Two dynamic and driving forces are converging – technology and aging. Advances in information technology, robotics, material sciences and other fields are producing opportunities to change how we will live, work, learn, care and play in older age. Global aging is slowly moving from a research topic relegated to gerontology journals to a place on the business pages garnering the attention of big and small enterprises. There is an unprecedented raw synergistic potential of these two forces— both to improve the quality of life of older people and their families and to drive entirely new industries in the fast-growing longevity economy.

But as they pay serious attention to aging and technology, researchers, industry and investors may be making some critical errors based on recurring misperceptions about the aging marketplace. Here are five misperceptions that, if not corrected, may hinder innovation and, worse, perpetuate a story of old age that limits the potential of the world’s fastest growing population.

**Misperception 1. Old Age = Health**

Technology powers the imagination. It enables life-saving innovations; it facilitates; it empowers; entertains; it connects; it moves us. Unfortunately, many researchers and new product developers only see aging as a medical problem to be solved rather than a life stage to be invented. The Internet of Things or IoT is routinely being applied to check in on a parent, predict an event, or detect a fall. How many pill reminder systems are the subject of student theses and technology competitions? All of these are critical needs. They are not incorrect technology applications—but they are woefully incomplete.

Older people, especially the oldest among us, are more likely to suffer from multiple chronic conditions and require significant care. But while this may be the story for some older adults, illness and older age are not equivalents. And even elderly patients managing chronic disease want to do things that do not involve their ‘conditions’.

Technology can also be used to support activities higher on Maslow’s hierarchy of needs. How might technology be used to enable social connectivity, creativity, volunteering, part-time work, learning, or simply laughter? How often is fun and play for older adults a theme in hack-a-thons? A focus on health
is often driven by the business imperative to be paid by government or private insurance. But innovation rarely comes by designing to the specifications of predetermined government policy or insurance underwriting. Real innovators identify needs not articulated and wants never considered.

**Misperception 2. Universal Design Either Means Too Little or Too Much**

Universal design has been a celebrated approach to designing for older adults and the disabled—and rightly so. But is the universal design ethos being used as an excuse to provide less experience and more boredom? Accessibility and usability are not design features—they are basic characteristics of any minimally acceptable product. We do not think of a door or windows in a home as a feature but as an expectation.

Some developers, unfortunately, have used universal design as an excuse to eliminate functionality. It is the job of the designer and engineer to provide easy and accessible capacity to the user, not dictate what the user can or cannot do effectively. Rather than cracking the code on how best to offer capacity and usability, many developers simply offer less-functional versions of products, creating a second- or third-tier user class.

Other developers use universal design as an excuse to offer more…a lot more. Consider aesthetically unacceptable (read: ugly) products such as gigantic big-button television remotes, or countless devices that try to pass off beige and clinical blue as desirable color choices.

Real innovators and real designers do not merely respond to the user’s needs. They set out to excite and delight the consumer. Interfaces that can be personalized make a product that is usable and cool to users of any age or capability. Colors that exude energy and verve are ageless. Carefully providing functions that stimulates the user’s imagination shows respect for the consumer and fosters a buyer-seller relationship that builds brands and loyalty.

**Misperception 3. We Need Products Exclusively for Older People**

The automobile industry has a frequently cited adage: “You can’t build an old man’s car. A young man will not buy it and neither will an older man” (and nor will an older woman, for that matter). Few products made and marketed to older adults exclusively have been successful with older buyers. Devices and services that shout ‘old man walking’ or ‘hey, you, you’re a fall risk’ are not icons people choose to sport in public or even in the privacy of their own home.

Personal emergency response systems or social alarms are rational, easy to use and relatively affordable. Yet their adoption and actual use has a checkered record. Some research suggests that market penetration is less than five percent for those who could benefit from such a service and only 12 percent in countries like the United Kingdom where such services are entirely reimbursed by the government.
Developers would be wise to appeal to ageless values. Products that are easy to use, convenient, purposeful and (yes) cool appeal to everyone. These characteristics enable technology developers to commercialize systems that may be sought by younger people for convenience, but as the user ages, the device becomes less about providing convenience and more about providing care – becoming assistive technology seemingly by stealth.

Consider the microwave oven. Few people would think of the contemporary kitchen fixture as assistive technology. However, an older person living alone who feels unmotivated to cook may find a quick press of the microwave’s buttons to be the difference between a nutritious hot meal or a bag of stale cookies in front of the television.

**Misperception 4. The Older User is the Same as the Buyer**

User-centered design is critical to a successful device or application. Human factors researchers have contributed much to our understanding of older user needs from a number of perspectives, e.g., accommodating diminished vision, arthritic hands, and declining strength and learning ability.

However, the user is not always the buyer. Nearly one in four American families include someone who has taken on the role of a caregiver. Most often that face is of a spouse or oldest daughter. She—and it is most often she—is the online researcher, shopper, trusted influencer and, in many instances, ultimate buyer of a product or service.

Differentiating between user and buyer has implications for technology product and service developers. Product design and performance must appeal equally to the older user and her caregiver buyer. A product may be best distributed where the buyer shops, not where the older user is often found. For example, online sites that cater to 40 and 50-somethings, consumer electronics stores, home improvement centers and even employers who offer employee caregiver assistance programs may be more successful in moving ideas out of the laboratory and into the living room than relying on specialty online sites, stores or clinicians.

**Misperception 5. Technology is Innovation**

In recent years, countless devices and technology-enabled services have been developed to address the needs of older adults. Researchers, start-ups and some industry laboratories appear to be trying to address aging one device at a time. But invention alone is not innovation. Innovation is putting practical ideas into use.

Understanding the true jobs of older adults or their family caregivers requires thinking well beyond a specific task—providing a technology or app is only part of the answer. Innovators must consider the context in which a technology is being used. How will the device be purchased? Who will install it? When it malfunctions (and it will), who steps in to help the adult daughter respond to a panicked or aggravated call from her mother complaining that her smart pill reminder won’t stop beeping? For
nearly all technologies, even the simplest, there is a consumer journey that includes: research, shop, buy, install, teach, use, maintain, repeat. Understanding and anticipating the customer and user journey as well as the comprehensive context that a technology will be used is critical to providing value and ultimately to providing a solution, not just a device, that people will buy and use.

Technology offers the opportunity to invent a new life stage, if we use our imaginations, engage in multidisciplinary thinking, and make a commitment to excite and delight older people and their families. By moving beyond ingrained misperceptions of what older age means to us, we can empower, connect, engage and enable people to be productive across the lifespan, transforming aging from a problem to be solved into an opportunity to create new markets in today’s longevity economy.

Joseph Coughlin is founder and Director of the Massachusetts Institute of Technology AgeLab (agelab.mit.edu) and author of the forthcoming book The Longevity Economy: Inside the World’s Fastest-Growing, Most Misunderstood Market. (http://www.publicaffairsbooks.com/book/the-longevity-economy/9781610396639) Follow him on Twitter @josephcoughlin

Joe will be the keynote speaker at the IAGG 2017 World Congress “Tech Day (program/tech-day)” on Wednesday, July 26. (This event is open to all registered IAGG attendees).
The National Council on Aging (NCOA) is proud and excited to be a co-host of IAGG, the largest, most significant worldwide conference on aging that will highlight the latest science, research, training, technology, and policy development presented by experts from around the world.

An important body of work that NCOA has focused on for over 12 years is falls prevention. The reason for this focus is that falls present a real and growing risk to older adults’ health and independence—and to their very lives. Many falls can be prevented (https://www.ncoa.org/healthy-aging/falls-prevention/), and NCOA and experts from around the country and the world are working to engage health care and aging network professionals, older adults, and caregivers in prevention efforts.

According to the Centers for Disease Control and Prevention (CDC), falls are the leading cause of injuries among older adults, causing severe injuries such as hip fractures and head trauma, as well as death. Injuries and fear of falling also significantly limit older adults’ activities and independence.

A decade ago, the NCOA led development of an evidence-based national falls prevention action plan. The 2005 plan (https://www.ncoa.org/resources/falls-free-national-action-plan/), Falls Free®: Promoting a National Falls Prevention Action Plan, focused its goals and strategies on key risk factors—physical mobility, medications management, home safety, and environmental safety—as well as cross cutting issues.

While substantial progress has been made in falls prevention efforts over the past 10 years, gaps and challenges remain to stem the tide of this growing public health problem.

Falls among older adults are common:

- Millions of people age 65 and older fall each year—one out of four in this age range.
- Falls are the leading cause of both fatal and nonfatal injuries among older adults, causing severe injuries such as hip fractures, head trauma, and death.
- Every 11 seconds, an older adult is seen in an emergency department (ED) for a fall. In 2015, about 27,000 older adults died from unintentional fall injuries, 2.8 million were treated in emergency departments for nonfatal falls, and more than 800,000 were hospitalized.
- Older adults are hospitalized for fall-related injuries five times more often than for injuries from other causes.
Falls significantly affect independence:

- Among people who fall, 20 to 30% suffer moderate to severe injuries such as lacerations, hip fractures, and head traumas. These injuries can make it difficult to get around or live independently, and they increase the risk of early death.
- Falls are the leading cause of traumatic brain injury (TBI), accounting for 40% of all TBIs in the United States that resulted in an ED visit, hospitalization, or death. More than three-fourths (81%) of TBIs in adults aged 65 and older are caused by falls.
- Many people who fall, even if they are not injured, develop a fear of falling. This fear may cause them to limit their activities, which leads to reduced mobility and loss of physical fitness, and in turn increases their actual risk of falling.
- People age 75 and older who fall are four to five times more likely than those age 65 to 74 to be admitted to a long-term care facility for a year or longer.

Costs are high:

- In 2015, the direct medical costs of falls, adjusted for inflation, were $31 billion.
- On average, the hospitalization cost for a fall injury tops $35,000.

NCOA and its partners are fighting to reduce falls

NCOA’s federally-funded National Falls Prevention Resource Center (NFPRC), alongside its multitude of national and state partners, is leading the charge against falls and fall-related injuries. The Center, funded by the Administration for Community Living (http://acl.gov/), supports the implementation, dissemination, and sustainability of evidence-based falls prevention programs and strategies across the nation to reduce falls risk factors and the incidence of falls and injuries among older adults and adults with disabilities.

Outlined in the updated 2015 National Falls Prevention Action Plan (https://www.ncoa.org/resources/2015-falls-free-national-falls-prevention-action-plan/), the NFPRC endeavors to lead the nation in executing untapped opportunities in falls prevention to increase physical mobility; improve medication management; enhance home and environmental safety; increase public awareness and education; and fund and expand falls risk screening, assessment, and intervention

Goals and strategies

NCOA is working in partnership with key organizations and agencies to accomplish the goals and strategies of the 2015 National Falls Prevention Action Plan. Highlights are provided below.

- Strive to ensure all older adults have knowledge of, and access to, effective programs and services that preserve or improve their physical mobility and lower the risk of falls. Successful strategies have included educating consumers and health care providers about evidence-based falls
prevention programs, such as A Matter of Balance, Fall Scape, Stepping On, and Tai Chi, and connecting older adults to community-based organizations and others who offer these programs. NCOA facilitates the annual Falls Prevention Awareness Day (https://www.ncoa.org/healthy-aging/falls-prevention/falls-prevention-awareness-day/) on the first day of fall. This year marks the 10th observation of FPAD and we hope to reach millions of older adults, caregivers, and others with falls prevention messaging and educational activities in conjunction with State Falls Prevention Coalitions (https://www.ncoa.org/resources/list-of-state-falls-prevention-coalitions/).

- Educate all older adults, health care providers, and pharmacists about the common adverse falls risk of both prescription and non-prescription medications. NCOA partnered with the American Society of Consultant Pharmacists (http://www.ascp.com/) and developed a falls prevention tool kit to increase the role of pharmacists in falls prevention efforts.

- Ensure all older adults, and health care, aging network, housing and other service providers will have knowledge of and access to effective home safety measures (including information, assessments, and home modifications) that reduce home hazards, improve independent functioning, and lower the risk of falls. NCOA’s partner in these efforts is the Fall Prevention Center of Excellence (http://stopfalls.org/) at the University of Southern California Leonard Davis School of Gerontology who is developing new resources for the field related to home safety, home modifications and universal design. A workgroup of experts in the field is also being formed to accomplish the home safety strategies in the Action Plan.

- Increase available funding and reimbursement sources and mechanisms to support falls prevention programs, interventions, and activities. NCOA’s Public Policy Department is educating policy makers about the importance of falls prevention and advocating for continued funding and reimbursement mechanisms for clinical and community based falls prevention efforts for screening, assessment, and intervention.

- Collaborate with health care providers and community-based organizations to expand the availability and infrastructure of evidence-based falls prevention programs. The Evidence-based Leadership Council (http://www.eblcprograms.org/) is NCOA’s partner in continuing to expand new evidence-based falls prevention program, and in 2017 launched the Evidence-Based Falls Prevention Review Council that developed a national submission process to identify new programs that meet the Older Americans Act Title III-D criteria.

**NCOA Presentations at the IAGG conference!**

Research continues to demonstrate that falls are multifactorial and that an interdisciplinary approach is the best. In partnership with Mariana Wingood, DPT from the American Physical Therapy Association, Chelsea Gilchrist from NCOA’s National Falls Prevention Resource Center will present at the IAGG conference on July 24 to explore the evidence of a multi-disciplinary approach, how to implement it in practice, and what policy changes are needed to ensure that older adults get the care they deserve. In-depth topics included interdisciplinary (PTs, OTs, RN, MD, and pharmacists) fall risk clinics around the United States, including identifying what makes these clinics successful, what limitations are keeping them from advancing their care, and the institutional and national policies that impact future success.
NCOA is also coordinating a symposium on Innovation in Health Care Delivery for Adults Aging with Disabilities on Sunday, July 23 from 9:00 AM - 10:30am. Speakers will include Joe Caldwell and Angelica Herrera-Venson from the National Council on Aging, Tamar Heller from the University of Illinois at Chicago, and Ivan R. Molton, University of Washington School of Medicine. The symposium will summarize key findings central to health care delivery for individuals aging with disabilities, including innovative models of care coordination and participation in evidence-based healthy aging programs.
written by debra whitman, aarp chief public policy officer

across the globe populations are aging, and this far-reaching change is happening much faster than most people realize. in just five years, the number of older persons will surpass one billion; they are already a fast-growing presence in cities and towns of all sizes, every region and all segments of society.

this change provides countries across the globe with a great opportunity, because older individuals have so much to offer the communities where they live. but making the most of it will require vision and innovative thinking.

fortunately, we have a growing body of knowledge about what it takes to make a community more “age friendly.” and it is becoming clearer all the time that cities and towns that embrace this priority are rewarded with a better quality of life for all their residents. there really is no alternative, because demographic trends are transforming societies around the world whether they are prepared or not. consider these numbers:

- for the first time in human history, by 2030, the number of people age 60 and over will exceed the number of children age 10 and under, an unprecedented demographic milestone that signals new challenges – and opportunities – for institutions, communities, government and the private sector.

- our very notion of what it means to be “old” is changing profoundly. a 10-year-old in the united states now has a 50 percent chance of living to age 104. by 2050, the united states is projected to have more than 1 million centenarians.

nations and local communities that take steps to become more livable for all will have the advantage over those that do not. the good news is that practical models on improving communities to be age friendly are available. pioneering work by the world health organization (who) provides many insights into how communities can promote healthy, active aging and support inclusion and engagement that benefits all their residents.

the who also sponsors a global network for age-friendly cities and communities (http://www.who.int/ageing/projects/age_friendly_cities_network/en/) that share insights on best practices and lessons learned. aarp is committed to making this information more available, and in 2012 we created the aarp network of age-friendly communities (http://www.aarp.org/livable-communities/network-age-friendly-communities/info-2014/an-introduction.html) to further that goal, in affiliation with the who.
These age-friendly networks highlight eight domains of livability (http://www.aarp.org/livable-communities/network-age-friendly-communities/info-2015/8-domains-of-livability-resources.html.) that help shape quality of life for people of all ages: Outdoor spaces and buildings; transportation; housing; social participation; respect and inclusion; civic participation and employment; communication and information; community and health services.

Importantly, Alexandre Kalache (https://www.youtube.com/watch?v=qVNggrAeXkY)*, who helped create the WHO network, points out that age-friendly features do far more than just help seniors, they help everyone. Take the example of a bus that is designed for easy access. “If it is easy for an older person to get in and out of this bus, it is going to be more (accessible) to a child or a teenager, to a pregnant woman or to someone carrying her luggage.”

Design, land use and infrastructure all help pave the way for people to stay engaged in the world around them. But Kalache notes that for a place to be truly age friendly, inclusiveness must become a broadly shared cultural value. As he puts it, such a community is a place “where the attitude is right – from the policymakers to the service providers to the population as a whole…”

Age-Friendly Communities

Promoting the value of inclusion requires a multi-faceted effort. Age-friendly communities should have physical infrastructures and offer services that help residents of all ages live active, engaged and secure lives. They should enact policies and rules (e.g., zoning and land use regulations) that create an accessible built environment and ensure affordable and convenient housing alternatives.

Age-friendly communities should provide transportation options that meet the varied needs of residents, including easy access to health care and retail shopping for basic necessities. They should keep the environment clean and public spaces safe and free of crime.

Age-friendly communities should give residents access to housing that is located near crucial services, such as transportation, health care, retail and recreation. Available housing should include choices that meet the needs of residents of all ages, including families with kids and those with grandparents.

All of these things make it easier for people to live the way they want to. And the fact is that most of us want the chance to age in our homes and communities for as long as possible. AARP surveys consistently show that older people desperately want to hold on to their independence and avoid moving into nursing institutions.

Yet obstacles often stand in the way of living independently and securely, particularly as we get older. Take the basic example of walking safely to the store or strolling around the block. In the United States, adults 65 and older make up 13 percent of the population, yet they suffer nearly 20 percent of
pedestrian fatalities. Communities can do better. As a start, they should make changes to street, crosswalk and sidewalk design, maintenance, and signage. Poor infrastructure is also often the cause of older adult falls and falls are the cause of 68 percent of older adults’ hospitalizations.

**Engagement, Foresight and Inclusiveness**

Importantly, age-friendly places recognize older adults as the community assets that they are. They know that older residents offer experience and perspective that should be taken advantage of when it comes to planning, implementation and evaluation of programs and policies. They understand that in the process, the benefit flows in both directions: Older adults who get involved benefit personally from a sense of purpose and engagement, while the community gets the value of their experience. Inclusion leads to better decisions that help everyone.

An inclusive approach to age-friendly planning also raises awareness of changes affecting communities and the needs of residents. Noteworthy changes include the growing role of grandparents in raising grandchildren, the increase in multigenerational families, and growing ethnic and racial diversity in older age groups. An inclusive approach also seeks out input from a diverse set of older residents who may offer insights and solutions that would otherwise be overlooked. Further, age-friendly planning recognizes that as the population ages, there will be an increasing number of individuals with disabilities who rely on local services to stay independent.

**Commitment and On-the-Ground Action**

AARP’s goal is to help people live more easily and comfortably as they age and it has been gratifying to see that this goal is widely shared. Since its start in 2012, the AARP Network of Age-Friendly Communities has boomed, with a membership that has now reached 163 localities that are home to more than 64 million people living all over the United States. These are communities of all shapes and sizes – from small towns and rural counties to cities as large as Atlanta, Boston and Dallas.

AARP state offices work with local officials and activists across the network to promote age friendliness, and our communities have shown real leadership to prepare for demographic change rather than passively wait for it.

Within the network, we’ve seen a wide range of programs and successes.

- Portland, Oregon adjusted zoning codes and reduced municipal fees to make it easier for homeowners to add an accessory dwelling unit (or granny-flat), which can help residents to age in place.
- New York City added 1,500 new benches and 3,500 new or improved bus shelters, providing resting places for pedestrians and encouraging bus ridership, particularly in locations where older riders were likely to board.
• Washington, DC engaged over 500 volunteers in a multigenerational block-by-block walk program to identify pedestrian challenges such as broken sidewalks, missing curb cuts, and traffic signals that don’t allow safe crossing. It also introduced a free mobile app so people can report problems directly to transportation officials.

• Macon-Bibb County in central Georgia undertook a series of improvements to Tattnall Square Park, such as numerous resting facilities and a new gateway, in order to make the park more accessible and enjoyable for all.

• Westchester County, New York established a program to coach family caregivers who are often faced with difficult tasks in caring for loved ones who want to remain in the community.

Given the breadth of issues that age-friendliness must address, this work requires a local government commitment from the very top – one that filters down through every department to frontline workers. Age friendliness has to work for everyone, so it is vital that local officials and planners work across silos and reach into other disciplines to find holistic solutions. I am heartened by the extent to which age-friendly awareness is increasingly embraced by disciplines as varied as planning, architecture, real estate development and zoning, as well as increasing examples of cross-sector collaboration.

To support this multi-discipline approach, in March AARP sponsored a Summit on Livable Communities, which brought together two key organizations representing different disciplines – the American Society on Aging and the American Planning Association. The summit included 250 aging network professionals and local/regional planners, who talked about ways to work across professional silos to advance livable communities for all people, regardless of their age or ability. I believe some great partnerships were formed during the event, and look forward to hearing about future accomplishments.

We now know that people of all ages want their communities to be age friendly, whether they live in small villages, big cities or suburbs. The need is growing and not just in the developed world. By mid-century, one in five people in developing countries will be over 60. Communities of all sizes, all stages of development and in all regions of the world will benefit by making age friendliness a priority.

Building on our existing knowledge about age friendliness to find new and more effective approaches should be a priority in communities all over, and AARP is committed to helping.

Across the globe, community leaders cannot afford to ignore their aging populations. Everyone will benefit when we embrace this change and work together to prepare for the future.

Debra Whitman is AARP’s chief public policy officer and leads policy development, analysis and research, as well as global thought leadership that supports and advances the interests of older people and their families. Follow Deb on Twitter: @policydeb (https://twitter.com/policydeb)
This year’s IAGG World Congress occurs at a pivotal time in gerontology and geriatrics. Scientists around the world are translating more than three decades of rigorous research on the fundamental biological processes of aging into exciting new drug and biotech interventions that promise to alter the architecture of aging research.

The American Federation for Aging Research (AFAR) has supported this important work since its founding in 1986. To date, AFAR has supported more than 4,000 investigators through our grant programs—many of whom are presenting in workshops throughout this summit.

As co-hosts for this year’s IAGG gathering in San Francisco, we are looking forward with great anticipation to learning from colleagues representing different disciplines from around the world. We also are excited to share information about translational work from AFAR-supported scientists.

In numerous animal studies in labs across the globe, researchers have shown that the new class of drug and biotech innovations can modify the underlying mechanisms of aging and delay the onset of multiple age-related chronic diseases—including cancer, heart disease, diabetes, and Alzheimer’s. More than 30 molecules and compounds that have demonstrated their effectiveness in the lab are already moving toward clinical trials in humans. And many more are in various stages of development.

Changing the architecture of aging research—moving from the disease-specific paradigm that has dominated research for so many years to one that addresses the fundamental processes of aging to delay multiple chronic diseases—will change how people age and alter our perception of aging. It will also result in substantial savings in health care costs. A recent economic analysis showed that slowing or modifying age-related diseases by just 20% would save more than $7 trillion in health care spending in the United States alone over the next half-century.

For the past three years, a core group of leading geriatrics researchers in the United States has been working in partnership with groups in the European Union to develop a strategic blueprint to move new drug and biotech innovations forward. With funding through an R24 research grant from the National Institute on Aging, the group known as the Geroscience Network, led by AFAR affiliated experts including our Scientific Director Steven N. Austad, Deputy Scientific Director Nir Barzilai, and President-elect James L. Kirkland, has mapped a framework to dramatically cut the time and cost required to gain regulatory approval for these new interventions.
What is the TAME Trial and Why Does It Matter?

One of the auspicious projects to emerge from the Geroscience Network’s planning efforts is the TAME (Targeting Aging with Metformin) Trial, which seeks to establish proof of concept that we can delay the onset of multiple major chronic diseases by influencing the fundamental processes of aging.

Metformin is a front-line drug to treat type 2 diabetes and has been used effectively and safely for 60 years. Studies have already shown that metformin can delay aging in animals. These findings point to the likelihood that metformin may influence fundamental aging factors that underlie multiple age-related conditions in humans, including cancer, heart disease, Alzheimer’s, and others.

Managed by AFAR, TAME is a series of Phase 3 clinical trials over six years that would enroll 3,000 people between the ages of 65 and 79 nationwide to see whether those taking metformin experience delayed development or progression of age-related chronic diseases compared with those who take a placebo.

If successful, TAME would offer the U.S. Food and Drug Administration the opportunity to review whether aging can be made an indication for age-targeting drugs.

Recognizing aging as an indication would provide considerable incentive for the pharmaceutical industry to develop next-generation drugs that are even more effective in treating a wide range of age-related diseases. While the TAME Trial represents a significant and essential first step in altering the architecture of aging research, there are many other innovative drug and biotech innovations moving forward.

The New Frontier of Drug & Biotech Interventions

The new interventions that influence the fundamental processes of aging hold the promise that we can at last transform aging from a period of sickness to a time of extended vitality. Scientists around the globe are advancing drug and biotech innovations that have demonstrated the ability to delay and even reverse the harmful effects of aging in animal studies. These innovations include:

- **Senolytics.** This new class of drug, first identified in Aging Cell just two years ago, specifically targets senescent cells —cells that, due to myriad stresses, can no longer divide. The problem is that senescent cells tend to not die, accumulating as people age. And they actively secrete substances that exacerbate chronic inflammation—one of the underlying factors in virtually every major age-related chronic disease, from arthritis to Alzheimer’s to cancer. By clearing out senescent cells without harming healthy cells and tissues, senolytics have demonstrated in studies in mice the ability to delay age-
related chronic diseases. The first wave of senolytics are now proceeding toward clinical trials in humans for specific disease indications, such as osteoarthritis and glaucoma.

**Rapamycin.** This drug has been approved by the U.S. Food and Drug Administration (FDA) since 1999 for transplant patients. It also is used in some cancer chemotherapy regimens, and to prevent overgrowth of cardiac stents. But what makes this drug especially tantalizing to scientists is its potential to increase the number of healthy years in humans. In numerous studies in mice, Rapamycin has shown that it can extend life even when first administered at the human equivalent of 70 years. Those findings have led scientists to reevaluate previous assumptions that interventions aimed at delaying age-related chronic diseases would have to begin much earlier in life, when people were in their 30s or 40s. Researchers are now working to identify the correct dosage of Rapamycin that will be effective, and to eliminate serious side effects, including immune system suppression.

**NAD Boosters.** Sirtuins, which play a role in virtually every aspect of aging, are dependent on nicotinamide adenine dinucleotide, or NAD. However, our NAD levels drop by half as we age. In the March 2017 issue ([http://science.sciencemag.org/content/355/6331/1312](http://science.sciencemag.org/content/355/6331/1312)) of Science, a Harvard Medical School research team identified a critical step in a molecular chain reaction responsible for cellular DNA repair, cell degeneration, and aging in mice. Researchers found that giving old mice the NAD precursor NMN restored their cells’ ability to repair DNA to the levels seen in young mice. As the study published in Science shows, it is possible to use NAD Boosters, such as NMN, to reverse the effects of aging. The Harvard team hopes to begin proof of concept trials in humans in 2017.

These are only a few of the many promising innovations that are moving forward in labs around the world. The countless hours spent gaining a better understanding of the fundamental processes of aging have opened exciting new pathways for research that are now being translated into therapies that enhance human health and well-being.

**Working Across Disciplines and Borders**
That life-changing translational work will define the new architecture of aging and aging research. Meanwhile, the foundation on which that work is built—seminal studies on the basic biological mechanisms of aging—remains as critical as ever for the generations of interventions that will follow.

The Geroscience Network has developed a strategy of advancing short-term, proof-of-concept trials for new drugs that have little or no track record in humans, and longer-term, more advanced Phase 3 trials for established drugs that have shown evidence of extending healthspan and/or lifespan. It will require building a national—and eventually an international—network of aging centers working in parallel on clinical trials. And it will call for a cadre of trained scientists who understand the regulatory approval process as well as research conducted at the highest level.

Working together and sharing knowledge is what the IAGG World Congress is all about. In that spirit, AFAR is hosting a luncheon symposium on biotechnology and longevity titled, “The Architects of Aging,” on Tuesday, July 25, from noon to 3 p.m. A panel discussion will feature some of the brightest
minds in biotech innovation, and we hope you will consider joining us. For full information, please visit the AFAR website (https://www.afar.org/events/view/2017-afar-luncheon-symposium-and-awards-ceremony/).

As we prepare to gather for the IAGG World Congress in the beautiful, vibrant, and historic city of San Francisco, we look forward to a lively exchange of knowledge and ideas. And we look forward to working together, across disciplines and borders, to improve the health and well-being of older people around the world.
Universal health coverage – Leaving no older person behind

Written by Patricia Conboy, Head of Global Advocacy and Ageing, HelpAge International

“The hospitals say ‘we have no pill to treat old age’. We are not made to feel welcome in hospitals. They are impatient with us.” Nora, South Africa

“In hospitals, where we have to wait a long time to see a doctor, they don’t bother to listen to everything we have to say, let alone examine us properly….When we start explaining what health problems we have, doctors often say they are age-related, that they are natural changes.” Vera, Kyrgyzstan

Access to Universal Health Coverage (UHC) is a central goal of Agenda 2030 for Sustainable Development. It is a goal supported by the World Health Organisation (WHO) which defines UHC as ensuring that all people and communities receive the quality health services they need, and are protected from health threats, without financial hardship. UHC underpins the right of every individual, regardless of age, sex, disability, race or other socio-economic characteristics, to health.

From the perspective of older people in low and middle-income countries (LMICs), increased access to UHC is a priority, as is the implementation of ageing-inclusive models of UHC that optimize health and wellbeing as people age - that is to say UHC that is person-centred, responsive to complex and chronic health conditions arising in old age, and inclusive of long-term care. While there is considerable global momentum behind efforts to achieve UHC, action on four issues is critical if older people are not be left behind. These relate to ageism, the empowerment of older people, gaps in geriatric competency among primary health care workers, and data gaps regarding older people’s health and wellbeing.

Challenging ageism

Ageism - essentially negative behaviours, attitudes and feelings towards individuals and groups based on their age - is pervasive globally. The experiences of Nora and Vera, quoted above, are not isolated in terms of the barriers older people encounter in accessing respectful and appropriate healthcare. The rights of children and of women of childbearing age are now - as they should be – accepted and included in the design of health and care systems. In contrast, older people’s rights to health and care remain contested on grounds ranging from affordability to attribution of total responsibility for elder care to families. What these arguments fail to recognise is older people’s right to health and care on the same terms as everyone else. WHO is now developing a global campaign on ageism in advance of the planned UN Decade on Healthy Ageing 2020–2030. HelpAge International supports the WHO campaign and will focus on bringing older people’s voices and experiences of ageism to the fore through this global platform.
Older people’s empowerment

The dominant narrative on demographic ageing identifies older people as a drain on limited resources and inevitably passive consumers of health and care services. The reality is more complex. Across Asia, for example, many older people participate in flourishing Older People’s Associations (OPAs) which are proactive in promoting members’ health and wellbeing, and in contributing to home and community care in their localities. OPA activities range from health information sessions at regular meetings, training for health volunteers, screenings by health volunteers – body mass index, blood glucose levels, blood pressure to exercise sessions, health checks and trainings by formal health providers. They also involve volunteer based care for older people requiring assistance with activities of daily living, including those who are house-bound. Services provided vary based on need and may include befriending, cooking, cleaning, physical labour, personal care and assistance getting out and about. Older people’s empowerment is core to the development of ageing-inclusive UHC. The tipping point will come when sufficient numbers of older people learn about their own ageing, are aware of their rights to health and care services and supports on equal terms with everyone else, and are assertive individually and collectively in challenging ageism.

Geriatric competency among primary health care staff

The health workforce needs the right competencies to care for older people. Current gaps in training of staff in LMICs are widely acknowledged. Rather than “the comprehensive bio-psycho-social approach that needs to be taken when working with older populations”, there is a focus on acute illness and communicable diseases. A 2012 study found that of 40 countries in Africa, 35 had no formal undergraduate training for medical students in geriatrics and 33 reported no national postgraduate training scheme for geriatrics. While the inclusion of training in geriatrics in undergraduate and postgraduate medical curricula is vital, it is a longer term objective. There is an immediate need to equip primary care staff with core competencies in the care of older people. These include the diagnosis, care and management of chronic conditions such as cancer, cardiovascular disease, diabetes and respiratory disease which now cause 7 out of 10 deaths in LMICs. A broad range of stakeholders, HelpAge among them, have been involved in pilot curriculum and resource development projects with Ministries of Health, academic and training partners, to promote core geriatric competencies among primary care staff. However this work has tended to develop in separate national settings and the learning remains fragmented. While WHO is aiming for a globally endorsed mandatory curriculum for the health workforce at all levels, it will take time to achieve this goal. Meanwhile, there is an urgent need to consolidate relevant learning and experience, and to disseminate resource materials and lessons learned to build sustainable capacity and competency in the care of older people among primary health care staff.

Data gaps regarding older people’s health
Health systems in LMICs have developed in response to communicable diseases, acute, time-bound conditions focused on cure rather than long-term care, and issues related to maternal and newborn child health. LMICs now face the challenge of adapting their systems to meet the needs of people ageing with one or more complex, long term, chronic condition i.e. access to a continuum of care that is person-centred and integrated across health and care systems. There are gaps in international and national data systems about the health status of older populations and life-course patterns of disease and disability. Decision-makers at global, regional and national level must be presented with in-depth evidence and expert analysis that is both country-specific and specific about the health and care status of older people in order to evidence the need for ageing-inclusive UHC. This is an issue that HelpAge is focusing on in the preparation of our study Global AgeWatch Insights which will be published in 2018. A significant concern is that current measures of UHC under Agenda 2030/the SDGs fall short in terms of monitoring outcomes for older people. It is essential that data is collected for all age groups, including older people; captures barriers to access, including physical and attitudinal barriers, that are specific to old age; and is disaggregated by age, sex, disability and location as a minimum.\(^9\)

**Conclusion**

- In order to realise the promise of UHC for older people, HelpAge International is calling for:
  - Action on ageism and support for the WHO global campaign on ageism;
  - Empowerment of older people and recognition of their agency in promoting health and care;
  - Consolidated action to build sustainable geriatric competency among primary health care staff in LMICs; and
  - Closure of data gaps on health status of older people; and ageing-inclusive monitoring of UHC within the framework of Agenda 2030 and the SDGs.

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2 Ageism is the stereotyping of and discrimination against individuals or groups based on their age. Ageism can take many forms, including prejudicial attitudes, discriminatory practices, or institutional policies and practices that perpetuate stereotypical beliefs…. It can be a major barrier to developing good policies because it steers policy options in limited directions. It may also seriously impact the quality of health and social care that older people receive (WHO, Report on Health and Ageing, Geneva: WHO, p.11). [3 http://www.helpage.org/newsroom/latest-news/older-women-speak-out-about-their-rights-in-new-helpage-international-report/](http://www.helpage.org/newsroom/latest-news/older-women-speak-out-about-their-rights-in-new-helpage-international-report/)


5 [http://www.who.int/ageing/publications/health-workforce-ageing-populations.pdf?ua=1](http://www.who.int/ageing/publications/health-workforce-ageing-populations.pdf?ua=1), accessed 12 July 2017 6 Dotchin, CL et al, Geriatric medicine: services and training in Africa, Age and Ageing 2013, 124 – 128, accessed online 12 July 2017 7 National Institute on Aging and World Health Organisation, [http://www.who.int/ageing/publications/global_health.pdf](http://www.who.int/ageing/publications/global_health.pdf), accessed online 8 March 2017. 8 Health care staff who participated in such courses in Mozambique, Tanzania, Ethiopia and Zimbabwe as part of a three year DFID-funded Better Health project reported increased empathy with, and more positive attitudes to, older people as a result of their training. Personal communication with staff member, 20 June 2017. 9 HelpAge International (July 2017), Healthy lives and wellbeing for all at all ages: a call to action, [http://www.helpage.org/resources/publications/](http://www.helpage.org/resources/publications/)
By 2025, at least one-fifth of the population of 15 countries in the Americas will be 60 or older. As in the United States, the older population itself in Latin America is rapidly aging, and those 80 and over are projected to quadruple from 2015 to 2050.¹

The most poignant example is the Mexico-U.S. contrast. Mexico and the United States share a border over 2000 miles long; they also share the reality of swiftly aging populations. Yet this shared demographic trend is in the context of very different levels of economic development and distinct political, cultural, and institutional histories. In Mexico, the old age dependency ratio is expected to triple by 2050 and converge to the same proportion of older to younger people as in the United States. While the United States became rich before it became old, Mexico is becoming old before it has become rich.²

Perhaps most importantly, as these societies age, they are contending with multiple demands for scarce public resources and have overlapping but independent populations and family networks transcending both nations.

The Mexican-origin population now comprises the largest minority group in the United States. Because of relatively longer life spans and poorer health, older Latinos, especially Mexican-origin immigrants, spend a greater number of years with chronic health problems than non-Latinos. This longer period of frailty and infirmity means a greater need for assistance. Yet, low levels of institutional care use suggest that in the future Latino communities will need and demand more and better community-based long term care services.

Since both nations are swiftly becoming very old, local, state, and federal governments are faced with increasing challenges related to the care of vulnerable citizens, both young and old. As older individuals become impaired, the caregiving demands faced by the family become more difficult to meet. Uncertainty about the potential dependency burden affects government’s ability to project and plan for future health care and social services.³
The Conference Series on Aging in the Americas (CAA) began in 2001 to facilitate the interdisciplinary exchange of ideas and research aimed at addressing these critical issues. Participation expanded over the next five years resulting in a competitive NIA project award led by a four-member Investigative Team: Jacqueline Angel (UT Austin), Kyriakos Markides (UTMB), Fernando Torres-Gil (UCLA), and William Vega (USC) and an international Advisory Group [http://sites.utexas.edu/caa/advisory-group/](http://sites.utexas.edu/caa/advisory-group/). Each installment in the series — in addition to two bridging workshops called the International Conference on Aging in the Americas or ICAA — is unique in setting an agenda for understanding and improving the health and well-being of this important subgroup of the older Hispanic population and their families. The ultimate goal of CAA is to develop a consensus of healthful aging in this underserved and understudied ethnic group and to produce new knowledge.\(^4\)

The two-and-a-half day conference is convened during National Hispanic Heritage Month and near Mexico’s Independence Day to investigate Latino health, health care policy, and behavioral and social aspects of aging, from theoretical, transdisciplinary, and conceptual perspectives to cutting-edge methodological approaches. ICAA provides an opportunity for emerging scholars involved in the study of Latino health and aging to disseminate and discuss their current research with leading researchers in the field. These mentoring activities further the development of emerging scholars through increased exposure to this body of knowledge, assistance in creating their individual research agenda, and career planning. A major outcome of the initiative is the dissemination of this knowledge through the highly successful, peer-reviewed publication series *Aging in the Americas*, including referred journals and book chapters.

The 2017 conference, titled, “Space, Time, and Place: Effects on the Older Latino Population,” will be hosted by the Edward R. Roybal Institute on Aging at the University of Southern California from September 20-22, [https://roybal.usc.edu/2017icaa/](https://roybal.usc.edu/2017icaa/). The upcoming ICAA will provide a forum to examine a topic that has received comparatively little attention in the field of aging or aging services, especially when compared to the health of children.

This conference will gather a broad array of researchers and scholars to develop a more precise understanding of how “place,” as a social and physical environment
over the life course, affects aging people’s health. Papers will also explore the context of resource reliance in Mexican-origin families. Although there remains much to be learned about the material and non-material assets aging Mexican-origin people rely on to cope with adverse environmental circumstances, thereby producing a wide range of effects on health and functioning, rarely are these studies systematically assembled for examination to advance the field. The distinguished keynote speakers for the upcoming conference include Margarita Alegria (Harvard), Eileen Crimmins (USC), Roberto Ham-Chande (El Colegio De La Frontera Norte), Manuel Pastor (USC), and Steve Wallace (UCLA).

For registration and for more information visit the CAA website at http://sites.utexas.edu/caa/

References


Palliative care and old age: A perfect fit
Written by Diane E. Meier, MD, Director of the Center to Advance Palliative Care (CAPC)

In 2014, the World Health Organization (WHO) called for all member nations to standardize access to palliative care as a human right as a human right (http://apps.who.int/gb/ebywha/pdf_files/WHA67/A67_R19-en.pdf). The resolution calls on all governments to provide funding to support policy change, universal clinician training, multi-sector partnerships, and strengthening support for family caregivers and the communities they live in to care for persons living with serious and chronic illness.

Yet in 2017, palliative care remains inaccessible to most Americans with serious illness, especially the growing number of frail elders with multiple chronic conditions, functional dependency and cognitive impairments. Healthcare professionals lack knowledge and skills in the core palliative care domains—treatment of pain and other symptoms, family caregiver support, communication, care planning and coordination, and most Americans are only vaguely aware of the benefits of palliative care and how and when to access it.

Palliative care is a team-based specialty focused on improving the quality of life and relieving the suffering of persons living with serious illness (https://www.researchgate.net/profile/Amy_Kelley/publication/264799356_Defining_Serious_Illness/links/544134040cf2e6f0c0f6043f/Defining-Serious-Illness.pdf). Provided by teams of doctors, nurses, social workers and chaplains, palliative care treats pain and other distressing symptoms; supports physical function and independence; helps patients and families understand their illness, plan treatment options, and matches treatments to goals; and coordinates care across a fragmented healthcare system (http://www.nejm.org/doi/full/10.1056/NEJMra1404684#t=article). Eligibility for palliative care is determined by patient and family need regardless of prognosis, with the exception of the U.S. hospice program (Figure 1). When palliative care is offered under the Medicare Hospice Benefit (MHB), it is limited by statute to persons who agree to give up Medicare coverage for “curative” disease treatment in return for hospice services, and whom 2 physicians determine will live for 6 months or less if the disease follows its usual course. Outside of the MHB, palliative care is appropriate for patients with serious illness who are benefitting from concurrent curative or life prolonging disease treatment (e.g., leukemia); those who may live for years with one or more serious illnesses (e.g., frailty, dementia), as well as those with progressive and clearly terminal disease (e.g., advanced cancer, advanced COPD and ESRD, Amyotrophic Lateral Sclerosis). At present, there is very little access to palliative care in non-hospital settings where most seriously ill individuals live and need care (home, nursing homes, assisted living facilities).

What are the outcomes of palliative care?
Palliative care is associated with a growing body of evidence consistently supporting its ability to achieve the triple aim—improve the patient experience of care, improve health, and as a consequence, reduce unnecessary and inappropriate medical interventions and their associated costs (/improve%20the%20patient%20experience%20of%20care,%20improve%20health,%20and%20reduce%20unnecessary%20medical%20interventions). Yet in 2017, palliative care remains inaccessible to most Americans with serious illness, especially the growing number of frail elders with multiple chronic conditions, functional dependency and cognitive impairments. Healthcare professionals lack knowledge and skills in the core palliative care domains—treatment of pain and other symptoms, family caregiver support, communication, care planning and coordination, and most Americans are only vaguely aware of the benefits of palliative care and how and when to access it.

What patient populations benefit from palliative care?
The majority of persons with serious and complex illness and associated high health care spending are not dying and are not in their last year of life. Among the 5% of patients who annually account for roughly 50% of all health care spending, only 11% in retrospect incurred these costs in the last 12 months of life (Figure 2) (https://www.nap.edu/read/18748/chapter/14).

About half of the costliest 5% have one-time very high costs, but go on to recover and their subsequent health spending falls back to the baseline in the following year (e.g., those undergoing a complicated surgical procedure). The remaining 40% of the costliest 5% have continued high spending, year-after-year, and are characterized by old age, multimorbidity, functional and/or cognitive impairment, and/or one or more serious illnesses (e.g., dementia, frailty, advanced organ failure). This group is predominantly at home or in assisted living facilities or nursing homes, ineligible for hospice until the very end of their lives, and although hospitalized frequently, spend most of their time out of the hospital. Access to palliative care for this group of patients is limited despite its potential to improve quality of life and care and reduce unnecessary health spending.

Barriers to Accessing High Quality Palliative Care.
Barriers to access to quality palliative care are not specific to the U.S. but are universal across high-income nations and include lack of public and professional awareness of the benefits of palliative care and workforce shortages and inadequate training.

Awareness.
A major issue impeding access to palliative care is the misperception among doctors and other healthcare professionals that palliative care is appropriate only at the end of life, is synonymous with hospice or end-of-life care, and that patients will react negatively and “lose hope” if palliative care is discussed. While physicians have misperceptions about palliative care, many patients simply do not know about it. A recent national survey revealed that only 8% of Americans were either knowledgeable or very knowledgeable about palliative care (https://media.capc.org/filer_public/18/ab/18ab708c-f835-4380-921d-fbf729702e36/2011-public-opinion-research-on-palliative-care.pdf).

Workforce.
Workforce shortages also prevent many patients from accessing palliative care services. The number of palliative care specialists falls far short of what is necessary to serve the current population. Even a specialist workforce, however, will never be large enough to meet the needs of all Americans living with serious illness and their families. Enhancing the palliative care knowledge and skills of front-line clinicians must occur if care for the seriously ill is to improve. At present U.S. clinicians receive little to no training in the essential knowledge and skills of palliative care including skilled communication, care coordination and care planning, expert pain and symptom management, and psychosocial assessment.

Lastly, it is important to recognize that much of the care for patients with serious illnesses is provided by family and other ‘informal’ caregivers who routinely perform nursing tasks, such as wound care and medication management with little or no training and support, often for many years. Adequate training, supervision, and ongoing support of family caregivers are imperative if patients are to receive safe care of reliable quality.

Efforts to improve access to quality palliative care for all who could benefit will require not only investment in clinician training and public and professional awareness, but also a commitment to accountability for quality. Enormous pressures to reduce health spending are driving many new models of community based palliative care, but there are no regulatory or accreditation oversights despite the vulnerable and complex nature of the patient population. Although The Joint Commission has developed an optional advanced certification for hospitals and certification for home care agencies and hospices delivering palliative care services, such services are not a required condition of accreditation, either in hospitals nor in the multiple other settings (home, assisted living, nursing home, office practices) where the seriously ill receive care.

A national strategy is required to engage public and private sectors in developing the delivery models, payment options, clinician training, and quality measurement and accountability so that the promise of palliative care—better quality of life for both seriously ill patients and their families; better care outcomes; and prevention of unnecessary medical intervention becomes reliably available in the United States.

Dr. Diane E. Meier is Director of the Center to Advance Palliative Care (CAPC), a national organization devoted to increasing the number and quality of palliative care programs in the United States. See her keynote presentation, Palliative Care in the Mainstream: Stepping up to the Plate the Case for Integrated Geriatric and Palliative Care Strategies, at IAGG 2017 on July 24, 2017 at 10:00 am.
Thinking Globally about Ageing

Written by Norah Keating, Co-Director, Research on Aging, Policies and Practice at University of Alberta

The world has discovered ageing. From all continents, we see articles and media reports on the growth and impact of population ageing; and visual and literary portrayals of older people. This new awareness is mostly good news from the perspective of those of us who spend our professional lives devoted to improving quality of life for older people. Moving ageing from private to public is surely the first step toward action at national levels.

Yet such gains are tempered by public pronouncements that often fly in the face of the evidence. A typical example occurred this week with a Canadian census release indicating that there are now more Canadians over age 65 than under age 14. Almost immediately, a news outlet responded, describing a wave of retiring baby boomers crashing onto Canada’s demographic shores. ‘Crashing waves’ indeed. Surely there is enough evidence to challenge such hyperbole.

The eve of the 21st World Congress of Gerontology and Geriatrics is a good time to reflect both on how we create knowledge about issues of ageing and how best to link this knowledge to policies and practices that will make a difference to older people in diverse settings across world regions.

Researchers know that creating a body of evidence within one aspect of ageing is time-consuming and resource-intensive. The ‘cells to society’ sweep of gerontology/geriatrics and regional perspectives on global agendas present complex challenges. Transdisciplinary approaches are needed, but are new territory for many of us. Scaling up promising practices and embedding principles into policies and programs to enhance health and foster inclusion bring their own challenges including the vagaries of societal values, government priorities and budgetary constraints. Importantly, these processes are often invisible to those dealing with similar issues in other world regions. We may all be in this together, but we don’t always know about our commonalities.

So how do we create and advance knowledge and action about ageing that is informed and inclusive? From the perspective of an international professional organization such as IAGG, there are some key principles that are fundamental to our ability to influence global agendas:

- Take regional membership seriously.
- Create global research/policy structures.
- Develop capacity.
- Adopt a global conceptual framework for research and policy development.
The actions of recent IAGG presidents have shown their commitment to these principles. Gloria Gutman (Canada, 2001-2005) brought together Gerontology and Geriatrics, broadening the International Association of Gerontology (IAG) to the current International Association of Gerontology and Geriatrics (IAGG). The IAGG umbrella provides the potential to reduce the oft-seen silos of health and social aspects of ageing. Under Dr. Gutman’s leadership, the International Council of Gerontology Student Organizations was launched, providing a structure for building capacity of the next generation of scholars in ageing.

Renato Maia Guimaraes (Brazil, 2005-2009) brought Africa into IAGG, completing membership from all world regions and sending a strong message that global ageing requires the voices of global stakeholders.

Bruno Vellas (France, 2009-2013) developed the Global Ageing Research Network (GARN), a group of collaborating research centres working together to address clinical and basic research issues fundamental to the health of older people. Concurrently, The Global Social Issues on Ageing (GSIA) was created to coordinate and foster research on global contexts of ageing including liveable environments and families.

Hueng Bong Cha (Korea, 2013-2017) has devoted considerable effort and resources to the expansion of gerontological and geriatric research and training in developing countries in Africa, Middle East and Asia. His experience in creating national policy structures on ageing provides a basis for developing conversations with policy makers on strategies to reduce inequalities among older people across and within world regions.

All of these IAGG presidents have been engaged in important debates within UN organisations on issues related to rights and social inclusion of older people.

Advancements within IAGG to be inclusive of regional constituencies, to create structures to facilitate working across disciplines and regions, and to build capacity, have created opportunities for us to undertake the challenges of creating and implementing global research and policy development. A framework to identify key issues, foster discourses and identify knowledge gaps seems a logical next step if we are to take action toward improving quality of life of older persons.

Conceptual approaches to understanding ageing are hardly new. In fact, gerontological theory has become a virtual cottage industry in which ideas are produced, debated and sometimes valorised. For the most part, this theorising is created by those of us who are from the industrialised West. For the most part, we fall short of a comprehensive plan of action.

How do we take action that is global and that just might move us toward the goal of improving quality of life? The recent World Health Organization Global Report on Ageing and Health presents a bold template that could

serve as a rallying point. The report has three premises. The first is that understanding healthy ageing requires attention both to individual physical and mental capacities and to how the social, physical and societal contexts of ageing can enhance or constrain those capacities. The second is that well-being is the outcome, determined by the extent to which individuals are able to be and to do what they value. Well-being is an indication of the ‘fit’ between individual needs and resources and the settings in which they occur. The third is that inequalities among older people across and within world regions are not inevitable. The term inequity is used to indicate unfairnesses that can be changed.

The upcoming IAGG World Congress is one opportunity to discuss how such an ecological approach could be the basis for creating global action. We will address these questions directly in a keynote symposium entitled, Beyond Rhetoric: Taking Global Action on Ageing https://www.iagg2017.org/program/keynotes/17-july-24-2017/37-beyond-rhetoric-taking-global-action-on-ageing. (https://www.iagg2017.org/program/keynotes/17-july-24-2017/37-beyond-rhetoric-taking-global-action-on-ageing.) There will be many opportunities at the World Congress to engage in these debates. Yet, we also know that such conversations themselves are exclusive. Inequities exist not only among older adults but also among the academics, policy makers, members of NGOs and others who are not privileged to travel to international events.

It is time for action, for challenging the rhetoric and for creating global understandings of our similarities and particularities. Together we know ageing; together we know the contexts of ageing. In an increasingly divisive global landscape, our collaborative efforts are even more important. We must be vigilant to avoid the exclusion we decry.

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Extraordinary Professor, Optentia Research Programme, North-West University, South Africa.

Welcome to IAGG
Written by John W. Rowe, MD President-Elect, IAGG President, 21st IAGG World Congress of Gerontology and Geriatrics

Welcome to the IAGG 2017 blog, The Bridge. This space will be a tremendous resource for representatives from medicine, nursing, social science, psychological science, finance, policy fields, and other disciplines. The Bridge will publish posts from IAGG Member Societies from around the world and offer a unique look into critical issues surrounding quality of care for the aging population. The Bridge will also offer news and updates about the 21st IAGG World Congress of Gerontology and Geriatrics (https://www.iagg2017.org/) in San Francisco, California, July 23-27, 2017.

As President of the 21st IAGG World Congress, I am delighted to have The Gerontological Society of America (https://www.geron.org/) (GSA) as the host society. GSA will provide a global platform where leading scientific research are shared to improve our knowledge on health, welfare, and rights of a growing proportion of the world’s population.

Over 6,000 professionals in gerontology and geriatrics are expected to attend the World Congress. This year’s theme, “Global Aging and Health, Bridging Science, Policy, and Practice” will bring together the very best in the field of aging and provide a unique forum for you to share your science.

If you have not registered, I encourage you to register online (/register-now) before the early bird deadline. I look forward to your participation and together we will address the challenges and opportunities that aging presents in the 21st century.