WORLD HEALTH ORGANIZATION
EUROPE

Healthy ageing profiles

Guidance for producing local health profiles of older people

Healthy Cities 21st Century

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Abstract

This guidance uses a positive and dynamic model for profiling older people at the local level. Health profiles are important tools for health development planning and for monitoring progress in and accountability for the health of the community. Profiles should not simply promote positive features of city life but should also highlight gaps in services and difficult socioeconomic circumstances. The guidance covers 22 indicators grouped into three sections: (A) population profile, (B) health and social care systems and (C) social portrait, indicating wider determinants of health and empowerment.

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Foreword

The phenomenon of ageing and the challenges posed by the need to change societal perceptions and to reorganize social and economic institutions are becoming universally shared experiences in the world. Effective responses are sought in all countries.

The growing, ageing population is a source both of joy and worries. Joy because people are living longer and healthier lives. Worries about how to best respond to a future with a larger, older population, with their rightful demands and needs.

Active ageing depends on a variety of influences or determinants that include material conditions as well as social factors that affect individual types of behaviour and feelings; greater knowledge and understanding of their inevitable consequences and of the processes they may start up are critically needed. Working proactively to identify and discover risk factors among citizens is getting even more important, since decisions of all kinds and policies should be made based on sound evidence.

The WHO Healthy Cities Subnetwork on Healthy Ageing developed the healthy ageing profile to be an instrument to this end. With this guidance it will hopefully become an effective tool. Profiles have three parts: population; health and social care systems; and a social portrait. The first two parts build on traditional ways of profiling older people – basic demography, morbidity, mortality and access to services and support. The third dynamic element, the social portrait, relates to the determinants of health (such as income and socioeconomic status, housing and the environment) and the life-course approach. Special attention has also been given to positive features of ageing such as older people as a resource for their families, communities and economies in supportive and enabling living environments.

Profiling therefore provides indispensable knowledge for health care and social services. This knowledge must lead to action, a responsibility for governments, municipalities and councils, which should provide opportunities for health, participation and security to enhance the quality of life as people age. Further, this knowledge must lead to a more enlightened positive and proactive perspective on and understanding of individual and population ageing to achieve maximum benefit from humanity's development and to dealing more effectively with the challenges of ageing. The cities taking part in the Subnetwork on Healthy Ageing have already gained and experienced this knowledge in the healthy ageing profiles.

As Mayor of Udine, I am proud to witness how this guidance has been capable of generating added value in my city in terms of motivation to improve policy-making, with the ultimate goal of completely satisfying the needs of our older citizens. It has been useful to those working in local government, the health sector, the voluntary sector and other bodies whose work influences (or is influenced by) public policy. Moreover, it has been adopted as the basis for intersectoral action and has drawn attention to older people in a way that will permit constructive changes in the future. For instance, healthy ageing has been mainstreamed as a cross-cutting theme and linked with healthy urban planning, providing the framework for a city more liveable and enjoyable for all age groups. Emphasis has been given to accessibility, safety and opportunities for older people through design approaches and solutions (reducing architectural barriers, street safety and creating urban spaces enabling physical activity and social cohesion). In the case of Udine, these processes have certainly been supported by the qualitative community research that the city could conduct thanks to its participation in the WHO Global Age-Friendly Cities project. Consistent with the WHO principles of equity and active ageing, the assessment research has produced precious results on the age-friendliness of the community from the perspective of older people, caregivers and service providers.

The ongoing considerations therefore impel me to sincerely thank the WHO Regional Office for Europe for giving Udine the opportunity to actively engage in the Subnetwork on Healthy Ageing, the editors of this guidance, Lena Kanström, Gianna Zamaro, Claes Sjöstedt and Geoff Green, and all the cities that have used and will use it in the future as a tool for action and progress.

Furio Honsell
Mayor
City of Udine
Italy

Foreword

This guidance was produced as part of the work of the WHO European Healthy Cities Subnetwork on Healthy Ageing, for which Stockholm is the lead city. It complements generic guidance on developing city health profiles and differs from traditional approaches to profiling older people that tend to focus on illness and dependence. The editors, Lena Kanström, Gianna Zamaro, Claes Sjöstedt & Geoff Green, have drawn on their experience of working across many sectors of city life to apply the concept of healthy ageing. I am grateful to the City of Udine for facilitating the publication of this guidance and commend it to policy-makers and decision-makers in cities and towns across the European Region.

Agis Tsouros
Unit Head, Noncommunicable Diseases and Environment,
Division of Health Programmes, WHO Regional Office for Europe

Preface

The guidance has been written as part of the strategy of the WHO European Healthy Cities Subnetwork on Healthy Ageing. It was developed within the Subnetwork from 2005 to 2008 and uses the WHO concept of healthy ageing to develop an innovative approach to profiling the life of older people. The indicators cover life as well as death, health as well as illness and include the wider determinants of health and well-being that are beyond the reach of traditional health and social services. A rationale is provided for each of the 22 indicators, complemented by technical advice on how to proceed and an example of how it was applied in a member city of the Subnetwork. Several cities have tested this core set of indicators. Although cities are encouraged to adapt and perhaps expand this core set of indicators to reflect their own circumstances, maintaining a holistic perspective on the lives and contribution of older people to wider society is important.

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Claes Sjöstedt (Stockholm, Sweden)
& Geoff Green (Sheffield, United Kingdom)

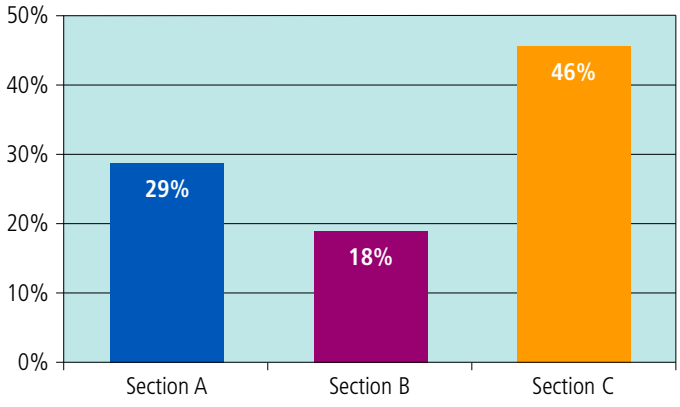
Introduction

The healthy ageing approach uses a positive and dynamic model for profiling older people in cities. Health profiles are important tools for health development planning, monitoring progress in and accountability for the health of the community. The profiles should not simply promote positive features of city life but should also highlight gaps in services and difficult socioeconomic circumstances. They should be accessible and readable and provide quantitative and qualitative information on the health and the living circumstances of older people.

This updated guidance is both a scientific and pragmatic response to feedback on the guidance presented and discussed at the first full meeting of the WHO European Healthy Cities Subnetwork on Healthy Ageing in June 2005. This initial guidance for Subnetwork cities was in the form of a template proposing 75 indicators grouped into three sections: (A) population profile, (B) health and social care systems and (C) social portrait. Later, cities attending the WHO Network Business Meeting in Bursa in September 2005 and the Subnetwork meeting in Vienna in December 2005 recommended the selection of a set of core indicators from the original list of 75 and updated guidance on the rationale and method for each of these core indicators.

The Vienna meeting recommended that the lead city of Stockholm convene a small task group to meet these objectives. This group met in June 2006 to undertake the task. To help cities in creating proper and complete profiles and having an actual instrument for comparing their different situations, we analysed the 10 profiles presented by the end of May 2006. We found out that many cities had difficulty collecting all the data requested, especially in section C, the social portrait. Fig. 1 shows the percentage of unanswered questions in each section.

Fig. 1. Percentages of questions cities did not answer in each section



Rationale, structure and content

The updated template retains the three-part structure of the original: (A) population profile; (B) access to health and social support services; and (C) the socioeconomic portrait: vulnerabilities and strengths. The first two elements build on traditional ways of profiling older people – basic demography, morbidity, mortality and access to services and support. The third dynamic element, the socioeconomic portrait, relates to the determinants of health (such as income and social position, housing and the environment) and the life-course approach. Cities are recommended to measure positive features of ageing – older people as a resource, participating in civic and family life. Periodically surveying the views and perceptions of older people about their health, living conditions and needs can be a valuable source of information.

For this reason we recommend selecting several easily available indicators and building an overall portrait that can help in comparing Subnetwork cities and in developing guidelines and shared local strategies (Table 1).

Table 1. List of indicators

Section A	**Population profile**
1	Population structure
2	Small-area residence
3	Life expectancy
4	Population dynamics
5	Dependency ratio
6	Single household status
7	Mortality by cause, age and sex
8	Morbidity
9	Mental health
10	Functional impairment
11	Behaviour
Section B	**Access to health and social support services**
12	Values
13	City delivery and social support system
14	Health and social care responsibility
Section C	**The socioeconomic portrait: vulnerabilities and strengths**
C1	*Employment, income and social position*
15	Economic status
16	Income
17	Education
C2	*Housing and environment*
18	Housing ownership
19	Safety and security at home and in the neighbourhood
20	Access to transport
C3	*Participation and empowerment*
21	Participation in decision-making
22	Influence in the community

Equity

The principle of equity runs throughout this booklet. Certain ethical principles are especially relevant to older people, but they accord with definitions of equity that apply to the whole population. The Toronto Declaration on Equity and Health adopted at the Second International Conference of the International Society for Equity in Health in 2002 maintains:

> Equity in health is a cornerstone of individual, community, societal and international well-being. ... Equity in health is built upon people having access to the resources, capacities and power they need to act upon the circumstances of their lives that determine their health.

Hence, governments and international agencies must develop policies and programs built not only on equitable access and outcomes to primary care but also on the social, economic and environmental determinants of health.

Some of the 22 indicators explicitly refer to equity in their rationale. For example, in section B, indicator 12 includes equity in the values that describe the goals and orientation of health and social services. Equity is concerned with the provision of services to older people, or any other social group, in a fair and appropriate way. At the most basic level, equity is concerned with broad notions of social justice.

As the Toronto Declaration on Equity and Health indicates, equity also applies to developing a friendly city environment that supports older people in their every day life. For example, in section C, indicator 19 on safety and security highlights how older people, especially older women, fear crime much more than younger neighbours; and fear of crime, influenced by hostile urban environments, is associated with poor mental health.

Section A
Population profile

This part includes six indicators of a city's population dynamic and five indicators of health status (Table 2). A demographic profile is important because it gives the ratio of older people to the working-age population, showing the capacity of cities and countries to provide pensions and health and social care for older people. Traditional indicators of life expectancy, mortality and morbidity for all ages are key elements of the core data set. They help to predict future trends and to identify interventions in the early life course to prevent illness, disability and dependence in later life.

Table 2. Section A: list of indicators

Section A	Population profile
1	Population structure
2	Small-area residence
3	Life expectancy
4	Population dynamics
5	Dependency ratio
6	Single household status
7	Mortality by cause, age and sex
8	Morbidity
9	Mental health
10	Functional impairment
11	Behaviour

1. Population structure

Rationale

This indicator provides an overall picture of the city's population and includes all age groups to provide a context for the older population and facilitate the determination of the dependency ratio (see indicator 5).

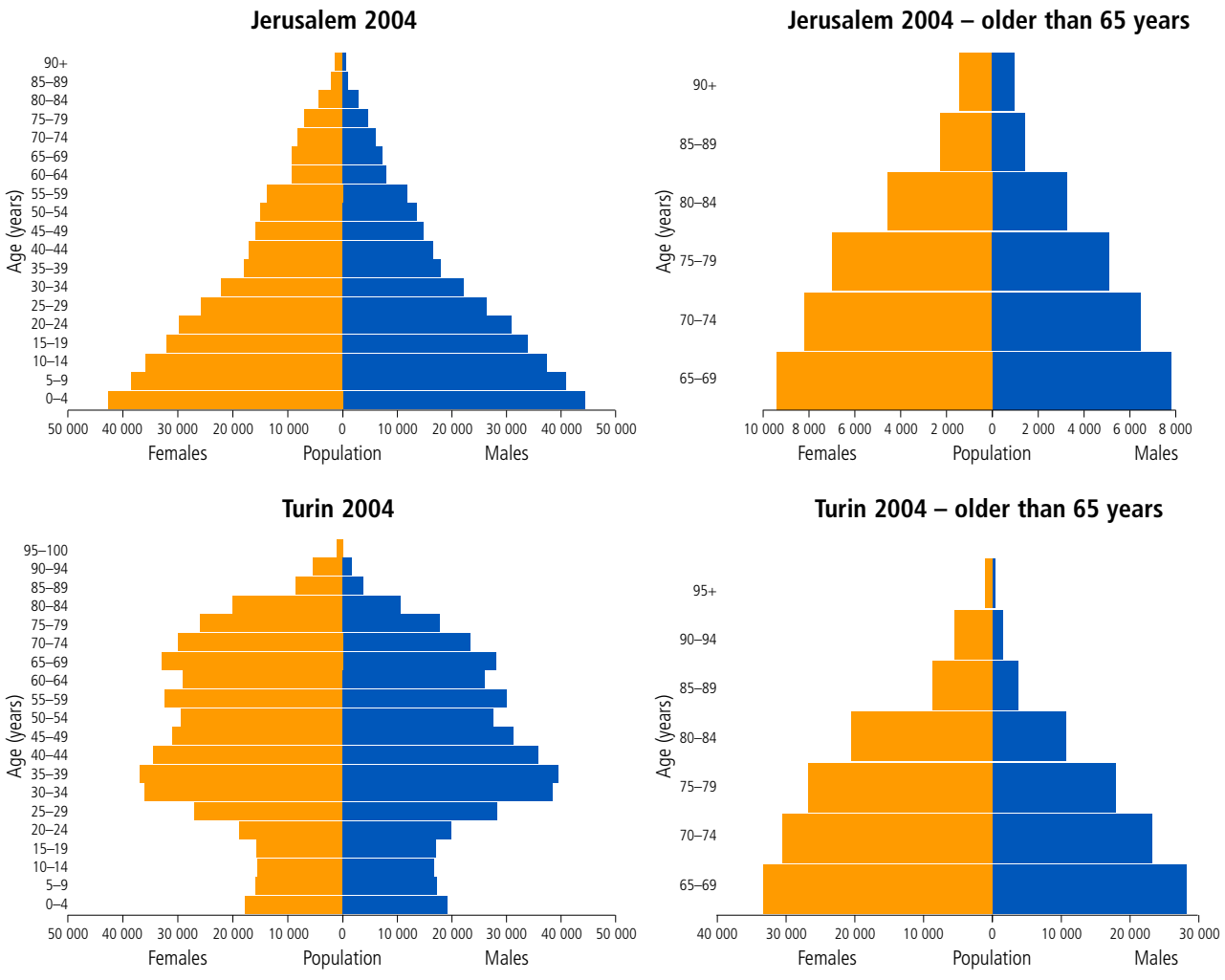
Technical

Cities should use internationally accepted five-year age groups by sex for comparison of trends with other WHO Network cities. Numbers and not percentages should be provided initially. Cities are recommended to use the most recently available data and to present them in the form of population pyramids.

Example

Turin and Jerusalem are examples from extreme ends of the spectrum. Jerusalem has a very young population and Turin an ageing population typical of Italy (Fig. 2).

Fig. 2. Age pyramids: Turin and Jerusalem



2. Small-area residence

Rationale

Here the rationale is to determine the variation in spatial density to enable cities to allocate resources and plan the distribution of services. This is especially useful for larger cities operating out of several district centres.

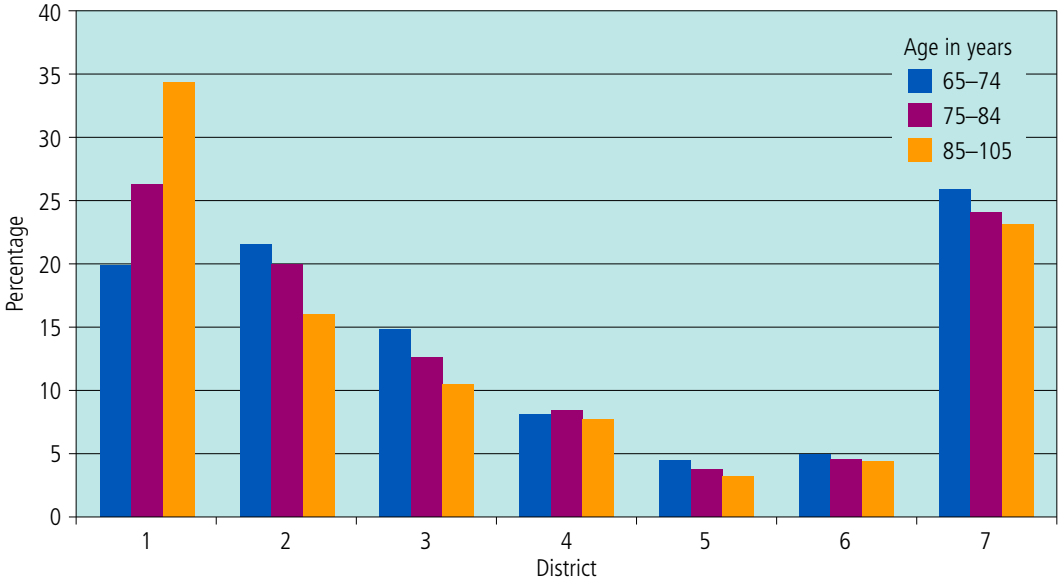
Technical

Data could be presented as maps and/or tables. Cities are recommended to use a geographical information system (GIS) if possible. It is easy to understand and manipulate to provide a portrait showing the links between age and, for example, disability or morbidity or housing situation. Such information is useful in developing equity of distribution and access.

Example

Vienna has 23 districts, and district 13 has a significantly higher proportion of people of 50 years and older. In Udine, older people, who have provided economic and social stability, are moving out of the city centre, which is one of the seven districts (Fig. 3).

Fig. 3. Distribution of older people in Udine by city district



3. Life expectancy

Rationale

Comparatively low life expectancy in a city signals serious health problems. Conversely, increased life expectancy could signal better health. Longevity is increasing in most European cities, promoting some debate about, for example, whether and how far the retirement age should be raised and whether health and social services should be reoriented to reflect the greater number of older women.

Technical

The calculation requires some statistical and epidemiological expertise[1] that local health authorities often have. The life expectancy for residents of a city can be calculated using the variables (see below) and importing local data.

$$T_x = L_x + L_{x+1} + \cdots + L_{w-1}$$

$$e_x = \frac{L_x + L_{x+1} + \cdots + l_{w-1}}{l_x}$$

$$e_o = \frac{T_o}{l_o} \qquad e_x = \frac{T_x}{l_x}$$

Legend

x = age

e_x = the (remaining) life expectancy of people alive at age x

T_x = total number of person-years lived by the cohort from age x until all members of the cohort have died. This is the sum of numbers in the L_x column from age x to L_{w-1}

L_x = total number of person-years lived by the cohort from age x to x+1

l_x = "The survivorship function"; the number of people alive at age x

Example

Table 3 shows the life expectancy in Udine by age.

Table 3. Life expectancy in Udine by age

Age (years)	Life expectancy (years)			
	Females		Males	
	2002[a]	2050[b]	2002[a]	2050[b]
0–4	83.18	97.38	76.72	81.32
5–9	78.47	92.75	72.01	76.62
10–14	73.51	87.78	67.04	71.65
15–19	68.56	82.81	62.07	66.68
20–24	63.62	77.85	57.25	61.84
25–29	58.70	72.90	52.51	57.06
30–34	53.79	67.95	47.70	52.21
35–39	48.88	62.99	42.91	47.37
40–44	44.00	58.06	38.11	42.52
45–49	39.22	53.16	33.48	37.79
50–54	34.54	48.29	28.91	33.10
55–59	29.99	43.45	24.63	28.61
60–64	25.55	38.63	20.49	24.20
65–69	21.16	33.81	16.70	20.01
70–74	17.07	29.06	13.29	16.08
75–79	13.27	24.36	10.36	12.47
80–84	9.82	19.73	7.90	9.23
85–89	6.87	15.24	5.55	6.20
90–94	4.72	11.02	3.92	3.96
95–99	3.38	7.28	2.79	2.31
100–104	2.36	4.22	1.93	1.97
105–109	1.63	2.35	1.33	1.69

[a] 2002 because this is the latest year for which mortality statistics are available.

[b] 2050 because the data are sufficiently robust to make this long-term projection.

[1] Livi-Bacci M. *Introduzione alla demografia [Introduction to demography]*. 3rd ed. Turin, Loescher, 1999.

4. Population dynamics

Rationale

Policy-makers want to know the prospects for their city so they can plan services and influence the determinants of population change. Many European cities have major issues related to falling birth rates, increasing longevity and immigration. All combine in population dynamics that leads to growth or decline, with policy implications for the sustainability of city economies and the provision of health and social services, particularly for older people.

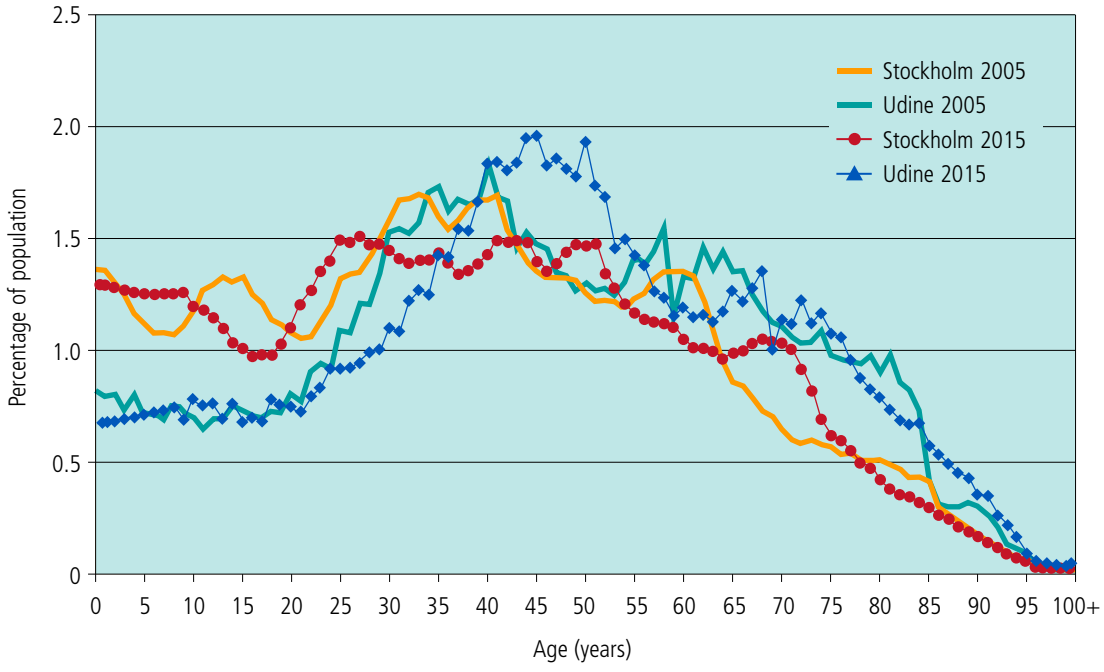
Technical

This indicator combines data on (1) the natural increase or decrease in a city population using the mortality rate and total fertility rate and (2) migratory flows, both of which signal future trends and age structure in a population. These quantitative data could be supplemented by qualitative information addressing equity issues, such as the degree to which immigrants and ethnic minorities are integrated into the economic and social life of the city.

Example

Fig. 4 shows the distribution of population by age in Stockholm and Udine. From 1990 to 2001, annual deaths in both Stockholm and Udine exceeded births, leading to a natural decrease in the population. However, migration into Stockholm compensated for this decrease. The prognosis for Stockholm is that migration and an increasing birth rate will maintain the balance between younger and older people in 2015. In Udine, a continuing low birth rate and increasing longevity will sustain the high proportion of people older than 60 years until 2015 and beyond.

Fig. 4. Distribution of population by age (single-year cohorts) in Stockholm and Udine, 2005 and 2015



5. Dependency ratio

Rationale

The dependency ratio corresponds to the proportion of the dependent segments of a population in a city relative to the working-age or "productive" segments; it is a measure of potential social support needs compared with available resources, being based on the assumption that all people 15–64 years old provide direct or indirect support to those younger or older. Network cities may wish to produce variations of the dependency ratio to acknowledge older people as a resource.[2]

Technical

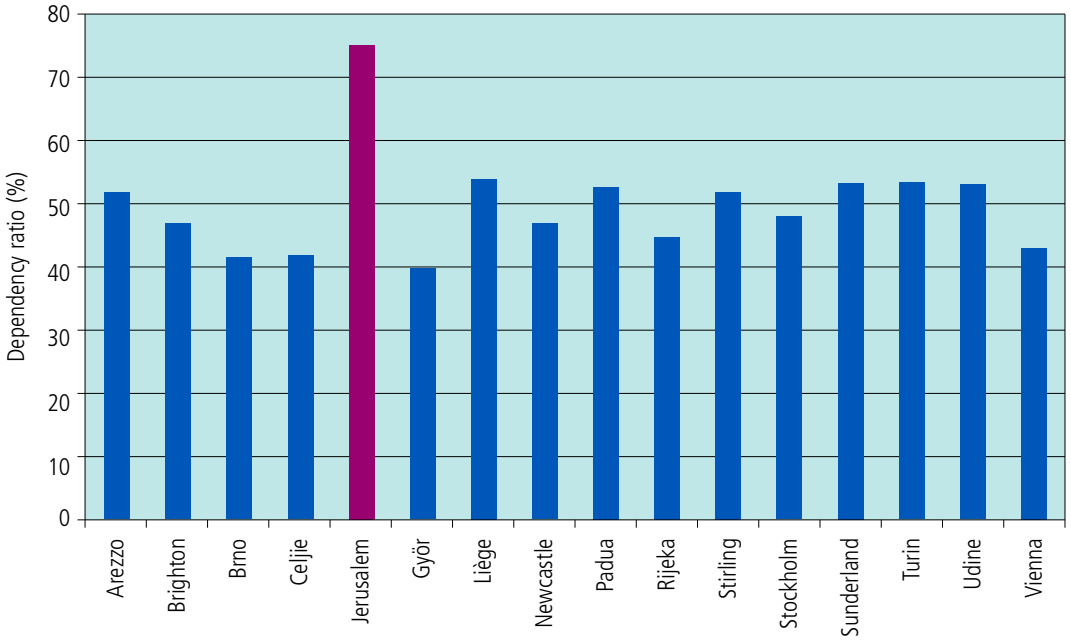
The classical formulation is as follows:

$$\text{Dependency ratio} = \frac{[\text{population 0–14 years old} + \text{population >65 years}]}{[\text{population 15–64 years old}]} \times 100$$

Example

The dependency ratio is much higher in cities with more young people such as Jerusalem (a population in demographic transition) or in countries with an increasing population of older people, such as Arezzo (Fig. 5).

Fig. 5. Dependency ratios in 16 Subnetwork cities



[2] Zamaro G, Green G, Tsouros A. A new model dependency ratio for European cities. *Italian Journal of Public Health* (in press).

6. Single household status

Rationale

The focus is the number and proportion of people 65 years and older living alone. Marital status (widowed or divorced) may provide one possible explanation of why people live alone. More important are the consequences. Older people living alone are more likely to need social services.

Technical

The indicator refers to a household, not an individual, as a person defined as being single by marital status may live in a household with other people. The indicator should refer to the percentage of each age band older than 65 years living alone.

Example

The Stockholm profile is preferred because it refers to the status of households and not individuals. The proportion of women 75–84 years who live alone is very high (Table 4).

Table 4. Household status by age and sex in Stockholm County, average for 2000–2003

	Men (%)		Women (%)	
	Age (years)		Age (years)	
Household status	*65–74*	*75–84*	*65–74*	*75–84*
Cohabiting with an adult and at least one child <18 years	0.6	0.4	0.0	0.0
Cohabiting with an adult and with children ≥18 years	0.8	1.2	1.3	0.0
Cohabiting with an adult and without children	70.2	69.4	56.0	34.2
Single and living with at least one child <18 years	0.0	0.0	0.0	0.0
Single and living with children ≥18 years	0.5	0.0	1.2	1.7
Single and living without children	27.5	29.0	41.5	63.6
Still living with their parents	0.4	0.0	0.0	0.5
Total	100.0	100.0	100.0	100.0

7. Mortality by cause, age and sex

Rationale

Estimating mortality numbers and trends by age and sex facilitates the planning of services, including the equitable allocation of hospital beds. The results from profiles show a general pattern of heart disease, followed by cancer, as the most common cause of death. All top five causes of death are from noncommunicable diseases, which are determined by proximal influences of lifestyle and related structural factors such as housing and employment. A life-course approach (including primary prevention and healthy urban planning) can influence the future pattern and prevalence of these diseases.

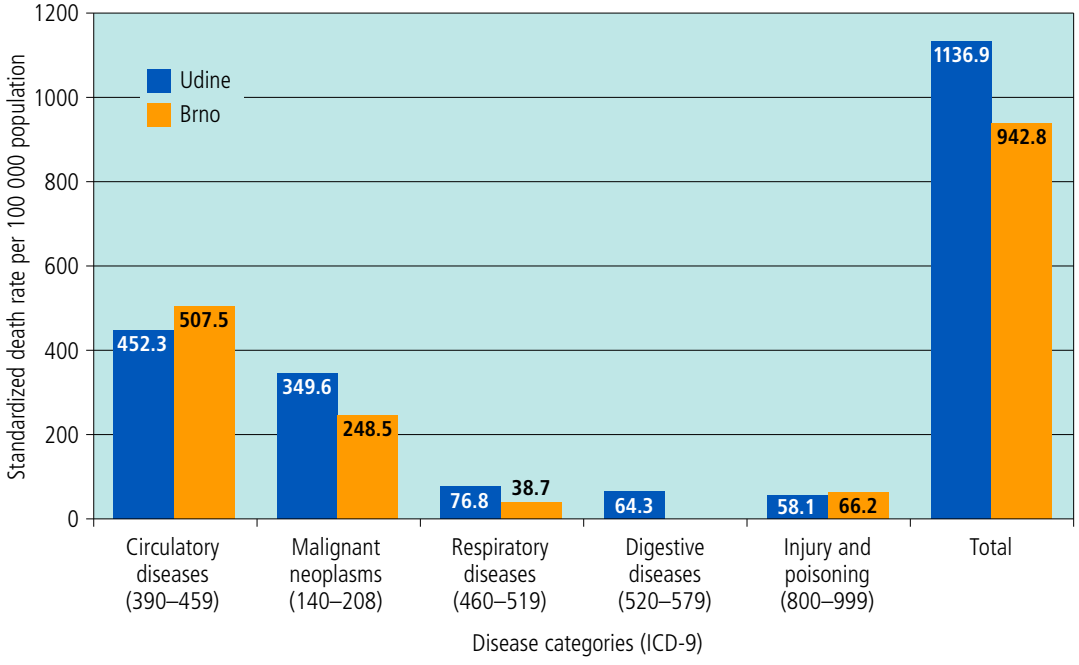
Technical

The International Statistical Classification of Diseases and Related Health Problems, tenth revision (ICD-10 – the latest version) is recommended to calculate the indicator. Standardizing crude data is recommended to compare with the European population and not the national population.

Example

The Rijeka profile refers to absolute numbers, and the Vienna profile refers to the percentage of deaths attributable to various causes. Both the Brno and Udine profiles present standardized mortality rates, which facilitate comparison between the two cities. Fig. 6 shows Udine with a mortality rate for cancer significantly higher than that for Brno. A possible explanation is the legacy of difficult working conditions in shipbuilding and industry, high radon concentrations and more frequent unhealthy lifestyle.

Fig. 6. Specific standardized death rates in Udine-Brno



8. Morbidity

Rationale

A simple presentation of the pattern of illnesses in a city population could establish a link between age and ill health and permit the reorientation of policies and programmes.

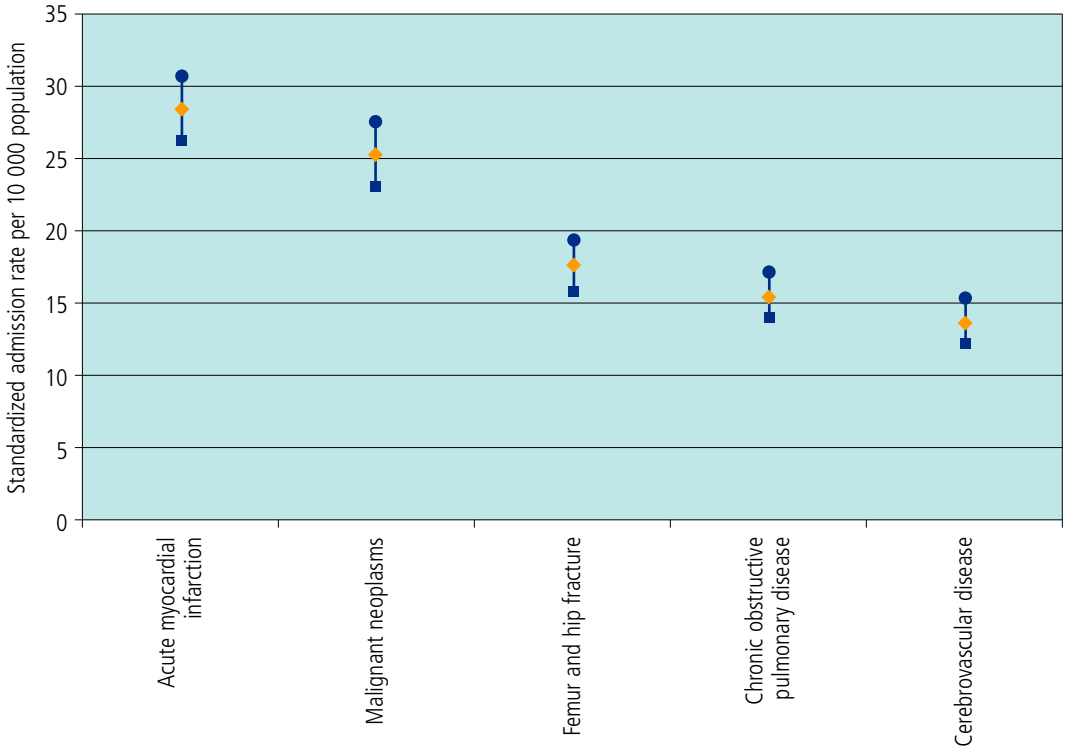
Technical

There are two basic complementary approaches to establishing the prevalence of morbidity in a city: (1) small sample surveys that are representative of the whole city population and (2) agency records of the utilization of health services. One advantage of option 1 is that it can capture low levels of morbidity, such as people with symptoms of back pain. But this is expensive if it requires a special survey. International instruments for measuring specific morbidity facilitate comparisons between cities. Option 2 is less costly because it draws on routinely collected data.

Example

Fig. 7 shows the standardized rates of admission to hospital (with 95% confidence intervals) in Udine for the five most frequent causes among people 65 years and older.

Fig. 7. Standardized rates of admission to hospital in Udine for the five most frequent causes among people 65 years and older



9. Mental health

Rationale

Mental health is a prerequisite to living a good life integrated into family, workplace and the wider society. Poor mental health among people 50 years and older is one of the most frequent causes of leaving the labour market. Because most people can maintain good mental functioning throughout their life course until close to death, they are able to continue contributing to society, although this potential is sometimes not recognized. A minority suffers from degenerative disease leading to dementia, requiring support from health and social care services.

Technical

The basic approach (approach 1) for establishing the prevalence of mental health in a city is by small-sample surveys that are representative of the whole city population and capture low levels of depression and anxiety (common mental disorder) because, for example, people are lonely or afraid. But this can be expensive and can be achieved by either a special survey or as part of a more comprehensive population survey. Standard measuring instruments (such as the EQ-5D, five-item Mental Health Inventory (MHI-5) or General Health Questionnaire (GHQ-12)) facilitate comparisons between cities. On the other hand, mental illness is captured by data routinely collected by local health authorities (approach 2). Cities are recommended to focus on degenerative diseases such as dementia because they are more prevalent in older age.

Example

Stockholm uses the GHQ-12 to construct an index of mental health. Fig. 8 shows the percentage of women in each of the four age bands reporting poor mental health. Fig. 9 illustrates hospital admissions for mental disorders.

Fig. 8. Approach 1: percentage of people 21–84 years old with poor mental health by age group in Stockholm, 1990–2002

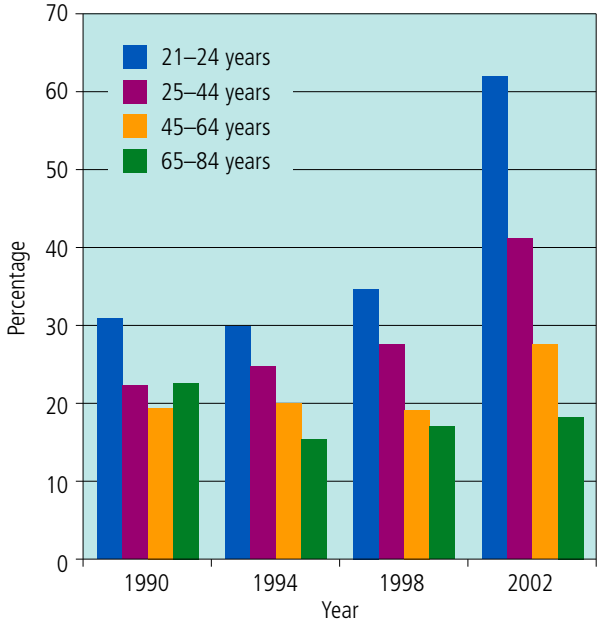
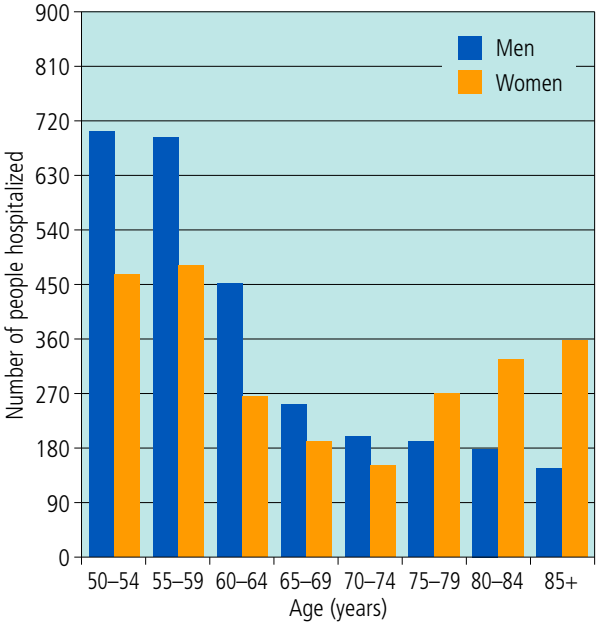


Fig. 9. Approach 2: number of people hospitalized for mental disorders in Stockholm (population 1.8 million), 2003



10. Functional impairment

Rationale

This broad indicator include all levels of functional impairment ranging from being incapable of self-care to relatively minor impairment such as inability to reach down and tie shoelaces. Many people 50 years and older are prevented from working (see section C) because of disability, and in older age incapacity places demands on health and social care services. It is therefore necessary (1) to indicate the magnitude of the problem in older age to plan and project the level and equitable distribution of supporting health and social services and (2) to indicate the prevalence rates earlier in the life course to focus on prevention.

Technical

There are two basic approaches to establishing the prevalence of functional impairment or disability in a city: (1) small-sample surveys that are representative of the whole city population and (2) agency records of the utilization support services. The first one can be expensive and is achieved by either a special survey or as part of a more comprehensive population survey. Standard measuring instruments such as the International Classification of Functioning, Disability and Health will facilitate comparisons between cities. The second one is less costly because it draws on routinely collected data but it does not reveal minor functional impairment unknown to the authorities.

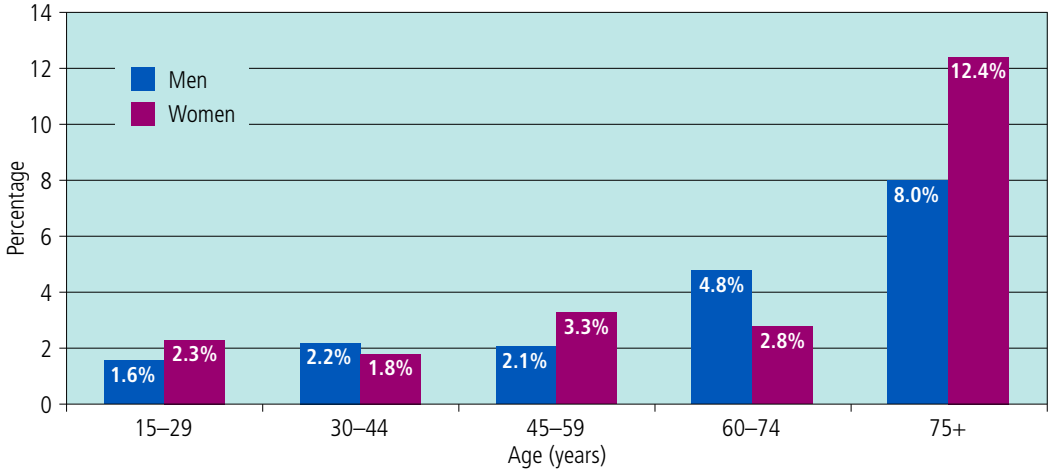
Example

Vienna provides an example of approach 1 (Fig. 10) and Stockholm County approach 2 (Table 5).

Table 5. Stockholm County: utilization of home-help service by age

Age (years)	Using home-help service
65–74	2.5%
75–79	6.9%
80–84	13.6%
85–89	23.8%
90+	31.3%

Fig. 10. Vienna: activities for personal needs (such as washing and dressing) required by age



11. Behaviour

Rationale

During the 20th century there was an epidemiological transition from communicable to noncommunicable diseases, which are now the main cause of disability and death. Behaviour is a proximal (downstream) influence on noncommunicable diseases. For example smoking, nutrition, alcohol and drugs and insufficient physical activity may lead to cancer, diabetes and cardiovascular and respiratory diseases. These lead to disability, dependence and death. Policies need to address both distal (upstream) determinants and these proximal influences.

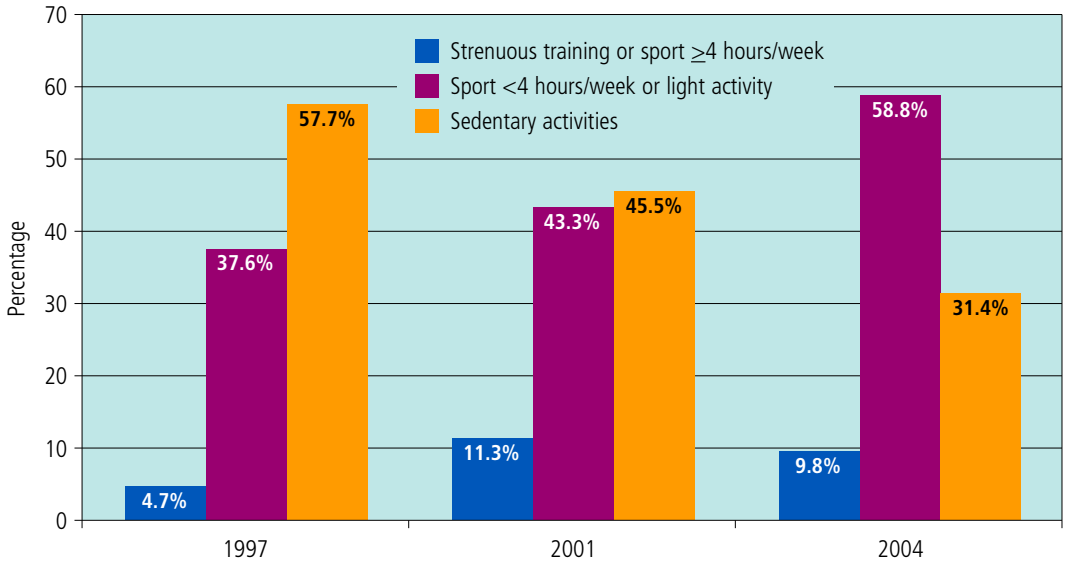
Technical

The prevalence can only be established by small-sample surveys that are representative of the whole city population. These can be expensive and are achieved by either a special survey or as part of a more comprehensive population survey. Standard measuring instruments will facilitate comparison between cities.

Example

Liège presents an example (Fig. 11).

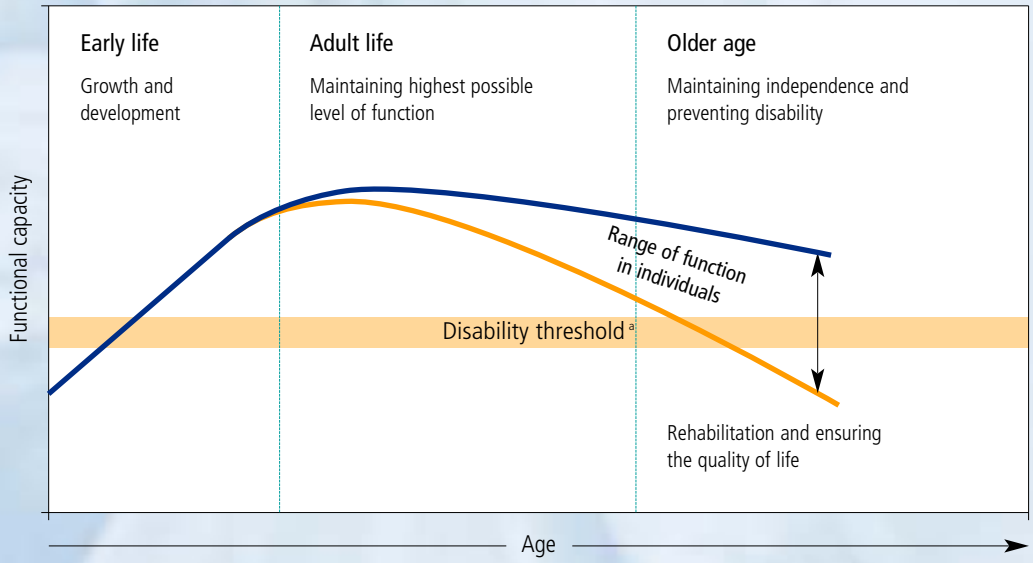
Fig. 11. Leisure physical activity among people 65–74 years old in Liège, 1997, 2001 and 2004



Section B
Access to health and social support services

One of the four objectives of Subnetwork cities is "to promote accessible health and social care services that support independence while providing, where needed, formal care for older people and support for their families and carers". This section of the profile highlights traditional health and social services that support older people with functional impairment. A figure from *Active ageing: a policy framework* (Fig. 12) shows wide variation in the rate of decline in physical functioning from a high point in early adult life.

Fig. 12. Maintaining functional capacity over the life course



[a] Sources in the environment can lower the disability threshold, thus decreasing the number of disabled people in a given community.

Source: Kalache A, Kickbusch I. A global strategy for healthy ageing. *World Health,* 1997, 50(4):4–5.

Section C highlights interventions in the middle of the life course to slow the rate of decline. Section B (Table 6) focuses on older people whose decline in functional capacity has taken them through the threshold of functional impairment (see indicator 10 on functional impairment). The first meeting of the Subnetwork in June 2005 identified three levels of support from health and social services to match different levels of disability (functional loss). They can be represented by the pyramid (Fig. 13) recommended by the Department of Health of the United Kingdom.

This and similar models groups the people with long-term conditions into three distinct groups based on their degree of need, with 70–80% effectively able to care for themselves. Our review of this section concludes that the basic requirement is a description of each city's health and social care system, whether provided through national, regional or local government. This includes:

- describing the values, goals and orientation of health and social services in the city;
- summarizing the main components and flows of people and services in the health and social care system; and
- analysing how responsibilities are allocated between the municipality, health service and other agencies.

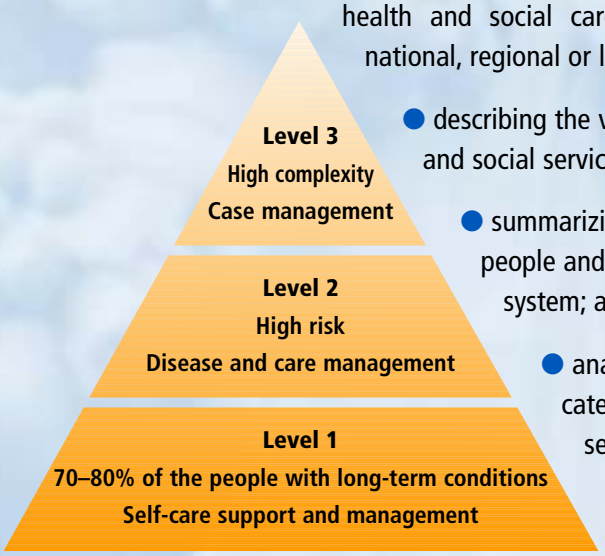


Fig. 13. Delivery of support systems

Source: NHS Modernisation Agency and Skills for Health. *Case management competences framework for the care of people with long term conditions.* London, Department of Health, 2005.

Table 6. Section B: list of indicators

Section B	Access to health and social support services
12	Values
13	City delivery and social support system
14	Health and social care responsibility

12. Values

Rationale

This indicator describes the goals and orientation of health and social services in a city. It gives a sense of purpose. It may cover universal values such as health as a human right or the respect and dignity given to older people who rely on public services. It should challenge age discrimination. These values govern fair and appropriate access to health and social care services.

Technical

Cities may refer to the United Nations Principles for Older Persons:[3] independence, participation, care, self-fulfilment and dignity. Does a city's health and social care services include these values in the key strategies and policies? Assessing the specific access and barriers to these services may include (1) age discrimination in relation to health and social care, (2) cost as a barrier to using services and (3) health insurance coverage.

Example

Liège refers in the text below to (3) the insurance system and in Table 7 to (2) cost as a barrier to use.

It is generally recognized that Belgium has one of the most interesting health insurance systems. Many countries would like to have the same! This insurance is managed by the mutual society chosen by the insured person and at a higher level by the National Institute for Health and Disability Insurance (INAMI/RIZIV) under the Federal Ministry of Social Affairs and Health. A current trend is that the population is being urged to purchase complementary insurance (for example, hospitalization) to be even better protected.

Table 7. Cost as a barrier to using health services in Liège: accessibility to health care in the Walloon Region – 2004

Cost barriers	Age (years)				
	45–54	55–64	65–74	75+	15–75+
Expenses for health per month (mean)	€89.5	€136.6	€118.5	€145.3	€109.9
Health expenses as a proportion of total budget (%)	5.0	8.2	8.0	12.6	6.7
Families considering these expenses difficult or very difficult (%)	35.7	36.1	38.3	35.9	33.2
Families that have had to postpone some care (%)	16.2	14.6	11.5	5.6	15.6

Source: Bayingana K et al. *Enquête de Santé par Interview Belgique 2004 – résultats.* Brussels, Scientific Institute of Public Health, 2006 (http://www.iph.fgov.be/epidemio/epifr/crospfr/hisfr/table04.htm).

[3] *United Nations Principles for Older Persons.* New York, United Nations, 2008 (www.un.org/ageing/un_principles.html, accessed 29 September 2008).

13. City delivery and support systems

Rationale

Active ageing: a policy framework[4] recommends that cities "develop a continuum of affordable, accessible, high-quality and age-friendly health and social services that address the needs and rights of women and men as they age". The model of delivery and support systems (Fig. 13) distinguishes different levels of care required to meet different levels and types of need. This indicator is an overview of how a city organizes its facilities to meet these needs.

Technical

It is recommended that cities describe their system diagrammatically by adapting the "hubs and flows" model outlined in Fig. 14. This summarizes the overall situation of facilities and services in their city as it relates specifically to older people. The diagrammatic model should be followed by a brief description of each component and the number of users.

At the core are the majority of older people living at home. In principle, they have access to a range of health and social services. These are configured differently in different cities, reflecting their national systems and policies. Some of the essential flows are similar. Older people routinely visit general practitioners or other health professionals providing primary care. If they have a disease or disorder they may be visited in their homes. They may visit a hospital for specialist (secondary) health services and, in most cases, will return home. If they require personal care that cannot be managed at home then they may move to a residential home (institution). Most of them do not return home because their disabilities are irreversible. When health conditions deteriorate further, some move to nursing homes to obtain extra care and support.

Example

Fig. 14 shows the system of nursing and social care in Sunderland (Table 8). Box 1 shows the system in Udine.

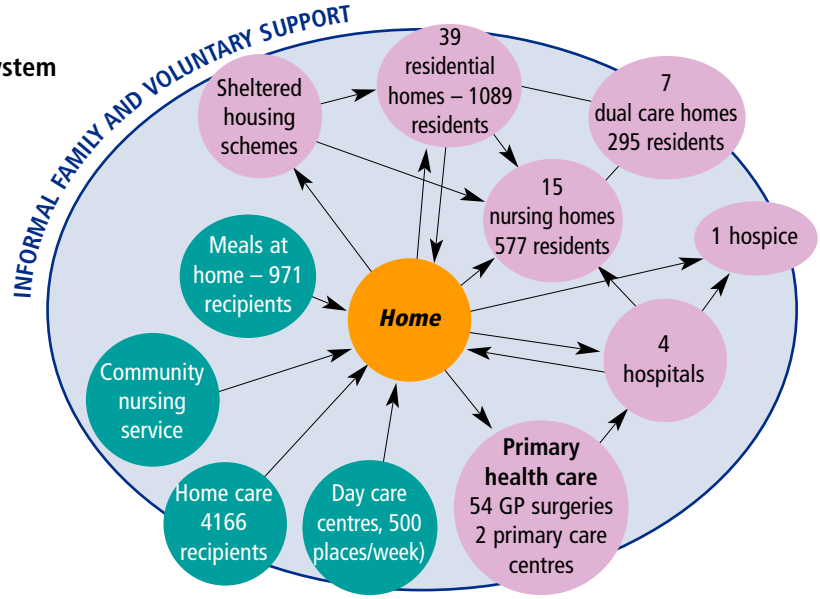


Fig. 14. Service delivery and support system for people 65 years and older in Sunderland

[4] *Active ageing: a policy framework*. Geneva, World Health Organization, 2002.

Table 8. Definition of the components of a city health and social care system

Type	*Definition*
Community nurses	Nurses based in the community visit older people at home
Meals on wheels	Hot meals are delivered to older people at home by municipality or private companies
Primary health care	Older people visit a health centre to consult a doctor or nurse for an initial diagnosis and health maintenance
Day care centre	During the day, an older person visits an institutional centre providing meals, leisure activities and social support
Sheltered home	An older person lives independently in one of a cluster of flats with access to heath and social support services on site and communal leisure activity
Residential home	An older person lives in a room in an institutional building sharing common facilities with other residents and supported by carers
Nursing home	An older person lives in a room in an institutional building sharing common facilities with other residents and supported by carers, nurses and, as necessary, by physicians
Hospice	An older person with terminal disease is provided with care support, in a special building, to die with dignity
General practitioners	Older people visit first of all their physicians in a health centre to consult about a health problem
Home care	Social care assistants visit old people at home to support them in the activities of daily living

Box 1. Support for older people in Udine

The city provides support to older people through three day-care centres. One is for self-sufficient people; the others are for partly or totally disabled adults and older people who need to have a break from their home environment, by meeting new people, learning new skills, sharing experiences and overcoming feelings of isolation and loneliness. The centres promote several recreational activities such as craft workshops (painting, mosaic and fabric crafts), gym sessions, guided tours to exhibitions, lectures on special issues, outings, bingo and other board games, seminars, videos, readings, blood pressure screening, etc. All the activities are organized with the help of voluntary organizations and some representatives of the older people themselves. Moreover, they offer support and respite to family caregivers but also therapeutic care for cognitively and physically impaired older adults without depriving them of their family and home habits. Qualified and professionally trained experts ensure continuous support as well as recreational, socialization and rehabilitative activities and provision of meals.

Nursing homes in the city provide to frail or disabled older people residential care combined with either nursing, supervisory or other types of care: a mix of health and social care. This long-term institutional service is provided when the round-the-clock care that is necessary can no longer be given at home. These establishments have a permanent core staff of registered or licensed practical nurses who, along with other staff, provide nursing and continuous personal care services. By means of a report drawn up by the competent social worker, an assessment unit evaluates the health and social situation of the applicant. If the person in need asks the municipal administration for a financial contribution, his or her income is also assessed. The assessment unit also determines the length of stay according to the person's needs.

14. Health and social care responsibility

Rationale

This indicator divides responsibilities for key services and facilities between municipality and partner agencies, including the health sector and nongovernmental organizations. This enables cities to oversee the major centres of expenditure, promoting cooperation between commissioning authorities and integration of care provision.

Technical

Cities are recommended to complete the simple schedule illustrated by the City of Sunderland in Table 9, allocating responsibility for commissioning and the direct provision of services, either to the municipality, health authority (where different) and/or other agencies.

Table 9. Responsibilities for commissioning and providing services in Sunderland's health and social care system

Responsibility	*Municipality*		*Health authority*			
	Provision	*Commissioning*	*Provision*	*Commissioning*	*Private provision*	*Voluntary provision*
Residential home	✔	✔			✔	
Home care	✔	✔			✔	✔
Day-care centre	✔	✔			✔	✔
Meals at home	✔	✔				
Sheltered homes						✔
Nursing home			✔		✔	
Community nurses			✔	✔		
Hospice				✔		✔
Hospital			✔	✔		
General practitioners			✔	✔		

Section C

The socioeconomic portrait: vulnerabilities and strengths

This third dynamic section, the social portrait, relates to the determinants of health (such as income and social position, housing and the environment) and the life-course approach. The key determinants are reproduced from the Dahlgren and Whitehead model (Fig. 15).

Cities should also measure positive features of ageing. Health is not only as a beneficial outcome (an end in itself) but also as enables older people to be a resource, participating in civic and family life. Eight indicators were selected for this section (Table 10).

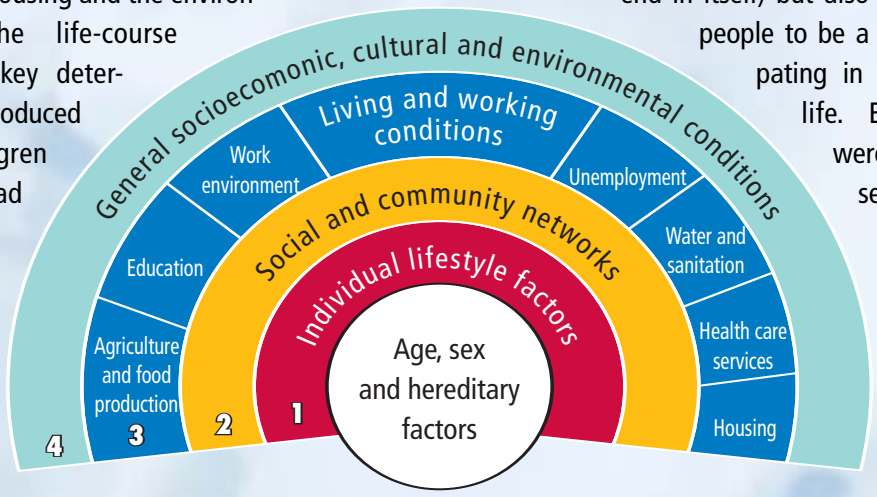


Fig. 15. The determinants of health

Source: adapted from: Whitehead M, Dahlgren G. What can we do about inequalities in health? *Lancet*, 1991, 338:1059–1063.

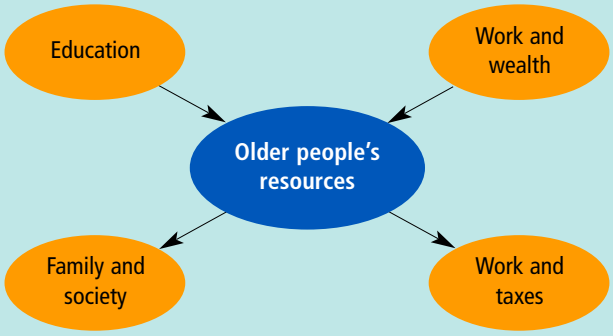
Table 10. Section C: list of indicators

Section C	The socioeconomic portrait: vulnerabilities and strengths
C1	*Employment, income and social position*
15	Economic status
16	Income
17	Education
C2	*Housing and environment*
18	Housing ownership
19	Safety and security at home and in the neighbourhood
20	Access to transport
C3	*Participation and empowerment*
21	Participation in decision-making
22	Influence in the community

C1. Employment, income and social position

This subsection relates to the model of older people as a resource (Fig. 16). Throughout a life course of education and work, older people have accumulated resources, both human and social capital. Having accumulated resources, many older people continue to contribute taxes or work in the formal economy, and also donate financial and non-market resources (such as social capital) to family, friends and society.

Fig. 16. Resources of older people



The contribution of these resources is quite difficult to measure. Cities are recommended to consider the (non-market) care of family members (such as looking after grandchildren while parents work) and voluntary contributions of time or financial resources to nongovernmental organizations and representative bodies such as city councils. Three formal measures (indicators) of an older person's ability to accumulate resources were selected. They can be supplemented by qualitative analysis of age discrimination in the workplace, possibilities for training and life-long education and preparation for retirement, etc.

15. Economic status

Rationale

The level of financial resources commanded by older people derives principally from their relationship with the labour market, past and present. Because of illness, discrimination or choice, people older than 50 years are increasingly excluded from the labour market as they approach retirement age (usually 65–67 years). National and city governments across Europe are encouraging higher levels of labour market participation to increase economic production and reduce the number of years during which a pension has to be paid.

Technical

This indicator should show four basic categories of economic status for five-year bands from 50 to 70 years. The categories are: (a) employed (distinguishing full time from part time if possible), (b) unemployed, (c) retired and (d) economically inactive (outside the labour market). If possible, cities should distinguish causes of economic inactivity such as (a) long-term illness or disability, (b) caring for family and (c) looking after the household.

Example

Vienna has provided Table 11, showing five categories of economic status by five-year age bands from 50 to 65+ years.

Table 11. Vienna: economic status by age

	Age (years)				
	50 or older	*50–54*	*55–60*	*60–65*	*65 or older*
Men			Number		
	229 640	51 774	49 495	41 373	86 998
			%		
Employed (including part-time) [a]	35.1	78.3	60.0	17.7	3.5
Unemployed [b]	6.5	12.4	14.5	3.2	0.0
Pension (own, widow)	57.1	7.2	23.6	78.1	96.0
Other income	0.9	1.4	1.2	0.9	0.5
Household	0.4	0.7	0.7	0.2	0.0
Other	0.0	0.0	0.0	–	–
Women			Number		
	317 533	55 528	54 185	46 681	161 139
			%		
Employed (including part-time) [a]	18.7	69.3	28.8	7.3	1.1
Unemployed [b]	2.4	9.8	3.6	0.3	0.0
Pension (own, widow)	68.6	7.5	53.0	81.2	91.2
Other income	1.5	1.8	1.8	1.5	1.4
Household	8.8	11.5	12.8	9.7	6.3
Other	0.0	0.0	0.0	0.0	0.0

[a] Employed means paid work of at least one hour per week in the week before the survey (including self-employed and co-working relatives).
[b] Unemployed people do not have any contract for work but are searching for work, whether or not they receive unemployed benefit. People receiving emergency benefits are not considered unemployed.

16. Income

Rationale

People's average personal income declines relatively as they approach formal retirement age, with average retirement incomes less then half of working income. In Europe, there is major political and policy debate about affordability, source of pensions (whether from private schemes, from the state or from an employer) and inter-generational equity.[5]

Technical

Obtaining representative income data at the city level can be difficult. Some city profiles have succeeded, but there is no standard local source. Income data are routinely collected in national surveys of sufficient size to permit regional subdivision.

Example

The Stockholm County profile shows four types of income (employment, capital, pension and social support) for different age bands (Table 12).

Table 12. Proportion (%) of income sources by type, age (20+ years) and sex in Stockholm County

Sex	*Age (years)*	*Employment*	*Capital*	*Pension*	*Social benefits*	*Total*
Men	20–65	68	15	7	11	100
	66–69	17	12	68	3	100
	70–74	7	11	79	3	100
	75+	4	12	83	2	100
Women	20–65	64	14	9	13	100
	66–69	9	11	77	3	100
	70–74	2	12	82	4	100
	75+	2	13	76	8	100

[5] Martin J. *Live longer, work longer.* Paris, Organisation for Economic Co-operation and Development, 2006.

17. Education

Rationale

Formal education is linked to better health and a resource that enables people between 50 years and retirement age to continue in employment and maintain levels of income.[6] Further, older people can impart their skills and experience as a resource to wider society.

Technical

This indicator should compare levels of education by sex and across the full range of age bands to assess the relative position of older people. At least four levels of education should be identified (primary or basic, secondary, higher and university). Cities can then link the level of education to income and participation in the labour market by older people.

Example

The Stockholm County profile shows six levels of education and four age bands (Table 13).

Table 13. Distribution (%) of level of education by sex and age in Stockholm County

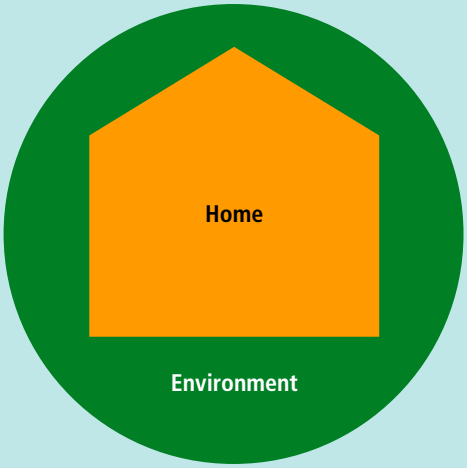
Educational level	Men				Women			
	Age (years)				*Age (years)*			
	18–49	*50–59*	*60–65*	*66–84*	*18–49*	*50–59*	*60–65*	*66–84*
Nine-year compulsory school	10	22	28	36	10	22	29	49
Vocational school	21	17	14	16	17	14	14	11
Lower secondary school	0	9	14	18	1	11	21	21
Upper secondary school	27	16	13	12	26	11	7	5
Higher education	41	35	30	16	46	41	29	11
Other	1	1	1	2	1	1	1	2
Total	100	100	100	100	100	100	100	100

[6] Martin J. *Live longer, work longer.* Paris, Organisation for Economic Co-operation and Development, 2006.

C2. Housing and environment

This section is divided into two parts: ownership and amenities of the housing stock; and a description of the wider physical environment, which can be improved by healthy urban planning. The relationship between home and environment is complex, involving many dimensions that influence the health and well-being of older people (Fig. 17).

Fig. 17. Home and environment



For the first housing part, the core indicator recommended is housing ownership. For the second part, accessibility and safety issues are important. Two other core indicators are recommended: safety and access to transport.

18. Housing ownership

Rationale

The type of ownership of a house influences the opportunities and costs of the occupants. Many retired owners in high-income countries have paid off their mortgage, providing an asset that reduces the cost of living but also makes them liable for repairs to their property. In high-income countries, many older people rent social housing: they continue to pay rent and (because of their low income) are often subsidized and protected more than tenants of working age. Some municipalities provide sheltered homes (reference indicator B13) for special needs.

Technical

It is recommended that cities distinguish a minimum of two age bands (younger and older than 65 years) by four categories of ownership: (1) rented from the municipality, (2) rented from another owner, (3) owned with a mortgage and (4) owned with no mortgage. Cities may add data about the types of home, including special housing for older people with disabilities.

Example

The Stockholm County profile distinguishes owners from renters by four age bands (Table 14).

Table 14. Home tenure in Stockholm County (%)

Sex	*Age (years)*	*Own their home*	*Rent their home*	*Unknown*	*Total*
Men	16–24	48	48	4	100
	25–44	54	45	1	100
	45–64	63	37	1	100
	65–84	63	37	0	100
Women	16–24	48	49	3	100
	25–44	58	40	2	100
	45–64	68	31	1	100
	65–84	57	43	0	100

19. Safety and security at home and in the neighbourhood

Rationale

Safety and security are major issues for older people and related to levels of mental health and physical well-being. Accident and fear of crime undermine confidence and self-identity.

Technical

Cities may wish to address these wider issues of safety and security by referring to levels of crime and accidents at home, at work and at leisure. However, cities are recommended to focus on fear of crime and home accidents. The basic approach to establishing the prevalence of fear of crime in a city is via small-sample surveys that are representative of the whole city population or neighbourhood or housing block. Standard measuring instruments (such as developed by the WHO LARES (Large Analysis and Review of European Housing and Health Status) project) facilitate comparisons between cities. (Each year the British Crime Survey asks a population sample "Do you feel safe home alone at night?".) Regular city population surveys are recommended to include safety and security questions alongside health questions to establish links. Further, home accidents are captured by data routinely collected by the local health authority and other agencies.

Example

No city has produced an indicator that reports feelings of safety and security in relation to potential crime at the home and neighbourhood levels. Vienna uses national data to report the location and frequency of accidents. Stockholm reports on the number of people saying that, in the past 12 months, they ever refrained from going out in the evening because they feared being assaulted, robbed or molested (Table 15).

Table 15. People in Stockholm County (%) saying that, in the past 12 months, they ever refrained from going out in the evening because they feared being assaulted, robbed or molested by sex and age (years), 1980–2005

Sex and age (years)	*1980–1983*	*1990–1993*	*2000–2003*	*2000–2001*	*2002–2003*	*2004–2005*	*2000–2005*
Men							
16–24	2.5	7.5	6.9	7.4	6.4	6.4	6.7
25–44	3.3	9.2	6.9	8.2	5.5	4.9	6.2
45–64	9.6	8.9	8.7	11.1	6.5	8.8	8.8
65–84	15.7	20.2	22.7	25.3	20.2	17.5	20.9
16–64	5.2	8.8	7.6	9.2	6.0	6.6	7.3
16–84	6.7	10.5	9.6	11.3	7.9	8.1	9.1
Women							
16–24	17.2	27.7	26.0	29.0	23.0	36.0	29.4
25–44	20.4	32.3	24.7	28.6	21.1	22.9	24.2
45–64	31.0	29.8	24.3	27.6	21.4	25.1	24.7
65–84	46.2	57.4	49.4	51.2	48.1	42.3	47.2
16–64	23.4	30.6	24.8	28.2	21.5	25.7	25.1
16–84	27.9	35.9	29.1	32.4	26.0	28.5	29.0
Men and women 16–84	17.7	23.7	19.6	22.2	17.1	18.5	19.3

20. Access to transport

Rationale

"Design a city for older people and everyone can use it." Older people require easy access to a whole range of facilities to be included in the economic, cultural and social life of society and live healthy and fulfilling lives.

Technical

Cities may include wider issues of access to (1) green space, (2) public buildings, (3) transport and (4) services such as shops, health services, banks etc. Cities may refer to these issues and provide supporting evidence. Collaboration with the WHO European Healthy Cities Subnetwork on Healthy Urban Planning will provide more reliable indicators of access. The core indicator is recommended to be access to transport: public and private. Car ownership and use of public transport should be recorded for standard age bands. Supplementary information should be provided on measures to enhance the access of older people to public transport: for example, free use and low entrance access for buses and trams.

Table 16. Percentage of individuals who have access to a car in Stockholm County, 2002–2003

Sex	*Age (years)*	*Access to a car*
Men	16–24	62%
	25–44	73%
	45–64	84%
	65–84	68%
Women	16–24	66%
	25–44	70%
	45–64	72%
	65–84	47%

Source: Statistics Sweden (http://www.scb.se).

Example

Stockholm County monitors access to a car (Table 16) and Vienna access to public transport.

Vienna is developing a barrier-free city and reports the following.

Almost all the underground stations have elevators with tactile and verbal signals for blind people or people with impaired vision, and all underground stations have guiding systems. Buses, trams and underground trains have secure entrances. Low-entrance buses have ramps. The low-entrance trams have the lowest entrance worldwide (19 cm, which can be reduced on demand to 10 cm). New underground trains have barrier-free entrances, which means the gap between the train and platform has been minimized and the car at the end of the train has a ramp that closes the train–platform gap completely. All new vehicles for Wiener Linien have optical and acoustic signs for stations.

C3. Participation and empowerment

This subsection relates to older people as a resource, with skills, experience and social capital to contribute to civic life. European studies and population surveys show that older people (up to age 75 years) are more likely than younger people to engage in civic and community activities. The aim of this small subsection of just two indicators is to signal this contribution and measure the influence.

21. Participation in decision-making

Rationale

Older people contribute their skills and experience to local community and city life, often as volunteers. They can contribute to an organization without influencing its decisions. This indicator attempts to assess the participation of older people in decision-making about important political, economic and social issues at the city level. These are organizations on the right side of the continuum in Fig. 18.

Technical

Cities can choose to describe the general level of participation by reporting evidence from population surveys. They may also report on the influence of older people on decision-making in nongovernmental organizations, public services and businesses. The recommended core indicator is a description of a city-wide forum for older people engaged in social and political action plus an assessment of the degree to which it influences key decisions in city development.

Example

Since 1999, Brno has organized the annual European All Generations March, a joint event initiated by WHO in the framework of the global campaign for active ageing. The programme focuses on promoting joint active living by all generations by organizing many activities, such as healthy nutrition tasting, physical activity in the open air, blood pressure measuring, health counselling, games and competitions.

Fig. 18. Community empowerment as a continuum

Source: adapted from: Laverack G. *Health promotion practice: power and empowerment.* London, Sage Publications, 2004.

22. Influence in the community

Rationale

Municipalities have a major role in providing basic services and shaping the future development of cities. Municipal councillors are key decision-makers. Older councillors use skills and experience to make decisions on a range of issues, although they may have a special interest in issues concerning older people.

Technical

The core indicator is a simple table (Table 17) showing the number and percentage of councillors in each age band. The recommended bands for comparative purposes are <20, 20–34, 35–49, 50–64 and 65+ years.

Example

The Stockholm profile reports as follows.

Several studies have shown that older people in Sweden on the whole neither feel unwelcome nor discriminated against in their everyday lives. In the political sphere, however, the 65-year limit has been generally observed. On reaching that age, politicians normally retire from and refrain from taking up political appointments. A specific target in connection with the strengthening and development of democracy in Sweden should be increased participation in decision-making processes by people over 65 years, who are currently underrepresented in elective assemblies (Table 18).

Table 17. Number (%) of city councillors by age (example)

Councillors' age (years)	*Number*	*%*
< 20	A	Y%
20–34	B	Y%
35–49	C	Y%
50–64	D	Y%
65+	E	Y%
Total	A+B+C+D+E	100%

Table 18. Number of councillors elected and resigning by age in the Stockholm County Council

Age (years)	*Elected*	*Resigned*
18–21	1	0
22–36	23	6
37–50	58	2
51–64	72	8
65+	11	0
Total	165	16

Conclusion

This guidance demonstrates how a positive and dynamic profile of older people in cities can be produced using a mere 22 easily collected indicators. For each indicator, guidance is provided on the rationale and technique, with examples drown from the local profiles of member cities of the WHO European Healthy Cities Subnetwork on Healthy Ageing.

Section A on population profiles contains 11 largely orthodox indicators, often derived from international standards, protocols and classical formulations, facilitating comparison between cities. The three indicators of section B give a preliminary overview of a city's health and social support system. They reveal complex relationships between public-sector, private-sector and nongovernmental organization services. Section C includes eight indicators of the social, economic and environmental influences on the health and quality of life of older people. These distal determinants have a strong impact, but the pathways to health are complex and sometimes difficult to measure.

Most of the 22 indicators are quantitative and can be applied at different points in time, facilitating assessment and trends and helping to make projections. Qualitative indicators, in contrast, can give a more rounded portrait of the local context but are more difficult to scale.

This set of indicators (both quantitative and qualitative) can provide a baseline portrait of the older people in the city as a prelude to policies and programmes promoting better health and quality of life. Subsequently the indicators can be applied again and again to measure and monitor progress. They should be considered an important component of the evaluation process.

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Healthy ageing profiles

Guidance for producing local health profiles for older people

This guidance uses a positive and dynamic model for profiling older people at the local level. Health profiles are important tools for health development planning and for monitoring progress in and accountability for the health of the community. Profiles should not simply promote positive features of city life but should also highlight gaps in services and difficult socioeconomic circumstances. The guidance covers 22 indicators grouped into three sections: (A) population profile, (B) health and social care systems and (C) social portrait, indicating wider determinants of health and empowerment.

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