Overall Summary

The 12th ASEAN and Japan High Level Officials Meeting on Caring Societies under the theme of "Resilient Communities for Active Aging" was held from 21 to 23 October 2014, in Tokyo, Japan, hosted by the Ministry of Health, Labour and Welfare, the Government of Japan (MHLW).

With the aim of enhancing close collaboration between ASEAN countries and Japan in the health and social welfare fields, participants shared views and had a valuable exchange of ideas, experiences, lessons learnt and good practices, especially related to the need to build communities that support Active Aging, defined as the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age.

The proceedings and outcomes of this meeting are shown in the ANNEX as agreements and recommendations.

Day 1: Tuesday, 21 October 2014

Opening Ceremony

The meeting began with an opening address by Mss. Atsuko Muraki, Vice-Minister of Ministry of Health, Labour and Welfare. She thanked all of the delegates for joining the meeting from so far away. In previous meetings, they moved forward with all participants for the purpose of sharing knowledge, thinking together, learning from good practices, and strengthening cooperative relations between Japan and ASEAN, about common challenges related to health, social welfare, labor, and human resources.

The growing aging population was a common issue not only to ASEAN and Japan, but around the world. In order to achieve Active Aging and improve quality of life for the elderly, it was crucial to encourage seniors to participate socially, including in work, and provide social security. Making those efforts sustainable was another challenge. Their main challenges were forming communities that facilitate interaction for the elderly, and how to financially support them. Japan had a long history of maintaining friendships with ASEAN, South Korea, and China, and Ms. Muraki noted they worked together to build relationships in a variety of fields. It was her hope that they continued that path together for a better future. She believed the meeting would provide valuable opportunities for all to deepen discussion and develop friendships.

The meeting resumed with an explanation of the purpose of the event by Dr. Eiji Hinoshita, Director, Office of International Cooperation, MHLW, with the session 'The Current Status and Issues Surrounding "Active Aging" in the ASEAN+3 Countries.' First he displayed a comparison of aging-related indicators of the countries. Japan had the most advanced aged population in the world; but the situation was

not limited to just Japan, and would spread to the other ASEAN+3 countries. For most of the countries, in just about 20 years on average they would face the same situation. Next, he elaborated on recent cooperation on Active Aging with ASEAN countries, carried out by both Japan and ASEAN.

He brought the focus to last year's meeting, the 11th ASEAN-Japan High Level Officials Meeting on Caring Societies, whose theme was "Active Aging." Major recommendations from the meeting included policy-recommendations for long-term care and health care and human resources for the elderly, ensuring proper services, and more. He also elaborated on the ASEAN-Japan Active Aging Regional Conference, held in Jakarta in June. Major recommendations there included building a sustainable cooperative network among ASEAN countries and Japan to develop periodical regional conference to utilize best practices, incorporation of the needs of the elderly in to healthcare and welfare policy recommendations. Further steps for promoting Active Aging included exploring the establishment of regional cooperation networks among ASEAN and Japan on those issues, and to continue the regional conference as a platform for realizing the aforementioned network. He reminded the delegates that the 2nd ASEAN-Japan Regional Conference on Active Aging was to be held next February to March.

Dr. Hinoshita next showed more statistics showing the drastic effects on social security and more due to aging populations, along with milestones along the way. Total expenditure of long-term care insurance was increasing yearly. He also introduced the concept of the integrated community care system, consisting of five elements (housing, medical care, long-term care, prevention, and life support services), with housing and life support expressed as a 'flowerpot and soil' with the others expressed as the 'plants' that grow from that soil.

Discussion points included health care and healthy lifestyle for the elderly by utilizing potential of communities; long-term care for the elderly and human resource development; age-friendly cities and communities; social participation and contribution for the elderly; and future cooperation with ASEAN countries to facilitate these.

Panel Discussion 1: "Health Care and Healthy Life Style for the Elderly by Utilizing the Potential of Communities"

The session facilitator was Mr. Shintaro Nakamura, Senior Adviser on Social Security, JICA. First up was a presentation from Dr. Takao Suzuki, Director of the Research Institute National Center for Geriatrics and Gerontology. He first showed what would happen in a super-aged society in Japan. There will be a rapid increase in the number and proportion of elderly age 65 and over; a rapid increase in elderly needing care; rapid increases in elderly afflicted with dementia; a rapid increase in the number of deaths in a year; and a rapid increase of single and married couple households with members over age 65.

Generally speaking, the young-old elderly whose age 65-74 in Japan are very healthy, with good social ties and networks, who hoped to work as long as they could. The new generation of young-old is capable of actively contributing to society. However, the old-old, those 75 and over, suffering from geriatric syndrome, need long-term care services, they are frail and suffer sarcopenia, and have dementia. Dr. Suzuki listed common symptoms of geriatric syndrome. He elaborated on the long-term care insurance system, which began in April 2000, and was reformed six years later to focus on preventive care. The main backbone of the reform was the Community Comprehensive Support Center, which was supposed to be a headquarter to prevent geriatric syndrome with the aim of securing independence and autonomy for the elderly and also to be proactive a good care management.

Next, Dr. Suzuki focused on RCT for preventing dementia in the elderly with MCI in the community. The prevalence of dementia in Japan increased exponentially with age, especially from age 75 and older. He elaborated on practices to screen for dementia in Japan, which included cognitive assessments, neuroimaging, and intervention.

Dr. Suzuki showed some examples of cognitive function tests, and described the multicomponent exercises ("cogni-cise") program for MCI, to stimulate the brain. Results showed that exercise improved cognitive function as compared to a control group; a small benefit, but a benefit nonetheless. With that, he concluded his presentation.

Next was a presentation from Lao PDR, by Dr. Nikone Vongsavath, Deuputy Director General of National Health Insurance Bureau. First he gave general demographics on the country, including life expectancy at birth (65), and age and sex distributions. Those over age 65 were just 4% of the population. Next he describe their health facilities, consisting of a central level with 5 central hospitals and 3 specific curative centers; the provincial level with 4 regional hospitals and 12 provincial hospitals; the district level with 131 district hospitals and 892 health centers, and the village level with 5561 village drug kits and 1,133 private clinics. Health insurance was divided into four administrators: SASS, SSO, CBHI, (Community Basic Health Insurance, which aimed to cover 65% of population but only covered 2.5%) and HEF. However, only 0.87% of the elderly were ensured. He described the Prime Minister's Decree No 153/GM from July 2001, which established a National Committee for Aging.

Accessibility for health care for the elderly was complicated. For instance, there was no aging home care; all elderly lived with their family; and more. Current and future plans to combat the problems included merging the insurance systems to work for universal health coverage. With that he concluded his presentation.

Next to present was Prof. Ko Ko from Myanmar. Traditionally they followed the extended family, wherein they valued and respected the elderly, with the common traditional practice of looking after the elderly. He also gave current statistics on the country. There was estimated to be 5.23 million elderly over age 60 in Myanmar. 30% were being

looked after by family; thus they had to look after the vulnerable 70%. He listed current programs for the older people, which included the ROK-ASEAN Home Care Program. They worked with many partner organizations, as the government could not cover all the initiatives on their own. They also had numerous health care programs for the elderly on the district/township level, like physical exercise and counseling programs. He also elaborated on rural health centers, which served the elderly in remote areas every Wednesday, providing education and counseling. Myanmar also had 71 homes for the aged, covering 2,300 elderly, which was supported by the Department of Social Welfare. He also described the Rural Development on Aging initiatives, which focused on reducing economic vulnerability.

There were many challenges. A national elderly health care program was not implemented yet, there was low awareness on active and healthy aging concepts, they needed to strengthen geriatric care, the amount of home for the aged needed to be extended; and so on. Future plans included forming the National Committee for Older People, raising awareness on caring for older people, to implement programs in line with the National Plan of Action for Older People, establishing a trust fund, organizing community-based care. To conclude, Myanmar was having the Ministry of Health with other ministries and partner organizations to focus on the Active Aging concept, aiming to work with the rest of the world to approach those issues.

Next was a presentation from Ms. Minh Thanh Tran from Vietnam. Current challenges were that it was one of the countries in the world with a quickly rising elderly population, poised to be within the top ten in the world. That would take a mere 17 to 20 years. The rapid growth was displayed clearly in demographics from 1979 to 2008, with nearly a 200% increase in those 80 years and over in thirty years. Although their life expectancy was high, there was also a huge prevalence of disease, with many elderly dealing with a double burden of diseases. Over ¼ had difficulty in daily life and required support, and nearly 70% were weak in health. Unless they moved on to good practices, the situation would not improve. Those practices included propagation and dissemination of knowledge about physical training, health promotion and disease prevention; guiding elderly in prevention skills,

self-healing and wellness; organizing physicals to document health monitoring for the elderly, encouraging physician network organizations and family health care services to care for the elderly at home; periodic health exams at least once a year, examinations for the elderly at medical clinics in communes; and rehabilitation of community-based for the elderly with disabilities to prevent sequelae and to help them recover from injuries or accidents.

Future vision included developing a partnership between private, public and community care providers to promote synergy, mutual support and learning; adopt and adapt successful innovation and programs to promote active inclusion of families and communities; improving the capacity of both public and private health care systems; strengthening treatments for elderly outpatients, training and capacity building for doctors; nurses specializing in geriatrics; and more. Vietnam improved legal frameworks to work on these, improving labor laws as a first step. The Ministry of Health, charged with providing health care to the public, gave the Circular No. 35 to encourage community care and health care. Other initiatives were focused on promoting self-care.

For the elderly, they need extensive support in terms of outpatient care, nursing home care, and many more; but Vietnam had very limited resources to tackle the problem, and found it difficult to expand public services while still making them affordable and available. With that Ms. Tran concluded her presentation.

Going on to panel discussion, Mr. Nakamura first asked what kind of human resources or mechanisms in communities could potentially contribute to healthy lifestyles for the elderly; and how to keep up the motivation of the key players for maintaining these initiatives; and how to make them cost-effective? Prof. Ko Ko said that it was very difficult, stating that they were doing lots of things for advisory. Due to poor nutrition, they had to do a lot of reeducation and providing food; and sustainability was difficult as well. They relied on a lot of local support. In Laos, it was a similar situation, and they struggled with funding issues, and struggled with developing health care for the elderly in such a short timeframe. Sustainability initiatives were focused on a local level, enlisting rural farmers to help provide food. Ms. Tran from Vietnam added that her country had developed particular legislature to tackle the issue, as well as facilitating local care initiatives. As it was an issue that crossed many industries, not simply health, they worked together on many initiatives; such as infrastructure guaranteeing buildings

as equipped to be elderly-friendly. For sustainability, they worked with other organizations to gain financial and technical support and infrastructure for the services they provided to the elderly, hoping to use those as a foundation to establish sustainable initiatives.

Dr. Suzuki commented that one important factor for developing activities for the elderly was continuous education. For example in Japan, they needed lots of volunteers to work on this, which they mostly took from the young-old people, as well as simply educating people about themselves and the tolls that things like dementia can take on them. He also commented that they might need different initiatives for women and men.

A delegate from Malaysia asked Dr. Suzuki how to ensure that the health sector and community participation is fully utilized; and for Lao, asked if universal coverage would cover the elderly and how; and for Vietnam, she asked about their yearly health exam for the elderly, asking how many elderly were covered by that exam and how feasible it was to get everyone on board. Dr. Suzuki replied that ideally, in Japan, they were moving towards community-integrated systems where all sectors were included in health promotion. Every sector had to be involved in order to make such a comprehensive, integrated community. Many municipalities were involved, but business was behind. One of their targets in Japan was to get the business sector more heavily involved in integrated care.

Dr. Nikone replied that they had a plan in place, focused on gathering funding to support their goal through implementing a social security law. The government had established a special bureau to develop a master plan for the issue, using revenue from sources like tobacco to fund things at first. They hoped to have at 60% of the population covered by 2025. Another delegate from Vietnam replied that about 90% were in urban areas, and could easily go; but 10% in rural areas could not attend. There, rural doctors traveled to care for them and carry out the exams.

A comment from Thailand came about universal health coverage, and that they had to consider a full package of benefits, thinking that it also had to serve a benefit for caregivers, not just for recipients. They could not say that they covered long-term care totally due to the exorbitant cost, however. A final comment came from the Philippines, asking Dr. Suzuki about further information on pneumonia and mental deterioration. Dr. Suzuki noted that pneumonia was not from viral infections; mostly it came from

mis-swallowing. One way to prevent that was simply building muscle around the mouth and neck. Dentists were very eager to advise elderly about muscle exercises in that area. Mr. Nakamura brought the session to a close, summarizing the key issues they discussed during the morning.

Panel Discussion 2: "Long-Term Care Service for Elderly and Human Resource Development"

Mr. Reisuke Iwana of MURC facilitated the first afternoon session, "Long-Term Care Service for Elderly and Human Resource Development." He elaborated on Japan's social insurance model established in 2000, where those 40 years old and over pay contributions monthly to long-term care insurance. He described the facilities available, Tokuyo, Roken, and Ryoyo. In 2000, home visit services had more than doubled, as well as day care services; indicating it was easier to enter the market for service providers. LTC service providers in Japan by corporate type were largely local public entities (governments, etc.) made up barely less than 5%, and the majority was carried out by the private sector. He explained the financing system for LTC insurance: 50% of revenue comes from contributions, while the remaining half comes from taxation. Mr. Iwana showed a graph clearly elucidating the system. Public provider/public financed services tended to be minimum services, while private financed/private providers were typically for higher income groups. Japan, with public financing/private provider systems, had to figure out how to provide good, accountable service.

Private initiatives have a negative legacy, including control over the private sector by government, relatively loose regulation for entering the insurance market for the sake of rapid increase of service providers at an earlier stage of LTCI, which resulted in de-integration and fragmentation of providers. Due to loose regulation, private companies have tended to join the day service market or housekeeping services—those with low barriers to entry.

However, Japan faces the big problem of increasing elderly and decreasing labor force. Community-based Integrated Care systems are essential, but due to market fragmentation this will be difficult to integrate services. That was a key issue to overcome. For the future, they hope to have 'normative integration', while integrating services on the community level.

Next, Mr. Haruhiro Jono, Deputy Director, Employment Policy Division, Employment Security Bureau, MHLW, described the problem they were facing for long-term services and difficulty in retaining care worker staff. He introduced two measures from the Ministry of Health, Labour and Welfare to limit the high turnover rate.

First, he elaborated on the demographics of new employment and turnover of visiting care staff and long-term care staff. Most people leave the job after three years, it turned out. He explained two ongoing measures to address this: the consultation support program for improvement of employment management, administered by Care Work Foundation. The other was the Working Conditions Improvement Subsidies for Small to Medium Size Businesses. That provided financial assistance for evaluation and treatment systems, training systems, or health promotion systems. For long-term care-related businesses, financial assistance was provided for evaluation and treatment systems, training systems, health promotion systems, or long-term care equipment.

Next they moved on to Dr. Supakit Sirilak from Thailand, presenting on Thailand's experience in the matter. He gave quick demographics on Thailand first before going into detail. Thailand was facing a population 'tsunami', where the bulk of the population would become 30% of the country in 2040. They also faced along with that the challenge of an aged society and long-term care. Policy on long-term care in Thailand was still not solid, with universal coverage in Thailand being solely funded by general tax, which elicited future

concerns about funding. For care workers, they had unclear roles and no standard training; there was a shortage of HRH for care, and the movement of technical specialists in ASEAN was still limited under MRA. They had to consider the level of care, not simply providing it.

Thailand spent many years learning from the CTOP, Project of Community Based Integrated Health Care and Social Welfare Services Model for Thai Older Persons; and from the LTOP, Project of Long-Term Care Service Development. He elaborated on the Lumsonthi Model, based on the rural district located 120km from central province. There a district hospital coordinated with local administration, and had an established care team of family members, semi-volunteers, HC staff, hospital staff, and more. Local administration funded salaries, and underwent an extensive amount of training. For the future, they hoped to base a care system on local initiatives, starting from the family, to the community LTC team, and beyond. Ways forward included encouraging local governments to establish local mechanisms, and for the Ministries to set standards for social and medical care, curriculum, education and training, and a regulatory system for both public and private practice; to establish a sustainable source of funding, and to strengthen the primary care system.

Next to present was Ms. Fong Su-Yi Gwenda from Singapore. Singapore also faced a severe demographical challenge, with the number of seniors expected to need assistance for mobility projected to triple between 2010 and 2030. The problem was that there would be only 2.1 working adults to support each senior citizen. Singapore examined the entire senior population, sorting it into different profiles based on care needs and impairment, so as to identify care options. Singapore discussed taking a patient-centric view to long-term care, which involved home and center-based care, since seniors desire to remain in the community even as they grow frail; and integration of care under one roof to enhance convenience to seniors and caregivers, with day care centers offering both health and social care, and also developing nursing homes to provide a community for seniors.

She summarized their vision for long-term care, with three priorities of accessibility

quality and affordability. Accessibility included day care services for seniors, homebound care, and residential care for those who could not be part of community. They anticipated that government would pay for the capital cost of developing new care facilities, and planned to tender out to the best operator who could offer quality care at affordable prices. For enhancing quality of care, Singapore had established standards already, but hoped to change those to focus more on care processes and outcomes. Affordability was crucial in order to give seniors peace of mind. They significantly enhanced government subsidies in 2012, made home and community care more financially attractive than residential care, and implemented a severe disability insurance scheme.

They also clearly had to step up efforts to develop manpower. They had a four-pronged strategy: the 'right number' of manpower through central employment schemes, scholarships, and reaching out to mid-career professionals and retired nurses. There was also 'right skill', which provided scholarships, study awards and subsidized training programs, 'right pay' to provide competitive wages, and 'right use' to provide funding to redesign jobs for greater efficiency and effectiveness. She summarized that the government had to play an important role in catalyzing accessibility, quality and affordability.

The final presentation in the session was Ms. Ying Liang from China, who discussed her country's approach to care initiatives. China faced a drastic situation of its own, with 202 million aged 60 or over by the end of 2013. The growth of those over 80 and over would be even more rapid. The national reality of 'growing old before getting rich' highlighted the heavy burden on the elderly, as did the 'aging before preparation' mentality, and the weakening of the traditional family role in caring for their elderly members. Skilled nursing workers and adequate facilities were also woefully lacking.

She shared two examples next of successful good practice in China, beginning with the Happy Old Age campaign in Changning. The campaign was focused on bringing health care and lifestyle facilitation to seniors, such as doctor visits to perform physicals and

provision of meals and transportation. Another initiative, the 12349 hotline in Tianning, was developed as an information platform, serving as communication for housework assistance, legal consultation, psychological consultations and more.

For the future, the Chinese government would make great efforts to offer LTC for the disabled and elderly, taking into consideration establishment of LTCI. Their priority was to supplement the care of elderly at home with community service and social services.

After the presentations, Mr. Iwana commented on each one. On Thailand, discussing capacity of the community, he commented that he was involved personally in particular projects and felt a certain affinity. He added that the Japanese government was working toward similar initiatives towards those in Thailand, with community-based systems, and posited that their attitudes towards family were changing, and asked if they can expect that same enthusiasm over time. Thailand replied that several ASEAN countries were concerned about that social capital. They found in Thailand that people were moving to the city more and more, and that they had to be more aware of the expense that would incur; thus they had to work on making the initiatives community-based and affordable. Another Thailand delegate emphasized the power of social capital, and training the people to use their social capital for the good of the community.

Mr. Iwana moved on to Singapore, thinking that it was similar demographically to Japan in terms of structure. He asked if there were clear incentives for the private sector to go along with government initiatives. Singapore responded that they had about 60 nursing home providers, with about half private and the others NPOs. Before anyone could open a nursing home, they were required to obtain a license from the Ministry of Health, which prescribed minimum standards. New enhanced standards will be introduced in 2015, giving employers a one-year grace period. They know that there would be a steady stream of consumers and that their activities would be subsidized, so they were not shy about getting into the market.

Next, Mr. Iwana commented on China, and his concern about how services as concerning income gaps in the country, with companies of course wanting to target the luxury range. The Chinese government of course considered that, noting that the population decline was even more drastic in rural areas, finding that more crucial to work on. They had the New Rural initiatives, which enticed caregivers to work in those areas. Concerning the gap in income, they started a contract program for doctors that

guarantee visits and care; those in high-income areas had only about 30% in a contract while rural areas had over 60%. Additionally, in urban areas, the government did at least offer a basic service to make sure that at the very least no one was uncared for.

Malaysia commented that they were looking into a 'blue ocean' strategy where government agencies work together to enhance their resources and inviting the private sector to work with them as well. Cambodia asked Mr. Iwana how to sustain long-term care service financially, given that most of the discussion and presentation centered on that issue. Mr. Iwana answered frankly that in Japan's case, it was *not* sustainable, and they were really at a critical point. When the system started in 2000, expenditure was only 3 trillion yen; in just fifteen years that had tripled, and was expected to still yet triple, along with compounding demographics issues.

Thailand asked about funding for long-term care, where the money for government subsidies was coming from and what was taxed. Singapore replied that they did not have a dedicated tax for it in Singapore, that it was a simple general tax from which they got a cut. Another source of revenue was out-of-pocket payments. It was a very difficult fine line to strike, and they were constantly reviewing what the balance should be. Japan, for its part, had 50% coming from a general tax and the remaining came from insurance payments by the insured. For the elderly, those payments were automatically deducted from their pension payments—and many people were likely not even sure how much they were even paying.

A question came about why the age for collecting payments started only at 40 in Japan; and also for Singapore, regarding the reason for shifting people away from residential care. Singapore replied that first, just by talking to people, they knew that senior citizens' preference was to remain with family and friends, and they wanted to facilitate that as much as possible. The simple fact of limited land availability to build residential care facilities was another factor. For Japan, they discussed how to expand coverage and payments, and decided to start by increasing co-pay rates from 10 to 20% for specific higher-income groups. It was theoretically possible to consider expanding contribution responsibility, but as it stood in Japan the elderly generation was much better off financially than younger generations, and the younger generation could not expect to bear a greater burden. One last question asked Singapore about their incentives for caregivers. They had grants where they offered applicants S$200 to take classes in care provision.

Mr. Iwana brought the session to a close, and thanked everyone for their cooperation.

Panel Discussion 3: “Age-Friendly Cities and Communities”

Mr. Alex Ross, WHO Centre for Health Development, facilitated the third panel discussion on “Age-Friendly Cities and Communities.” First to present was Prof. Hiroko Mizumura, Department of Human Environment Design, Faculty of Human Life Design, Toyo University.

Prof. Mizumura began her presentation “Barrier-Free Law in Japan: How to Create Age-Friendly Cities and Communities.” The current barrier-free policy law came into force in 2006, and was promulgated in response to rapidly aging populations and shrinking communities. However, the law targeted small children and the disabled, in addition to the elderly. There were two laws prior: the Heart Building Law in 1994, and the Barrier Free Transport Law in 2000. She briefly discussed the content of each, which focused on standards compliance, and transport accessibility.

The new law expanded the scope of targeted people, the scope of facilities targeted, expanded its basic vision, included participation of stakeholders in the basic vision formulation process, and enhanced software measures. Next Prof. Mizumura displayed the framework of the law, and an overview of the regulatory provisions for buildings. She also showed photographs showing accessibility measures for the disabled and elderly. Provisions for children play areas were increasingly put in place as well.

Next, a presentation was given by Dato' Norani Hj. Mohd Hashim of Malyasia. She offered demographics about her country, and stated that the number of senior citizens in the country was at 8.35% of its population, about 2.5 million. She highlighted the issues of aging that affect that segment of the population, and the fact that most countries did not prioritize those needs in their design. In Malaysia, they had the National Policy for Older Persons, to enhance the respect and self-worth of senior citizens in the family, society and nation; to develop the potential of senior citizens so that they remain active and productive, to encourage the establishment and the provision of specific facilities; and to ensure the care and protection of the older people. The Ministry of Urban Wellbeing, Housing, and Local Government was one of the government agencies implementing the Policy and Action Plan for Older Persons. The physical planning guideline was drawing up by them as well, to plan for the older persons living in living settlements.

There were four planning principles underlying the guidelines: to have harmony, interaction, and image; to be practical and user-friendly; accessible; and to have safety and comfort. Dato' Hashim introduced aging-in-place guidelines, featuring specifics for their construction. They aimed to development retirement villages, featuring active life for seniors and special care. She elaborated on many of the supporting services for these villages, especially transport and one-stop center facilities. Social programs supported by physical planning included the life-long learning program to provide supporting facilities in senior citizen settlement areas, and health awareness programs. She also discussed spiritual programs, offering religious programs and recreation programs. She concluded by saying that that the Ministry was campaigning heavily for this plan as a part of its development as a country.

Next, Mr. Mateo Gelito Montaño from the Philippines discussed their situation for age-friendly communities. Age-friendly cities and communities recognized the initiatives of local government units and communities in establishing measures conducive for senior

citizens, and at the same time, motivated them to stay productive and actively participate in community activities. The private sector was also beholden to uphold its commitment to these communities. Incentives were being implemented to ensure funding for building communities that were inclusive for senior citizens.

They next listed effective examples of the best practices found in the Philippines, found in Cabadbaran, which empowered senior citizens and motivated them to contribute to nation building. The city features self and social enhancement services for the elderly; cash incentives; advocacy services and information drives; support of medical and mortuary services; support to FSCAP meetings/transportation/seminars and meetings for senior citizens; and healthy lifestyle and long-term support. With that he concluded his presentation.

Mr. Ross first had a question for Prof. Mizumura: what advice would she give as an urban planner to a country starting to build cities in a new way? She responded that in Japan's case, the physical environment already existed; so for them to promote the policy was very difficult because they had to work with existing infrastructure. Considerations for accessibility had to be in mind from the first step, as it was much cheaper to implement them at that stage than spending money to retrofit later.

Mr. Ross then asked Dato' Hashim and the Philippines about any concrete examples about the coverage and equity issue, and who was paying for the communities. The Philippines replied that local governments were struggling to be financially stable enough to provide such programs. Only a few local governments really were able to showcase their services. For now, the Department of Social Welfare and Development had developed a program of strategic goals to establish a number of cities and municipalities with fully functional services. In Malaysia, they had a ministry that provided guidelines for assuring age-friendly facilities; but they also had to abide by the Persons Disability Act where it was spelled out that the features had to be included. Given the law, they always tried to keep accessibility in mind, though it was a difficult task. Retrofitting was especially difficult. It was not easy, but they were looking outward for solutions to their task.

Malaysia asked Prof. Mizumura about how long it took a country that implemented these process to mature and accept such facilities in their planning progress, given that it was expensive and few investors would likely want to consider it given the costs. She

replied that it was very complicated, but as a first case in Japan, it began as a movement started by disabled people who demanded awareness. She thought that the considerations should harmonize with different aspects too, such as in Japan where they also had to consider measures to defend against earthquakes. Dato' Hashim added that in Kuala Lumpur, they worked hard with its city center to ensure that it put those facilities in place.

Singapore asked Malaysia about the policy and action plan for older persons, that one of the goals was to construct technology for senior citizen housing, and asked what technology that was. Dato' Hashim replied that one condition was that the residences must be on the ground floor and surrounded with enabling technologies. Such technologies included an IT center for a person with disabilities to attend, and plans to build similar facilities for senior citizens. Mr. Ross gave other examples from Japan, such as medical devices and monitoring of utilities.

He asked the group if they ever spoke directly to senior citizens to field their opinions about what they needed. Philippines replied that their senior citizens were organized in a federation with representation, and that they were vocal with their requests. Dato' Hashim replied that in Malaysia, different advocacy groups consulted them and requested certain issues to be discussed, which the relevant Ministries picked up. They were very much local-based in that case, such as the home-help service conducted with the ROK; and the all-purpose activity centers requested by seniors themselves. In Japan, Prof. Mizumura mentioned her work in building safe communities. Municipalities voted to become part of those, taking into account the needs of senior citizens and making the appeal that they were facilitating those communities. Mr. Ross added information about the Future Cities Project in Japan, which sought to develop integrated housing in a compact zone for senior citizens.

Mr. Ross asked if they had any success in getting different sectors to work effectively together. Philippines replied that they started working with other sectors that would help them provide the services that they were being asked for, and to use their resources in human development.

The ASEAN Secretariat asked Japan about who covered the costs for ensuring accessibility in private companies, and how they encouraged the companies to do it. Prof. Mizumura replied that ordinances in Tokyo were set in place for the small shops to

take up the retrofitting. However a large number of them did not have the systems; in that case, they simply asked the owners of the shop to implement. Considering that more access equals more business, many shops were able to oblige. Cambodia also asked how the Japanese government got the business sector involved in the process. Prof. Mizumura replied that it was difficult, and that they had to emphasize that considerations for accessibility were cost-effective from the beginning, as well as the fact that Japan was already at the critical point and they had to do it sooner or later. However, accessibility was still very low in many places.

Mr. Iwana added that the greatest difficulty was on the local scale between private homes and public spaces, especially considering there was no capacity at a local level to do everything. Prof. Mizumura thought the problem was that this was not solidified in building laws, especially because there was no obligation in Japan to make a building fully accessible. Mr. Ross added that they used regulation and incentive in New York City to urge compliance. He summarized the discussion briefly, reminding them that in Asia, countries were already highly urbanized, and it was especially crucial for them to tackle the issue. Inter-sectoral collaboration was going to be crucial as well to solve the problem, along with innovation and adaptation.

Afternoon Presentations

Next, they moved on to presentations from three speakers, the first being Mr. Ross again. He discussed Innovation for Resilient Communities for Active Ageing, and emphasized it was crucial to have a community where everyone took care of each other. He touched on three specific aspects of a resilient and caring society: age-friendly cities and communities; innovation that was technology and social; and universal health coverage.

The largest population of older adults in history would soon live in the developing world, rather than the urban. In the Western Pacific, roughly 13% of the population was already age 60 or over. He then turned to Active Aging, the process of optimizing

opportunities for health, participation and security in order to enhance quality of life as people age. Very soon ‘age’ would be much more about the range of function, rather than simply a number. Raising the threshold of considering a person ‘disabled’ was the primary goal.

A rapid increase in aging populations was coupled with lower fertility in some countries, along with more persons living alone or with one other. Equity and social inclusion was another factor, as income gaps widened severely. The burden of non-communicable and infectious diseases was also prevalent. They had to reorient health services to address functional and cognitive decline. There was a widening gap between life expectancy and healthy life expectancy, and a shift from facility-based to home-based care. All of the issues made it more obvious that urban planning and public health required innovations, and systems change and strengthening.

Mr. Ross introduced the WHO Guide for Global Age-Friendly Cities, which discussed outdoor spaces and buildings, transportation, housing, community and health services, civic participation and employment, respect and social inclusion, social participation, and communication and information. WHO had a network of age-friendly member cities, which all promised to share information about their initiatives. The most important thing was that the WHO Kobe Center had been developing a set of indicators to measure and monitor the age-friendliness of cities, so that cities around the world could test it and report back on its effectiveness. He cited an ongoing initiative by the University of Tokyo Institute of Gerontology, which was an example of such research; as well as one in New Zealand.

Innovation for ageing population was another focus by WHO, to ensure the improved access, quality, and use of medical products and technologies. Their challenge was adapting those technologies for a lower-income environment. The WHO completed a survey on advancing technological innovation for ageing populations in Asia. He introduced the various strategies for improving access to assistive and medical devices, which had to allow for the actual maintenance of the technologies in the countries in question. In the end, countries had to have holistic policies: they focused on ageing, but did not include the health technologies, health technology assessment and regulation, nor financing, which were also all crucial.

He also introduced universal health coverage, which included services from promotion,

prevention, treatment, rehabilitation and palliation; home-based services; health technologies and more. Key recommendations were embracing the community, talking to senior citizens and identifying their needs, to consider equity, and to consider a life course of people and not just reacting to needs. He concluded his presentation, commenting briefly once more on the initiatives that the WHO was taking to address all of the issues.

The next speaker was Ms. Keiko Kamioka, Director, International Labour Organization Office for Japan, discussing "Activating Older Workers in the New Demographic Context." She started her presentation by introducing labour market dynamics in the new demographic context; Impact on economic development –high dependency ratio, shrinking labour force with reliance on productivity growth, aging population with higher public spending on health care and pensions. Poverty and informality-public pension programs will not provide sufficient income thus old-age income poverty is higher than population poverty rates. Labor skills shortage and labor productivity-poor incentives for employers to invest on older people.

She asserted the need for new policy mix taking into consideration of employment, international labor standards, social dialogue, and social protection. Legal framework is also a part of solution and awareness raising has a role to play. ILO Convention 111(Discrimination) and ILO Recommendation 162 (Older Workers) address that by explicitly including age as a form of discrimination, and increased their efforts to enact age discrimination legislation. Legal framework was part of the solution, and raising awareness had an important role to play.

To activate older workers, the ILO recommended guidance, training, life-long learning and placement services to be provided to foster employability and to create enabling environment. Many Western countries already had initiatives in this area. Canada was a particularly successful example of such training initiatives. Working time and work organization considerations were also essential. The single male breadwinner model was shifting to the dual-earner household. An increasing availability of working time

arrangements for older workers is a positive step, but before implementing specific measures, detailed assessments were necessary as well as an understanding of the capabilities of older workers.

In conclusion, a comprehensive policy mix was important, so as to have policies that reinforce each other in employment, social protection and economic development, as well as policies that corresponded appropriately to the present situations of each country. Long-term objectives and support throughout the life cycle are needed, as well as policies for increasing productivity. Those included education, training, and lifelong learning; social protection; improved working conditions and sound OSH; and non-discriminatory practices. Policies addressing skills mismatches and shortages are needed as well; development of the care sector; and fiscal sustainability of pension systems and flexible transition from active working life to retirement. Social dialogue was key for managing reform processes for employment and social protection, along with collective bargaining.

There was a comment from the Philippines. Because most of Ms. Kamioka's examples were from Western countries, they wondered if there were any experience or studies that could be a reference for alternative solutions to senior citizens. Ms. Kamioka replied that as there were not many relevant statistics available from ASEAN countries, she used OECD statistics. However, worldwide, countries were following a similar trend, so she believed it would be useful as an indicator about what was and would be happening in the world. The training systems she described did not only have to be for the elderly; they could also be for housewives and other group of people who never received any formal training.

Mr. Ross also asked if the ILO had any ideas about reasonable accommodation for an older person. Ms. Kamioka replied ILO had issued a special report on that which provides guidance and numerous examples of how to accommodate for not only senior citizens, but other workers with special conditions.

Finally, the last speaker was Mr. Nakamura from JICA once more, who discussed "JICA's Role in Promoting Aging Cooperation." Once again, he introduced the demographics of aging throughout ASEAN and Japan. He regarded JICA's aging cooperation as a 'time machine', which would take participants to an aged society and enabled them to imagine what their own societies would be and what could happen

when their societies actually would become aged in, for instance, 30 years from now. He offered JICA's cooperation as a way to gain access to the expertise and experiences of dedicated Japanese specialists. He also shared the basic direction of aging cooperation from JICA, which was to share Japan's current and past experiences that included responses to challenges in health, education and more. Mr. Nakamura introduced JICA's Study Program "Strengthening of Policy on Aging in Asia," and the LTOP Project in Thailand that aimed to develop a long-term care system for the elderly. With that he concluded his presentation.

Malaysia asked if he had a simple example of a care plan. Mr. Nakamura replied it was a plan to figure out what sort of services should be allotted for an individual person, and that under Japanese insurance schemes it was restricted just to care initiatives.

With his presentation concluded, the meeting ended at 17:15 PM.

<u>Day 2: Wednesday, 22 October 2014</u>

Field visits to various facilities in the Tokyo metropolitan area to study good practices supporting the elderly. The afternoon trip to Kawagoe City involved studying their health care services and welfare for the elderly, their preventative long-term care projects, and how they trained supporters for dementia.

Kasumigaseki Minami Hospital

Kasumigaseki Minami Hospital

Kasumigaseki Minami Hospital

Kasumigaseki Chuo Clinic

Kasumigaseki Chuo Clinic

Shinjen

Kawagoe City

Day 3: Thursday, 23 October 2014

Briefing Session

The first session of the third day of the conference began with a presentation by Mr. Katsuyuki Tanaka, Executive Officer, Riei Co. Ltd., presenting on "Japanese Care for the Elderly in Foreign Countries." He first shared the company profile of Riei. Their staff included Chinese, Korean, Filipino, and Myanmarese staff. They specialized in developments in care overseas, and Mr. Tanaka described some of those initiatives, such as visiting care in Thailand and nursing care home in China.

He described some facts they had learned over the years. In marketing, they realized that 70% of prospective customers used the Internet to search for information; but a long-term care manager was more important in Japan. They also found that dementia was the largest condition inquired about in Shanghai, although not the only one in Japan, so they had to focus on it a bit more in other markets. Care services included special care for patients with dementia and other serious conditions, as well as cleanliness, sanitation, and machinery. They also found that family requests required much more communication. Mr. Tanaka also elaborated on the training their staff undertook for J-Care, and localization practices in each country. With that he concluded his presentation.

A question came about care in Thailand, asking about the demographics of their care in that country; Mr. Tanaka replied that it was local Thai people. Another question from Thailand asked about the training for care workers in Thailand. Mr. Tanaka replied that they have a Japanese program for Thai to become caregivers. They are already caregivers, but the Japanese program furthers their skills. Thailand also asked if they had any connections with nursing homes, etc. in Thailand to discover more nurses; and also asked about their salaries and compensation. Mr. Tanaka replied that they had several connections with hospitals, and salary for staff was 20,000 baht per month.

Malaysia asked about how they chose which countries to start their services and training in, and if there were any specific objectives in the training program. They replied that they started first in Thailand because of their hospitability, and their belief that Thai were very qualified as caregivers. Next, Brunei asked if they were giving training to professional caregivers or family members, as family members largely took charge of the issue in their country. Mr. Tanaka responded that they only had training for professionals. Brunei also asked if they could offer any advice for training trainers themselves; Mr. Tanaka replied that they did. Malaysia also asked what they meant by 'caregivers'—if that meant professionals or also family members. Mr. Tanaka thought that for family members to give care, they needed training as well as knowledge. Thailand also asked if they could share the current number of those in training, how many hours, and what kind of curriculum they had. Mr. Tanaka replied that they could access the website for the details, but said that training was approximately three months.

Next to present was Ms. Noriko Fujita, Manager, International Division, Osaka Chamber of Commerce and Industry, introducing Japanese Assistive Devices. She briefly gave an overview of the OCCI. For the last few years, they had been focusing on promoting Japan-China collaboration in the senior care industry, given that each country will experience an enormous expansion of the senior care market. Some systems and innovations she introduced were for the use and disposal of adult diapers, shower baths, and toothbrushes. She also introduced some of the initiatives taken up by Japanese companies involved in providing assistive devices and tools for senior care, such as Osaka Jikei Gakuen and Medical Care Service Company Inc. With that, she concluded her presentation.

There was a question from Malaysia about what 'Japanese-style care' was. Ms. Fujita replied that it meant that the care was focused wholly on the residents who needed care, such as the tools meant for elderly to continue their independent lives.

Next to present was Ms. Kayoko Nomoto, Marketing Division, EN Otsuka Pharmaceutical Co. Ltd., on "iEat; Foods for Recovering Eating Function". The corporate philosophy of Otsuka Group was "people creating new products for better

health worldwide." Their companies developed their products in line with that philosophy. She shared demographics about the number of elderly in Japan, and also about their food intake, surveying how many calories the elderly took in per day in Japan. About 80% of elderly at home were at either of risk for malnutrition or definitive malnutrition, which itself might lead to dysphagia. The survey also indicated there might be relationship between nutritional status and appetite & "please of eating." Ms. Nomoto introduced iEat, which was visually appealing foods to help better appeal to the elderly palate, specially designed for the purpose of recovering eating function as well as increasing nutritional intake. She showed, by using a movie, that iEat was soft to be able to be easily mashed by the tongue. She concluded her presentation there.

A question came from Brunei about if there were any plans to localize their efforts, as they had only Japanese items on the menu. Another EN Otsuka representative replied that they wanted to export their products in the future, but some countries had restrictions on importing particular materials. They were still investigating possibilities. Malaysia also asked a question, asking if they could share what the technology used to soften the food was, and if the nutritional value was compromised. EN Otsuka replied that the first was a trade secret; but they developed original methods to soften raw materials by enzymes. As for the second question, they replied that the method made it possible that vitamins permeate cells of plants if it needs to be rich with vitamins. Another question was about what the benefits would be for the elderly who consumed the food in terms of nutrition. EN Otsuka replied that the elderly might have small appetites, but since iEat had normal appearance, it could help them take in enough calories. The WHO asked what the average cost of iEat was, compared to the cost of the blended versions. EN Otsuka replied that they were usually 500-600 yen, more expensive than the blended versions, but hoped they would sell well regardless. Myanmar asked if there were any studies or research into the effectiveness of their product and what the results are. EN Otsuka answered that they were currently conducting studies in Japan.

The final speaker in the session was Ms. Hiroko Masuda from Ryukakusan Co. Ltd. On "Market Creation and Development of Swallowing Aid Jelly." First she gave details about the company history and its origins in early 1700s, and moved on to describing the product. Dr. Atsuko Fukui stepped up to discuss the product, the Raku Raku Fukuyaku Jelly series, which they developed to solve the difficulty of taking medicine. She described some of its characteristics, such as no physical interaction with medicines, and ideal solidness and size of crushed jelly in order to avoid choking over and getting caught in your throat.
They had tested the product effectiveness many times. There was less stress on the throat when swallowing, and medicine took eight seconds to reach the stomach after being swallowed.

Next, Mr. Fujii, President, explained the market introduction process. At first they limited the product only to medical nursing care, prevented an erroneous swallowing under the supervision and guidance by specialists such as doctors and nurses, and distributed samples at exhibitions of medical nursing care. They expanded the product to infants, which helped mask the bitter taste of medicine, and prevented them from melting in the mouth. They also developed jelly to suit Chinese medicine. Ryukakusan ended its presentation there.

Malaysia asked about the ingredients, as it was a product that they thought their elderly would like to use but they had to ask about the ingredients in consideration of their Muslim population. They replied it was made of agar. Singapore asked about why they needed to have a special jelly for Chinese medicine if the jelly was meant to be non-interactive with the medicine. They replied that Chinese medicine in Japan was not easily taken with water, and the jelly mixed with the medicine in a different way. Vietnam asked if they make a general jelly or just jelly for specific markets, and how much types they had. Regarding the first, they replied that their jelly was only for taking medicine, so they controlled the content and viscosity. They had thirteen products in total, which used the same contents. The cost was 350 yen per package, which was 12 servings. As there were no more questions, the first morning session ended there.

Panel Discussion 4: "Social Participation and Contribution of Elderly"

Next was panel discussion 4, facilitated by Dr. Reiko Hayashi, on "Social Participation and Contribution of Elderly." She introduced the upcoming speakers, beginning with Prof. Katsunori Kondo from Chiba University; Mr. Haruhiro Jono, and the representatives from Cambodia, Indonesia, and Brunei.

Prof. Kondo thanked everyone for attending for beginning his presentation. He reported on the lessons learned from the Japanese experience of prevention policy for Active Aging and limitations of high risk strategies, and to demonstrate another strategy of the 'community approach'. In 2006 the Japanese government introduced various policies to screen the elderly for checkups, but this was harder to implement than expected. They learned that high-risk strategies by screening during health checkups seemed to be ineffective, because those from lower socioeconomic backgrounds at high risk did not attend exams. Social factors were pinned as the major cause. They thus organized a research project to focus on social determinants of health and social environment focused on the elderly. They analyzed relationships between various factors, such as the rate of falling and participation in sports clubs. Likewise, the rate of fall or dementia risk fell with higher rate of participation in community organizations.

They also conducted an intervention trial promoting social participation among the elderly. They introduced various activities such as Ping-Pong, making short poetry, and other physical exercise, and found that there was an 8% points lower difference in the number of those who suffered social decline compared to those who did nothing; 6% vs 14%. Their conclusion was that high-risk strategies by screening during checkups were ineffective, and that pursuing social participation showed better results. He concluded his presentation there.

Dr. Hayashi asked about their methods to decide activities, and Prof. Kondo replied that they simply asked. They found that jogging or walking were popular, along with working out in gyms. 10% of men enjoyed golf. They realized that half of the membership of some Japanese gyms were already senior citizens, because younger people were too busy at work. Cambodia asked how they enticed elderly to attend sport clubs and why some still did not participate. Prof. Kondo replied that some kind of social participation, no matter what, was good for their health, so it did not need to be gyms per se. He hypothesized that social support was a well-established factor that would promote good health. Prof. Kondo was not sure entirely why not everyone went to sports clubs, but those who lived in proximity to parks or walking paths seemed to contribute to their membership. Malaysia asked if they found the number of hours per week that an elderly should participate to meet the point of improvement for their functionality. Prof Kondo said that was one of their upcoming research questions, but found that roughly once per week was enough. Some statistics showed that even once per month showed protective effects for health.

Dr. Hayashi led them to the next presentation by Mr. Haruhiro Jono, to give an overview of employment measures for older persons. He first gave some numbers describing the demographic change in Japan. In 2006, the Japanese government implemented changes that required companies to have measures securing employment for older workers. They had a very strong willingness to work still, with many stating that they wanted to work as long as they could. Japan had a mandatory retirement system, where employment was automatically terminated after a certain age. Likewise, eligibility age for employee pensions also rose. Elderly who wished to continue working had to be on a continuous employment system until age 65 as the pension age rose.

Most important was to ensure employment within companies to allow those who wished to work to work until age 65, as companies were merely obliged to provide measures. They had to advertise the work to emphasize senior citizens' experience and knowledge, that it was a valuable thing to keep these people on. He concluded his presentation there.

Dr. Hayashi thanked him for his presentation, reminding the audience that now 1 out of 4 in Japan was elderly. Singapore asked what the motivation was for elderly to work as long as possible; and asked if seniors stay in their same role or if it was reduced, even if at the same company; and asked if the pay was commensurate to the role that they play, referencing seniority wage. Mr. Jono replied that he was not sure of any surveys regarding motivation, but supposed that one might be the need to be praised or thanked for their service. Regarding the second question, he said that it was up to the company. For the third, regarding the seniority wage system, it was still prevalent in Japan, but companies were struggling with the implications of that in a rapidly-aging society; thus they introduced a salary system related to work performance rather than on seniority.

Thailand asked if there was actually any jobs for them—noting that in Japan things were extremely automated, for one, and asked how they could reach that goal if there were no jobs for the elderly to take. Mr. Jono replied that the life expectancy of Japanese was very high and still rising, and jobs in construction and nursing were still in high demand. Dr. Hayashi added that the population was dropping by 300,000 every year; and the demand for jobs would rise for sure, so they were very conscious of opening up positions for both elderly and women.

Malaysia asked which sector in Japan took in the most workers 65 and over. They thought that most airlines, for one, would not accept anyone 60 or over, and would ask for exemption. Mr. Jono replied that they had not observed any change in accepting the intake of young workers as compared to older. He did not have the answer to the first question. Dr. Hayashi supposed that most would continue in the same sector. Those who worked in manufacturing might have to retire, but office workers could continue. Regarding the airlines question, Mr. Jono replied he did not know about that; that they did not specifically regulate it. The law itself prohibits setting a mandatory retirement age under 60.

The Philippines asked about statistics regarding that 97% of companies in Japan employed older people, and asked if the government was offering any incentive to these. She also asked that if the government was not providing any incentive, if the employed elderly received the same compensation; and third, if the company made any adjustments in order to accommodate their employment. Mr. Jono replied that if the company had some advantage for hiring elderly, they would pursue it anyway, but that he did not have information regarding any particular subsidies. As for special

accommodations, that was left up to each company.

A question came from Myanmar, wanting to know more about the Japanese senior volunteer system from JICA, specifically the Silver Overseas Volunteer Program, and if it was a method of reemployment for senior citizens. Mr. Nakamura from JICA replied that they recognized the wisdom and experience of seniors, and it can be helpful for the development of other countries, and that was why they started the program.

They moved on to the next presentation, given by Dr. Kol Hero from Cambodia. First he offered various statistics on the country, and noted that its demographics were in a much better shape as compared to other countries. However, projections showed that the 'pyramid' would level out and the number of elderly would increase, which they were not ready to handle yet. They did not have a national social security fund, had no facilities to treat health problems for the elderly, and had limited experience in building facilities. To address these, for social participation they had the National Committee for Disaster Management, which responded to the needs of affected people in the short and medium term; and Civil Society Engagement, which largely worked with the Cambodian Red Cross. They also had the Union Youth Federation of Cambodia, the Help-Age Cambodia and Relevant Development Partners, and many community centers. In the private sector, opportunities included the Bayan foundation, private companies and banks, and activities with university students.

Future plans included a law on a national social security fund, reviewing national policy for the elderly, developing a national social security system, enhancing elderly welfare by 100 OPAs per year, building and strengthening the capacity of health and non-health personnel for elderly, and strengthening cooperation with other countries in the region to develop policy.

They moved on quickly to the next presentation from Indonesia, given by Dr. Makmur Sunusi. He first offered demographics on the country. Life expectancy in the country had steadily risen, and had increased nearly 25 years from 1970-2013. The elderly in

Indonesia faced many serious issues, not just in health, but also domestic violence, managing property and inheritance, and susceptibility to fraud. They had to deal with triple burden diseases, of nutrition, metabolic, and degenerative; lacking economic growth along with the increase in the number of elderly; and the poor education of their elderly. Most elderly, over 50%, were forced to work by necessity due to the low level of welfare.

Indonesia had many national policies to address these, including the National Commission for Older Persons, which was to assist the president in coordinating implementation efforts to increase social welfare, and to provide recommendation and considerations in developing policy on efforts to improve the social welfare of older persons. The government had to be made aware of the problems, so as to be able to address them, and needed to have a network to work with those who had developed strategies, which NCOP could provide. They also had the National Plan of Action on aging and its objectives. That supported policymakers and NGOs, religious leaders and community leaders, and more, to improve elderly welfare; they also created informal support for the elderly by helping to maintain family and community support, increasing improvement in health services and more. With that he concluded his presentation.

Next was Ms. Dayang Rostinah Binti Pokssp Dato Paduka Haji Mohd Tahir from Brunei. She introduced the demographic profile of the country and the social development of the elderly in her country. As of 2008, they established the National Council of Social Issues, and established the Plan of Actions for Older Persons and People with Disabilities in 2011. That addressed the nine issues of law and regulations, health, employment, education, transportation, housing, social participation, recreational, and infrastructure and research. They were currently drafting the formulation of a Disability Order, and joined the Convention on the Rights of People with Disability in 2007.

They had a number of programs that served to help the elderly. Since 1955, everyone from the age of 60 received a pension of $201 every month—even their king and queen. They also had mean-tested welfare allowance, and the Supplementary Contribution Pension, which commenced in early 2010. Brunei had a number of activities in place to ensure the activities of the elderly, setting up activity centers for the elderly to meet up. Brunei could not offer retirement home services, as the family as core was enshrined in law; but they worked with countries like Korea to develop those skills for the family. One example of an NGO working closely with hospitals was PENYULUH, which promoted healthy aging and collaboration with local hospitals.

Challenges they faced were to enhance the role of family in elderly care furthermore (since the youth had to work), maintaining the sustainability of financial resources, to encourage a healthy lifestyle, maintaining sustainable health care, encouraging committed voluntary work, addressing the ‘empty nest syndrome’, achieving all actions in line with the Plan of Action on Elderly, providing support for caregivers, establishing a database on the elderly, working within their limited healthcare resources, and multi-sectorial intervention on achieving healthy aging. She ended her presentation on that note.

Malaysia had a question for Cambodia, about their community centers and how they played their roles in involving people; and a question for Brunei, asking who took care of the poor family in Brunei if they had no family. Cambodia answered that they served as Buddhist meditation centers and served food from time to time, and they also served as meeting places for older people associations. Brunei replied that for those who had no family, as much as possible they ask volunteers in the community or neighbors to look after them.

The Philippines asked Brunei regarding ‘empty nest syndrome’. Usually elderly took it into their own hands, arranging programs for themselves, only monitoring activities as a government agency without any specifics. With that, Dr. Hayashi closed the morning session.

Panel Discussion 5: “Future Cooperation With and Among ASEAN Countries for the Aging Population”

The afternoon session started up with the fifth panel discussion, “Future Cooperation with and among ASEAN Countries for the Aging Population.” The first presentation was given by Ms. Mega Irena, ASEAN Secretariat, on “Resilient Communities for Active Ageing.”

The ASEAN Mandate for Active Aging undertook the concerns and initiatives on Active Aging, and involved the two sectors of social welfare and development, and health. She highlighted an important declaration by ASEAN, the Declaration on Strengthening Social Protection, which emphasized a resilient ASEAN community for Active Aging from an early age; that they needed awareness and capacity building for family units and how to have communities support families; that they had to extend coverage, availability, quality, equitability, and sustainability of social protection; and that social protection was an investment in people that had to be supported by adequate resources. Related factors included universal health care coverage and the sustainability of such.

They worked together with ILO on the Project of Promoting and Building Income Security and Employment Services in ASEAN, for enhancing the capacities and facilitating knowledge of employment opportunities, particularly for the elderly. Project activities included conducting review of the social protection situation in AMS as baseline information for monitoring the effective implementation of the ASEAN Declaration; conducting an inventory and reviewing pension practices; and more. Strategic framework on social welfare and development included studies and research, such as regional studies on the socio-economic impacts of the growing trends of ageing societies and the existing social security and pension schemes in ASEAN Member States, done by the Philippines; and the establishment of an ASEAN-wide research network on ageing, done by Malaysia. Networks included the ASEAN Social Work Consortium, and the establishment of an ASEAN Network of Family Development. She also elaborated on their capacity building activities, led by the various member states, such as the regional conference on caring and self-caring for the elderly in homes and communities, by Vietnam and Singapore.

Next, Dr. Ferdinal Moreno Fernando spoke on ASEAN Health Cooperation and Its Support to Initiatives in Active Aging. That was complementary support to the initiatives of the Social Welfare and Development Sector. The ASEAN Strategic Framework on Health Development structured most of the work, and allotted for activities like the Task Force on Noncommunicable Diseases, Focal Points on Tobacco Control, and the Mental Health Task Force. Another part of the framework was increasing access to health services for ASEAN people, which involved increasing access to primary healthcare for ASEAN citizens through developing a regional strategy on health care and services and primary health care.

He discussed the ASEAN+3 universal health coverage network, which was a result of the tasks from the joint statement of the 5th ASEAN+3 health ministers meeting in 2012. There they endorsed the TOR and Work Plan, which complemented the Increasing Access to Health Services for ASEAN People. Current advocacy was a focus on elevating UHC in the ASEAN platform. The Network objectives were to share experience and knowledge for better understanding of UHC; to support strengthening each country to enable them to put UHC in place, to promote collaborative research; and to strategize and position the UHC agenda at the highest regional and global forums. The salient work plan activities for 2014-16 included the UCH baseline in 2014, strengthening data systems, monitoring UHC progress, and knowledge generation.

They also planned to incorporate the initiatives introduced in the Bandar Seri Begawan Declaration on Noncommunicable Diseases in ASEAN, which were aimed at expanding efforts to spread UHC, effective implementation of action lines related to NCDs, urging ASEAN health ministers to enhance efforts towards achieving the set of nine voluntary global targets for the prevention and control of NCDs by 2025, and calling on the ministers to tackle initiatives that address unhealthy lifestyles and risk behaviors. The ASEAN Post-2015 Health Development Agenda called for a vision for a healthy, caring, and sustainable ASEAN community, with a cluster on promoting healthy lifestyles to achieve the maximum health for all ages. With that he concluded his presentationThailand had a comment, saying that it fully supported the collaborations to move forward in Active Aging activities. They thought if they wanted to move forward

with ASEAN and Japan collaboration that there should be some team or working group to focus on Active Aging. Malaysia commented that they fully supported cooperation among ASEAN countries towards Active Aging. They also wished to address that Malaysia had two programs for capacity building in the pipeline: the CBR network, and at the national level were working on the social work consortium. Ms. Irena highlighted that under the ASEAN Secretarial Board on Social Welfare, the issue of aging society and the elderly was one of its core areas since the first strategic framework was implemented in 2000. However, she thought the issue was related to efforts and policies, as well as resources, at the national level, which reflected the depth at the levels below. She mentioned there would be a workshop in Cambodia in December to discuss issues related to social welfare and development, to develop an ASEAN plan of action to develop the Declaration and inter-sectoral collaboration. Japan stated that it would like to contribute to these efforts.

Developing Recommendations

The meeting turned to developing recommendations for the meeting draft. They moved through the paragraphs of the draft, asking for comments or suggestions. It was suggested to use ‘older persons’ throughout the document. A suggestion was made to include rural older persons. There were also questions about the use of function in regard to the physical capacity of older persons, and recommendations about the use of dementia, with slightly stronger language throughout for ensuring their commitment to their goals. They also wanted to emphasize that they would be making active efforts to achieve those goals, and use more proactive language such as ‘appreciate’ rather than ‘note’ in various circumstances. Another suggestion was to recognize the importance of reliable databases and statistics for developing policies and strategies.

Once the draft was completed, Dr. Hinoshita thanked the participants for their input. He introduced Mr. Akira Isawa, Assistant Minister for International Affairs, Ministry of Health, Labour and Welfare.

Closing Address

First, Mr. Isawa greeted all of the delegates and thanked them for their attendance. He thanked everyone again for the successful outcome and productive results. He recognized that they all had a great responsibility to support the elderly in each of their countries, and became convinced through their discussions that governments hold an important key in responding to the upcoming aging society, including how to cooperate with communities, how to enhance and expand their functions of communities, and how to develop their human resources.

While communities played an essential role for ageing societies, he added that they should remember they could be affected by international, economic and social change; and mobilization of population. In that context, he hoped that they would have further opportunities to discuss in the ASEAN region how to create and maintain resilient communities under such changing circumstances. Finally, Japan wanted to continue to contribute to the discussion on Active Aging in the ASEAN region through platforms such as the high-level meetings, and regional conferences. He thanked everyone once again for their attention.

With that, Dr. Hinoshita concluded the 12th ASEAN and Japan High Level Officials Meeting on Caring Societies.