Germany	72
Luxembourg	72
Austria	71
Belgium	71
Greece	71
Israel	71
Malta	71

COUNTRY	YEARS
Netherlands	71
United Kingdom	71
Denmark	70
Singapore	70
Slovenia	69
United States	69
Argentina	65
China	64
India	53
South Africa	44
Rwanda	38
Afghanistan	36
Malawi	35
Swaziland	34
Zimbabwe	34
Angola	33
Sierra Leone	29

Source: World Health Organization, World Health Statistics, 2008.

See also *The World Health Report 2008*, Annex Table 4. Further development in collaboration with Member States is under way for improved data collection and estimation methods. Figures not endorsed by Member State as official statistics.

APPENDIX II

Reports from International Longevity Centers

Robert N. Butler, M.D.
President and CEO

- *Professor of geriatrics at the Brookdale Department of Geriatrics and Adult Development at the Mount Sinai Medical Center*
- *Founding Director of National Institute on Aging*

United States of America

Report from ILC-Centers

ILC-United States

Section 1: Profile of ILC-United States

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• President:

Robert N. Butler, M.D., is President and Chief Executive Officer and Co-Chair of the Alliance for Health and the Future of the International Longevity Center-USA, and professor of geriatrics at the Brookdale Department of Geriatrics and Adult Development at the Mount Sinai Medical Center in New York City.

From 1975 to 1982 he was the first and founding director of the National Institute on Aging of the National Institutes of Health. In 1982 he founded the first department of geriatrics in a U.S. medical school. He held the Brookdale Professorship of Geriatrics. In 1990, with Shigeo Morioka he co-founded the International Longevity Center (ILC) a policy research and education center, which studies the impact of longevity upon society and its institutions. There are now Centers in France, the United Kingdom, the Dominican Republic, India, South Africa, Argentina and the Netherlands as well as Japan and the United States.

In 1976 Dr. Butler won the Pulitzer Prize for his book *Why Survive? Being Old in America*, which has been translated into Japanese and published in Japan in 1992. He is co-author (with Dr. Myrna I. Lewis) of the books *Aging and Mental Health* and *Love* and *Sex After 60*. The newest and 4th edition of *The New Love and Sex After 60* appeared in 2002. He completed a new book *The Longevity Revolution: The benefits and challenges of living a long life* and is working on another, *Life Review*.

He was Chair of the advisory committee for the White House Conference on Aging in 1995. Dr. Butler was a principal investigator of one of the first interdisciplinary, comprehensive, longitudinal studies of healthy community-residing older persons, conducted at the National Institute of Mental Health (1955-1966), which resulted in the landmark books *Human Aging I and II*. It was found that much attributed to old age is in fact a function of disease, social-

economic adversity and even personality. This research helped establish the fact that senility is not inevitable with aging, but is, instead, a consequence of disease. The NIMH research contributed to a different vision of old age. It set the stage for the later concepts of "productive aging" and "successful aging."

In 2003 he received the Heinz Award for the Human Condition.

• Mission Statement:
Devoted to science-based policy development on the aging of populations, our vision is to help individuals, government, and business navigate the age boom in positive and constructive ways, and to highlight older people's productivity and contributions to society.

• Year Organized:
- 1990 — Founding Member

• Major Affiliations:
- An independent affiliate of Mount Sinai School of Medicine

• Sources of Funding:
- Private Foundations, Corporate Contributions and Individual Donations.

• Major Activities/Programs:
Ageism in America Project — The ILC-USA conducted a comprehensive analysis of age discrimination across multiple sectors in the U.S. to further identify and analyze various forms ageism and stereotyping, to push the issue into public discourse and to encourage public and private institutions to remedy ageist attitudes, policies and practices. Among the domains studied were the denial of appropriate medical care and services, discrimination in the workforce, degrading stereotypes in the media, and physical and financial abuse. The resulting report, *Ageism in America*, which included "report cards" of the nation's performance in these various domains was presented at the White House Conference on Aging. Since then the ILC has received funding to continue the project, enabling us to continue work, which includes advocacy in Washington, D.C. on behalf of a variety of initiatives that promote equity for older Americans and enhanced media outreach.

In fall 2007 the ILC-USA unveiled the *Ageism in America* blog on our website. It is the first comprehensive online community dedicated to age discrimination in the United States, opening new channels for documentation, and knowledge-sharing and encouraging interaction among key stakeholders in the fight against ageism. The blog offers a stream of topical, linked content on issues of age discrimination, with up-to-date editorial content, links to other organizations fighting ageism, and reader comments.

Other reports devoted to exposing ageism in our society have been completed, including *Myths of the High Medical Cost of Old Age and Dying; Improving Drug Safety; Fallacy of the Lump of Labor*. Finally, a comprehensive research project, *Understanding the Older Worker: A Study of Job Skills and Constrained Opportunities for Older Americans* is underway. This report analyzes the extent to which reductions in required job skills among older workers in the United States are indicative of constrained job opportunities.

The Caregiving Project for Older Americans — The Caregiving Project for Older Americans is an action-oriented collaboration that aims to improve the nation's caregiving workforce through training, the establishment of standards, and the creation of a career ladder. A joint three year project of the ILC-USA and the Schmieding Center for Senior Health & Education (SCSJE), located in the state of Arkansas, this project builds on our collaboration on the Arkansas Aging Project, which provided a detailed template for how a state with a high percentage of older people handles its aging services, specifically the growing crisis in demand for home health care workers. The aim of The Caregiving Project for Older Americans is to create greater awareness of the caregiving crisis, to develop a national systemic approach to recruiting, training and retaining paid professional caregivers, and to enhance the key role of the new generation of caregivers. The project's ultimate goal is the creation of an accreditation process to train caregivers, the development of a certification/licensing process and continuing education requirements to maintain certification.

In July 2007, The Caregiving Project and the MetLife Foundation awarded twelve U.S. community colleges grants to develop home-based caregiver training courses. Each selected community college will be awarded up to $25,000. The grants provide funding to community colleges to either establish new home-based caregiver training programs or enhance programs that already exist for professional and family caregivers.

A national survey of paid professional caregivers was conducted to determine how to improve the quality of caregiving in the United States. Following this, leaders and experts convened to discuss the state of the paid caregiving workforce and family caregivers, resulting in recommendations for a national curriculum, certification program and career ladder.

A comprehensive report produced by The Caregiving Project, entitled *Caregiving in America* documents the growing caregiving crisis in the U.S. — the fact that, increasingly, there are too few caregivers, both paid and unpaid, and too many people needing care. Among the major topics covered are who provides care, and where; the burden on family caregivers; the severe shortage of paid caregivers; and the barriers to affordable, quality care.

The Caregiving Project is supported by the Schmieding Foundation, MetLife Foundation, Amgen Foundation, Pfizer Inc. and UniHealth Foundation.

The Sleep & Healthy Aging Project — The ILC-USA is working with medical professionals and researchers to counter the fallacy that poor sleep is an inevitable, natural by-product of aging. Built on earlier work done by the ILC-USA on sleep and older adults, we convened a

conference, with the primary goal of laying the groundwork for the formation of a broad-based coalition of respected organizations to take the lead in the creation and wide dissemination of principles and practical guidelines for the evaluation and treatment of sleep disorders in older people. A comprehensive report, *Sleep and Healthy Aging* organized and summarized the presentations and discussions that took place during the conference. Additionally, two issue briefs were written to address different audiences: *The Role of Sleep in Healthy Aging* was directed toward policy and decision makers, and *Sleep: The New Vital Sign* was written for practicing clinicians. Also, a supplement to the journal *Geriatrics*, authored by Phyllis Zee, MD and Harrison Bloom, MD, and entitled "Understanding and Resolving Insomnia in the Elderly", was circulated to journal subscribers. An article on sleep problems in older individuals has been submitted to a peer-reviewed journal, and Eons website featured "What's Keeping You Awake at Night? Symptoms and Consequences of Chronic Insomnia". A number of media interviews resulted from both the Gallup Poll's Sleep and Healthy Aging Survey findings and the conference proceedings.

The project was supported by an unrestricted educational grant from Takeda Pharmaceuticals, North America, Inc.

World Cities Project — As urbanization and population aging increase throughout the world, we need models of how to accommodate these population shifts, as well as analyses of best practices. World Cities Project Co-Directors Victor Rodwin, Ph.D. and Michael Gusmano, Ph.D., work jointly with New York University's Robert F. Wagner School of Public Service and Columbia University's Mailman School of Public Health to:

* establish a critical understanding of how world cities, and subsequently megacities in developing nations, can prepare for a world in which 20 percent of the population will be over 65 years old
* identify specific program interventions and policies that may be replicated
* collaborate in the design of innovative programs that respond to the challenges posed by increasing human longevity and population aging

On the basis of quantitative data collection and case studies, working group meetings are organized on specific themes, with the participation of city officials, policy analysts, and health and social service professionals. In the final stage of the project, designated areas of each city will serve as a laboratory in which to evaluate the effectiveness of alternative interventions.

The Clinical Education Consultation Service — In conjunction with faculty of Mt. Sinai Department of Geriatrics and other leading geriatrics and gerontology centers, ILC-USA offers collaborative assistance to governments, non-governmental organizations, academic institutions, community hospitals and clinics, and community agencies in establishing new

clinical, educational, and policy approaches to their demographic trends and health care needs for older adults. Consultations may include:

- assessment of community or institutional clinical resources for care of the older population, and consultation regarding a spectrum of care, including in-hospital care, outpatient care, home care, institutional and non-institutional long term care
- consultations regarding the incorporation of geriatric medicine and gerontology curriculum into the training of medical students, residents in internal medicine and family medicine, nursing students, and faculty and fellows in the medical and surgical subspecialties
- interactive symposia on geriatric clinical syndromes
- application of principles of evidence-based medicine to curriculum development and delivery of clinical care
- planning and implementing a geriatric fellowship training program
- topics in geriatric nursing
- topics in geriatric psychiatry
- consultation with national or international organizations, businesses, or corporations wishing to implement and support programs for their older employees and/or retirees. Such programs would likely focus upon appropriate physical activity, nutrition, screening and preventive health measures, and advance directives
- formal presentations to clinical faculty, residents in training, medical and other health professional students

Section 2: Profile of Ageing in the Region

1. Brief Review of Aging Demographics

- Currently in the U.S.12.7% of the population is age 65+, U.S. life expectancy is now 77.
- After a slight drip in the 1980s U.S. fertility has been near replacement for 15 years.
- A baby born in the United States in 2004 will live an average of 77.9 years. That life expectancy ranks 42nd, down from 11th two decades earlier.
- Black Americans have an average life expectancy of 73.3 years, five years shorter than white Americans.
- Black American males have a life expectancy of 69.8 years.
- A relatively high percentage of babies born in the U.S. die before their first birthday, compared with other industrialized nations.
- The U.S. rate was 6.8 deaths for every 1,000 live births. It was 13.7 for Black Americans.

Researchers said several factors have contributed to the United States falling behind other industrialized nations, including:

- high obesity rates

- racial disparities
- a relatively high percentage of infant mortality

2. Summary of the Main Trends/Issues of Ageing in the Nation

A. Health/Medical Care

- Forty five million Americans lack health insurance.
- Adults in the United States have one of the highest obesity rates in the world. Nearly a third of U.S. adults 20 years and older are obese, according to the National Center for Health Statistics.

The current health care system in the United States provides limited medical care for the indigent through a program administered by individual states (Medicaid) and for the aged through a federal program (Medicare). The Medicare program, created in 1965, focuses on patients being treated only when sick, with little or no emphasis on prevention and coordination. The following data provides a thumbnail sketch of healthcare in the U.S.:

- Regardless of age and work status, unmarried respondents are more likely to be uninsured.
- Compared to privately insured individuals continuously uninsured individuals were 63% more likely to experience a deterioration of overall health and further 23% more likely to new difficulties with an activity of daily living involving mobility.
- The lowest income and education group reported the most cases of diabetes, hypertension, heart disease, heart attack, stroke, chronic lung disease.
- Highest income/education had lowest reported aliments. The only disease for which the inverse is not true is cancer.
- Health insurance costs discourage retirement, but only modestly.

B. Caregiving

The United States is in the midst of a significant and growing caregiving crisis. About 1.4 million older Americans live in nursing homes, nearly 6 million receive care at home, and significant numbers go completely without the help they need. And the growing disparity between the demand and supply of caregiving services will only worsen with the aging of baby boomers in this country.

Studies have found that women who provide an average of 2 or more hours per week of parental help worked 43% fewer hours than women overall. Women age 53 to 63 who helped their parents with personal care reduced their hours of paid work by about 70%.
Analyses suggests that devoting time to informal care of older parents may be incompatible with having a full-time job in middle age.

C. Pension/Economic Security

In 2002, 30 percent of individuals who remained economically active after age 70 held professional and managerial jobs. The share of workers in clerical and sales positions was only slightly less, accounting for about 27 percent of all jobs over age 70. Among workers over age 50, older people appear to have more flexible work arrangements than do younger people. An increasing percentage is self-employed.

Retirement income in the U.S. rests on three sources of income: pension, social security and personal savings. Pensions that were traditionally defined benefits, have been largely supplanted by defined contribution plans that makes employees responsible for creating and managing their retirement funds.

The defined benefit plan (DB) was, for many years, the main type of plan that large employers offered, wherein the employer defines and guarantees a specific pension amount to the employee. The benefit is determined according to a formula or computation based on the employee's salary and years of service. Under the DB plan the employee is entitled to the promised specific benefit. Employers with DB plans are required to set money aside to pay promised benefits and to pay into an insurance fund to cover benefits if the employer is unable to fulfill that commitment.

The defined contribution plan (DC), which is becoming the predominant plan in the US, operates very differently. Under a DC plan the employee, often aided by the employer, sets aside a specific amount of money at regular intervals. At retirement, the employee has an account balance which is completely dependent on how much has been put into the fund and how these contributions have grown over time as they have been invested. Thus, in a DC plan, the employee is at risk if invested funds do badly. The account balance can be taken as a lump sum or used to receive a pension.

Workers with defined benefit plans (usually including retirement incentives, lifelong benefits and reduced pension investment risks) retire on average 1.3 years earlier than those with defined contribution plans such as 401k (s). Continued workforce participation: By age 65 both male and female labor force participation decreases to close to half of people in their 50s. However, an increasing proportion of people in their mid-50s state that they expect to be working fulltime after reaching age 65. In 2000-2002 people cited a variety of reasons for retirement: One third cited more family time. One quarter stated they wanted to do other things. In the 55-59 age range, 35% cited poor health. Cigarette smoking and sedentary lifestyle had a large impact on both the incidence of workforce disability and death in men and women who left the work force before the early retirement age of 62. Arthritis and hypertension were the most commonly reported afflictions in those ages 55 and older who were employed.

Social Security, on the other hand, is a government run pension program that protects all older Americans by providing a guaranteed subsistence safety net.

D. Status of Older Women

Women in the United States make up a full 70 percent of all older people who are poor. The poverty rate increases substantially with duration of widowhood, rising 22% for 20 year of widowhood. Women are far more likely than men to outlive their retirement incomes because of several factor:

- women are more likely than men to leave their career to work in unpaid caregiving roles
- women still earn significantly less than men, leading to less retirement savings
- women live longer than men
- many pensions decrease in value or are eliminated entirely when the husband dies
- a divorced woman must have been married at least 10 years to be eligible for her former husband's social security benefits

Section 3: Current and Future Needs for Research/Training/Policy Change in the Region

Every day, 12,000 baby boomers in America turn 62. A new generation of older Americans is forming. With each year we gain in life, the United States falls further behind in preparation. Corporations are watching their workforce age. Policymakers are struggling to keep financial and health support systems in place. Scientists are rushing to find treatments for age-related illnesses. The key issues for the United States to address are as follows:

1- Age Discrimination: Ageism is one of the most pervasive prejudices across human society, especially in the United States. Although ageism is less acknowledged than racism or sexism, it is a harmful prejudice that results in widespread mistreatment, ranging from stereotypic and degrading media images to physical and financial abuse, unequal treatment in the workforce, and denial of appropriate medical care and services.

2- Redesigning Healthcare: The essential structure for health care for older adults in the United States has not changed for 40 years. It remains a reactive medical insurance system rather than a proactive health system, with an emphasis on acute in- and outpatient care. In 1965 the fields of geriatrics and gerontology were not well established in the United States. Consequently, neither experts in the care of older persons nor older persons themselves were included at the Medicare planning table to make a case for the specific needs of older patients, which include the complexity of issues associated with their health and the extra time a physician needs to take care of such complex patients.

3- Geriatric Training: Medical students in the United States are not prepared for the older patients who will dominate waiting rooms and hospitals during the next decade. Only 11 of the

nation's 125 medical schools require courses in geriatrics, and only 5 have established geriatrics departments.

4- Caregiving: The United States is in the midst of a significant and growing caregiving crisis. About 1.4 million older Americans live in nursing homes, nearly 6 million receive are at home, and significant numbers go completely without the help they need. There is a shortage of well-trained professional caregivers and a lack of structured support for family caregivers.

5- Longevity Research: Rates of disability and the cost of health care among older people could be avoided if the United States invested in research that looks at the basic biology of aging. The National Institute of Health is funded at $28 billion in 2006 but less then 0.1% of that amount went to the understanding of the biology of aging and how it predisposes people to a suite of costly diseases and disorders.

Section 4: Proposal of an Agenda to Help Resolve the Concerns Outlined in Section 3

The International Longevity Center-USA is committed to solving some of the most important issues facing the aging population of the United States. Our recommendations and agenda for future action include:

1- Age Discrimination: The effort to transform the culture and the experience of aging in America is quintessential and urgent. Legislative initiatives must be proposed at the local, state and federal level to provide legal protection against age discrimination, incorporating age in the Title VII of the Civil Rights Act which already protects Americans against sex and racial discrimination.

2- Redesigning Healthcare: The United States must work to develop health care that is proactive, rather than reactive. As our population ages, our system needs to focus on health promotion, disease prevention and the treatment of chronic disease. The Medicare program created in 1965 focused on patients being treated only when sick with little or no emphasis on prevention and coordination. We must integrate what we now know about health care for older persons into a new system with an emphasis on keeping people healthy and productive as they grow old.

3- Geriatric Training: In order to improve the health and well-being of older adults in the United States, we must develop a cadre of 1,440 or more academic geriatricians, enabling each of the 144 medical schools in this country to at least have ten academic geriatricians on its faculty. There must be continued support for Geriatric Career Awards through the federal government in addition to private support to ensure the a foundation of knowledge and leadership sufficient to improve our health care system's capacity to care for our aging population.

4- Caregiving: To combat the growing disparity between the demand and supply of caregiving services the public and private sectors must join together to solve the growing caregiving crisis in the United States. Our recommendations include developing a curricula for paid and family caregivers with special modules on dementia, congestive heart failure, and other conditions; working to create an accreditation and national certification program for paid professional caregivers; establishing a success career ladder initiative to help recruit and retain caregivers; and create a national association for professional caregivers.

5- Longevity Research: The United States must adopt a new research paradigm and provide major new infusions of money to be devoted to the basic biology of aging and longevity to complement funds allocated to specific diseases. Congress should invest $3 billion annual to this effort, or about 1% of the current Medicare budget of $309 billion. Federal government also needs to provide the organization and intellectual infrastructure to make this work.

Japan

Shigeo Morioka
President

- *Former CEO of Yamanouchi Pharmaceutical Co., Ltd. (current Astellas Pharma Inc.)*
- *Former Chairman of the Fair Trade Council of the Ethical Pharmaceutical Drugs Manufacturing Industry*

Report from ILC-Centers

ILC-Japan

Section 1: Profile of ILC-Japan

• Contact Information:

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• President:

Shigeo Morioka is president of the International Longevity Center-Japan. He was president and CEO as well as chairman of the board of Yamanouchi Pharmaceutical Co., Ltd. (current Astellas Pharma Inc.) for about twenty years until he assumed the present position in 1999. Mr. Morioka has served in a number of key positions in the pharmaceutical industry in Japan and abroad, including as chairman of the Fair Trade Council of the Ethical Pharmaceutical Drugs Manufacturing Industry and executive vice-chairman of the International Federation of Pharmaceutical Manufacturers Associations. In 1999, he was awarded Japan's Order of the Rising Sun, Gold and Silver Star.

• Mission Statement:

Since its founding in 1990, the ILC-Japan has conducted international, interdisciplinary surveys, research and education on various issues related to the aging society with declining birthrate. Japan leads the world with the rapid pace of the aging of its population, and the ILC-Japan recognizes its important responsibility to share the results of its surveys and research with wider society and to actively make proposals based on the concept of "productive aging," which the ILC Global Alliance has consistently advocated.

In addition to conducting surveys and research in various fields, the ILC-Japan plays a role in national policymaking projects, including participating in the Japan-U.S. Joint Commission on Aging. The ILC-Japan also implements education programs that provide accurate information to the media regarding the aging society with declining birthrate. These programs have produced meaningful results. Moreover, the ILC-Japan disseminates scientific information nationally and internationally on various topics through its journals and website, with the aim of creating a new value system for the epoch-making longevity revolution.

Aiming to make Japan into a society where the longevity of individuals is a great asset to society, the ILC-Japan will continue to address issues in the future drawing on its cooperative relationship with the ILC Global Alliance.

• Year Organized:

- 1990 — Founding Member

• Major Affiliations:

- Ministry of Health, Labour and Welfare
- International Network for the Prevention of Elder Abuse

• Sources of Funding:

- Subsidies from the Ministry of Health, Labour and Welfare and some private companies and organizations
- Annual membership fee paid by supporting members (approximately 40 major Japanese companies)

• Major Activities/Programs:

- PR and educational activities through the journals and website
- Five-Year Longitudinal Study on People Age 75+
- "A Profile of Older Japanese" Project

Section 2: Profile of Ageing in the Region

1. Brief Review of Aging Demographics

As of April 2008, Japan had a population of 127.69 million, of which 27.78 million were persons age 65 and over (11.89 million men and 15.98 million women) for an aging rate of 21.8 percent. In 1985, the aging rate was 10.3 percent, indicating that the aging rate has climbed rapidly in that twenty-years' period. The aging rate is estimated to reach 31.8 percent in 2030 and 39.6 percent in 2050. What should be noted in particular is that the old-old (those age 75 and over) segment is expected to make up 19.7 percent of the total population in 2030 and 24.9 percent in 2050. At the same time, Japan's birthrate is still low with 1.34 in 2007. Japan has the highest aging rate in the world today and this will continue in the near future.

2. Summary of the Main Trends/Issues of Ageing in the Nation

A. Health/Medical Care

Japan's life expectancy at birth was 79.18 years for men and 85.99 years for women in 2007. The healthy life expectancy was 72 for men and 78 for women, the longest in the world. Japan has a universal healthcare system. Patients can select their provider of healthcare services, and

they pay a 10 percent to 30 percent co-payment in principle. Japan's healthcare system functions effectively today, although it faces various challenges which it must overcome.

B. Long-Term Care Insurance System

The long-term care insurance system, initiated in April 2000, aims to have all members of society join together to support older persons who need long-term care (in principle, those age 65 and over) through the end of their lives. Services include in-home services, institutional services, and preventive care. The level of services provided for an individual is determined based on his or her long-term care needs; and he or she can select home-help services, home-visit nursing, or day services depending on the level of services needed. The co-payment is 10 percent.

At the time of the 2005 revision to the long-term care insurance system, preventive care services were incorporated, and efforts aimed at preventing the need for long-term care were strengthened.

C. Pension/Economic Security

Japan's universal pension scheme is essentially a two-tiered system. It is composed mainly of (1) the national pension system for all people and (2) the employees' pension for salaried workers. The income replacement ratio for a model Japanese household in which the head of household is employed for forty years is about 59 percent today, and policymakers hope to stabilize that figure at about 50 percent in 2023. The annual per capita income of older-person households is about 1,900 million yen. Pension income makes up 70.2 percent of the income of older-person households.

D. Employment and Retirement

The Labour force rate of older persons is high in Japan, standing at 68.4 percent for those aged 55 to 64. To further expand employment opportunities for older persons, the revised Law Concerning the Stabilization of Employment of Older Persons came into force in fiscal 2006. Under the revised law, companies that presently impose mandatory retirement on their employees are obligated to (1) raise the retirement age from the currently common 60, (2) introduce a viable plan to continue the employment of post-retirement age workers, or (3) abolish the retirement practice.

In a Cabinet Office survey on older persons' participation in the community, those responding that they had participated in a group activity in the community at least once in the preceding 12 months increased from 43.7 percent in 1998 to 54.8 percent in 2003. There are high hopes that baby boomers will get involved in volunteer activities after they retire, and some say that a new culture will be created. However, it is not yet clear what kind of activities the baby-boomer generation will choose to get involved in.

E. Status of Older Women

Older women living alone made up 19.0 percent of all older persons in 2005 (older men living alone: 9.7 percent), representing a significant increase from 12.9 percent (men living alone: 4.6 percent) in 1985. The annual per capita income of older-person households (including pension income) is about 1,900 million yen. The income of older women living alone, however, is 1,679 million yen (older men living alone: 2,266 million yen). One reason for this is that there were few employment opportunities for the current generation of older women when they were in the working age.

The total number of people certified by municipal offices as needing services in the long-term care insurance system was 4,637,100, of which 3,239,100 were women and 1,398,000 were men.

F. Abuse Prevention Laws

In Japan, the Elder Abuse Prevention and Caregiver Support Law (Elder Abuse Prevention Law) was promulgated in 2005. The only countries that have promulgated elder abuse prevention laws on a national level are the U.S., South Korea, and Japan; and Japan is the first in the world to incorporate support programs for caregivers (mainly family members providing care) in a law that both protects human rights and provides for welfare services.

Prior to the Elder Abuse Prevention Law, Japan promulgated the Law Concerning the Prevention of Child Abuse (Child Abuse Prevention Law) and the Law for the Prevention of Spousal Violence and the Protection of Victims (Domestic Violence Prevention Law) in 2000 and 2001, respectively. Not many countries have enacted laws in all three of these areas, and in terms of legislation Japan is considered an advanced nation in the area of abuse prevention.

Section 3: Current and Future Needs for Research/Training/Policy Change in the Region

It can be said that Japan today has an industrious, highly-educated populous, prosperous economy, a low level of crime, and a well-developed social security system. So far, the reform of the social welfare programs and the change in people's attitude about aging have kept up with demographic changes — namely, the launch of the long-term care insurance system (2000), the reform of the healthcare system (2004), the reform of the pension system (2004), and the measures to raise the retirement age (2005), which have been supported by people's strong desire to work.

It is forecast, however, that Japan's aging rate will exceed 30 percent and the old-old will make up 20 percent or more of the total population within the next 30 years. If we think about this Japanese society of the future, dramatic reforms of the overall social system and of people's value system are called for. The key issues for Japan to address are as follows:

A. Is Economic Growth Possible in a Society with a Declining Working-Age Population?

Japan's real GDP in 2007 was up 1.6 percent from the previous year. Today, the economic recovery is expected to continue. However, a major risk factor is the decrease in the working-age population accompanying population aging. The Japan Institute for Labour Policy and Training estimates that the workforce, which numbered 66.6 million in 2006, will fall to 62.2 million in 2017 and further to 55.8 million in 2030, assuming that labor force participation rates remain unchanged by gender and age from those of 2006. In other words, a decrease of about 10 million workers is forecast. If the economy were to slow down, the employment, savings rate, and investment activities of older persons are forecast to decrease, as is government expenditure for social security. This would have a dramatic impact on the lives of older persons.

B. Can Japan's Social Security System Handle an Era Where the Old-Old Make up More than 20 Percent of the Population?

The ratio of the social security burden to national income was 15.0 percent in 2008, representing a dramatic increase from the 1980 figure of 9.1 percent. The aging rate is expected to increase further in the future, and the number of the old-old in particular is predicted to rise. This will pose a great challenge to the pension system, which supports the lifestyles of older persons, as well as to the health insurance and long-term care insurance systems. Needless to say, the number of people needing medical treatment or long-term care increases as people enter the old-old age group. Moreover, the rise in the number of the old-old is forecast to link directly to an increase in the dementia rate, and data indicates that the number of people with dementia will climb from today's 1.7 million to over 3 million in 2025. It is urgent for Japan to train physicians, nurses, and care-giving professionals with in-depth professional knowledge of dementia.

Number of Older Persons Certificated for Long-Term Care Services

(1,000 people)

Young-old (age 65–74)	Old-old (age 75 and over)
649 (4.4%)	3,797 (29.3%)

Sources: Ministry of Health, Labour and Welfare, *Monthly Report on the Actual Condition Survey Concerning Long-term Care Benefits, March 2008* and Ministry of Internal Affairs and Communications, *Population Estimates*, estimates as of March 1, 2008.

C. Can Japan Attain a Balanced Population Structure in the Future?

Japan's birthrate was 1.76 in 1985, 1.42 in 1995, and 1.26 in 2005. Although the birthrate recovered slightly to 1.34 in 2007, the number of marriages is on the decline, so it is not expected that this upturn represents a lasting recovery. With the declining birthrate, the aging of society as well as a decrease in the population are anticipated. Japan's population in 2006 was 127.77 million. Based on medium variant projections, the birthrate will be 1.24 in 2030, 1.26 in 2055, and the population would be 89.93 million in 2055. These changes represent a major

demographic transformation of Japan. Using an "optimistic" birthrate estimate of 1.53, 1.55 for those two years, respectively, the population in 2055 would be 97.77 million. Effective national policies and national dialogue are needed to deal with the challenge of population decrease.

Section 4: Proposal of an Agenda to Help Resolve the Concerns Outlined in Section 3

As an answer to the issues mentioned in the preceding section, we would suggest the definition of older person to be changed: for example, the age limit to working/employment should be raised from the current 65 to 70. Aging societies face the crucial task of encouraging the members of the traditionally called "retired" generation continue to contribute to their community and society.

At the same time, a change in the "grand design" is called for to transform the social structure according to the change in definition of older person. Various issues must be explored to identify ways to facilitate older persons' contribution, such as how they can continue to perform highly productive labor, how we can create flexible work formats for them, and how we can help them develop work skills and pass them down to the next generation. This is the essence of the quest for productive aging which we believe important enough for the ILC-Global Alliance to address together.

From the perspective of preventive medicine, Japan is now promoting the Health Frontier Strategy as a broad national health promotion campaign. Additionally it is crucial that Japan extend the healthy life expectancy by striving to change people's attitude. By increasing the number of healthy and active older persons, we will be able to provide more generous assistance to older persons who need healthcare, long-term care, or welfare services. We should allocate resources effectively by refraining from classifying all older persons categorically as vulnerable.

Other key tasks for the ILC-Japan are to conduct activities to promote the independence of older persons, improve their QOL, and foster a new 21st century image of older persons as independent. The ILC-Japan should publicize the findings of its longitudinal study currently underway regarding the daily lives of people age 75 and over. After the completion of this five-year longitudinal study, we intend to broadly publicize the new independent lifestyles of older persons revealed in the study.

Regarding older persons who require long-term care, including those with dementia, we need to improve the quality of care and to support caregivers. Japan's long-term care insurance system aims to make long-term care not just a family issue. A national awareness-raising campaign is underway to promote community measures to support people with dementia and their families. This is part of a movement to encourage people to view long-term care as something that all members of society join together in providing.

In addition to enhancing the understanding of Japan's system, we need to evaluate it critically. Furthermore, it is important that we widely disseminate our findings both nationally and internationally. As Japan will be the first in the world to experience a super-aged society, the ILC-Japan is committed to actively cooperate with government and private corporations to promote the improvement of the QOL of older persons.

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- OECD, *Health Data 2007 Employment Outlook 2007*
- The Japan Institute for Labour Policy and Training, *Workforce Supply and Demand 2007*
- WHO, *World Health Statistics 2007*

France

Françoise Forette, M.D.

CEO

- *President of the Board of Directors of the Hospital Broca*
- *Former Special adviser on aging of the Minister of Health, Social Security, Elderly, Family and Disabled persons*

Report from ILC-Centers

ILC-France

Section 1: Profile of ILC-France

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• President:

Professor Françoise Forette MD is CEO of ILC-France. She is Professor of Internal Medicine and Geriatrics, University Paris V, CHU Cochin-Necker, since 1994. Director of the French National Foundation of Gerontology since 1982. President of the Board of Directors of the Hospital Broca since 2002, Past president of the French society of Geriatry and Gerontology, Member of the board of the Croix-Rouge.

• Mission Statement:

- To catalyze the development of all innovating and constructive solutions to accompany the challenge of the demographic revolution
- To promote information in order to modify the political decisions for an active longevity in good health
- To develop an interface with researchers and decision makers on ageing

• Year Organized:

- 1996

• Major Affiliations:

- None

• Sources of Funding:

- Grants from Public Health Ministry and private companies
- Membership fees
- Earnings from consultant activities

• Major Activities/Programs:

- Dissemination of Guidelines (vision, cognitive health, hearing, Advice for Parents, balance) to the general public

- Research studies on health and activity life expectancy indicators (HWLE)
- Conferences on health prevention as a major factor of productive longevity with numerous institutions (OECD, Les Echos, Women's forum, FNSEA, FNAR, private companies and institutions, etc.)
- Pilot study "Company in good Health" on going
- International conference with UNESCO in 2005- Paris: in press FIAPA
- 12th, 13th, 14th Parliamentary meetings on Longevity — Paris in 2005/2006/2007
- Regular meetings of the Parliamentary working group on Longevity

Section 2: Profile of Ageing in the Region

1. Brief Review of Aging Demographics

In 2007, the total population of France was estimated at 63.4 million. As in other nations, the French population continues to age (Figure 1), and the proportion of the youngest age groups is diminishing despite the fact that births rose sharply to 2 children per woman in 2006, reaching their highest level since 1981.

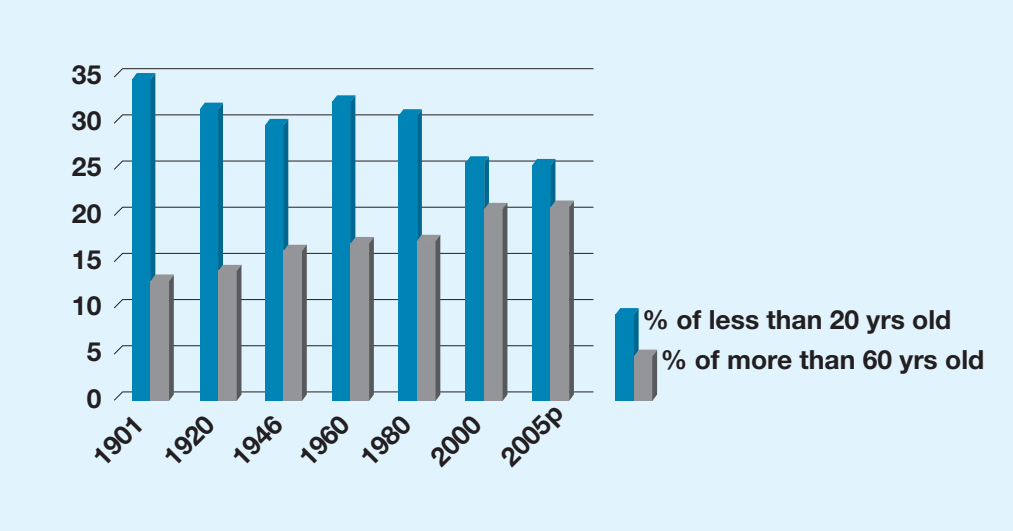

Figure 1: Evolution of the structure by age of the French population since the beginning of the XX th century.[1]

2. Summary of the Main Trends/Issues of Ageing in the Nation

A. Health/Medical Care

In 2005, 20.9% of the population (14 millions persons) is aged sixty and over (Table 1), and there will be a continuous increase in the populations over sixty until 2050[1].

Year	2005	2010	2020	2030	2040	2050
> 60 yrs (%)	20.9	23.1	27.3	31.1	33.5	35.0
> 75 yrs (%)	8.1	9.0	9.6	13.1	16.1	18.1
> 85 yrs (%)	1.8	2.5	3.4	3.8	6.1	7.5
>100 yrs(%)	0.02	0.03	0.04	0.09	0.14	0.26
centenarians(x1,000):	15	21	24	60	87	165

Table 1: Evolution of the percentage of the French population aged 60 and over from 1950 to 2050 (central scenario) – Adapted from[1]

Life expectancy (Table 2) remains on a steady uptrend, exceeding 77 years for men and reaching 83.3 years for women[2]

Years	Men		Women	
	At birth	At 60 years	At birth	At 60 years
1994	73.6	19.7	81.3	25.0
2000	75.3	20.4	82.1	25.6
2006(p)	77.1	21.7	83.3	26.6

Table 2: Life expectancy at birth and at sixty years old.[2] *Insee Première N° 1118- January 2007*

The female advantage over males in life expectancy remains nearly universal at each age and period, and the same trend is observed in France. But there seems to be a slight stagnation in the increase of life expectancy for women, probably because of the increase in lung cancers in female smokers. Nevertheless, the demographic pyramid[3] clearly shows the predominance of women in the older population. (Figure 2)

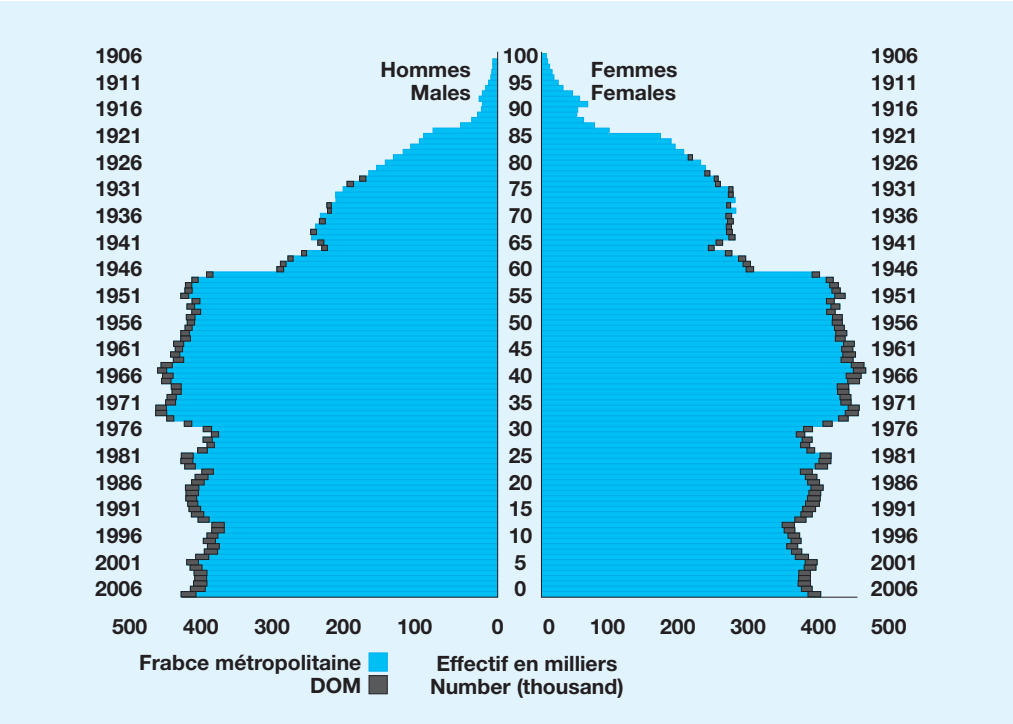

Figure 2: The French population pyramid at January 1, 2007 - Insee-Edition 2007-France in figures-

All people do not equally enjoy an excellent health status reflected by their life expectancy: for example, in France, the place where one lives may also have an influence. Life expectancy at birth is five years lower for men in the north of France than in the Paris region. The difference is only 2.7 years in women (Table 3)

Region	Men	Women
North of France	73.6 yrs	81.8 yrs
Paris and around	78.4 yrs	84.5 yrs

Table 3: Mean life expectancy at birth in France, comparison of two regions (Insee 2004)

B. Long-Term Care Insurance System

The absolute number of frail elderly needing assistance or long-term care, either at home or in an institution is close to one million individuals — but it must be emphasized that the percentage is low: only 6.63 percent of the population over sixty — suffer from loss of autonomy because of disabling diseases. The rate of loss of autonomy is higher in women than

in men at very advanced ages. (Table 4)

Age	Men	Women	Total
60-69	2.19	1.95	2.06
70-79	4.99	4.35	4.65
80-89	13.40	19.85	17.69
90+	29.31	46.45	42.55
Total	5.00	7.80	6.63

Table 4: 6.63% of people with Loss of Autonomy among the Senior Population Aged Sixty and Over in France-(Insee –HID study -GIR 1-4) Etudes et résultats N° 94-décembre 2000

The age-related increase in the prevalence of Alzheimer's disease and related disorders, represent 70% of the causes of institutionalisation and 72% of the requests of the APA allowance. Existing structures for elderly over 75 years old are in Table 5.

Type of structures	years 1984	1991	2003
Number of 75+ (in millions)	3.1	3.9	4.8
Home helps (x1,000)	510	507	278
Home care nursing services(x1,000)	24	42	71
Number of beds in housing and living facilities (x1,000)	450	498	589
(of which nursing home x1,000)	*47.7*	*110.8*	*284*
Number of beds in long term care institutions (x1,000)	54	69	79
Total : 75+ in public and private structures (x1,000)	504	567	669

Table 5: Evolution of home services and public/private housing facilities for 75+. BEH-N° 5-6/2006

After the heat wave in the summer 2003, the French government strengthened existing policies and introduced new plans:

- The law "Vieillissement et Solidarité" in 2004 was completed by the law "Solidarité-Grand Âge" in 2006. One of the most important outcomes was the creation de novo of a new branch of the Social Security System (the Health system covers all persons living in France) called "Caisse Nationale de Solidarité pour l'Autonomie", CNSA. It covers the risk of dependency and offers part of the financing of long-term care either at home or in institution. This new agency is financed by the Health System for medical costs and by a new system for the remaining costs: 9 billion € for the 2004-2008 period, funded from the product of an extra work day called "Solidarity Day" for all employees and a 0.3% tax for the employers. It covers: The costs of dependency care either at home or in institutions through a specific allowance called APA (personalized allowance for autonomy). In 2007, 1,078,000 persons beneficed of this allowance, 61% were living at home and 39% were institutionalized.[4]

Total expenditures on Long Term Care represent a little more than 1% of GDP (15 billiard €).

- A Geriatric University Plan was implemented in 2005 in order to double the number of Professors of Geriatrics from now to 2010. In addition, geriatric acute care units are being set up in all hospitals with emergency wards and the number of rehabilitation beds is increasing.
- Shifting the balance toward home-based care and home services aimed at giving a choice to the older persons (Scénario du libre choix). The creation of a new check system «chèque emploi service universel» (CESU) co-financed by employers and communities will also facilitate the payment of the social workers and a variety of home helps by the community.
- An Alzheimer Plan was implemented which aimed at raising the rate of early diagnosis (presently at 50%) by increasing the number of Memory Clinics (263 up to 300) and the number of Resources and Research Memory Centres (24 up to 30). The second objective is to train GPs, professionals, patients and caregivers, and to support families and informal carers. A new Alzheimer's Plan was recently implemented by the President Sarkosy in order to strongly promote research and high quality cares for Alzheimer patients. This plan was published in November 2007.

As a whole, these new laws and plans should greatly improve the condition of the frail and dependent elderly in France.

C. Employment and Retirement (Profile of Retirees)

While the lawful age of the retirement in France is fixed at 60 years, French stop working at 58 years as a mean. The recommendations of the European Council in Stockholm in 2001 established an objective of employment rate of 50% for the 55-64 age group by the year 2010. In 2005, the employment rate for this age group in France is 37.9 % despite a recent trend

upward and it still remains far behind the European average of 44.1% (EU 15). After age 60, the French situation is even more critical with 7% of men and 4% of women in the economic circuit as compared to Sweden (respectively 23% and 14%).

Reforms are under way to improve the incentives and opportunities for older people to play a part in the labour market for longer, and to tackle the various disincentives and barriers to employment facing older workers. This requires collaboration between the public authorities, employers and unions in the following areas:

- Reform retirement and social welfare systems to strengthen work incentives (progressive retirement, new contracts, simultaneous working/retiring). The French pension system is based on the pay-as-you-go principle and its financing is mainly ensured by contributions from workers and employers. A "capitalisation" scheme will be proposed to individuals in complement of this "repartition" system.
- Encouragement to change the attitudes of employers and workers.
- Adaptation of employment protection rules to promote safe working conditions and employment of older workers.
- Promotion of training for upgrading skills and acquiring new ones.
- Improvement of the access to high-quality employment services for older job seeker.

Recently, an ILC France research project put forward an innovative **Healthy Working life expectancy indicator (HWLE)**[5] at age 50 in Europe, which offers a model of successful ageing combining two essential dimensions: the absence of disease and the employment of seniors. In average in Europe, among the 20 years available between 50 and 70 years old, men spend 14.1 years in good health, of which about one half at work, and women 13.5 years in good health, of which about one third at work. Therefore, it should be in theory possible to increase healthy working life expectancy between 50 and 70 years old, especially for women, by reallocating years in good health from retirement to work.

Section 3: Current and Future Needs for Research/Training/Policy Change in the Region

Despite the important political measures that were undertaken during the last 5 years, further research and policies are necessary to turn France's demographic challenge into an opportunity. Professor Françoise Forette highlights that *"Active and healthy ageing is a unique opportunity for France and Europe to create wealth. Our leaders and the French President should create the right health and labor environment to ensure that we do not fail meet this challenge".*
The ILC-France recent manifesto proposes the promotion of policies and initiatives to improve both healthy and active ageing.
Key points of the manifesto include:

Healthy Ageing

Promoting health, prevention and lifestyle education through the life course is a priority and should start at an early age. Therefore, specific school programmes should promote concrete safe daily behaviors which can contribute to maximize children's health, e.g. global lifestyle with more physical exercise, careful dietary supervision, protection of vision, healthy heart, skin and brain.

Prevention should also be at the core of any public health policy. In particular, public authorities should develop the contact points between consumers and doctors. Strengthening the role of occupational medicine and the relationships with schools, universities or companies would help spread key prevention messages and best practices.

Involving the healthcare community is another key element. Therefore, ILC France recommends that lectures on ageing and geriatrics become mandatory not only for medical students, but for all health care professionals.

Promoting ICT and gerontechnology is also an important challenge for the next decades.

Active Ageing

It is important that the lifecycle approach to work be strengthened, including more incentives for prolonged active ageing. There is a strong need to better appreciate and recognize the value of experienced workers. Therefore, the government should provide mechanisms to financially support training schedules for older workers, and encourage lifelong learning to maintain their competitiveness and employability.

It is also important to provide more flexibility for older workers. Working environments should be adapted to accommodate physical and health conditions, and the retirement age should be based on a number of years of contributions to the pension scheme and not on a defined age limit. Tax incentives for those people who want to work longer have to be implemented.

Another major objective for the French society should be to change the image of aging in order to accept longevity as an opportunity and not a handicap. Then, it is mandatory that the government implements a communication plan towards the French public at large. This plan has to lasts for several years, in order to obtain deep change in citizens' minds and in public's perceptions.

Numerous experimentations on intergenerational integration have to be implemented to fight the discrimination against the elderly. Preventing maltreatment of elderly and improving end of life care are also major objectives.

Section 4: Proposal of an Agenda to Help Resolve the Concerns Outlined in Section 3

The agenda for the next 2 years is as follows:

- Complete the pilot study **"Companies in good health"** aimed at evaluating the efficacy of a prevention program in the work place which is a prime location to improve the health literacy of employees. If the efficacy of such prevention approaches is proven, the methodology of the study will be proposed to other companies and organizations and to English speaking countries. The results of the study will be published in a peer-reviewed journal and largely communicated to policy makers when considering possible employment reforms.
- Strengthen a communication plan **to promote the important results of HWLE** with press conference and specific EU colloquia on indicators of healthy and active life expectancy. Expand if possible the methodology to North America and Japanese countries.
- Follow up of the studies with ILC-US e.g.: Expand and **develop the "World City Project"** in suburb with comparison of Great Paris and New York.
- Set up workshops and experimentations on **gerontechnology** with ICT companies.
- Take an active part inside the French Parliamentary working group on Longevity.

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Sally Greengross OBE
Chief Executive
• *A crossbench (independent) member of the House of Lords*

United Kingdom

Report from ILC-Centers

ILC-United Kingdom

Section 1: Profile of ILC-United Kingdom

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• President:

Baroness Sally Greengross is Chief Executive of the ILC-UK.
She is a crossbench (independent) member of the House of Lords and a Commissioner on the Equality & Human Rights Commission.

• Mission Statement:

The ILC-UK is an independent think-tank influencing policy on societal ageing and population change. The ILC-UK develops ideas, undertakes research and creates a forum for debate and action.

• Year Organized:

- 1997

• Major Affiliations:

- None

• Sources of Funding:

Income from grants and donations in 2006 was significantly higher at £472,125 (2005, £290,873) with the addition of a number of new research projects funded by such organisations as the Nuffield Foundation (Living & Caring? An Investigation of the Experiences of Older Carers), BUPA (Food Preferences in Care Homes), PRU and Partnership Assurance (Jointly - Asset Accumulation Across the Life Course) and Pfizer (The Effectiveness of Public Health Interventions, Intergenerational Approach to Dementia and Ageing & Gay). The Alliance for Health and the Future programme has continued.

We have received some core funding from Norwich Union, Age Concern and new corporate partners of the ILC-UK. Legal and General sponsored our new website design and

maintenance plus ILC-UK promotional material.

• Major Activities/Programs:
Research links continue with European Nutrition for Health Alliance (malnutrition), Bristol Myer Squibb (mental health and hepatitis B projects) and the Alliance for Health and the Future. As well as research mentioned above, the ILC-UK has been working with Help the Aged on *'The Voice of Older People in Society'* which has now been published.

Arising from our 'Building our Futures' project there has been a great deal of work on 'Older People's Housing and Regional/National Strategies', including local consultancy work with the Department of Health, Housing and Learning Improvement Network, as well as a Department of Health publication using data in housing planning entitled *'Sustainable planning for housing in an ageing population'* and a *'Lifetime Neighbourhoods'* discussion paper.

Past publications include *'Navigating Health, the role of health literacy'*, *'State of Ageing & Health in Europe'* (funded by Merck) and *'Dementia in my family'* (funded by Pfizer).

More recent publications include *'Asset Accumulation'*, *'Age of Inheritance'*, *'National Care Fund'*, *'Living & Caring'*, *'Obesity in the UK'*, and *'Successful Ageing & Social Interaction'*.

We have initiated some think pieces & policy briefs on our new website, eg. *'Retirement Capital & Online Social Networking'* by James Lloyd; *'Older people's housing and under occupancy'* by Ed Harding and *'Unlocking the Community'* by Simon Goodenough, Director of 'Upstream' Healthy Living Centre.

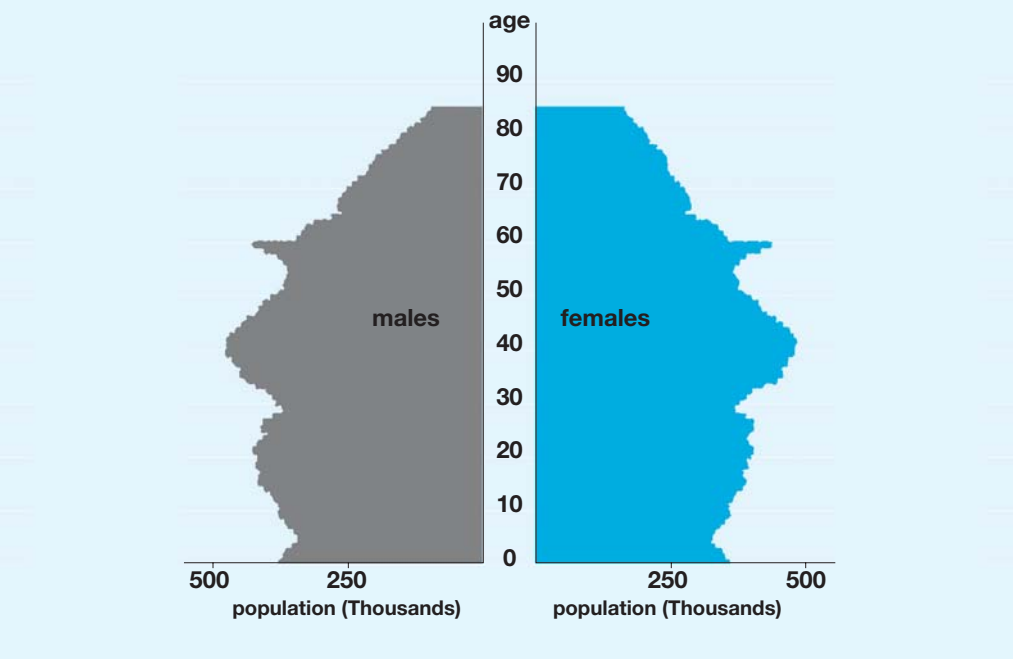
Events have included 'Promoting inertia, how should government sell personal accounts and what should their message be?'; 'House blockers? Older people & the housing stock in an era of under occupancy' and 'The Great Wealth Transfer? asset accumulation, inequality and the generations'. The global conference and parliamentary debate and events on 'Human Rights and Older People', was held in October in London to coincide with the ILCs last annual meeting.

Recent events have included '*Living and Caring? An Investigation of the Experience of Older Carers'*, *'The New Age of Inheritance and Public Policy'*, *'Funding Long-term Care — Finding a Fair Solution across the Generations'* and *'Risk Perceptions and Policy Responses'*.
Future events include *'The State of Intergenerational Relations Today'* and *'Choosing Population Projections for Public Policy'*.

Section 2: Profile of Ageing in the Region

1. Brief Review of Aging Demographics

UK population grows to 60.6 million



Population: by gender and age, mid-2006

In mid-2006 the resident population of the UK was 60, 587, 000 of which 50, 763, 000 lived in England. The average age was 39.0 years, an increase on 1971 when it was 34.1 years. In mid-2006 approximately one in five people in the UK were aged under 16 and one in six people were aged 65 or over. (Ref: ONS. Population Estimates).

In the UK the ratio of people over 65 has risen from 1 in 20 a century ago to around 1 in 6 today, and will be around 1 in 4 by 2051 when the average man of 65 is likely to have around 22 years of life ahead of him, compared with only 12 years in 1950, and 19 today. By the mid-century, the average woman of 65 will expect to reach almost 90. Secondly, with long-term improvements in health, more of us — 8 in 10 men and 9 in 10 women are surviving middle life to reach 65. (GAD).

At the same time there is a long-term trend for families to have fewer children or no children at all so that people over 50, over 65 and (especially) over 85 are set to increase rapidly and they will form a larger proportion of the total population. By 2051, people over 65 are likely to represent over a quarter of the population. Over-85s now form just 2 percent of the total population and 12 percent of the population over 65. By mid-century, they will account for

nearly 4 in 10 of the over-65s, and 6 percent of the total population. By 2007 the number of people over 65 will exceed the number of children under 16.

2. Summary of the Main Trends/Issues of Ageing in the Nation

A. Health/Medical Care

The NHS is still the overwhelming provider of health care.

Expenditure doubled in 10 years to nearly £90bn — with significant increases in primary care, new GP contracts etc.

The establishment of the National Services Framework has meant a fundamental change in thinking about health and social care services, a cultural shift, resulting in services being designed and delivered around the needs of children and families.

Also there has been a major policy shift towards prevention and early intervention such as campaigns on 'behaviour-related' disease. For example, a brief smoking cessation intervention costs £500 compared to £30, 000 — £40, 000 for treating patients with advanced cancer.

However there is fragmentation of responsibility for health behaviour change amongst different Government departments. It is recognised there needs to be much more integration of services, especially health and social care and better training for carers and care assistants for older people.

There has still been a belief in an all-embracing NHS, and that medical advances will reverse the impact of their lifestyle choices. However, now there is an increasing awareness of rationing as fact of life in NHS — eg. the role of National Institute for Health and Clinical Excellence (NICE) is impacting on the NHS by giving contentious judgements on dementia drugs, etc. We are in fact moving inexorably towards a social insurance/shared costs model.

Cancer survival rates are up, but the UK is still behind similar nations. Crucial is the need to see dignity with older issues especially in palliative and preventative care.

The issue of Mental Health gives a continuing dilemma over rights of individuals versus the rights of society and need for coordinated services. However, the Government is to produce the first ever national dementia strategy in response to one of the great challenges now facing society. Workstreams will cover improved awareness, early diagnosis and intervention and improving the quality of care for dementia.

B. Long-Term Care Insurance System

There is increasing awareness of the unaffordability of the current system: LGA/ADSS report March 2006 identified a shortfall of £1.76bn. in care spending.

The Wanless Report and Joseph Rowntree Foundation research have been encouraging the partnership model of shared funding: The Government is yet to legislate but a bill is expected autumn 2007 to bring forward co-regulation for health and social care sectors. There is recognition of an artificial distinction between health care and social care.

A Dignity in Care Campaign was launched in 2006 aiming to eliminate tolerance of indignity in health and social care services through raising awareness and inspiring people to take action. To date the campaign has focused on older people to ensure that high quality health and social care services should be delivered in a person-centred way that respects the dignity of the individual receiving them. Unfortunately, older people are not always treated with the respect they deserve.

Also there has been increased debate over end of life issues — moving from medico-legal dilemma into the arena of patients' and human rights.

Recently a report by the Joint Committee on Human Rights showed poor standards in care homes — 21% of care facilities were failing to meet minimum standards on dignity and privacy. There is a continuing legal wrangle over the exclusion of private care home residents from protection of the Human Rights Act.

C. Pension/Economic Security

The State Pension reforms in the recent UK White Paper are intended *to make the State Pension fairer and more widely available and to provide a solid foundation on which people can save.*

The Pensions Act 2007 will greatly improve the situation for many women. Both men and women will gain from the reforms, but a number of the measures — focusing on fairness and improving coverage — will particularly improve the pension outcomes of women. For the first time, caring will be valued equally with work so people taking time out of the labour market to undertake caring responsibilities will not be disadvantaged in terms of their state pension entitlement.

This increased income is income which women can receive independently — they do not need to be reliant on a partner to receive these amounts.

Auto-enrolment into personal pension accounts has potential advantages which should lead to an increase in the number of people saving for their retirement. But there are concerns around this — eg. failing to address under-saving by the low paid, self-employed, contract workers.

However, the Government's proposals to increase the state pension age to 68 by 2050, will improve the overall sustainability of the system.

The Welfare Reform Act intends to reduce dependency on the Incapacity Benefit, a contributory but expensive benefit. Half the claimants are aged over 50. The Government do not seem to have the right balance between coercion and incentive.

Between 2004 and 2006, total membership of occupational pension schemes fell. Although over the last eight years pensioners' incomes in Great Britain have risen faster than average earnings, the levels of income that older people receive falls with age so that older pensioners have less wealth than those around State Pension Age.

D. Employment and Retirement

The distinction between two states is much less obvious than even a decade ago. There has been a slow policy adaptation to the idea of flexible work generally and continued working beyond 'normal' retirement age: A Work and Families Act gives workers the right to request flexible working hours but not the right to receive them...if we are serious about recognising complex inter-generational care issues, and the contribution of older workers, there must be an improvement on this. 56 percent of working-age people in Great Britain expected their retirement to last at least 20 years. Only 7 percent thought they would be in retirement for less than ten years.

The Retail sector has led on employing the over 50s around the time that Age Discrimination legislation came into force in October 2006 to give new employment rights to everyone in work or looking for work. This Age Discrimination legislation will also do away with compulsory retirement below age 65. Three priorities for government action are to achieve higher employment rates and greater flexibility for over-50s combining work with other commitments; to enable older people to play a full and active roll in society and to allow us all to keep independence and control over our lives as we grow older.

E. Status of Older Women

The final report of the Equal Opportunities Commission (August 2007) showed worrying gender gaps across all areas of life and at the current rate of progress, change will be painfully slow. For example, it will take almost 200 years to have equal representation of women in parliament. This is disappointing given the priorities of the present Government over 10 years, particularly in implementing EU social chapter directives.

However an earlier report, April 2007 'State of the Modern Family — the ageing population and the demands on parents and carers' highlighted care responsibilities stating:

"Support for modern families does not just mean childcare. Millions of people care for older relatives or friends and 1 in 4 carers also have dependent children to look after. The increasing expectation of disabled and older people to be able to live independently can only be achieved by effective social support services. At the moment much of this support is provided by unpaid carers, many of whom face real difficulties in finding work that fits with their caring responsibilities."

The new UK Government in July 2007 has announced 3 priorities:

1. Supporting the care of older and vulnerable relatives by families, particularly as they bring up children;
2. Tackling violence against women and improving the way society deals with women who commit crimes;
3. Empowering black and ethnic minority women to build cohesion within and between communities.

Women continue to form the bulk of the professional care workforce, i.e. informal carers and child carers. However, a visible polarisation in wealth in UK impacts disproportionately on women; for example, there is a geographical north-south divide with more poorer women in north.

F. Issues unique to the United Kingdom

There are tensions arising from the clash between economic policies that promote flexible workforce, de-regulation and competitiveness in global economy, and the need to adapt our labour market, in particular, to the realities of demographic change and longevity.

For instance, the UK opted out of the EU Social Chapter during much of the period of economical and industrial change in the 80s and 90s, so we are now 'bolting on' these directives (designed to safeguard workers' rights, work/life balance, etc) on an economy and society not adapted for them.

Another major issue is weaning the British away from attachment to traditional welfare state model towards social insurance and partnership models.

One of the most pressing needs throughout the UK is to achieve the *better integration of health and social care* to allow older people to be cared for within their communities.

Section 3: Current and Future Needs for Research/Training/Policy Change in the Region

Health and Social Care

It is estimated that 1.2 million older people in England use social care services (Commission for Social Care Inspection 2005b). Yet the full costs of social care are poorly understood. Funding derives from a multitude of sources. Social care is means-tested, thus state funding is restricted to those with relatively low financial means. This often comes as a surprise to older people who have assumed that social care for a frail older person with dementia or severe arthritis will be provided by the state in the same manner as NHS funded health care. Policy efforts are focused on finding alternatives to means-testing which may give individuals greater flexibility to fund their care. For example, pilot schemes are underway in Scotland looking at *direct personal payments* for all social care.

Mental ill-health

Mental ill-health is also a significant concern for older people. *Depression in later life* affects 10-15% of persons over 65. Yet many older people attribute depressive symptoms to physical causes, effectively contributing to under-diagnosis and under-treatment — and physician attitudes often match those of their older patients.

The Government is to produce the first ever national dementia strategy in response to the growing toll of dementia in the older population. This strategy will focus on early diagnosis and intervention; improving the quality of care for dementia and professional training needs.

Finally, *health promotion efforts* are too often targeted solely at younger populations and need to take into account the full age spectrum.

Housing

Housing is central to efforts to ensure our healthcare, social care, community services and built environment are equipped cope with the demands of population ageing. Older people spend more time at home than other generations, around 70-90%. Yet the UK has a very large stock of older, ageing homes. One survey estimated that around 1 million older people live in properties over 90 years old. Decent, appropriate housing has the potential to make government goals of active ageing and wellbeing in later life real, but conversely poor housing will do the opposite, exacerbating chronic conditions and disability. For example, falls amongst older people are a major cause of loss of independence and entrance into sheltered housing, costing the NHS around £1bn per year. Home environments have been proven to influence the likelihood of falls, hence preventative spending offers significant and cost-effective outcomes.

The Government has recognised the centrality of housing to the 'active ageing' agenda, and housing is mentioned in a raft of cross-sectoral guidance issued by the Department of Health,

Department of Work and Pensions and Communities and Local Government. Regions and local authorities have been instructed to plan new strategies linking housing, communities, health and care yet in most cases have been slow to include older people and population change as key drivers of local economics and housing markets. For example, few senior social services managers and even fewer NHS senior managers are engaged in policy or strategy on adaptation and DFG issues, despite their major implications for healthcare spending. (CLG 2005 DFG).

Yet key opportunities to shape the future of our housing, such as regeneration areas and new housing investment, are still going ahead with little assessment of the needs of older people, who represent important market drivers who will only grow over the next few decades. Housing planning is still dominated by issues of affordability and allocation by locality.

Carers and Finance

Older Carers
Given the growing demand for care that will result from an ageing population, and the fact that the majority of care will continue to be provided by friends/family, most likely by older people themselves, there is an urgent need for research into the effects that providing care has on the lives of older people, the effect on their pension accumulation, their participation in the labour market, and their entitlement to receive help and financial support.

Funding Retirement
Rising asset prices, particularly in housing, across much of the Western world, has seen the asset wealth of older cohorts rise dramatically, at the expense of younger cohorts who have been saddled with large mortgages. This creates important questions around intergenerational equity, solidarity and justice. It is causing many policymakers to review again how society proposes to pay for its ageing population, particularly as policymakers consider the retirement saving activities of younger cohorts. Research and action is needed to explore how housing wealth can be better used to fund retirement.

Section 4: Agenda to Help Resolve the Concerns Outlined in Section 3

Integration of health and social care
With increased decentralization of health and social services, we risk seeing significant shortages in skilled staff in the community. Governments must invest further in community services and work closely with the voluntary and private sectors, who are playing a growing role in filling the service gap across many communities.

Investment in skilled personnel who can work across the health and social care settings is particularly important.

Moreover, greater resources (used effectively and equitably) are needed, particularly for social care. Policy-makers must recognize that there will be an increase in social care costs and accordingly they should plan and prepare for the financial consequences. The critical role played by Informal caretakers must be factored into any planning of care capacity in the community.

Mental health
There is a need for better data on the costs of care at home for people with dementia and details of the services which people with dementia receive, all of which is vital for proper planning for the expected rise in the number of dementia sufferers.

Health Promotion
Actions targeted at modifying lifestyle behaviours, for example stress, obesity and tobacco use, should be developed over the entire life course. If implemented from midlife onwards, these actions may prevent and postpone the onset of cardiovascular disease, stroke and dementia in later life.

Better Research
An overarching need is also required for better indicators to allow us to measure not only health status but quality of life and functional abilities of individuals as they age. Too often, data on older people are lumped together in a single group — 'aged 65 and over'. There is a need for data to be available by age group, to allow for a better understanding of risk factors and health outcomes across all segments of the older population.

Housing
Key planning documents, such as regional strategies, need to accept that the wellbeing of older populations are as much an economic issue as the wellbeing of younger ones. This involves a recognition of the social, civic and economic capital that older populations represent alongside an appreciation of the potential savings offered by preventative investment in housing adaptations and maintenance.

It also involves a strategic realignment of policy towards consideration of existing homes and communities as much as the planning of new ones does.

Best practice and examples of innovation do exist in some areas, but need to be collected together and more effectively communicated to planners.

Bricks and mortar are only part of the solution. Planning should encompass a vision of communities that encourage an active and engaged later life for all. This implies the involvement of housing, health and social care in planning. Cross-sectoral planning offers

many benefits, including sharing of information to target services more effectively, and eventually, mutual recognition of the inter-dependency of funding streams and joint planning; for example, Primary Care Trusts cooperating in the strategic management and roll out of adaptations and maintenance schemes designed to reduce older people's accidents in the home.

Local authorities also need increased funding to ensure that the training and retention of skilled staff allows the creation of enhanced expertise in any given area. This will ensure better regional strategies by feeding an improved local evidence base upwards. Finally, ministerial commitment is needed to ensure real attitudinal change from the top down.

Older Carers

More research is needed about the effects of providing care on older people. It is necessary to consider new and innovative ways of thinking about how older people can be supported in their caring roles, particularly when they have to balance the work and responsibilities involved in paid and unpaid care.

Retirement Savings

More research is required into how the different financial responsibilities on younger cohorts affects their retirement saving activities. At the same time, more research must be carried out on how older people can be enabled to use their housing wealth to fund their retirement, and contribute to the costs of their long-term care.

Sources: Mid-year population estimates: Office for National Statistics, General Register Office for Scotland, Northern Ireland Statistics and Research Agency; National Government statistics UK; Government Actuary Department; Pensions Policy Institute; Department for Work and Pensions.

Dr. Rosy Pereyra, M.D.
President

- *Organizer of Grand Parents Institute*
- *Former General Director of State Services to the Elderly of the Ministry of Health and Social Assistance*

Dominican Republic

Report from ILC-Centers

ILC-Dominican Republic

Section 1: Profile of the ILC-Dominican Republic

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• President:

Rosy Pereyra MD is an English trained geriatrician who has been one of the pioneers of geriatrics in the Dominican Republic. She was, for a period of 10 years, General Director of State Services to the Elderly of the Ministry of Health and Social Assistance position to which she resigned in 1996 to organize the Grand Parents Institute, umbrella organization to ILC-DR and well recognized in the country for its contribution to the wellbeing of the elderly in the DR. She has been a consultant in the field of ageing to the Pan-American Health Organization, member of the UN Group of Experts in the revision of the Plan of Action for the World Assembly of 2002 and past President of the Dominican Society of Geriatrics and Gerontology. She is also the creator of the Code of Rights for the Older Dominican converted into law in September 1998 and has written numerous research papers and publications.

• Mission Statement:

Our mission is to promote healthy, productive ageing and at the same time help our societies to address the issue of ageing in a more positive way, visualizing the older population as an asset rather than a burden, recognizing their contributions and incorporating them into the development plans of every country.

• Year Organized:

- 1998

• Major Affiliations:

ILC-DR is affiliated to PAHO, Help Age International, Inter-American Network of Associations for Older Adults (RIAAAM), Autonomous University of Santo Domingo, the Dominican Alzheimer Society, INPEA and ILC Alliance.

• Sources of Funding:

Our resources come from the Grand Parents Institute, the United Nations Population Fund and

Sanophi Pharmaceutical which sponsors most of our teaching activities.

• List of Recent Major Activities/Programs:
Conferences:

- The Importance of Physical Exercise in Mental and Physical Wellbeing of Older Adults and presentation of the Digi-walker.
- The Importance of Risk Factors in the Prevention of Cardiovascular Disease.
- The Use of Atypical Major Tranquilizers in the Management of Agitation in Alzheimer
- Osteoporosis. The Silent Epidemic.

Section 2: Profile of the Aging in the Region

1. Brief Review of Aging Demographics

Our region is at the moment in a demographic transition which means that our society is gradually moving from a situation of high rates of fertility and mortality to one of low rates. The older population is as heterogeneous as the younger population in most demographics and socioeconomic aspects. There is however a gender difference. Male mortality is higher than women and by ages 60 to 64 there are only 89 men per 100 women in the Americas and this ratio declines steadily to a level of 53 at ages 80 and above.
This translates into a great difference in marital status. As a whole, most older men are married but because women live longer and remarry less frequently, the majority of older women in the Americas are widow.
Our older population in general has been growing rapidly in the last decades and it is estimated that by 2010 its growth rate will be 10 times as high as that of the total population.
The oldest old group (age 75 and over) is projected to grow significantly in the coming decades, more than doubling between 1990 and 2020. There is a particularity in the region and it is that while this group constitutes only 1 to 2 per cent of the total population Latin-American countries, many Caribbean nations have proportions of 3 to 4 per cent.

2. Summary of the Main Trends/Issues of Aging in the Nation

At the moment our population is still relatively young. Projections, however, show that while in the year 2000, 33.5% of Dominicans were less than 15 years old and those over 60 were less than 7%, the 2002 National Census show that older population rose to 8% while those under 15 showed practically no change. In the next decades older population will continue to increase at a greater speed than the other groups and it is estimated that for the year 2025 it will reach 12% and this percentage will duplicate for 2050.

We really do not know how our population reaches old age in the way it is doing because we have poor access to health care, no social security, there are areas where access to sanitation and water is still deficient.

A. Health/Medical Care

Our health system do not secure quality health care for the majority of Dominicans, it is divided into public, private. The police and armed forces have their own health care system. If you have a good employment or could pay private care, you do not have great problems but this does not apply to the great majority. If you are an employee on minimum wage or are unemployed or elderly without a pension, you will probably have to go to the public health care system which is very deficient.

This system is however in transition now because in the year 2001 the law that creates our social security system was passed and should therefore create a revolution in the way health care and pensions are given. All these years since 2001 have passed making all the necessary arrangements for its implementation. The contributory regime which according to the law should cover pension and health care to private employees has just started last first of September. The other regimes contemplated in the law which are the contributory/subsidized (covering independent professionals and small business owners that do not have a stable income) and the non-contributory regime that covers the elderly, disabled and the indigent, have no defined date for its implementation because it stated in the law that it implementation has to be gradual and will depend on the economical capacity of the central government.
Finally, a mayor issue that is affecting our country as a whole is the extraordinary amount of illegal immigrants coming from our neighbor Haiti, bringing with them all sorts of diseases including malaria and VIH.

B. Long-Term Care Insurance System

We most say that that 51% of older people live in extended families, only 14% live on their own so long term care is not so far an important issue. There are however 4 long term care residencies run by the Ministry of Health and Social Assistance, 22 that are community based homes partially subsidized by the government and usually run by religious organizations and 20 private. There are also 18 day care centers that belong to the government. We must admit, the demand for long term care places is rapidly increasing due primarily to the incursion of women into formal education and consequently into the labor force.

C. Employment and Retirement (Profile of Retirees)

Age of retirement according to our law is 30 years of service or 60 years of age (whichever is longer) and it is the same for men and women. It is only mandatory in the private sector. People in the public sector in general work much longer.
For informal workers, since old age pension is not automatic, they will continue to work practically till they drop. This is reflected in statistical data taken from the 2002 National census. This data shows that for that year, 47% of older Dominicans were economically active and in men this percentage rose to 65%. This indicates that for a large percentage of our older population the only way to survive is to remain in the labor force.

Even though that is the case, there is unfortunately old age discrimination and this is easily noticed in our daily newspapers when a job is advertised and putting as the top age for recruitment, 35 years. The outcry has been so great that a resolution was passed by the government increasing the age announced to 45. As you can see there is still a lot to be done.

Other facts included in our 2002 census show that only 12% of older people in urban areas have a pension and this goes down to 3.4% in rural areas. There is also a great percentage that has no income at all and those that do have a pension because they have contributed to a pension fund, those pensions are inadequate because they have never been indexed according to inflation so they are on average well below minimum wage.

D. Status of Older Women

Women are at greater disadvantage. Illiteracy is higher in women than in men (30% in men, 35% in women and this percentage increases in those over the age of 75) as it is unemployment so they have to depend exclusively on the help coming from their family. This is rapidly changing; we are seeing a feminization of higher education that will result in a total change of our statistical data in a few years.

Section 3: Current and Future Needs for Research/Training/Policy Change in the Region

In the Dominican Republic, we have 17 geriatricians all of which have been trained abroad. We started our own training program just last year with the accreditation of the Autonomous University of Santo Domingo. The trainees will have to do 2 years internal medicine and 2 years of geriatrics. So far, we have 8 doctors in training and we have noticed an increasing need for places in public hospitals since according to our studies, 35% of hospital beds are occupied by people over 65 years of age. Research is necessary especially in the areas of quality of life and of services offered to the elderly. The need for a change in the general attitude of the different governments in our region has been outlined in different scenarios especially after the 2nd World Assembly. The next regional meeting to review what actions have been taken to comply with that plan, will take place in Brazil next November and we expect to be there as part of our official delegation.

Section 4: Proposal for Action to Help Resolve the Concerns Outlined in Section 3

Recognizing and understanding our problems and needs ILC-DR considers we have to concentrate in increasing advocacy with the government not only to point out our compromise with the international community but also to try to have the older population included in the national agenda. If we can permeate the government and get a positive response, we will be able to get funding for research, an increment in the amount of places for training and hopefully a change of attitude going from the idea of simple assistencialism to one of inclusion and opportunities.

India

R.A.Mashelkar, Ph.D.
President

- *Chemical engineering scientist*
- *Bhatnagar Fellow at National Chemical Laboratry*
- *President of Global Research Alliance*
- *Former Director General Council of Scientific and Industrial Research*

Report from ILC-Centers

ILC-India

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• President:

Dr. R.A. Mashelkar is a globally recognized chemical engineering scientist of distinction, a distinguished science manager and an articulate and passionate spokesman for Indian science and technology, both, in academia and industry.

He has been elected Fellow of all the learned academies of Science and Engineering in India. He was elected to the following societies: Fellow of the Royal Society, London, Foreign Associate of the National Academy of Sciences, USA; Foreign Fellow of US National Academy of Engineering, Fellow of Royal Academy of Engineering, and UK and Foreign Fellow of Australian Technological Science & engineering academy. The President of India honoured him with Padma Bhushan in 2000 for his contribution to nation building.

Dr. Mashelkar served as the Director of National Chemical Laboratory (NCL) and the Director General of Council of Scientific and Industrial Research (CSIR). Since his retirement from CSIR, Dr. Mashelkar is a Bhatnagar Fellow at NCL. He is also the Chairman of Reliance Innovation Leadership Council and President of Global Research Alliance. He serves on the Board of Directors of, ICICI Knowledge Park, Reliance Industries Ltd., Hindustan Unilever, Tata Motors Ltd., Thermax Ltd., Piramal Life Sciences Ltd., KPIT Cummins Infosystems Ltd., GeneMedix Life Sciences Ltd., and Indigene Pharmaceuticals Plc., and Gharda Chemicals Ltd.

• Mission Statement:

The mission of the ILC-I is to function as a not-for-profit organization in the areas of Education, Training, Research, Media, Documentation and Advocacy and also undertaking Pilot Projects for Population Ageing.

To work towards and support Healthy, Productive, Participatory and Qualitative Ageing!

• Year Organized:
- 2004

• Major Affiliations:
- Athashri Foundation, YASHADA, UN INIA.

• Sources of Funding:
Government of India, CASP, Bharatiya Vidyapeeth, Athashri Foundation.

• Major Activities/Programs:
a. Workshop on "Volunteers Bureau".
b. Workshop on "Recreation for the Care of the Elderly."
c. Workshop on "Enabling Devices for the Elderly."
d. Workshop of Leaders of Senior Citizens, ILC-I and the Pune Police Commissionerate.
e. Workshop on "Training and Orientation of Members of the Volunteers Bureau and the Police Officials of the HelpLine."
f. Research on "Crimes against the Older Persons in Pune, Delhi and Mumbai."
g. Research on the "Demographic Profile of the Elderly in India."
h. Training Course in "Geriatric Health Care."

Section 2: Profile of Ageing in the Region

1. Brief Review of Aging Demographics

As per the latest census of India of 2001, there were 76.6 million persons of age 60 years and above. This is about 7.4% of the total population.

The percentage of the elderly in the age group 60 to 64 is 2.7 of the total population. The percentage of the elderly in the rest of the age groups is as follows: 65-69 years is 1.9%; 70-74 years is 1.4%; 75-79 years is 0.6%; 80+ is 0.8%.

The proportion of females over 60 years is 7.8% and that of males is 7.1% of the total elderly population.

2. Summary of the Main Trends/Issues of Ageing in the Nation

A. Health/Medical Care

The Primary Health Centres set up in India are not as yet fully equipped with the necessary infrastructure and personnel trained to attend to the geriatric needs of the elderly.

B. Long-Term Care Insurance System

ILC-I, in collaboration with the Athashri Foundation will soon be initiating a Continuing Care Unit for the fragile elderly in need of geriatric care. This is a pioneering initiative in India.

C. Pension/Economic Security

At present there is no social security system in India. Pensions are only given to the retired Government employees.

D. Employment and Retirement

Common Retirement ages for men and women — As far as retirement age is concerned, it is the same for both, men and women. But the retirement age limit is not uniform in India. For some of the Central Government employees, it is 60 years, whereas for some of the Central Government employees, like the Judges of the Courts, it is 65 years.
The retirement age of the state government employees is 58 years.

The retirement age for the private institutions and the NGOs or voluntary organizations too differ — either 58 years, 60 years or 65 years.

In the last five years, a new concept of Voluntary Retirement Service has emerged in the Government services. Here the individual is given the option of taking voluntary retirement after having reached an age of either 45 years or 50 years (differs from institution to institution) or after having rendered a certain period of years of service. This is better known in India as VRS and here the individual gets all the benefits of retirement.

Measures taken by the public and private sectors to encourage workers to work longer (eg- re-training programmes, part-time positions) — In India, except for some extraordinarily exceptional individuals, the retired individuals are not given an extension of service in the government. But in the voluntary organizations and in private organizations, quite a number of retired individuals with expertise and experience are employed either on a full-time or Consultant basis. There are other organizations which recruit such experienced retired personnel. But no such re-training programmes take place for the retired individuals.

Obstacles for older workers to continue their employment (e.g. discrimination) — In India, re-employment of the retired personnel is a new initiative, yet to pick up and hence, ready acceptance of such individuals would take some time.

Another emerging concept is the voluntary services to be rendered by senior citizens to society which is also catching on in India.

E. Status of Older Women

Feminization of Ageing is apparent even in India. The sex ratio for the population of age 60+ is favorable to females (1029 females per 1000 males) indicating numerical preponderance of females in the group of elderly persons. Moreover it is important to note that this numerical excess of females is observed only in the elderly population. The sex ratio of the total population of India in 2001 was 933 females per 1000 males.

F. Spirituality and Family Bonding

Right from ancient times, India has always looked at Spirituality as a coping mechanism for ageing. Spirituality essentially is not running away from the responsibilities of life, rather it is doing your duty without expecting the fruits of your labour. The concept of Volunteerism of the senior citizens is an extension of this philosophy, whereby the senior citizens render voluntary service to society.

India has traditionally been a culture where the family ties are very strong and where the joint family system has been one of the most revered value systems practiced in the country. A few decades ago, the joint family had about four to five generations of an extended family residing harmoniously under one big roof. Today too, despite the industrialization and urbanization eroding the joint family system in the metros and cities, the family as an unit and senior citizens as an integral part of this unit is still largely prevalent all over India.

Section 3: Current and Future Needs for Research/Training/Policy Change in the Region

In India, as the Population Ageing grows, the problems of the elders also grow in proportion to it. India is not yet effectively equipped to adequately address the issues and concerns of the elderly especially with regard to the medical and health problems of the seniors.

Training: Trained geriatricians and gerontologists are a comparatively new concept in India. As mentioned earlier, industrialization has to a certain extent, especially in the metros and cities, led to the disintegration of the joint family system. Moreover, the younger generation is also migrating outside the country for better prospects, thus leaving behind the elderly parents to fend for themselves. This has given rise to a lonely generation of senior citizens in need of emotional and physical care.

Thus the urgent need of the hour is a cadre of trained geriatric caregivers who would be able to provide the necessary care and support required by the senior citizens.

Research: In India, research in geriatrics and gerontology is a field that requires urgent attention from the government and the concerned organizations. Research in the field of ageing is still in its infancy in India. ILC-I has forayed into this field with several research studies

like — “Human Rights of the Elderly”, “Crime against the Elderly in major cities of India”, “Demographic Profile of the Elderly.”

Policy: Policies specifically for the elderly became an issue of concern for the Indian government only in the late nineties. The National Policy for Older Persons (NPOP) was formulated in 1999. The Maintenance and Welfare of Parents and Senior Citizens Bill, 2007 has been tabled in Parliament in March 2007.

Section 4: Proposal of an Agenda to Help Resolve the Concerns Outlined in Section 3

1. One of the most important fields of action for the future is the training of geriatric caregivers, geriatricians and gerontologists to meet the growing segment of Population Ageing in India. For this adequate and appropriate training courses and orientation programmes need to be designed and developed. ILC-I has designed a course in “Geriatric Caregiving” (undergraduate level) and is developing a course in “Social Gerontology” at the Post-graduate level. In the offing is an orientation course for medical doctors to be trained in geriatric needs.
2. The rural elderly in India are an unorganized segment of the elderly population. If old age is compounded with poverty, as it very often is in the rural sectors, then this becomes a very cruel combination. Thus providing financial assistance through pensions or some kind of social security net is essential while addressing the concerns of this segment. Another important factor to be considered is the feminization of ageing in the rural areas with the percentage of widowed and destitute elderly women being quite high in comparison with the urban elderly. Thus the issue of dependent elderly destitute widows is also an important matter for consideration.
3. Advocacy and awareness in society on the issue of Population Ageing is imperative if we have to tackle this issue in its right perspective. For this, the government, NGOs and the society at large, including the grassroot rural areas need to focused upon programmes and projects aimed at creating awareness on Population Ageing. ILC-I is working on this through its seminars, workshops, research studies and publications.
4. With regard to the NPOP of India, the policy needs to be made more effective as it clearly lacks certain vital factors which would make it more effective. The NPOP has no special department in the government or ministry responsible for its implementation, no specific budget has been allotted to it and moreover, there are no penalties prescribed if the provisions of the policy are not implemented. These issues need to be addressed effectively for a better implementation of the NPOP.

South Africa

Monica Ferreira, DPhil.
President

- *Board of the International Institute on Ageing (UN-Malta) (INIA)*
- *Board of the World Demographic Association (WDA)*
- *Steering Group of the African Research on Ageing Network (AFRAN)*
- *Former Director of The Albertina and Walter Sisulu Institute of Ageing in Africa at the University of Cape Town*

Report from ILC-Centers

ILC-South Africa

Section 1: Profile of ILC-South Africa

• Contact Information:

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• President:

The current President of ILC-SA is Monica Ferreira, DPhil. Her disciplinary training was in Sociology and her career in Gerontology spans more than three decades. She retired as the director of The Albertina and Walter Sisulu Institute of Ageing in Africa at the University of Cape Town at the end of 2006, but continues to head ILC-SA, affiliated to the Institute. She has published widely on research and policy on ageing in Sub-Saharan Africa. She is a member of the Board of the International Institute on Ageing (UN-Malta) (INIA); of the Advisory Board of the World Demographic Association (WDA); and of the Steering Group of the African Research on Ageing Network (AFRAN).

• Mission Statement:

The mission of ILC-SA is to understand processes and implications of individual and population ageing in South Africa and Sub-Saharan Africa (SSA), and to help the societies adjust to an expanding older population and enhance the quality of life of older persons. ILC-SA carries out its mission through research, training, and dissemination of knowledge for decision support. It views population ageing and longevity positively, and aims to facilitate the optimisation of individuals' capacity for active, healthy and productive ageing.

• Year Organized:

- 2005

• Major Affiliations:

Strong partnerships exist between ILC-SA and the South African Gerontological Association, the South African Geriatrics Society, the Department of Geriatric Medicine at the University of

KwaZulu-Natal, the South African Older Persons' Forum, Alzheimer's South Africa, Action on Elder Abuse South Africa, Grandmothers Against Poverty and AIDS, and the African Research on Ageing Network.

• Sources of Funding:
Funds are allocated to ILC-SA from funding generated externally to support the Institute's research and capacity development programs. Solicitation of dedicated, substantial and stable external funds to support ILC-SA is ongoing.

• Major Activities/Programs:

- 'Study to Understand and Foster the Functioning and Involvement of Contributive Elders' (SUFFICE), in collaboration with the Stroud Center for Study of Quality of Life at Columbia University and ILC-USA in New York City.
- Regional and national coordination and expansion of the International Network for the Prevention of Elder Abuse (INPEA).
- Participation in national and regional policy development and formulation activities, in particular the *Older Persons Act* No. 13 of 2006.
- Presentation of papers in several international and national congresses, expert group meetings, workshops and policy fora, in which ILC-SA activities were publicized and ILC goals promoted.
- Numerous public presentations and media interviews, aimed at popularization of knowledge on longevity and promotion of ILC and ILC-SA goals in South Africa.

Section 2: Profile of Ageing in the Region

1. Brief Review of Ageing Demographics

ILC-SA activities focus on population ageing and longevity in South Africa, but take cognizance of related trends and situations elsewhere in Sub-Saharan Africa, with an aim to achieve a sub-regional understanding and to transfer technology and expertise in the sub-region. Sub-Saharan Africa is the world's poorest and least developed sub-region; all but two of 30 countries with low human development world-wide are in SSA (UNPD, 2006). Numerous social ills beset the sub-continent, challenge nations, and retard or reverse development, which include rural stagnation, the proliferation of urban slums, the HIV/AIDS crisis and armed conflict. Fertility and mortality rates remain high: 65 per cent of the population is younger than 25 years and only 5 per cent is 60 years or older (projected to rise to 8 per cent by 2050). The absolute number of older persons is however set to rise dramatically: from 36.6 million in 2005 to 140 million by 2050. Life expectancy at age 60, currently 16 years, does not differ markedly from other world regions. South Africa's population aged 60 years and over constitutes 7.2 per cent of the total population, projected to rise to 13.1 per cent by 2050. Life expectancy at age 60 in South Africa will

increase from 16.5 years at present to 19.5 years by 2050 (UN/DESA, 2007).

Hence, SSA countries have youthful populations, although a longevity trend is under way; the concerns of the governments are however primarily those of the young. Nevertheless, consequences of key issues and trends in the sub-region impact the welfare and well-being of older persons. The issues and trends include chronic poverty, weak infrastructure, high youth unemployment, rural to urban migration of young adults, changing family structures and kin support systems, inadequate social protection, persisting infectious diseases — especially HIV/AIDS, poor access to health care, gender inequality, and human rights violations. Specific issues and trends, and their consequences or impact are considered briefly.

2. Summary of the Main Trends/Issues of Ageing in the Nation

A. Health/Medical Care

Governments of SSA countries must still combat infectious diseases (especially malaria, tuberculosis, waterborne disease and HIV/AIDS) and very few resources are available to manage a growing burden of chronic disease. Health care for older persons is unsatisfactory widely, especially through poor access, or barriers to services and marginalization of older clients in health care delivery. Given widespread poverty, virtually all older Africans are reliant on public health services for treatment; very few are able to access private health care. The concept of long-term care is virtually non-existent in SSA. Frail and sick older persons are typically cared for by family members in domestic settings without help from formal agencies. Very few residential care facilities exist for older persons; institutionalization of elders tends to be unacceptable culturally, moreover; mainly socially indigent frail elders accept placement in such a facility.

A major crisis in the sub-region that impacts older persons severely are effects of the HIV/AIDS epidemics. Poor and affected older persons face a loss of support and care from kin in old age when their adult children succumb to the disease. In addition, they must assume responsibility for raising grandchildren orphaned as a result of the disease. Older women, in particular, bear a heavy material, physical and emotional care burden, and in most cases receive no formal support. Older persons themselves are increasingly susceptible to infection with the HIV virus, which is typically neither suspected nor diagnosed, and goes untreated.

Such is a thumb-nail sketch of the status and situations of older persons in the sub-region. The situation of older person in South Africa is similar to that in other SSA countries, except that South African elders who are poor enjoy virtually universal and relatively generous benefits of regular social pension income.

B. Pension/Economic Security

Only six SSA countries (Botswana, Lesotho, Mauritius, Namibia, Senegal, and South Africa) currently operate a social pension program; elders in the other countries are reliant on family for income support or continue to earn a livelihood. South Africa's non-contributory (but means tested) social pension program, along with that of Brazil, is the most expansive in the developing world (Barrientos, Ferreira et al., 2003). Studies show that beneficiaries (women age 60 and over, men age 65 and over, who are eligible based on a means test of income and assets) share pension income with family and household members — and contribute to development in this way. Beneficiaries are entitled to free treatment at public health care facilities and placement in a state subsidized residential care facility, where needed and if a facility is available. However, a downside of the pension program is that beneficiaries are required to be economically inactive, which effectively removes older workers from the labour force, limits their capacity for productive ageing, and increases an economic burden on the state.

C. Status of Older Women

African society is patriarchal and characterized by deep gender divides. Older women, in particular, are discriminated against and disadvantaged in numerous social, economic and political arenas. In South Africa, customary law is practiced alongside Western law, especially in rural areas which fall under the authority of tribal chiefs. In such cases women may not inherit their deceased husband's property (only males have rights to inheritance). Older widows in these areas are particularly vulnerable to exclusion, exploitation, abuse and destitution. Nonetheless, South Africa's Constitution prohibits discrimination on several grounds, especially gender and race, and the government conducts aggressive campaigns to ensure that women's rights are honoured equally. The government is less clear however on the eradication of age discrimination; for example, mandatory age based retirement rules continue to be enforced in most institutions. Older persons tend neither to enjoy equal application of policy and the law in practise, as do persons in other age groups.

Section 3: Current and Future Needs for Research/Training/Policy Change in the Region

Research, training and policy needs in the field of ageing in South Africa (and the sub-region) are multiple. ILC-SA has identified specific needs upon which it focuses, some of which are described below.

Research

Only scant research on ageing and older persons is under way in the sub-region. The Institute of Ageing in Africa and ILC-SA are the only dedicated agencies in South Africa that conduct research in this field. Among priority research needs identified in recent international and national research agendas for the sub-region (e.g. the AFRAN agenda (2005), the updated

UN/IAGG agenda (2007), and the US National Academies of Science (NAS) agenda (2007)), which guide ILC-SA's research program, are studies on health conditions, health care, social protection, and poverty reduction, specifically longitudinal studies. To these ends, ILC-SA is currently 1) participating in a five-year follow-up of the bi-national (South Africa and Brazil) Non-Contributory Pensions and Poverty Study (NCPPS) conducted in 2002/03, and 2) continuing subsequent phases of the collaborative SUFFICE project, which include a) a health intervention at two key geriatrics sites; b) a generalisation survey in three provinces; and c) comparative data analysis with a New York collaborator and database. Other research intervention projects under way deal with a) falls and their management; b) community stroke rehabilitation practises; c) the diagnosis and management of dementia in specific cultural settings; and d) the quality of geriatric care in different public health care settings.

Training

Enhanced training programs in Gerontology and Geriatrics are needed nationally and sub-regionally. At present, training in multidisciplinary Gerontology is not offered as a degree course at any sub-regional institution; graduate students may work in Gerontology but are required to graduate in their mother discipline. ILC-SA is working with national and sub-regional stakeholders to develop and formalize multi-disciplinary training in this field. Training in Geriatric Medicine is under developed in the sub-region in general. Thus far, health professionals and teaching institutions have tended to view Geriatrics as a Cinderella sub-speciality; consequently, it is hardly included in medical training curricula and attracts little interest as an area of specialization. Training of health professionals allied to medicine in ageing and the care of older persons equally needs a stronger focus. Similarly, training is needed for a range of workers in the non-formal sector (NGOs). Once again, ILC-SA is working with national and sub-regional stakeholders to expand and improve training in Geriatric Medicine and geriatric care broadly.

Policy

Policy on ageing in South Africa and the sub-region is relatively under developed; what policies exist are fragmented and uneven, and tend to have a sectoral bias. Given SSA governments' focus on youth development, poverty reduction, job creation and infectious disease eradication, the formation of policy to benefit older persons is not a priority. In South Africa, a major schism exists between policies and programs for older persons provided separately by the ministries of health and social development (welfare), whose strategies and programs are uncoordinated. The Social Development Ministry assumes primary responsibility for older persons, but interprets its mandate narrowly; it focuses on the provision of old age grants, subsidization of certain facilities and services, and the prevention of elder abuse. The Health Ministry has no specific policies on older persons, but operates a Geriatrics sub-directorate, which mainly develops geriatric care protocols. No other ministries have policies to benefit older persons specifically. Nonetheless, new landmark legislation in the form of the Older Persons Act No. 13 of 2006 is aimed at

protecting their rights, regulating facilities and services, and empowering older persons to live a life in dignity and security. ILC-SA participated in the drafting of the legislation as well as the establishment of the South African Older Persons' Forum; the forum assumes a policy implementation watchdog role. ILC-SA engages moreover with stakeholders, through advocacy and knowledge production and dissemination, to develop and reform policy. Special efforts it will make forthwith include 1) advocacy for the formulation and adoption of a national plan of action on ageing, and 2) participation in review and appraisal activities of progress made in the implementation of recommendations in the UN's Madrid Plan and the African Union's Plan of Action on Ageing. Key areas in need of policy reform in South Africa include a) improved health care provision and delivery; b) expanded community based care and support services; c) eradication of all forms of age discrimination; and d) empowerment of older persons to know and exercise their rights and to participate fully in social, economic and political processes, especially those that affect them.

Section 4: Proposal of an Agenda to Help Resolve the Concerns Outlined in Section 3

ILC-SA has set a forthcoming three year agenda for action, key items of which are:

- A strong, focused research program, which includes a) a longitudinal follow-up of the NCPPS project on the impact of social pension income on household poverty alleviation; b) a continuation of the SUFFICE project on sustaining the functioning of contributive elders; c) an investigation and intervention to improve the quality of care of older health care clients — specifically interdisciplinary management of falls; and d) possibly a multi-country ILC Alliance study (specifically, with ILC partners in developing countries), pending identification of a research topic.
- Strengthened education and training programs in Africa-relevant Gerontology and Geriatric Medicine.
- Even stronger participation in national and sub-regional policy development and evaluation activities.
- Engagement in a range of initiatives and activities to empower and capacitate older persons, within partnerships, through advocacy, program and project design and implementation, and replication of best practises appropriate in the sub-region.
- Continuing organizational development of ILC-SA, and core and new ILC-SA programs and activities.
- Stronger positioning of ILC-SA as an organization, and promotion of ILC principles, values and goals in SSA.
- Successful solicitation of medium to long term financial support, in an environment of scarce resources and competing demands and priorities, to ensure the sustainability of ILC-SA and its programs.

Specific short-term agenda items include:

- A two-week *in situ* international training course in Social Gerontology (that is relevant in the sub-region), in which ILC-SA staff members will give modules, in Pretoria in January 2008, in partnership with the International Institute on Ageing (UN-Malta) (INIA) and the University of the North-West.
- A workshop to review and expand Geriatric Medicine policy, education and practise in the sub-region, probably in Ibadan, Nigeria in 2008, in partnership with the African Research on Ageing Network (AFRAN) and the International Association of Gerontology and Geriatrics (IAGG).

Argentina

Lia Susana Daichman, M.D.
President

- *Chair of Latin American Committee for the Preventions of Elder Abuse*
- *President of INPEA*

Report from ILC-Centers

ILC-Argentina

Section 1: Profile of ILC-Argentina

• Contact Information:

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• President:

Dr. Lia Susana Daichman:

Academic Qualifications:

Medical Degree, MD, Faculty of Medicine, Cordoba National University, Argentina, 1970.
Postgraduate Training in Geriatrics and Psycho geriatrics in the United Kingdom (1972-1977).
Specialist Degree on Gerontology and Geriatrics, Buenos Aires National University, 1980.
Re-certified her Specialist Degree in Gerontology and Geriatrics at the Argentinean Medical Association and at the National Academy of Medicine, Buenos Aires, Argentina (1996 and 2001).
Associated Professor on Psychology on Ageing, Faculty of Psychology, Belgrano University, Buenos Aires (1991-1998).
Specialist Postgraduate Course's Scientific Coordinator on Geriatric Medicine National University of Buenos Aires (1995-2003).

Professional:

- Consultant in Gerontology and Geriatrics at the Instituto Argentino de Diagnóstico y Tratamiento, Buenos Aires, since 1988.
- Reelected President to the Buenos Aires Gerontological Society (AGEBA), in office till July 1994.
- Chair of the Latin American Committee for the Prevention of Elder Abuse (COMLAT-IAGG) since 1995.
- President, International Network for the Prevention of Elder Abuse (INPEA: NGO with UN Status) since 2001 (Vancouver, Canada), and reelected till 2009 in Rio, Brazil, 2005.
- Elected President of ILC-ARGENTINA at the International Longevity Center Alliance Annual Meeting, Brazil 2005

• Mission Statement:

- To help society address the issues of their aging population in a positive and constructive way.

- The protection of Human Rights and other fundamental freedoms, without any violence, abuse and neglect.
- To highlight older people's productivity and contributions to society as a whole.

• Year Organized:

- 2005

• Major Affiliations:

ILC-ARG is an independent affiliate of the INPEA, the Navarro Viola Foundation, the Eckman Foundation, the Barceló University and the Argentinean Gerontological Society.

• Sources of Funding:

There are not still formal sources of funding in Argentina apart of some National Governmental Support and very few private donations.

• Major Activities/Programs:

All our activities are of life-span perspective and interdisciplinary and on National and International levels.

- Due to the great increase of Elder Victimization within the community during the year 2005-2006, the Eckman Foundation, the National Direction of the of Elder's Policies, Ministry of Social Development, INPEA-ARG and ILC-ARG developed a National campaign on Elder's Crime Prevention, which was launched in May 2006 raising awareness on the subject and by means of education leaflets, posters, open discussions at different sectors, national websites and a with a great support from the National media.
- A more recent, intense and successful campaign to continue Preventing Elders Victimization and Financial Abuse was launched by ILC-ARG, INPEA-ARG, the Government of the City of Buenos Aires, the National Direction of Elder's Policies, National Ministry of Social Development, the Ministry of Security and the Federal Argentinean Police (2007).
- World Day Awareness Elder Abuse 2007 was successfully being planned for June 15th at Buenos Aires DC as well as the rest of the country in conjunction with hundred of cities all over the world.
- Since October 2005 the Eckman Foundation, ILC-ARG and the Gerontological Society of Buenos Aires, by means of a contract with the National Direction of Elder's Policies, had been officially giving Courses to train and supervise new Human Resources, mainly middleaged females as Formal Caregivers and Auxiliaries in Gerontology, as a result of a high demand from the labor market, and as a part of one of the National Ministry of Development Social Programs for the Aged, already being done nearly in all Argentinean's Provinces. We just started two new courses (56 persons) and hope to

follow the same pattern for the rest of 2007 and 2008. 103 Caregivers have successfully finished their formal training till 2007 in our Center.We also started to collaborate on the creation of a formal National Pool of Caregivers, this time with the full support and compromise of the National Labor Ministry and with PAMI, which is the National Social Insurance which covers Health and Social Services, as well as Social Security of nearly 80% of the Argentinean elder's population.

- Since 2005 ILC-ARG and the Eckman Foundation provides free Medical and Social Assessment and advise elders and their families on Day Care, Home Care and Long Term Care.
- Since 2006, a well known Psycho geriatric team provides also three Out-Patient's Clinics to the aged population with psychological problems for a quite small fee donation.
- Since July 2007 started a new project: "Between Peers". Training on Human Rights and Empowerment, (40 elders), in partnership with INPEA-ARG and the INDES Foundation.

"HIGHLIGHTS 2007-2008"

- The National Ministry of Social Development, under Resolution 215/07, delegates on the National Direction of Elder's Policies the responsibility of taking over Policies of Prevention on discrimination and mistreatment towards the elderly population
- Launching of the National Prevention Program on Discrimination and Elder Abuse in collaboration with INPEA-ARG and ILC-ARG advise and support (2007)
- At present, ongoing National Survey on :
  - Elder Abuse by the National Direction of Elder's Policies, National Ministry of Social Development in collaboration with INPEA-ARG and ILC-ARG (In progress)
  - Elder's perception on discrimination and elder abuse (In progress)
  - Elder's perception on the social representation of old age (In progress)
- To sensitize on the rights of elders orientated to key actors of the community
- Development a didactic kit orientated to the educators, social communicators and health professionals linked and working with elders, identified as key-persons for the transformation and changing of negative images of aging and the elder population (In progress)

Section 2: Profile of Ageing in the Region

1. Brief Review of Aging Demographics

According to the 2001 Population's National Census, the Argentinean total population consists of 36,260,130 people, Population's density is about 13 inhabitants for km^2.

Main Facts:

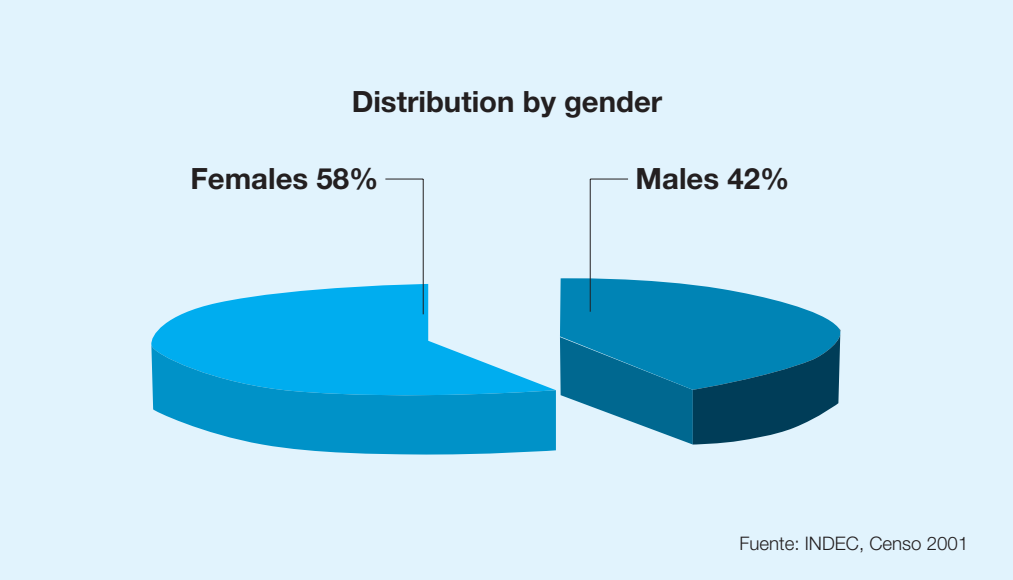
- Argentina is one of the most aged countries in Latin America.
- People 60 years old and older are nearly 5,000,000 millions inhabitants and represents 13.4% of the total population, with a female prevalence of 57.8% over 42.2% of males. This gap increases as they aged to a 70% of female population versus 29% of males at the age 85 and older.
- People aged 75 and older represent 30% of the elder population.
- People 60 years old and older represent 11.8% of the total rural population, and 13.6% of the total urban population with a higher of 63% living in Buenos Aires DC and 58% in the Buenos Aires Provincial Area.
- Life expectancy at birth was 67.3 years between 1970-1975, being 75.2 years in 2001.
- Taking gender into account life expectancy is 7.5 years longer for females than for males (M=71.56 y and F=79.06 y).

Demographic changes since 1975 are mainly due to:

- Lowering of the Fecundity rate such as 23.4 births/1000 (1975) to 19.7 births/1000, (2005).
- Lowering of the Mortality rate from 9 deaths per 1000 (1970-1975) to 7.9 per 1000 (2000-2005).
- This will continue to be so till about 2025 when will raise again due to an increase of the population ageing.
- It is expected that life expectancy at birth would be 84.5 years for females and 77 years for males by the year 2050.
- Elders 75 and older would also have increased from a 2.3 % (1975) to an 8.4% in 2050.

Elder Population in the Argentinean Republic

60 years and over: 4,871,957
Represents 13.4% of the total population



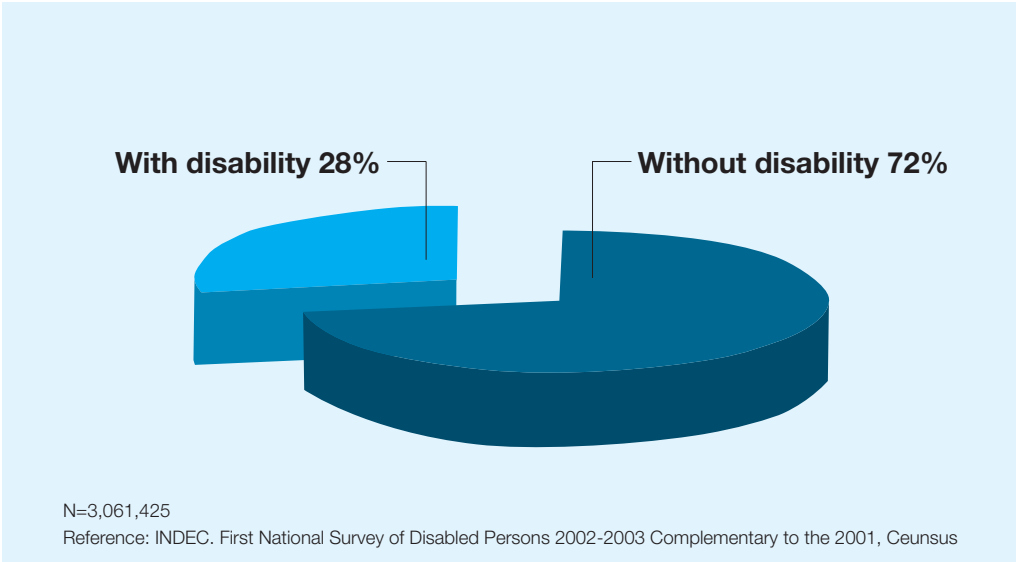
2. Summary of the Main Trends/Issues of Ageing in the Nation

A. Health/Medical Care

Argentina has a National Public Health system available to all people which every citizen has the right to access and use.
Other ways of Health care, including Social Services, are provided for trade workers within the formal market, and finally the Private Health Insurances.
77% of elders are under **PAMI**, the major entity of Health and Social Services for Retired people and other kind of Pensioners.
According to all Public Health Hospital discharges registered in 2000, the most common causes of the elder population's morbidity are: brain vascular diseases, hypertension, related liver's diseases, pneumonia and influenza, and injuries of the upper and lower limbs.
Primary case of deaths of 60 years old and over are cardiac failure with a rate of 480.7deaths per/100,000 inhabitants, followed by ACV and pneumonia with rates of 344 and 247 respectively. *(National Ministry of Health, Statistic and Information Department, 2000)*.

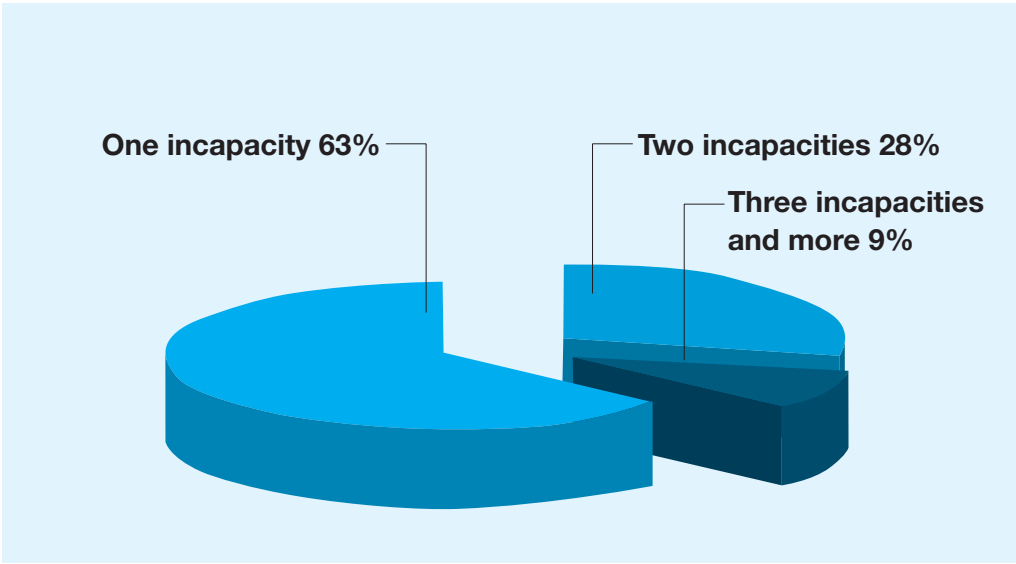
Regarding Incapacity rate it was found that 28.3% of people 65 years and over have some kind of incapacity and between 75 and over this increase to a 37.8%.

Argentinean Elder Population
65 years old with Disabilities
75 years and over Represents 37.8%.



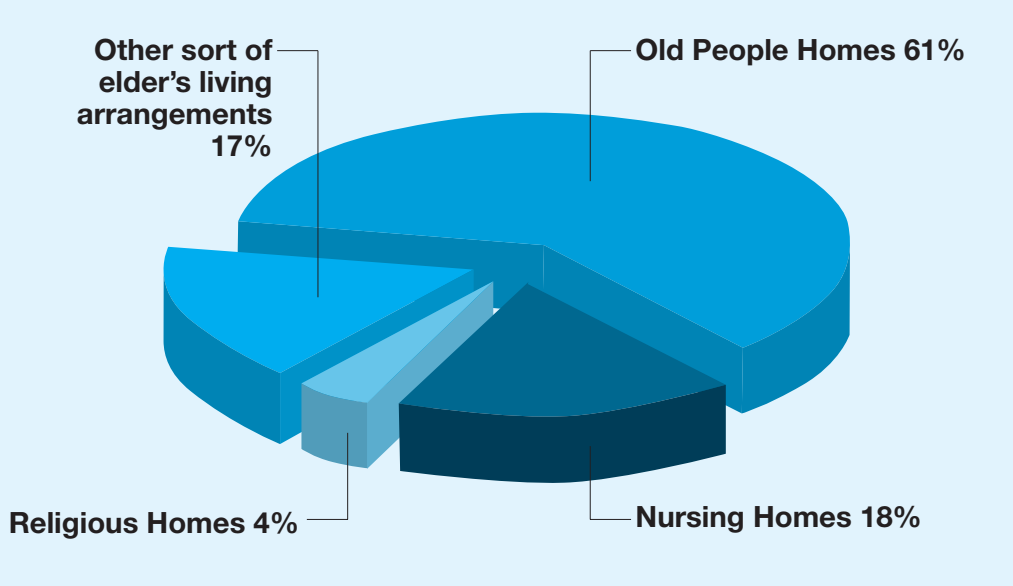
N=3,061,425
Reference: INDEC. First National Survey of Disabled Persons 2002-2003 Complementary to the 2001, Ceunsus

DISABLE ELDER POPULATION
First National Research on Elder's Incapacity (2002-2003)



Life expectancy without incapacity for sexagenarian's elders is different according to gender being 15.5 years for males and 17.2 years for females

B. Long-Term Care Insurance System
Only 2.3% of elders 60 and over live in Residential Care.



Most elders go on living at home, remaining fairly active and as part of their own communities. The percentage of homes run by elders has grown significantly:

1. 60 and over: 29%
2. 65 and over: 21%
3. 17.3% of elders, 60 and over are living on their own and 55% of the kinds of living arrangements (one person basis) are elders.

To "own a house" and have a better life were the main objectives and the "lei motive" of our immigrant's generation.

The deep socio-economical crisis of the last decade, mainly the 2001 crisis in Argentina has specially affected the middle-aged generation with marked unemployment, few chances of getting a new job and the "extreme situation" of loosing their homes.

Some have to leave and move with their own children to their parent's homes. Many occasions they took over their parents household management and *slowly but steadily* elders lost *"their place within their own territory"* and even sometimes, due to this new conflicted living arrangements, have to leave the premises in a pretty bad condition like going to live in a much smaller place, sharing with another relative or even getting admitted to a Old People Home.

This economical crisis has created ***"an unexpected and inadequate way of living within a***

family", which promoted conflict when facing the new intergenerational exchange. These forced living arrangements have generated also a reversal from the role that was historically and socially structured and programmed. (*Daichman L., 2002*)

C. Employment and Retirement

1. 73% of males, 65 and over and 60% of females, 60 and over have an official retirement pension.
2. Percentage of retired pensioners raises with age being more than 80% from 75 and over Mandatory.
3. Retirement age is 65 for males and 60 for females.
4. Since 2003, there has been significant changes regarding Elder's Social Security due to a new governmental Law Nº 13,478 by the Ministry of Social Development for a Benefit Pension to cover all elders 70 and over without any other economical resources; by June 2006 this benefit was covering 147,933 persons.
5. By the creation of "PROFE", a Federal Health Program from the Ministry of National Public Health, this same people have been granted all medical necessities at primary, second and third level of care.
6. There has been also a considerable increase of the amount of money regarding retirement pensions, mainly the lower ones, which were nearly unacceptable, and this new approach allowed diminishing approximately 50 % of poverty in Argentinean elders. *(SIEMPRO, 2005)*.
7. There have been some measures taken by the private sector to encourage workers to work longer by re-training programs or part-time positions and rather few by the public sector.
8. For those wanting and able to retire there are opportunities for meaningful volunteer activities and work.
9. Regarding employment 17% of the elder population, 60 and over are still working.
10. 52% of males (60-64) are still in the labor market and only 19% after 65. Only *21% of females* (60-64) are ***"officially"*** working and this falls abruptly to 6% after 65.
11. A significant **12% of elders (60 and over) are still working** and **don't perceive any kind of retirement pension.** *(INDEC-2001, Census).*

D. Status of Older Women

The Argentinean female generation which is elders now, had to go through a great amount of socio-cultural changes that implied modification of inherited principles and a generation which had not many chances to copy ***"significant models"***.

Due to the fact that most elder Argentineans ***"descended from the ships"***, a good number of that immigrant population had left their parents behind in the ***"old world"*** and only those, who succeed economically were able to bring their parents and other relatives much later, so many

of them lack a role model of ageing.

Demographic changes could also mean that ***"successful ageing will inevitably result in more people at risk..."***
Structural inequalities in both, the developed and developing countries that have resulted in low wages, high unemployment, poor health services, gender discrimination, and lack of educational opportunities have contributed to the vulnerability of older persons. For elders in the developing world, the risk of communicable diseases still exists and environmental hazards present yet another threat. At the same time they will be subject to the long-term, incurable and often disabling disease associated with old age in the developed countries. *(Daichman L., Wolf R. & Bennett G. 2002).*

Most elderly women are often in not very good health, disproportionably represented among the very old and quite vulnerable as they are particularly poor and more likely than men to be on their own.
They have more chances to have a poor education, nutritional status, and the labor market in earlier life have often left them with very few resources in their old age. *(Daichman L., 2004).*
Illness and a reduced quality of life as women age is *largely the result of* ***living conditions*** *and* ***gender discrimination*** *in earlier life, combined with* ***ageism*** *in later life.*
Being female and old is double jeopardy in many cultures and Argentina is not the exception...
Being female, old and poor is triple jeopardy. These discriminations are compounded when one is a member of an ethnic or racial minority group and alone.
Belonging to the rural areas, having a non-European racial background might also be cause of discrimination in Argentina.

E. Poverty and the Elderly

- 17.3% of the Argentinean older population is absolutely poor for insufficient earnings, meaning 910,540 people lives under "the known poverty line".
- 4.9% of elders are in a state of indigence and 11.8% of elders 60 years and over is considered POOR according to the unsatisfied basic necessities criteria.

Section 3: Current and Future Needs for Research/Training/Policy Change in the Region

Due to financial difficulties, which hadn't able to be solved yet, ILC-ARG is still finding rather hard getting sufficient funding to develop more projects for the near future.

It is still our hope to be able to start as soon as possible a:
Worldwide Research, (may be between at all ILC-Centers), on:

- Female Ageing, Poverty, Discrimination, Human Rights and Empowerment. We would like to know how people age in a large city like Buenos Aires, particular life styles and

socio economical differences.

- We also hope to do some research and be able to get more accurate data regarding "The real cost of Home Care versus Residential care" as well as *"The true Cost of Dependency"*.
- Try to encourage cooperation among the different specialized international agencies, Intergovernmental organizations, other NGO, Universities and Academia in order to approach the research in a coherent manner.

Other policies include:

"The Unspoken Right of Learning"

According to our national Constitution every person has the RIGHT TO EDUCATION

- To continue stimulating education of Argentinean Elders within our Universities special programs on related issues and other desirable options. (About 20% of elders are already in these programs, 2007)
- To alphabetize elders who never had the chance to really learn have to read and write properly, due to poverty, recent or past immigration) and/or complete primary and secondary school if they wish it to do so...
- To be able to continue with more and even better training of Primary Health Care Workers related to the population aging.
- To create new and validate already existing tests, to better evaluate the Health State of our growing LA population, and then monitor its changes.

The grey longevity revolution is a global event and a great achievement and the ILC Global Alliance must work together and learn from one another about how to best respond to these demographic changes and their impact throughout the world.

Act on an ongoing and coordinated basis at all levels by promoting strategic alliances between the State, Civil Society and Older Persons' organizations, and even engaging the private sector in the implementation of the strategy, while bearing in mind that the primary responsibility falls on National Governments. (*Report of the Regional Intergovernmental Conference on ageing: Towards a regional strategy for the implementation in Latin America and the Caribbean of the Madrid International Plan of Action on ageing, Chile, Nov, 2003*)

Section 4: Proposal of an Agenda to Help Resolve the Concerns Outlined in Section 3

It is hoped that we would come up in the near future with some more concrete action plans, suggest adequate and specific policies and work to ensure the budgetary support needed to implement the measures envisaged in policies and programmes for older persons, while never forgetting all Advocacy which could all of us as always undertake.

Jacques H. Schraven
President

- *Former president of Royal Shell Netherlands*
- *Former President of the Confederation of the Netherlands*

The Netherlands

Report from ILC-Centers

ILC-Netherlands

Section 1: Profile of ILC-Netherlands

• Contact Information:

International Longevity Center- Netherlands (ILC-NL)
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Tel: +31 30 - 2296 070
Fax: +31 30 - 2296 089
info@ilczorgvoorlater.nl
www.ilczorgvoorlater.nl

• President:

J.H. (Jacques) Schraven, former president of Royal Shell Netherlands and president of the Confederation of the Netherlands Industry and Employers (VNO-NCW) from 1999-2005.

• Mission Statement:

The Foundation ILC *Zorg voor later* is dedicated to interdisciplinary research and public debate and actions in the field of longevity and population ageing, aiming at influencing public opinion, decision-makers and politics. The Foundation supports organisations and individuals by providing up-to-date know-how and practical support

• Year Organized:

- 2006

• Major Affiliations:

Vereniging AEGON, Royal Holland Society of Science and Humanities, Jan Brouwer Fonds, Vereniging Het Zonnehuis, Deloitte en Touche, Portaal, OPG (Pharmaceuticals).

• Sources of Funding:

Core funding has been secured in 2007 for an office and a small staff (1.5 FTE) for three years by Vereniging AEGON and some other contributors. ILC Zorg voor Later is building up its portfolio of activities, financed through grants and donations by Deloitte and Touche, Zonnehuis Groep and other sponsors.

• Major Activities/Programs:

ILC Zorg voor Later is the co-organiser of the annual Jan Brouwer Conference on diverse aspects of population ageing. The next conference on Solidarity between the Generations will

take place in January 2009. Reports of these conferences with an English summary have been published. Public debate is organised through the website on 'Planning your future.' Based on a survey and expert meetings a study into the Productive Engagement of the next generation of third agers has been published in 2007 (titled 'Generatie op komst'). Expert meetings have been organised on issues such as creative solutions for long-term care and living arrangements. An expert meeting on 'Working longer — healthy for everybody' has been organised and its results have been discussed with associations of employers and employees. ILC-NL does not employ research staff, but commissions work out to researchers of universities or other scientific organisations. Presently a study on age barriers and age related opportunities in communication has been carried out for ILC Zorg voor Later by Communication Concert. ILC Zorg voor later is involved directly in a major (85 million Euros) Programme for the development of Geriatrics in The Netherlands and also in other programmes on IT and on Ambient Assisted Living.

Section 2: Profile of Ageing in the Region

1. Brief Review of Aging Demographics

According to the national agency for population and labour market statistics (CBS), the number of households in The Netherlands with an average of 2.2 persons will grow from 7.1 million in 2007 to 8.1 million in 2035. From then on the number of households will start to decline. The number of 65-year olds is expected to rise from 2.4 million (14 percent) to 4.3 million (25 percent) of the population in 2038. It will then equal 47 percent of the working population in The Netherlands. The CBS predicts a further growth of life expectancy for men from 77.6 years in 2006 to 81.5 years in 2050 and for women from 81.7 years to 84.2 years. However, these figures are debated since ILC board member professor dr Rudi Westendorp cited alarming reports indicating a decline of life expectancy from the age of 65 years onwards in The Netherlands and the US.

2. Summary of the Main Trends/Issues of Ageing in the Nation

A. Health/Medical Care

The Dutch health care sector is a 54 billion euros industry, providing jobs for 11 percent of the working poulation and still growing rapidly in terms of expenditure and employment. If the sector would continue to do so, expenditure would grow from nine to 14 percent of GDP, and according to some scenarios the sector would then employ 17 percent of the working population. That is why the whole system is under reconstruction. The government wants to build in incentives for cost awareness, efficiency and effectiveness. But growing staff-shortages due to the booming economy and population ageing are threatening the development of the sector, the level of services and the quality of long-term care. The fact that geriatrics is not fully integrated in healthcare is another challenge for the future.

As of January 2006, a new insurance system for curative healthcare came into force in The Netherlands, replacing the mixed system of public and private insurances. The new system is a private health insurance with public limiting conditions, operated by private health insurance companies. All residents of The Netherlands are by law obliged to take out health insurance. The insurers are obliged to accept every resident, enabled to do so by a (public) system of risk equalisation. People with low income who cannot pay the fixed premium can apply for a care allowance.

Chief aim is to make care more efficient and affordable in the long term and to offer more choice. Market parties have greater freedom to compete for the business of the insured. It is said that insurers will push for higher standards of their contracts with care providers in terms of quality and cost. The government remains responsible for the accessibility, affordability and quality. The insured pay a fixed nominal premium to the health insurer of on average 1,050 euros per year (2006) and an additional contribution of 6.5 % of their income (maximised on 2,000 euros per year) to a Health Care Insurance Fund. Employers are obliged to reimburse this contribution to their employees. (Self-employed persons and pensioners pay 4.4 percent). As from 1 January 2008, there is a compulsory excess of 150 euros a year, which will be collected by the health insurer. People with unavoidable long-term health expenses, for example due to chronic illness or disability, will be compensated financially.

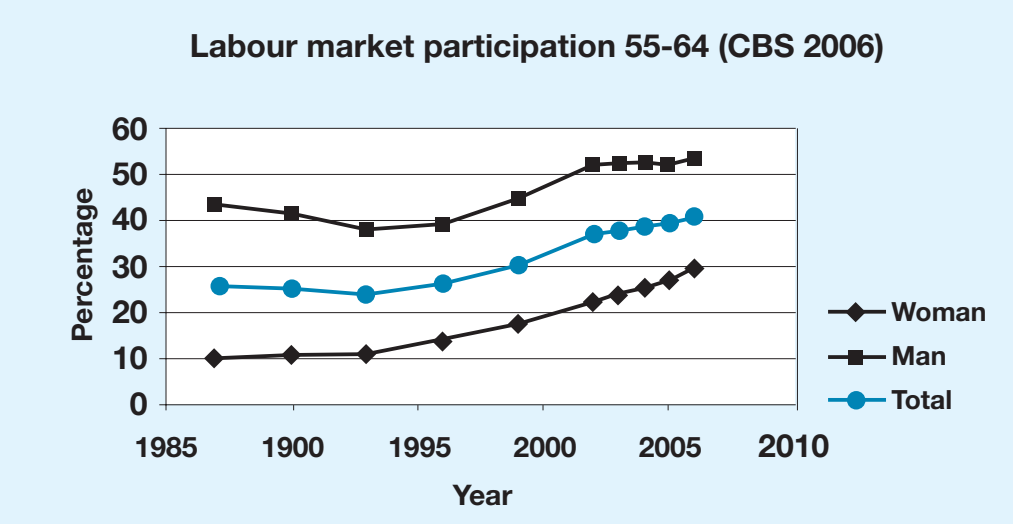
B. Long-Term Care Insurance System

Expenditure for long-term care was about 1.5 percent of GNP (465 billion euros) or 8 billion euros in 2007. Two third is spent in long-term institutional care; one-third in long-term home care. The overall policy is to take care of frail older people in their own home and environment as much as possible. The general financial system for long-term care is reconstructed in steps. The responsibility for part of the system is shifted to local communities who have to arrange technological, living and household provisions to support patients and informal carers. The government is compensating the communities for that task. A personal budget system was introduced some time ago and is growing in popularity. Important trends are reconstructing nursing homes with more privacy for residents (each resident has his own apartment), more fiscal and professional support for our 2.4 million informal carers, introduction of instruments for quality development, prevention and strengthening responsible citizenship. Furthermore, IT-solutions will be introduced for work performance, information and networking.

C. Employment, Retirement, and Pension/Economic Security

Employees in The Netherlands retire on average between 55 and 65 years of age. The median retirement age is now 61.5 years and slowly rising. Only 11 percent of the workers continue to work after the age 65, mostly in part-time jobs. The three-pillar pension system consists of a basic pension (for presently 2.6 million) citizens of 65 years and older, a company or industry pension and private savings. A single person receives 915 Euros net in basic pension, married

people receive 630 Euros net per month each. Seventy percent of the people entitled to a basic pension receive an occupational pension as well. Retirement income may amount to almost eighty percent of the last income just before retirement, for those with a lifetime career with one employer. Most final pay systems have been replaced by average pay systems. Fiscal support of early retirement has been abolished. Early retirement schemes were replaced by flexible retirement schemes in order to reduce the burden for younger working generations.



Employment agenda — Since the mid nineties the topic Employment and Retirement is rising on the social and economic agenda in The Netherlands. Labour market participation of older workers (55-64) has been extremely low since the seventies and eighties, in comparison with other European countries, Japan and the US. This was a result in the first place of the heavy use of preretirement schemes meant to solve youth unemployment problems. Secondly the equally heavy use of disability insurance schemes by the social partners contributed to reducing the numbers of older workers. Since the mid nineties, however, policies were redesigned to stimulate labour market participation of older workers, to reintegrate disabled workers and create more opportunities for women. In 2007, 43 percent of 55-64 year old was employed. There is a boundary line soon after sixty. The Netherlands are aiming to reach the Lisbon goal of 50 percent in 2010. A range of policies, measures and instruments have been developed in order to reconstruct the social system, so that retirement and social security systems encourage people to keep working up to the age of 65 years and beyond. Since 2001, several taskforces worked on the issue of the participation of older workers. One of these taskforces (Commissie Bakker) proposed in June 2008 to raise the official retirement age to 67 years in a rate of one month per year from 2014 onwards.

However, negative attitudes towards older workers are still deeply rooted in Dutch society. One

of these symptoms is that an unemployed person between 55 and 64 years has only 4 percent likelihood of finding a new job within one year. Other symptoms are a low job mobility and low participation in education and training. Since 2004 the Equal Treatment on grounds of Age at Work Act is forcing social partners to review industrial agreements and practices in such a way that barriers for older workers are taken away and social investments are concentrated no longer on leaving but on life long work ability, employability and mobility. Severe changes of the social system have forced Companies to fight absenteeism and disability of workers. Huge investments for reintegration programmes for chronically ill and disabled workers were successful, at least for the younger cohorts. The next step is concentrating on lifelong health by stimulating preventive instruments, attitudes and mechanisms. For that purpose the Finnish Work Ability Concept is being introduced in The Netherlands on a large scale. It includes a stronger role of occupational health services. Diversity management is another item on the industrial agenda.

D. Status of Older Women

The Netherlands come from a very traditional society were the roles and tasks of men and women were strictly divided. The graphic shows labour market participation of older men and women. The rise in older women's participation is mainly due to long-term effects of women entering the labour market since the sixties and gradually working more hours per week. This reflects women's emancipation and EU directives on equal treatment in that period. Women are now strongly represented in health care, welfare work and the educational sector. But we have a long way to go with respect to combined effects of age and gender. Older jobless women's chance to find a new job is practically zero. Older women are not equally represented in many areas of societal and political life, in leading managerial positions and in the way society is reflected in the media. The picture is different in informal care and voluntary work.

E. Voluntary Sector

Shortages of labour will put pressure on the voluntary sector and the informal care sector, where The Netherlands have a strong record with 4 million active volunteers and 2.4 million informal carers who care at least 3 hours per week or longer than 3 months per year. There are numerous possibilities here to tap into the potential of baby boomers' talents. ILC is preparing the dialogue between the voluntary sector and social partners, in order to identify barriers and introduce incentives for older unemployed people to become active in voluntary work and be trained for new tasks and new networks. Giving workers the possibility to switch from paid to unpaid work and vice versa and using part time retirement schemes could give older people a more meaningful, purposeful and healthier live, while tackling serious problems of society. ILC tries to stimulate the development of social applications of IT, first in the area of informal and formal health care.

Section 3: Current and Future Needs for Research/Training/Policy Change in the Region

In the framework of a training program on health literacy for all ages we should include strong incentives for long-term support of a healthier lifestyle and prevention of (age-related) health problems. Here public health services and occupational health services must together engage in policy development;

- Industrial agreements should reflect equal opportunities, diversity and proactive strategies aiming at life long workability, employability and mobility.
- Third agers have an important role to play in planning the future of a personal and public care environment that offers choice, quality and opportunities to engage in productive engagement and dignified ageing.
- The Netherlands need fast development and integration of geriatric care in the health care system. Focussed additional education and training of a leading edge of talented young doctors could raise the profile of geriatric care.
- We need susceptible attitudes and policies that allow identification and adaptation of validated social and health innovations from abroad (for instance the Finnish Work Ability Concept).
- We need companies and trade unions to adapt new roles, and corporate social agendas should reflect the silver potential for sustainable social, economic and ecological systems.
- This would also mean flexible arrangements for productive engagement and free mobility of older persons in and between paid work, voluntary work and informal care.
- Research is important into IT support and fast development of social IT applications for intergenerational community and participation development in an ageing society.

Section 4: Proposal of an Agenda to Help Resolve the Concerns Outlined in Section 3

ILC Netherlands proposes to transform chapter 3 into an agenda aiming at fast and large scale implementation of know-how, innovations and best practices, involving national, regional and local governments, social partners and social organisations. Strategy development and communication, aimed at influencing decision-making, should put to use the energy and knowledge of third agers and build on their responsibility for a sustainable future for all ages.

Israel

Sara Carmel, M.P.H., Ph.D.
President and CEO

- *Professor of medical sociology and gerontology at Ben-Gurion University of the Negev in Israel*
- *President of the Israel Gerontological Society*
- *Chairperson of the Fund for Research in Aging, Ministry for Senior Affairs*

Report from ILC-Centers

ILC-Israel

Section 1: Profile of ILC-Israel

• Contact Information:

International Longevity Center-Israel (ILC-Israel)
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• President:

Sara Carmel, MPH, Ph.D. is a professor of medical sociology and gerontology at Ben-Gurion University of the Negev in Israel, the president of the Israel Gerontological Society, the president of ILC-Israel, and Chairperson of the Fund for Research in Aging, Ministry for Senior Affairs. She is the author of more than a hundred fifty scientific publications including edited books, and has served on national and international committees for academic and policy affairs. Prof. Carmel established and directed the first MA programs in Sociology of Health and in Gerontology in Israel, and the Israel National Fund for Research in Aging at the Ministry of Senior Affairs. Her recent research focuses on effects of immigration, gender and ethnic origin on elderly persons' will to live, health, survival and well-being; end-of-life care related preferences and practices of patients and medical personnel; doctor-patient relationship and communication; and evaluation of health and welfare services.

• Mission Statement:

- Enhance multidisciplinary and interdisciplinary research in aging
- Promote knowledge about and awareness of the issue of aging in the region and throughout the nation
- Initiate and support interventions directed to improving treatment and services for the aged
- Contribute to the development of the future leadership in gerontology and geriatrics
- Influence policymakers and key persons in the services to improve current services and develop new ones

• Year Organized:

- 2007

• Major Affiliations:

- The Center for Multidisciplinary Research in Aging, Ben-Gurion University of the Negev, Beer-Sheva
- Maccabi Healthcare Services
- The Association for the Planning and Development of Services for the Aged in Israel (ESHEL)
- The Center for Research on Aging at the Myers- JDC-Brookdale Institute in Jerusalem
- Dept. of Nursing, Steyer School of Health Professions at Tel Aviv University
- The Herczeg Institute on Aging, Tel Aviv University
- Israel Gerontological Society
- The Israel Geriatrics Association
- The Center for Research and Study of Aging and the Department of Gerontology, Haifa University
- Yad Sarah
- Israel Ministry for Senior Affairs

• Sources of Funding:

So far funding is from the member organizations. We are seeking outside funding for the future.

• Major Activities/Programs:

Our major activity for this first year is the establishment of the organization and creating a framework for operations, i.e. writing the by-laws, establishing a web site, organizational meetings, seeking funding, defining topics for future working papers on aging in Israel.

Section 2: Profile of Ageing in the Region

1. Brief Review of Aging Demographics

In 2006, 9.9% of the Israeli population was age 65 and older, and 2.6% were age 80 and older. Of those 65 and older, 42.8% were male and 57.2% were female. In the Jewish population, 11.5% of the total were 65 and older, whereas in the Israeli Arab population 3.2% were 65 and older. Israel is a country of immigrants, so that in the aged population, 90% are Jews, and within the Jewish population, 85.9% are immigrants to Israel. Thirty six percent of the aged population are Holocaust survivors.

Israel differs from other developed countries in the pace of the demographic changes. In 1948 at the establishment of the State of Israel, the elderly population accounted for 4% of its total population. In three decades this percent more than doubled.

Life expectancy in Israel is relatively high — 82.2 for women and 78.5 for men. 94 percent of the elderly live in urban settlements.

2. Summary of the Main Trends/Issues of Ageing in the Nation

A. Health/Medical Care

Since 1995, universal health care coverage and a defined set of basic services are mandated under the National Health Insurance Law (NHCL) for all Israeli citizens through four Sick Funds (similar to the HMO's in the USA). The National Health Insurance Law does not fully address health care needs and needs arising from the disability of elderly persons. For example, dental services are expensive and are not covered by this law. People unable to pay for dental care and assistive devises have to turn for support to the local social security authorities. Also hospice care is scarce and not provided to all of those who need it.

Health and well-being: In 2005, 37% of the elders self-rated their health as very good or good (44% of the men and 33% of the women), in comparison to 77% of persons aged 20 and over.

B. Long-Term Care Insurance System

In 1988, the Community Long-Term Care Insurance Law (CLTCI) was implemented. Services included under the law are a defined list of community services including: personal care, housekeeping, emergency alarm systems in the home, etc. In 2006, 14.9% of the aged population were entitled to benefit under the CLTCI. In addition, community services in most municipalities provide assistance to older people including: nurse's aides, Meals-on-Wheels, volunteers' assistance, social clubs for healthy persons and day care centers for handicapped. In some municipalities programs of supportive communities have been implemented.

Institutionalization of the aged is considered a last resort when community services no longer suffice. Older persons who are incapacitated become eligible for institutionalized long-term care when their social or medical conditions no longer permit them to remain in the community. Institutionalized long-term care is available through both nonprofit and for-profit organizations. A wide range of institutions for elders exists including sheltered housing, nursing homes, and geriatric hospitals. Institutionalized long-term care is covered by the NHCL only in severe illness conditions, otherwise, it is paid for by the Ministry of Health and/or family, contingent on the patient's and his/her children's income.

Long-term care is one of the major unresolved problems in Israel, due to the existing multiplicity of public and private services, which overlap in terms of responsibility, ownership, provision of different kinds of services, entitlement criteria, and financing. This situation creates duplications and fragmentation in continuity of care, which are inefficient and confusing to the disabled persons, their families, and their formal caregivers. This constellation of services also reduces accessibility.

C. Pension/Economic Security (Social Security System)

All elderly citizens (men aged 70+ and women 65+, and according to income test, men aged 65+ and women 60+) are eligible for a basic pension benefit from Israel's National Insurance

System, even if they did not work previously. Elders who live solely on this minimal pension (about $460 a month) are eligible for supplementary financial support from the government — up to 13% of the average national income for a single person and 17% for a couple. Some Holocaust survivors are eligible for economic assistance from the Treasury. In addition, social services are provided according to need by the Ministry of Welfare and by local municipalities. Under the Elderly Citizens' Act (enacted in 1989) elders are eligible for financial benefits such as discounts on local taxes, tickets for cultural events and public transportation.

In general, elderly Israelis, especially elderly new immigrants, are a relatively poor population group. However, the percent of elders receiving supplementary financial support has decreased over the years (from 27% in 1990 to 18% in 2006). Significant differences in socioeconomic status exist within the aged population. For example, in 2006, 52% of elderly men received pensions from their workplaces on a regular basis, as compared to only 28% of elderly women. The current laws help reduce poverty among old persons. However, under the prevailing cost of living in Israel, old persons with such income levels still have difficulties in meeting their basic needs.

D. Employment and Retirement

In 2003 the official retirement age in the civilian sector was changed from 60 for women and 65 for men to 67 for both genders. This change has not yet affected the percent of working persons in the aged population. In 2006, only 10% of elders aged 65+ worked for pay — 17% of the men and 5% of the women. Twelve percent of the elders were volunteering on a regular basis.

E. Status of Older Women

In 2006, women comprised 57.2% of Israel's population aged 65 and older. The percentage was lower among Arabs (54%), and higher among the new immigrants from the former Soviet Union republics (62%). Women live longer than men, at the age of 65, women have on average another 20.1 years to live, while men only 17.9 years. In comparison to men, old women are disadvantaged in almost all indicators of well-being (objective and subjective) including education, income, health status, feelings of loneliness, satisfaction with life and self-esteem.

F. Family Caregivers

Families have to take care of their parents by law, including all kinds of support. If institutionalization is needed, according to the current law, children have to participate in the financial support according to their income. Neglect is considered abuse and prohibited by law. The Sick Leave Act of 1993 protects family caregivers at their workplace by ensuring full dismissal compensation in case of resignation due to parental illness and a paid absence leave up to six days per year.

G. Major issues unique to the nation:
The major issue unique to Israel is the question of security and the constant threat of war and terrorist activity from the neighboring countries. Since a significant part of the national budget is devoted to security and the military, fewer resources are available for social issues, among which the services for the elderly are often the first to be cut.

Section 3: Current and Future Needs for Research/Training/Policy Change in the Region

Research: Several institutions in Israel carry out research in gerontology. In addition to the JDC-Brookdale Institute of Gerontology and Human Development, which is a national center for applied research on aging, health policy and social welfare, all the major universities have research centers for aging and gerontology:

- The Belle and Irving Meller Center for the Biology of Aging at the Weitzman Institute of Science. The Center is dedicated to investigation in the biology of aging.
- The Herczeg Institute on Aging at Tel Aviv University. The Institute fosters interdisciplinary research projects and exchanges of views concerning universal and local issues in gerontology and lifespan processes at large.
- The Center for Multidisciplinary Research in Aging (CMRA) at Ben-Gurion University of the Negev. The creation of CMRA has facilitated the advancement of multi and interdisciplinary research projects on the local and national levels.
- The Center for Research and the Study of Aging at Haifa University conducts research, formulates and promotes social policy, and develops educational resources in the field of aging.
- In 2007, the government Ministry for Senior Affairs established a fund for encouraging research in aging, chaired by Prof. Carmel. In 2008, the first grant money was awarded to researchers in the field.

Considering the expected changes in the population of elderly persons, including their increased numbers especially in the older ages, the prevalent diseases and functional limitations in these ages, and the increasing needs for formal and informal caregivers, research has to be promoted in all areas of aging. Areas of focus include: economics, finance and pension policies; clinical and rehabilitative aspects; evaluation of needs of various social groups, in terms of ethnic and cultural origin, type of settlement, and religion; formal and informal caregiving needs and solutions; evaluation of old and new models of policies and services (medical and social) including their availability, effectiveness and accessibility for various social groups.

Manpower: Currently, neither geriatrics departments nor geriatric hospitals are authorized without certified geriatricians. All four medical Schools have included mandatory courses in

geriatrics. However, not all of them include training in acute geriatrics, long-term care, rehabilitation, and community services. A program for the specialty of Geriatrics in medicine has been developed for specialists in family medicine and internal medicine. Courses in Geriatrics have also been introduced to nursing and social work schools. In 1999, the first two MA programs in Gerontology were opened at the Ben-Gurion (Beer-Sheva) and Haifa universities. Since then, the number of certified gerontologists is steadily growing. In addition, formal and informal courses for nurse's aides, directors of nursing homes, day care center personnel, and volunteers exist all over the country. These courses are sponsored either by Eshel, the Minister of Labor and Welfare, or the National Insurance Institute. Although it is not mandatory, most of the qualified nurses and social workers do complete formal courses in geriatrics and gerontology. Despite all these efforts, a severe shortage in geriatricians and geriatric nursing staff is expected in the near future.

Section 4: Proposal of an Agenda to Help Resolve the Concerns Outlined in Section 3

Developing knowledge about aging, implementing it in policies, education and services should become important objectives of Israeli society considering the demographic trends. Currently, Israeli society is slow in adapting and implementing effectively and efficiently the accumulated and updated knowledge in any of these fields.

Education and caregiving: Significant efforts have to be invested in order to persuade young persons to study geriatrics and gerontology and work in this field. In addition, geriatrics/gerontology have to become part of mandatory learning and training for physicians specializing in family and internal medicine, nurses, social workers and other members of teams providing care to old persons, whether in medical clinics or other services and institutions. Palliative care has to be added to curricula of medical, nursing and social work schools.
Certified learning and training in geriatrics should be a prerequisite for formal caregivers (professionals and nonprofessionals) according to their specific roles. Courses and supportive programs should be developed for family caregivers.
Services: In recent years the sick funds have become aware of the special needs of the growing numbers of old patients. Some of them started to develop community geriatric services. For example, geriatric centers were established for conducting comprehensive diagnoses and providing consultation. Special clinics for cognitive diseases have been founded as well for the same purposes. Hospice services provided in institutions or at home are currently limited. These initiatives have to be further developed and expanded.

Human rights: More efforts have to be invested in reinforcing the aged population by increasing elderly persons' awareness to their rights and practical ways to become actively involved in reclaiming their rights in case of need, whether in the medical system, or in other national, public or private services, including using available legal planning tools.

Policies and laws: In order to address unmet current needs, such as the provision of long-term care and continuum of care, a numbers of amendments have to be made to the current laws:

- Adding long-term care to the basket of services under the NHCL will significantly reduce the fragmentation in care and the multiplicity of organizations involved in providing it, and become an incentive for the Sick Funds to increase prevention and health promotion programs.
- Increasing the weekly hours of home care under the CLTCI law will enable more people with disabilities to age in place.
- Adding to the current law a reference to abuse in institutional contexts and financial abuse, will cover all possible ways of abuse or neglect by action or omission.
- Although the official retirement age in the civilian sector was recently prolonged to 67 years for both genders, this has to be totally canceled, allowing old persons to work as long as they can and wish. Further reforms in the pension system have to be introduced in order to reduce dependence of the aged population on the national resources.

Changes in these domains will ensure access to comprehensive, continuous, and efficient care to all, providing more efficient protection for elderly persons, enhanced active involvement of elderly persons in claiming their rights and improved quality of life for senior citizens in Israel.

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