WHO CENTRE FOR HEALTH DEVELOPMENT

MEETING SUMMARY

Developing Indicators for the Global Age-Friendly Cities

30-31 AUGUST 2012

ST. GALLEN, SWITZERLAND

1. BACKGROUND

1.1. Rapid population ageing and urbanization are reshaping the global demographic landscape. In 2005, 51.5% of the world's older population already lived in urban areas (UNDESA 2009);

1.2. Population ageing, particularly in cities, underscores several key issues related to health:

- *1.2.1.* Sustainability of public welfare expenditures;
- *1.2.2.* Appropriate action for elderly-oriented health and social services;
- *1.2.3.* Appropriate urban planning and development.

1.3. To support governments develop and strengthen health and social policies that are responsive to population ageing, the World Health Organization (WHO) developed the Global Age-friendly Cities Guide and brought together 33 cities across 22 countries to create a checklist of essential features of age-friendly cities;

1.4. In 2010, The Global Network of Age-friendly Cities and Communities (i.e. the Network) was launched by the WHO with the following objectives:

- *1.4.1.* Connect cities and communities that share the commitment of becoming more age-friendly;
- *1.4.2.* Facilitate the exchange of information and best practices;
- *1.4.3.* Provide technical support and training; and
- *1.4.4.* Ensure that interventions taken to improve the lives of older people are appropriate, sustainable and cost-effective.

1.5. Participating cities in the Network are committed to continually assessing and improving their age-friendliness against a set of indicators as cities undergo a cycle of planning, implementation, progress evaluation, and continual improvement;

1.6. As figure 1 illustrates, indicators serve an important function at each stage. Therefore, it was considered important to identify a set of indicators which are globally relevant but also locally adaptable;

1.7. A starting point for identifying indicators are the eight domains of city life recommended by the Global Age-Friendly Cities Guide (figure 2);

1.8. This meeting in St. Gallen brought together experts on ageing and metrics, representatives from members of the Age-Friendly Cities Network ,and WHO officials with the following objectives:

- *1.8.1.* develop a preliminary list of indicators for Age-Friendly Cities Network utilizing the initial review provided in the background document;
- *1.8.2.* Identify the process for piloting and finalizing the list of indicators.

Figure 1 Planning and implementation cycle for cities in the Network

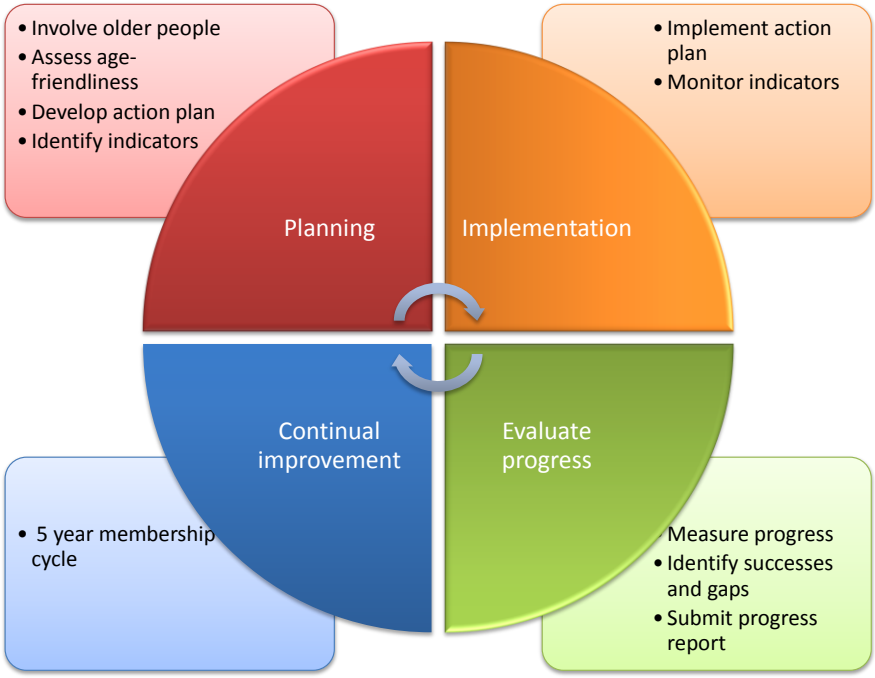


Figure 2 Eight domains of Age-Friendly Cities

1.9. A global review of relevant indicators for ageing and health was conducted by WHO Kobe Centre and a background document was prepared to serve as an input to the meeting along with the Global Age-Friendly Cities Guide.

2. SETTING THE CONTEXT

2.1. **Three presentations** were made in this session:

2.1.1. *WHO's global strategy on ageing and health* (Dr. John Beard, WHO);

2.1.2. *Introduction to Global Age-Friendly Cities Guide* (Dr. Louise Plouffe, Consultant);

2.1.3. *Review of global initiatives on developing indicators for monitoring population ageing* (Mr. Amit Prasad, WHO).

2.2. Dr. John Beard indicated in his presentation that "ageing" as an issue was becoming a priority for the WHO. In particular, WHO, in its new strategy is focusing on health across the life-course where issues relating to ageing have a prominent presence.

2.3. Dr. Beard also emphasized that the key objective of an Age-Friendly City should be to facilitate the process of Active Ageing[1].

2.4. Dr. Louise Plouffe presented the Global Age-Friendly Cities Guide (the Guide) including the process of developing the Guide;

2.5. Dr. Plouffe specified that the essential features of an Age-Friendly City are to:

2.5.1. Raise public awareness of the capacities and needs of a growing older citizenry;

2.5.2. Stimulate and guide local action to make urban settings and services more age-friendly.

2.6. Mr Amit Prasad presented the global review of ageing and health related indicators. A total of sixteen relevant initiatives were identified and 195 indicators from these initiatives were mapped to the eight domains of the Guide. Two additional domains were created for "health" and "other" issues. The latter mainly consisted of demographic and contextual variables.

Table 1 Distribution of indicators by domain based on WHO review in 2012

Domain	No. of indicators	Domain	No. of indicators
Health	42	Outdoor spaces and buildings	16
Civic participation and employment	27	Respect and social inclusion	16
Housing	21	Social participation	14
Community and health services	21	Transportation	12
Other	20	Communication and information	6

2.7. Mr. Prasad also described the process for developing indicators for the Urban Health Equity Assessment and Response Tool (Urban HEART).

[1] "Active Ageing is the process of optimizing opportunities for health, participation and security in order to enhance the quality of life as people age." WHO Active Ageing: A Policy Framework, 2002.

2.8. In the **plenary discussion** that followed a number of observations and suggestions were made;

2.9. Indicators for Age-friendly Cities should be adaptable for relevance at the local level. The indicators should be appropriate towards capturing the diversity within a city. Some indicators will also be relevant at the national and global levels;

2.10. Gender issues should be incorporated specifically in the Age-Friendly Cities set of indicators from both an urban and age-friendliness perspective;

2.11. Selected indicators should reflect planning and implementation stages, intermediary results as well as long-term outcome indicators;

2.12. Indicators should only be selected if they lead to or reflect the consequences of action;

2.13. There was substantial discussion on the value of having globally comparable indicators:

- *2.13.1.* The international comparability of indicators and their measurement strategies was considered to be of great benefit by some participants;
- *2.13.2.* Others disagreed with the importance on international comparability since cities were primarily interested in locally relevant indicators e.g. in Canada;
- *2.13.3.* Also, some cities may not want to be explicitly compared to other cities e.g. the experience of the Alliance for Healthy Cities in Asia;
- *2.13.4.* There was greater agreement to include indicators that were at least comparable over time within cities;

2.14. Although it would be useful to have consistent measures of progress over time there was a sense that some cities may be reluctant to do so in times of financial crisis and budget cuts e.g. in Ireland at present;

2.15. Indicators selected at the global level should be adaptable to local needs and the process of selecting indicators should be an iterative and dynamic process;

2.16. Consider the use of qualitative assessment methods as well e.g. stories, photographs etc.;

2.17. Timeliness of indicators was emphasized as well as the need to collect them from administrative systems as much as possible;

2.18. To sustain the use of the indicators it was important to engage non-governmental organizations (NGOs) and the government/parliament.

2.19. Indicators for ageing should also be recommended in the list of post-MDG (2015) indicators at the international level. However, participants noted that this would require a different process than the current one for developing indicators for the Network;

2.20. A glossary is needed to clarify and define various terms used in the Guide e.g. sustainability, accessibility, universal design etc.

3. Developing indicators for monitoring Age-friendly Cities: Criteria and Domains

3.1. **Three presentations** were made in this session:

3.1.1. *The experience of Japan Gerontological Evaluation Study (JAGES) HEART* (Prof. Katsunori Kondo, Nihon Fukushi University);

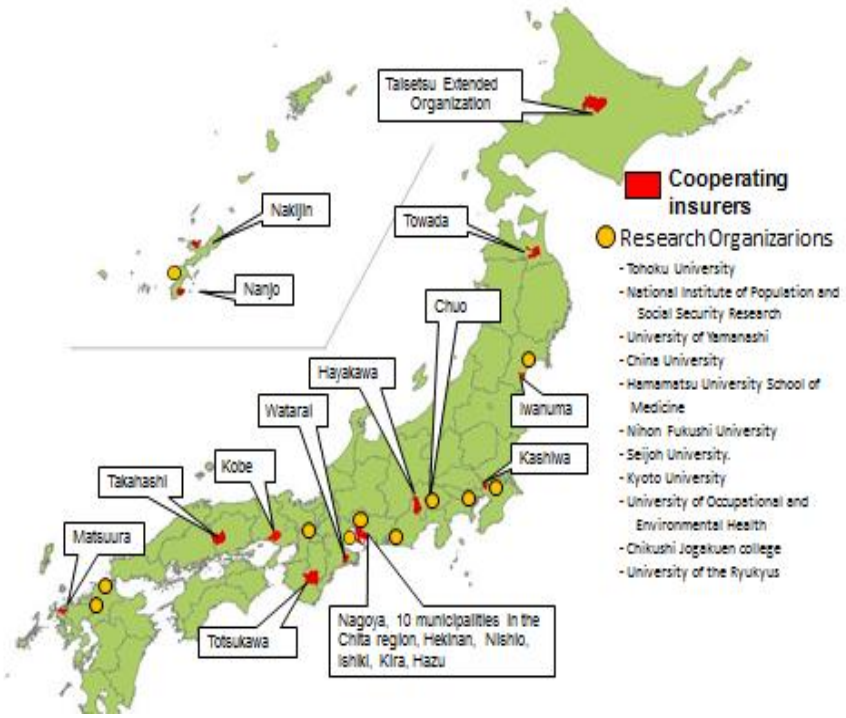
3.1.2. *The experience of developing indicators in Canada* (Dr. Heather Orpana, PHAC);

3.1.3. *The role of age profiles and indicators for the European Healthy Cities Network on healthy ageing* (Dr. Manfred Huber, WHO).

3.2. Prof. Katsunori Kondo provided an overview of the development of the JAGES benchmarking system. The purpose of developing benchmarks is to inform and improve the performance of Japan's public long term care insurance. The project has been funded by the Ministry of Health and Labour Welfare in Japan.

3.3. The latest JAGES study in 2010/11 included 31 municipalities in Japan with 112,123 respondents and the results were widely accepted. More municipalities may join the project in the future;

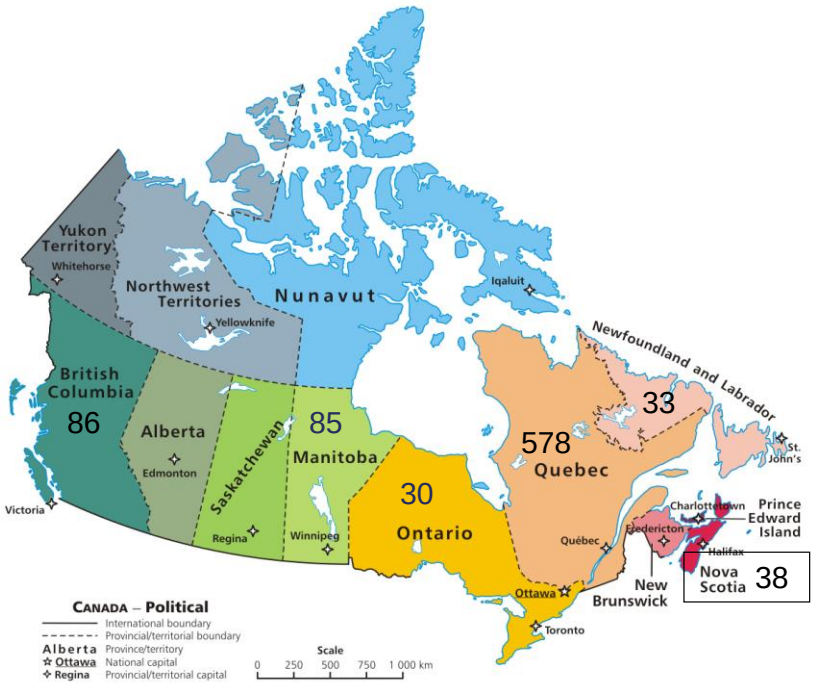
Figure 3 Municipalities in Japan who participated in JAGES in 2010/11, *Source: Nihon Fukushi University*



3.4. Dr. Heather Orpana presented, via Skype, the development of indicators to monitor age-friendliness of communities in Canada. There are more than 800 Age-Friendly Communities in Canada.

3.5. Canada's recognition program includes five milestones, the fifth of which is "Committing to measuring activities, reviewing action plan outcomes, and reporting on them publicly". In order to support communities, the Public Health Agency of Canada (PHAC) is currently developing a set of coherent indicators of age-friendliness for use by communities;

Figure 4 Distribution of over 800 AFCs in Canada *Source: PHAC (Canada)*



3.6. Dr. Manfred Huber presented the development of Healthy Ageing profiles for European countries at the local level as part of the work of the Sub-network on Ageing for the WHO European Healthy Cities Network;

3.7. Dr. Huber mentioned three main outputs of the Sub-network:

3.7.1. Action on implementation and exchange of good practice;

3.7.2. Development/consolidation of tools and guidelines;

3.7.3. Building external partnerships.

3.8. In the **plenary discussion** that followed a number of observations and suggestions were made;

3.9. A few similarities were noted between the three presentations:

3.9.1. Engagement of wider group of stakeholders;
3.9.2. Use of similar criteria to identify indicators;
3.9.3. Linkages were built between different efforts with similar goals.

3.10. A parsimonious list of indicators would be essential in taking forward this initiative especially if data collection methods are going to require surveys;

3.11. The Japanese example and some cities in Europe conducted surveys to collect data. Some cities are ambitious and have resources, both human and financial, to implement surveys. However, surveys may not always be feasible especially when resources are scarce;

3.12. The Canadian example provided a practical and good way of engaging stakeholders;

3.13. Focus for the future should be a policy and intervention oriented tool. The tool should be fit for purpose and should include a clear communication strategy;

3.14. It would be useful to have a "User Manual" or relevant tools with the indicators that can guide users through the process of outcomes reporting, developing policies and interventions;

3.15. In WHO Region for the Western Pacific, the approach is to build capacity on city health governance, then offer topic-specific advice, instead of building policy capacity on each issue;

3.16. It is important to capture the heterogeneity within cities as well. How can we deal with cities that are 90% age-friendly but 10% of the city is not age-friendly? There are some tools such as Urban HEART to assess inequity within cities but they do not cover ageing issues, explicitly, yet;

3.17. It will be important to recommend disaggregation by gender, socioeconomic status, ethnicity etc. The use of equity indicators could also be encouraged. For example, how do cities provide services to low-income groups?

4. Group Work 1: Developing criteria for identifying indicators

4.1. Participants were divided into **three groups** in this session and each group was expected to answer three sets of questions;

4.2. The three sets of questions related to:
4.2.1. Revisiting the domains
4.2.2. Key purpose of the indicators
4.2.3. Technical and practical criteria for identifying indicators

4.3. In revisiting the domains (from 4.2.1) the group agreed on the following key points:

4.3.1. The domains were mostly acceptable, easily understandable and relevant to measure the age-friendliness of a city;

4.3.2. Two new domains were proposed:

4.3.2.1. "**Economic Security**" ;

4.3.2.2. "**Governance**" including implementation and sustainability mechanisms;

4.3.2.3. The domains of "Social Participation" and "Respect and Social Inclusion" were recommended to be merged into "**Social participation, respect and social inclusion**".

4.3.3. A practical challenge in introducing new domains was noted as some countries had already been using the current set of eight domains in their respective Networks. Further discussion with a larger group of stakeholders on domains will be required;

4.4. For the questions in 4.2.1. the following issues were also considered to be of importance:

4.4.1. Stratification of data by gender, socioeconomic status minority groups should be explicitly included;

4.4.2. Life-long learning should be included within one of the domains e.g. civic participation and employment;

4.4.3. The importance of family, friends and pets (e.g., social support) should also be considered, in a new domain, or within one of the existing domains, such as "Respect and Social Inclusion";

4.4.4. Engagement of and ownership by older people should be considered a cross-cutting theme. Other cross-cutting themes include accessibility and affordability;

4.4.5. "Respect" should cover freedom from prejudice, discrimination and abuse;

4.4.6. Food security should also be included under one of the domains e.g. the new domain of economic security or the domain of community and health services.

4.5. The key purpose of the indicators was identified by all groups as "**Local planning and monitoring**". National monitoring and global comparability were considered secondary or tertiary objectives for the indicators;

4.6. Table 2 presents the list of all technical and practical criteria considered by the groups;

Table 2 Criteria for identifying indicators

TECHNICAL	PRACTICAL
Valid and reliable	Parsimonious list
Replicable	Core, recommended and optional indicators
Measurable and observable	Aligns with goals
Sensitivity	Within appropriate sphere of influence (local)

TECHNICAL	PRACTICAL
Representativeness	Ease of data collection
Process and outcome indicators	Social acceptability
Quantitative and qualitative indicators	Evidence of impact

5. Developing indicators for monitoring Age-friendly Cities: a Preliminary List

5.1. **Three presentations** were made in this session:

5.1.1. *The experience of Manchester City Council in developing indicators for population ageing and health* (Dr. Sophie Handler, Manchester City Council);

5.1.2. *Developing indicators for the Active Ageing Index in Europe* (Dr. Asghar Zaidi, European Centre for Social Welfare Policy and Research);

5.1.3. *Study on Global Ageing and Adult Health (SAGE)* (Dr. Somnath Chatterji, WHO).

5.2. Dr. Sophie Handler presented the Citizenship-based approach used to develop an Age-Friendly Manchester. She presented evidence on social inequalities in health among the elderly;

Figure 5 The association between rates of depression and wealth quintiles among the elderly in Manchester, *Source: ELSA*

5.3. Dr. Handler also presented the indicator development process in Manchester including the various issues that were being debated in the city e.g. accounting for the way the in which the baby boom cohort is starting to challenge prevailing assumptions around ageing;

5.4. Dr. Asghar Zaidi presented the experience of developing an Active Ageing Index in Europe including the conceptual choices made in defining the index, the criteria for selection of indicators and the selected indicators. Four domains were defined for the index:

5.4.1. Contribution through paid activities/employment;

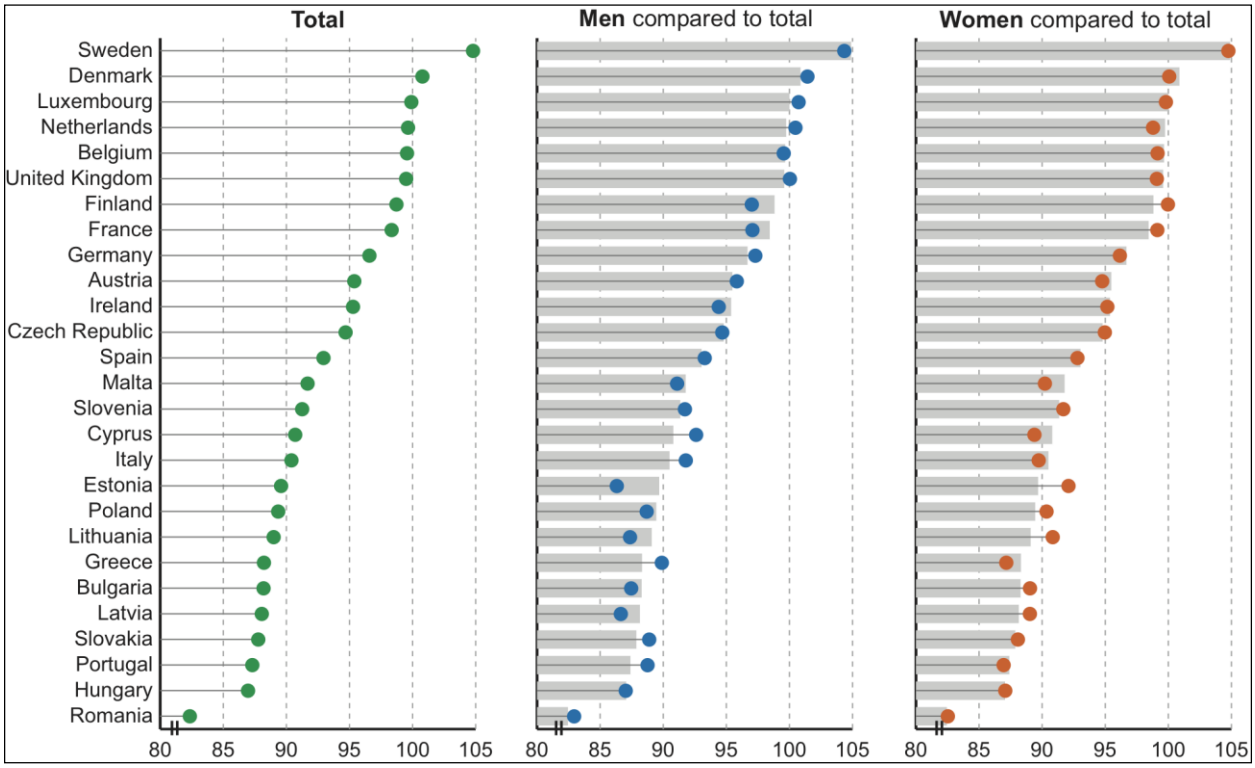
5.4.2. Contribution through unpaid activities/non-market productive activities;

5.4.3. Independent and autonomous living;

5.4.4. Capacity for active ageing and enabling environments.

An example of a country comparison for the fourth domain of the index is in figure 6.

Figure 6 Capacity for Active Ageing across EU 27 countries as ranked by AAI, *Source AAI*



5.5. Dr. Zaidi mentioned that the strength of the index was in its transparent numerical exercise coupled with a methodology offering strong data insights. However, there are critical data gaps in the EU 27 countries which limit the wide applicability of the index;

5.6. Dr. Somnath Chatterji presented WHO's SAGE initiative which is a longitudinal survey programme to compile comprehensive information on the health and well-being of adult populations and the ageing process. SAGE cohorts have been followed since 2002;

5.7. Dr. Chatterji mentioned that the core SAGE collects data on respondents aged 18+ years, with an emphasis on populations aged 50+ years, from nationally representative samples in six countries (China, Ghana, India, Mexico, Russian Federation and South Africa);

5.8. In the plenary discussion that followed a number of observations and suggestions were made;

5.9. Key lessons learned from the various indicator projects are:
- *5.9.1.* Importance of conceptual development before indicator selection (align with goals);
- *5.9.2.* Control ambitions.

5.10. The way to get the collection of neighbourhood data right:
- *5.10.1.* Obtain collected administrative data;
- *5.10.2.* Power a small study and link to the administrative data;
- *5.10.3.* Combining the above two steps can produce more reliable data.

5.11. Use administrative data which are relatively more sustainable than one-off survey data although there are exceptions e.g. case of Manchester;

5.12. Some primary data collection efforts may be necessary, as this information may not exist in administrative data systems;

5.13. Think of other opportunities that would allow collection of data – piggyback on existing efforts e.g. WHO STEPS survey should be expanded to include older adults;

6. Group Work 2: Identifying a Preliminary List of Core Indicators

6.1. Three groups were created to focus on identifying core indicators from three domains each:
- *6.1.1.* **Group 1** focused on the domains of:
  - *6.1.1.1.* Outdoor spaces and building;
  - *6.1.1.2.* Transportation;
  - *6.1.1.3.* Housing;
- *6.1.2.* **Group 2** focused on the domains of:
  - *6.1.2.1.* Respect and social inclusion;
  - *6.1.2.2.* Civic participation and employment;
  - *6.1.2.3.* Social participation;
- *6.1.3.* **Group 3** focused on the domains of:
  - *6.1.3.1.* Community and health services;
  - *6.1.3.2.* Communication and information;
  - *6.1.3.3.* Health.

6.2. In addition, all groups were requested to identify core indicators from the new domains of "Economic Security" and "Governance";

6.3. The groups were not asked specifically to address the two proposed to be merged domains ("Respect and social inclusion" and "Social participation"). However, since the two domains were addressed together this should not results in a loss of information from the exercise;

6.4. The "Health" domain identified during the review of ageing and health initiatives was including together with the "Community and Health Services" domain;

6.5. All groups used the annex to the background document prepared for the meeting as a reference for the list of indicators (175 indicators) to select from: "AFC Meeting - Complementary Background Paper - Tables and Annex.docx";

6.6. Figure 7 provides a sample of the various considerations that group members had to make when discussing the selection of appropriate and core indicators:

Figure 7 Sample table with key considerations in the selection of core indicators

Indicator	Valid?	Aligns with goals?	Actionable?	Comment
Licensed drivers (ages 75 + years)	N	N	Y	Not desirable
Public transport use	Y	Y	Y	Not important
Proportion of residents age 65+ who travel every day, once a week, once a month, or never	N	N	N	
Average number of trips taken on public transportation every day, once a week, once a month by residents 65 years old or older	Y	Y	Y	Note on 65 year cutoff Self report (mostly)
Average number of times per week that residents 65 years old or older report staying at home because of lack of transportation	Y	Y	Y	Self report
Proportion of residents 65 years or older that require assistance from family members or other individuals to access the following services: pharmacy, grocery store, bank, etc.	N			
Participation: There are public transportation options in the community that can accommodate people with mobility challenges, are reliable, and availability is congruent with the demand for service	Y	Y	Y	A good start! Availability and adequacy.

6.7. For each domain the groups were expected to identify **not more than five "core" indicators**;

6.8. The following are the **core indicators** identified by the groups by domain:

OUTDOOR SPACES AND BUILDINGS		
Issue	**Indicator**	**Comment**
Walkability	Proportion of roads suitable for walking	JAGES used perception-based definition
Safety	Proportion of residents 65+ who report feeling safe/ unsafe in their neighbourhood	Consider dimensions of time, location
Mobility	Availability of resting places should be 'satisfactory'	Need to define 'satisfactory'
Accessibility	Access to toilets	In public and private buildings
Accessibility	Accessibility to buildings	

TRANSPORTATION		
Issue	**Indicator**	**Comment**
Utilization	Average number of trips taken on public transport every day, once a week, once a month by residents 65+ years	The cut-off age need not be 65 years in all cities
Accessibility	Average number of times per week that residents 65+ years report staying at home because of lack of transportation	The cut-off age need not be 65 years in all cities
Quality of public transport	Public transportation options accommodate people with mobility challenges are reliable, available, and adequate	Comprehensive service at all times; include driver sensitivity
Quality of public transport	Public transportation vehicles are physically accessible	Need to define "accessible"
Priority parking	Availability of adequate, designated priority parking for individuals with mobility challenges	Needs to be developed

HOUSING		
Issue	**Indicator**	**Comment**
Choice	Proportion and numbers of residences in the community categorized by housing type	Include all housing types
Affordability	Affordable housing	Define “affordability”
Quality	Visitability and adaptability of existing houses	
Accessibility	Policy exists to guide the planning of new housing construction (private and public) that ensures accessibility	
Access to services	Proportion of housing within walking distance (500m) or within 10-min drive by car or public transit trip to the following services: pharmacy, grocery store, bank, hospital, seniors centre, retail shopping	

RESPECT AND SOCIAL INCLUSION		
Issue	**Indicator**	**Comment**
Loneliness	The proportion of older people who report feeling lonely in the past 12 months	Sometimes/ most of the time/ always
Social Support	Availability of support from family/ neighbours/ friends/ pets	
Ageism	Perceived negative attitude on the basis of age (by older people)	
Encourage positive relations	Opportunities for inter-generational activity	
Representation in the media	Proportion of positive images of ageing in print/ TV/ public media/ events	

CIVIC PARTICIPATION AND EMPLOYMENT		
Issue	**Indicator**	**Comment**
Volunteering	Opportunities for seniors to engage in volunteer activities	
Work environment	Employer provision of flexible employment and retirement options	
Employment	Satisfaction with level of employment	
Recognition	Community leaders recognize contribution of seniors through award programmes	
Paid employment	Paid employment rate	

SOCIAL PARTICIPATION		
Issue	**Indicator**	**Comment**
Culture and sports	Participation in cultural activities, arts and sports	
Satisfaction	Satisfaction with engagement in cultural activities, arts and sports	
Frequency of participation	Frequency of engagement in social/cultural activities	
Life-long learning	Participation in education	
Community engagement	Provision of gathering places for seniors, such as senior centres	

COMMUNITY AND HEALTH SERVICES		
Issue	**Indicator**	**Comment**
Utilization	Percentage visiting health facility in last 30 days	
Utilization	Use of health care services	
Accessibility	Home-based care/ chronic home care	
Health	Proportion with functional limitations	
Accessibility	Personal assistance and equipment	

HEALTH		
Issue	**Indicator**	**Comment**
Risk factor	Percent reported tobacco use by age 50+ years	
Risk factor	Percent reported physical activity/ inactivity by age 50+ years	
Outcome	Fatal and serious non-fatal injuries from falls	
QOL	Proportion of people with a high QOL (subjective wellbeing)	
Risk factor	Percent underweight	

COMMUNICATION AND INFORMATION		
Issue	**Indicator**	**Comment**
Information	Resource guide of leisure-recreation programs	
Information	Information about employment and volunteering opportunities	
Availability	Source of information about health concerns and service needs	
Accessibility	Proportion of 65+ with access to seniors centre, library, etc	
Accessibility	Internet access	

ECONOMIC SECURITY		
Issue	**Indicator**	**Comment**
Financial protection	Financial protection for healthcare needs	

GOVERNANCE		
Issue	**Indicator**	**Comment**
Participation	Participation in decision-making/ involvement of seniors	Ideal level of participation should be specified
Age-friendly lens	Leadership in the community has prioritised leisure/ recreation needs of seniors	Within planning and implementation processes
Resources	Percent of government spending on health	
Availability	Availability of community services	

6.9. A few other important issues were brought up during plenary discussion:

6.9.1. Health outcomes indicators may not be necessary as Age-Friendly Cities focuses on facilitating the process of Active Ageing;

6.9.2. Emergency management is an overarching issue. Every single aspect touches upon emergency management;

6.9.3. Access to a primary care physician or other provider such as nurse practitioner or physician's assistant is an important indicator of age friendliness with respect to health care;

6.9.4. Need for a comparable set of basic demographic profile indicators – require it for participation in the network.

7. Next Steps

7.1. Synthesize the results using the reduced initial list of core indicators;

7.2. Agree with the meeting participants on the synthesis report;

7.3. Conduct a broader stakeholder consultation for refining indicators;

7.4. Pilot indicators in cities from the Network as well as non-member cities, if possible;

7.5. Conduct a meeting after piloting of indicators is complete to finalize the list of indicators;

7.6. Develop a timeline for finalizing indicators.

Annex

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