Chapter

Researching into Commitments for Sustainable Development Goals and Healthy Aging

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Abstract

Implementing the Programme of Action (PoA), for the purpose of attaining Sustainable Development Goals (SDGs, also known as the *"Global Goals"*, adopted by UN Member States in the year 2015) requires, among other contributing factors, specific strategies on: (a) *aging*, and (b) *health*. The PoA was adopted at the International Conference on Population and Development (ICPD) that took place at Cairo, Egypt, in the year 1994. In view of these facts, the author of this paper makes two research statements: (a) *"SDGs and healthy ageing (HA) are connected"*, and (b) *"international community, across the regions of the globe, needs to make advocacy efforts for HA"*. These considerations gain increased significance if one looks at demographic trends: significant portion of the world population are older (also known as *"older people"*, *"older adults"*, and *"older citizens"*), with projections that share of older people (over the age of 65 years) will double by the end of 2050. The "UN Decade of Healthy Ageing (2021-2030)", is, thus, a significant development. The author, in the present work, *primarily* attempts to discuss and debate specific initiatives (in terms of strategic interventions) that stakeholders need to undertake for the purpose of ensuring HA. It has been concluded on several platforms that *"attainments of SDGs are closely linked with HA"*. This research note also presents quick highlights on how SDGs and HA are inter-linked. In terms of research mythology employed here, the author has collected secondary data (largely *'qualitative'* in nature) from various sources (*quoted under references*). Method of data analysis is '*descriptive*'. To sum up, key for HA aging lies in enlarging opportunities for positive health at all stages of life.

Keywords: Healthy Aging, Sustainable Development Goals (SDGs), Elderly Population, Millennium Development Goals (MDGs), Aging, Older People, Initiatives, Strategic Interventions, and Programme of Action (PoA)

1. Introduction

It has been increasingly recognized that all persons (of both sexes: males and females), in all parts of the planet, should be accorded with an opportunity that will facilitate them to live both *"long and healthy life"*. As against this commitment to long and healthy life, several international research institutes [including the office of the World Health Organization (WHO)], however, is of the opinion that the environments in which people live can (a) either favor health, or (b) be harmful to it [1]. The author of this paper makes a specific point here that the term

'environments' refer to situation which is multi-dimensional in nature. Environmental situations, from this point of view, are influenced together by four broad sets of contributing factors, namely,

a. peoples' behavior;

b. exposure to health risks (for instance, air pollution, violence, etc.);

c. peoples' access to quality health (including social care); and

d. the opportunities that aging brings in for people [1].

The term "healthy *aging*" (HA) refers to a situation wherein the policy makers and other involved stakeholders definitely resort to a process that ensures *'developing'* and *'maintaining'* the functional ability of older population. HA is, therefore, about creating the opportunities and environments that enable people to be (and to do) what they value throughout their live span. Under favorable situations, everybody can, therefore experience HA. However, it is pertinent to note here that merely being free of disease (or infirmity) is not a requirement for HA. This is because of the fact that since many older adults have one or more health conditions that, when well controlled, have little influence on their *"general well-being"* and overall "*better quality of life"* [1].

In the context of Sustainable Development Goals (SDGs) and HA, the conceptual framework of *"functional ability"* gains increased significance. The author of this policy paper briefly discusses here the modality of inter-connections between functional ability and HA (which, according to the WHO, can be defined as *"the process of developing and maintaining the functional ability that enables wellbeing among older age population"*). The WHO, *further*, states that the term "functional ability" is indicative of having the capabilities that enable people to be (and do what) they have reason to attach values in day-to-day life. *Furthermore,* in a more generalized sense, the relevant aspects of functional ability include a person's ability to make achievements in five matters, namely:

a. *meet their basic needs;*

b. *learn, grow and make decisions;*

c. *be mobile;*

d. *build and maintain relationships; and*

e. *contribute to society* [1].

Most importantly, in addition to what have been stated above, the concept of functional ability envisages the intrinsic capacity of the individual, relevant environmental characteristics, and the interaction between them. The author makes a point here that "intrinsic capacity", the context of HA, comprises all *'mental'* and *'physical'* capacities that an individual can draw on in his/her life. In addition, these capacities (both *"physical and mental"*) include peoples' ability in five key aspects, as outlined below:

a. *to walk,*

b. *to think,*

c. *to see,*

d. *to hear, and*

e. *to remember* [1].

In the context of discussion on developing capacities in the five areas, as indicated above, it is important to note that the level of intrinsic capacity is shaped and influenced by several factors, such as (a) the presence of diseases, (b) injuries, and (c) age-related changes occurring in the individual human being. Apart from this, the author, in this introductory part of the paper (which primarily aims to give an insight into commitments for SDGs and HA), states that environments include:

a. *the home;*

b. *community and broader society; and*

c. *all the factors within them* [1].

Notably, the factors within them, as outlined above, are comprised of aspects such as, (a) the built environment, (b) people and their relationships, (c) attitudes and values, (d) health and social policies, (e) the systems that support them, and (f) the services that they implement. The author of this research note makes a specific point here that being able to live in enabling environments that support and maintain peoples' intrinsic capacity and functional ability is key to HA [1].

HA is, therefore, one of the demographic indicators that all nations and societies strive to achieve, as mandated under the UN Decade of Healthy Aging (2021–2030). The functional ability, *in turn*, enables well-being in older age. *Further*, HA and functional ability (which, in broader sense, indicates: *"having the capabilities that enable all people to be and do what they have reason to value"*) of an individual are closely inter-connected. *Furthermore*, demographers, policy makers and other stakeholders are of the view that implementing the global strategy and action plan on two significant aspects will contribute to the realization of the SDGs: (a) *aging*, and (b) *health well-being* [2].

2. Materials and methods

2.1 Rationale and context

The SDGs (which are reflection of: *"universal call to action to end poverty, protect the planet and ensure that all people enjoy peace and prosperity by 2030"*) were developed in order to secure the future for present and future generations. The 17 universally and unanimously accepted SDGs are integrated: they recognize that: (a) action in one area will affect outcomes in others, and (b) development must balance social, economic and environmental sustainability [3]. The author does not find it appropriate to highlight more about conceptual framework and scope of SDGs, as it is beyond the objectives of this research work. Findings of several research studies are indicative of the fact that many people from across the regions of the globe are, today, in a position to live longer. Also, it has been discovered that sizeable portion of the world's population are in the age that reflects *"older population"* (aged 65 years and above). There are projections (based on data published by the WHO) that the world's population of people over the age of 65, by the year 2050, will

double. Demographic change and/or indicator of this type has implications for sustainable development (SD). The SD is a concept that signifies economic development linked with non-depletion of natural resources. It has been found (in findings of several longitudinal studies conducted by national and inter-governmental agencies, including the WHO) that *"as people grow older, their health outcomes, needs and what they value can change"*. This scenario (connected with old age population) mandates that these changes must be researched into and tackled in appropriate and scientific manners. This will require envisaging *"multi-sectoral actions on ageing and health"*. This aspect, therefore, is critical. It requires support from researchers, academicians, university/higher education administrators, and other stakeholders [2]. The facts presented above signifies relevance of this work. The objectives and other details about methodology employed are outlined in subsequent sections.

2.2 Objectives

The author has divided objectives of this research paper into (a) general objectives, and (b) specific objectives. They are outlined in the following sections. Detailed description on objectives is presented below:

2.2.1 General objectives

In terms of general objectives, this policy paper outlines the concrete actions that are required if the current decade (or twenty-first century) is to be a success in terms of HA for all. Relevant discussion on policy matters pertaining to HA for all are presented by the author at appropriate sections of the work.

2.2.2 Specific objectives

With regard to specific objectives, this work primarily attempts to discuss and debate initiatives that stakeholders need to undertake for the purpose of ensuring HA for all on the globe. Specific initiatives, suggested by the author, are in the form of *"strategic interventions"*: both at macro and micro levels. *Most importantly*, the author has outlined actual initiatives (outcome/s of projects) undertaken in various parts of the globe in support of each suggested strategic intervention. Further, in view of the fact that attainment of SDGs is closely linked with HA, this research note also presents quick highlights on how SDGs and HA are inter-linked. In addition, in view of global COVID-19 pandemic (considered as one of the hardest medical and health emergency the mankind has ever encountered), the author has attempted to make quick presentation, in this work, on how national governments are addressing "healthy lives and well-being for all at all ages" (which come under the category of SDG-3). Since this does not come within direct purview of the objectives of this paper, brief discussion on COVID-19 response has been incorporated.

2.3 Type, nature and sources of data

In this section, attempt has been made to highlights the type of data used in this paper. Also, it discusses the nature of data and source (s) from where they (required for analysis purpose, in view of defined objectives) have been obtained. With regards to type of data, secondary data haven been used by the author. Data used are largely *'qualitative'* in nature. Required data have been collected by the author from the secondary sources, largely published on internet platforms. They (data

sources) have been quoted under reference section of the work, as per standards research ethics. At this juncture, the author makes two specific points:

a. *First*, only data published by reliable sources have been used by the author. Some of such sources include: (a) World Health Organization (WHO), (b) European Commission (EU), (c) United Nations Development Programme (UNDP), (d) Pan American Health Organization (PAHO), (e) WHO Regional Office for Europe, (f) European Research Area in Aging (ERA-AGE 2) (2020), (g) Australian Unity (2018), and (h) Economic Research Institute for ASEAN and East Asia (ERIA).

b. *Secondly*, while quoting data sources (under references), the author has, wherever required (in case of copyright issues), obtained prior permission from the publisher. However, in some cases, email requests, sent for obtaining necessary permission for use of data (information), remained unanswered (for the reasons unknown to the author of this paper).

2.4 Processing and analysis of data

As outlined in the previous sections, the author has used data which are largely '*qualitative*' in nature, in view of objectives and scope of the paper. Thus, an attempt has been made to analyze the collected data (from secondary sources, quoted under references) in descriptive manner that ensures to meet objectives of this work; both general and specific objectives. No sophisticated statistical techniques have been used in this work. Nevertheless, the author makes a specific point in this section of the work that: "non-use of statistical or mathematical tools" (for the purpose of data analysis) does not defeat, in any manner, the purpose of "*qualitative research work method*" (which has been used in this paper to investigate into strategies needed to improve HA for all).

2.5 Methodology of data analysis

In this section of the paper, tool of data analysis has been discussed. As outlined above, the author has collected secondary data (largely '*qualitative*' in nature) from various sources (*quoted under references*) like books, book chapters, government publications, and publications of inter-governmental agencies (like WHO, EU, etc.). In terms of mythology of research employed here, method of data analysis is '*descriptive*'. Since this paper envisages secondary data collected from various sources, it involves "*desk-based research*". In addition, brief description of some of the key terms used in this research has been presented in the subsequent section. Conceptual framework of the frequented used terms has been briefly outlined.

Most importantly, in terms of plagiarism (which means "*the practice of taking someone else's work or ideas and passing them off as one's own*"), these issues are not prevalent in this research work. *However*, the author makes a specific point here that the readers of this work might find plagiarism (in terms of copying previous work) in some parts of this paper, although very limited in nature. This has resulted from the fact that while quoting examples of actual initiatives on HA on outcome/s of projects, undertaken in various parts of the globe (as outlined above, under sub-heading: General and Specific Objectives), not much changes the author of this work could make in presentation of the facts (data analysis). The author was, thus, inclined to make not much changes in text derived from various secondary sources

(indicated under reference section), failing which, the intended meaning (including the context) will be (or is likely to be) lost.

2.6 Scope and significance

This paper will give significant insight into strategic interventions that policy makers and stakeholders need to undertake for the purpose of ensuring HA all. This initiative will, *in turn*, facilitate achieve SDGs for all on a healthy planet by pre-defined time framework, i. e., the year 2030. Also, this work outlines selected actual initiatives (outcome/s of projects) undertaken in various parts of the globe in support of each strategic intervention suggested by the author in this work. Thus, based on findings and data analysis, lessons can be leant. Some of the lessons (including programme innovations) can be replicated elsewhere in the area of HA. Importantly, the author has used three terms in this work: "older people," "older adults," and "older citizens". They all carry the same meaning (people aged 65 years and above).

Additionally (and most significantly), the author categorically mentions herewith that, in this paper, these words have been used inter-changeably: (a) work, (b) research work, (c) research paper, (d) review paper, (e) manuscript, (f) research note, *(g) chapter*, and (h) policy paper. All these words, used in this manuscript, carry the same meaning.

2.7 Review of literature

Review of literature forms an integral part in research studies, especially in the field of social science research. It is for this reason that description on review of literature related to objectives of the research paper (and work done previously in the subject area, under study) needs to be presented. However, the author of this work did not find, despite several academic and research efforts (including consultation with experts in the field, located both in India and abroad), any relevant and meaningful research work that can be presented here as part of review of literature. This may be because of the fact that not much scientific work (that is available either in online or offline modes) has been done in the area of HA (for all). The author, thus, decided to not present any information under this section (review of literature) of this research work.

3. Description of key terms

In this section, the author briefly presents meaning and conceptual framework of some of key terms used in the present work. The idea behind this is that readers of this paper will understand the functioning framework within the context of which this research on strategies for HA for all has been authored. The key terms, arranged alphabetically, are defined below:

a. *Active Aging* (AA): It is a concept recently coined mainly by two international development agencies, namely (a) the European Commission (EC), and (b) the WHO. The conceptual framework of AA evokes the idea of longer activity, with a higher retirement age and working practices. The concept of AA is based on three pillars, namely (1) participation, (2) health, and (3) security. The key aspects of AA are:

1. *autonomy* (which is the perceived ability to control, cope with, and make personal decisions about how one lives on a day-to-day basis, according to one's own rules and preferences);

2. *independence* (which refers to the ability to perform functions related to daily living, that is, the capacity of living independently in the community with no and/or little help from others); and

3. *quality of life* (that is an individual's perception of his or her position in life in the context of the culture and value system where they live, and in relation to their goals, expectations, standards, and concerns).

b. *Aging*: The term *'aging'* (also sometimes written as *'aging'*), in the context of present work, and in its simplest form, implies *"the process of growing old or developing the appearance and characteristics of old age"*. According to internationally accepted definitions (including definition accepted by the WHO), aged people (also known as *"older adults"*, "*older citizens*", or *"older people"*) are those aged 65 years and older. The projections made by the WHO are indicative of the fact that by the year 2050, 80% of all older people will live in low- and middle-income countries.

c. *Elderly Population*: Elderly population (also sometimes termed as "*older people" or "older adults"*) are those people who aged 65 and over. Other key descriptions and demographic characteristics of the elderly population are same, as outlined above (under Elderly Population).

d. *Healthy Aging* (HA): The concept of HA, in its simplest form, refers to *"the process of developing and maintaining the functional ability that enables well-being in older people"*. *Further,* the functional ability refers to having the capabilities that enable people to (be and do what they have) reason to value. *Furthermore,* there are five key domains of functional ability [each of which can be enhanced (or constrained) by environmental factors]. These are the abilities to:

1. *meet basic needs;*

2. *learn, grow and make decisions;*

3. *be mobile;*

4. *build and maintain relationships;* and

5. *contribute to society.*

In the context of HA, policy makers and demographers opine that longer life brings with it opportunities, not only for older people and their families, but also for societies as a whole. It is advocated that additional years provide the chance to pursue new activities in several new areas (such as further education, a new career, or pursuing a long neglected passion). Today, in the 21st century, with emergence of Internet technology, many more avenues exist and await ahead for older people (who also contribute in many ways to their families and communities). The extent of these opportunities and contributions, however, depends mainly on one single factor: health. There is, however, not much research evidence to suggest that older people today are

experiencing their later years in better health and well-being than their parents. Improving HA for all, is, thus, need of the hour in the new millennium.

e. *Millennium Development Goals* (MDGs): There are eight MDGs with measurable targets and clear deadlines for improving the lives of the world's poorest people. In order to meet these goals (MDGs), including universal goal of eradicating poverty, leaders of 189 countries signed the historic millennium declaration at the United Nations Millennium Summit that took place in the year 2000. At that time (that is the year 2000), there were eight MDGs (ranging from providing universal primary education to avoiding child and maternal mortality) that were set to be met, with a target achievement date of 2015. At this juncture, it is pertinent to note that the MDG-F contributed (in both direct and indirect manners) to the achievement of the MDGs, with the main driver behind its work being the *"eradication of extreme poverty"*.

f. *Programme of Action* (PoA): It is also sometimes known as the International Conference on Population and Development (ICPD) Programme of Action (PoA). Alternatively, it is also termed as PoA of the ICPD. The ICPD was held in Cairo, Egypt in the year 1994. It is pertinent to note that Conference (the ICPD) adopted a 20-year Programme of Action (PoA). Most importantly, the PoA of the ICPD envisaged a bold and new vision of the relationships between population, development and individual well-being. Adopted by 179 governments, the ICPD PoA marked a fundamental shift in global thinking on population and developmental issues. Most importantly, it moved away from a focus on reaching specific demographic targets to a focus on the needs, aspirations and rights of individual women and men. Another significant aspect of the ICPD is that the PoA asserted that (a) everyone counts, and (b) the true focus of development policy must be the improvement of individual lives. The PoA also highlighted that the measure of progress should be the extent to which the international community addresses inequalities. In addition, it has, over the years:

1. provided a foundation for the Millennium Development Goals (MDGs); and
2. contributed to significant improvements in poverty reduction, health, education, and gender equality.

g. *Population Aging*: Population aging is considered as one of greatest demographic challenges of the modern era. With the international community already entering in the 21st century, it estimated that global aging is likely to add to increased demand for socio-economic amenities and other developmental infrastructure on economies of all countries in the regions of the globe. Although older people are precious (in terms of enriched knowledge and life experiences they possess), they are often ignored resource that has potential to make an important contribution to the fabric of the societies. Demographers, from across the regions of the globe, are of the considered opinion that national governments, international organizations and civil society need to join hands together to enact *"active ageing policies and programmes"* that favor enhancement of health, participation, and security of older citizens in all possible manners.

h. *Sustainable Development* (SD): The theory of SD provides guiding principle for meeting human development goals, while sustaining, at the same time, the ability of natural systems to provide the resources and ecosystem services on which the survival of the economy and society depends, from long-term point of view. The desired outcome of SD initiatives is situation wherein resources are used to continue to meet human needs without undermining the integrity and stability of the natural system. In its simplest form, the conceptual framework of SD can be defined as *"development that meets the needs of the present without compromising the ability of future generations to meet their own needs"*. Sustainability goals [such as the UN-level Sustainable Development Goals (SDGs)], address the global challenges, including:

1. *poverty,*
2. *inequality,*
3. *climate change,*
4. *environmental degradation,*
5. *peace,* and
6. *justice.*

The dentition of SD, as outlined above, was developed for the first time in the Brundtland Report in the year 1987. The author of this work makes a point here that *"Our Common Future"*, also known as the Brundtland Report, was published in October 1987 by the United Nations (UN). The UN is an inter-governmental organization which strives, in consultation and close coordination of its several specialized agencies (spread all over the globe), to (1) maintain global peace and security, (2) develop friendly relations among nations, and (3) achieve international cooperation. Also, it (the UN) serves as a center for harmonizing the actions of nations, across the continents.

Specifically, SD, today, is considered as a way of organizing society so that it can exist in the long-term. What it implies is that there is need to take into account both the imperatives of the present and those of the future (such as the preservation of the environment and natural resources, or social and economic equity).

i. *Sustainable Development Goals* (SDGs): The SDGs are also sometimes known as the *"Global Goals"*. They were adopted by United Nations (UN) Member States in the year 2015. This development (of adoption of SDGs or Global Goals) took place in response to universal call for action to end poverty, protect the planet, and ensure that all people enjoy peace and prosperity by the year 2030. In total, there are 17 SDGs. Most importantly, they are integrated, in the sense they recognize:

1. *that action in one area will necessarily affect outcomes in other areas,* and
2. *that development must balance social, economic and environmental sustainability in a balanced manner.*

j. *UN Decade of Healthy Aging (2021–2030)*: It is also termed as *"Decade of Healthy Ageing"*. The UN has designated 2021–2030 the Decade of Healthy Aging. Under this initiative, the WHO has proposed a series of actions aimed at improving the lives of older people, their families, and communities. The author of this chapter makes a point here that initiatives proposed to be undertaken as part of the Decade (i. e., Decade of Healthy Aging) will seek the participation of older people, who will be central to and fully engaged in this multi-stakeholder collaboration.

4. Healthy aging (HA) and active aging (AA)

Author, in this section of the work, finds it appropriate to present brief discussion on two inter-connected concepts: (a) HA, and (b) active aging (AA). The HA was the focal term used in the initiatives on aging undertaken by international developmental agencies, especially, the WHO between the periods: 2015–2030. Notably, HA replaces the WHO's previous focus on AA. The AA was a policy framework developed in the year 2002. The HA, like AA, places increased emphasis on the need for action across multiple sectors. Such initiatives are expected to enable older sections of the population to remain a resource to their (a) families, (b) communities, and (c) economies [1].

The AA, in terms of conceptual framework, is defined as *"the process of taking appropriate measures for the purpose of optimizing opportunities needed for health, participation and security in order to enhance overall quality of life as people age"*. More specifically, it (AA) is a term used to indicate the maintenance (and continuity) of positive well-being. Considered from this point of view, well-being also essentially takes into account two significant aspects, namely: (a) good physical, social and mental health; and (b) continued involvement in one's family, peer group, and community. These developments continue throughout the aging process. Everybody can experience HA. The AA and the HA together help reduce the pressure on (a) health care, and (b) social services. It has been found that aged population (or senior citizens) can make important contributions to:

a. *their families,*

b. *their communities,*

c. *the economy, and*

d. *their nation (s)*.

It has also been found that sections of the older people who stay healthy, active and independent can continue to contribute their skills, knowledge, and experiences for betterment of the society [4]. It is important to remember that process of preparing for an aging population is vital to the achievement of the integrated 2030 Agenda, with aging cutting across the goals on:

a. poverty eradication,

b. good health,

c. gender equality,

d. economic growth (accompanied by decent work),

e. reduced inequalities, and

f. sustainable cities.

Therefore, it is imperative to address the exclusion and vulnerability of (and intersectional discrimination against) many older persons in the implementation of the new Agenda to ensure sustainability in health initiatives. At the same time, it is equally important to go extra miles: beyond treating older persons as a vulnerable group. Today, there is increased need for macro level policies that ensure that older people are be treated and recognized as the active agents of societal development. This, in turn, will ensure achieving transformative, inclusive and sustainable development outcomes. The vision, mission and ultimate objective of all these initiatives is to ensure that order adults have HA in the later stages of life, as shown in the **Figure 1**.

It is in this context that the emergence of Decade of Healthy Aging (2021–2030), proposed by the UN, gains increased significance. Plan of action, to be implemented under the Decade, will seek active support and partnership of agencies, such as:

a. the United Nations Department of Economic and Social Affairs (including its regional commissions);

b. the United Nations Population Fund;

c. the Office of the High Commissioner for Human Rights;

d. the United Nations Development Programme;

e. the UN-Habitat;

f. the UN Women;

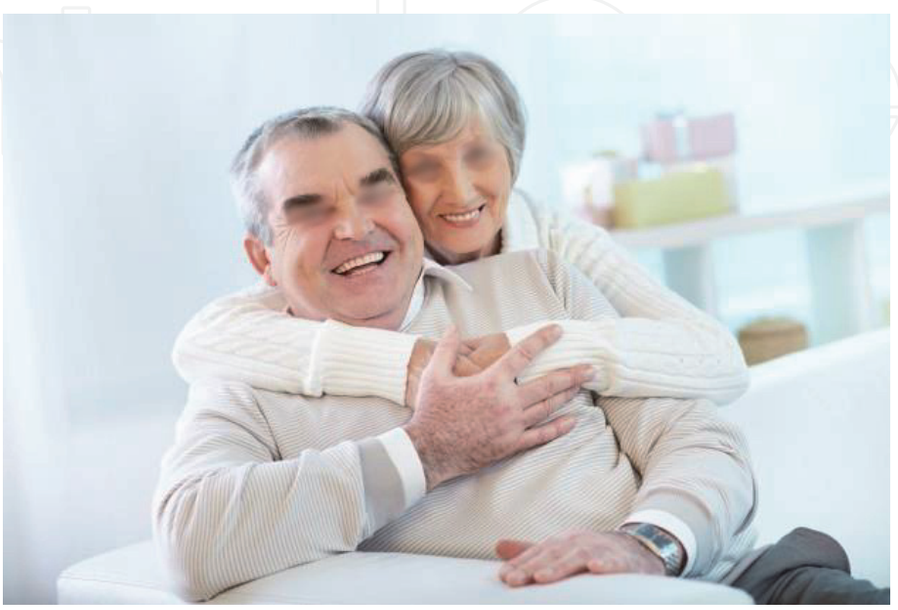

Figure 1.
"Enabling Environment among Older Adults at Later Stages of Life".

g. the World Bank; and

h. other relevant national, international and regional organizations.

5. Key considerations for healthy aging

The author of this review paper has previously outlined the conceptual framework of HA. An attempt has been made in this part of the work to research into key considerations that the policy makers and experts need take into account while framing guidelines for policies aimed at improving HA for all, in general. The author makes a point here that two aspects need special attention: (a) diversity, and (b) inequality. Brief description of these two considerations follows:

a. Diversity: Older persons belong to different ages (or age groups), with different levels of physical or mental capacity. Considered from this point of view, they are diverse in nature. Aging policy should, therefore, be framed to improve their functional ability, irrespective of whether they are robust, care dependent (or in between) [1].

b. Inequity: Inequity is another dimension of aging process. It has been found that significant proportion, nearly 75%, of the diversity in capacity and circumstance observed in older age is the outcome of the cumulative impact of advantage and disadvantage across lives of people. Again, importantly, one finds that the relationships older people have (or develop) with the environments, over the life-span, are shaped and influenced by factors such as (1) the family they were born into, (2) sexual orientation, (3) ethnicity affiliation, (4) level of education, and (5) financial resources [1].

The description presented above makes it important to frame policies for older adults that take into account both diversity and inequity aspects. Such an initiative will ensure HA for all. Health has a central place in SDG-3, entitled *"Ensure healthy lives and promote well-being for all at all ages"*. Also, meeting the goal of HA for all will require (a) commitments on the part of national governments (including all other stakeholders), and (b) enabling environment (that will be a facilitator while implementing actual actions at micro or community levels, across various societies and continents of the globe).

6. Discussion

As outlined above, ensuring healthy lives and promoting well-being at all ages is essential to sustainable development (SD). In this section of the present work, the author presents discussion and analysis of data on HA in the light of specific and general objectives. The discussion follows:

6.1 Inter-linkages between HA and SDGs

Implementation of action plan for ensuring HA will definitely contribute to the realization of the SDGs. It can be seen from developments taking place across the regions of the globe that the 2030 Agenda for Sustainable Development (2030 ASD, commonly known as: "2030 Agenda") is manifestation of the plan of action (POA) to achieve universal SD in a balanced manner [2]. The POA of this type seeks to realize the human rights for all. In addition, it (the POA) calls for a demographic

scenario wherein: (a) no one is left behind; and (b) SDGs are met for: (1) all segments of society, & (2) at all ages, with special focus on most vulnerable ones, including older persons [5].

Preparing the global community for an aging population is, therefore, crucial for achievement of the "integrated 2030 Agenda". *Further*, at this juncture, it is pertinent to note that integrated 2030 ASD of this type requires policy makers to *emphasize* (and also *prioritize*, wherever necessary and possible) addressing concerns of aging population in the context of significant demographic considerations: (a) *poverty eradication,* (b) *good health,* (c) *gender equality,* (d) *economic growth,* (e) *decent work,* (f) *reduced inequalities,* and (g) *sustainable cities.* Interventions in these areas are key to achieving overall sustainable development (SD) [5].

It is in view of scenario outlined above that the policy makers and all concerned stakeholders need to address the issues older citizens are confronted with, especially the aspect of: treating aged population as: *"vulnerable group"*. *Further*more, the integrated 2030 Agenda requires that sections of the population that are aged are accepted & recognized as: *"the active and more meaningful agents of desired changes in the society"* (at micro levels). This, *in turn*, will result in a situation that is conducive to achieve *"transformative, inclusive and sustainable developmental outcomes"* [5].

6.2 Demographic transition and need for ensuring HA for all (In the context of new millennium)

The new millennium is experiencing demographic transition that makes it necessary for all involved stakeholders to maximize initiatives, within the *"framework of available resources", for the purpose of "ensuring HA for all"*. *More specifically*, this aspect gains increased significance when one looks at unpredictable challenges for health care the international community is confronted with: *"the human populations around the globe are rapidly ageing"*. Notably, demographic transition of this type (in terms of significant swelling of aging population) will definitely impact almost all aspects of society [3]. The author of this work outlines below the very specific context in which need for ensuring HA for all can be justified in academic and research terms:

It is decade-old saying that health is: (a) wealth, *in general*, and (b) central to meaningful older age experiences, *in particular*. The author, herewith, makes specific point that although people today (in the new millennium), are living longer, there are not many research evidences which indicate that the extra years (read: *"years spent on old age"*) are spent in good (meaningful) health [4].

One very significant (and also practical) aspect of "old age" (or *"older age"*) is diversity of: (a) *'health'*, and (b) *'functioning'*. This aspect of diversity is (often) a consequence of the cumulative impacts of advantage or disadvantage across people's lives. The policy responses, therefore, need to be designed in manners that overcome (and not reinforce) these inequities. It is for these reasons that the global community together joined hands, in the year 2015, to implement the *"2030 Agenda for Sustainable Development"* (2030 ASD) [3]. The 2030 ASD includes: (a) 17 Sustainable Development Goals (SDGs), and (b) 169 targets. Both these SDGs and 169 targets were adopted on 25 September, 2015 by Heads of State and Governments at a special UN Summit. The 2030 ASD necessarily envisaged the plan of action on "commitment to eradicate poverty and achieve SD by the year 2030 world-wide". Notably, this Agenda (ASD) ultimately aimed at ensuring that no one is left behind. The adoption of the 2030 ASD (also known as: "2030 Agenda") was a landmark achievement, providing for a shared global vision towards SD for all [6].

The document titled "2030 Agenda" urges: (a) that *"no one on the earth will be left behind"*, and (b) that *"every human being will have the opportunity to fulfil their potential in dignity and equality"*. The document titled "Global strategy and action

plan on ageing and health (the Strategy)", published by the WHO, adopted by WHO's Member States in the year 2016, provides a policy level framework. This policy framework calls the international community to make efforts that are aimed at ensuring that "the global response to population ageing is aligned with this ambitious development agenda".

The Strategy (based on research by the WHO and other inter-governmental agencies) is based on new document titled *"WHO conceptualisation of Healthy Ageing outlined in the World report on ageing and health 2015"*. This document focus on the absence of disease. This consideration definitely envisages HA from the perspective of the functional ability that enables older people to be (and to do): *"what they have reason to value"* [4]. The Decade of Healthy Aging (2021–2030) will serve as important tool in ensuring HA for all (including in meeting SDGs for all countries).

6.3 Strategic interventions needed for ensuring HA

The author of this research paper suggests strategic interventions that are needed for ensuring HA for all on the planet. As outlined under specific objectives, each suggested strategic intervention is supported by evidences [actual initiatives (outcome/s of projects) undertaken in various parts of the globe]. The description given below is divided under two sections: (a) Section-1: Strategic Priority Areas, and (b) Section-2: Priority Interventions. The discussion follows:

7. Section-1: strategic priority areas

7.1 Strategic priority Area-1

7.1.1 Statement: healthy aging over the life-course

The aspect of good health needs to considered by all (including developmental planners) for overall SD. This acquires increased significance for older citizens or older people, as it helps them ensure independence, security, and continued productivity in later years of the life span. But it has been found that the non-communicable diseases (NCDs) (especially diabetes, cancer, cardiovascular disease) have potentialities to (a) deteriorate (and diminish) quality of life of aged population, (b) increase costs incurred towards health-care, and (c) add to pressure on family members (and others around) responsible for their care [7].

Addressing the NCDs among senior citizens becomes challenging for the health care providers. This concern is considered to be one of the key factors (a) in furthering HA (health gains) at higher ages, and (b) for resigning policies aimed at attaining long-term health and social sustainable goals. It is pertinent to outline here that NCDs account for considerable loss of *"healthy life years"* among aging population [8]. An individual's health, including the level of activity, during older age, therefore, depend on his/her living circumstances and actions (over a whole life span). Priority area in this matter will definitely (a) *"promote health"*, and (b) *"prevent diseases"*. Maintaining mental capacity (and overall) well-being, thus, deserves attention by policy makers and other stakeholders [8].

7.1.2 Evidence in support of statement

With regard to priority area titled "Healthy Ageing over the Life-Course", several initiatives have been undertaken across the regions of the globe. The European Research Area in Aging (ERA-AGE), for instance, launched and implemented joint

research programme in aging by publishing a call for multidisciplinary research applications on the "Active and Healthy Ageing Across the Life Course" in Europe. Aspects to be considered under the "Active and Healthy Aging Across the Life Course" are outlined in the **Figure 2**.

The call, in response to Active and Healthy Aging Across the Life Course approach is dedicated (a) to the achievement of enhanced and healthy aging and, (b) in particular, to address the major priority established by the Active and Healthy Aging Innovation Partnership (AHAIP). This project aimed at increasing healthy life expectancy by 2 years in the European Union (EU) by the year 2020. This is Europe's first response for aging research. It also envisages second round of ERA-AGE's post-doctoral fellowship programme, known as Future Leaders of Aging Research in Europe (FLARE) [9].

7.2 Strategic priority Area-2

7.2.1 Statement: health and long-term care systems fit for aging population

Attainment of long-term health care system that is appropriate for aging populations is another area of concern. This should form part of strategic priority area. In this context, the question needing answer is: what can be done in order to ensure that different levels of health (and social) care: (a) are better coordinated, and (b) provide services that are appropriate for sections of the aging population confronted with multiple chronic conditions and functional limitations? [8].

The above consideration becomes more important in view of increasing governmental spending on providing quality health care for older people (especially in the long-term) everywhere (and more in the context of countries in the European region. There are research evidences that suggest that several of the older people, today, look forward to enhanced access to high-quality healthcare services. Health care expectation of this type also includes informal health care that is provided by: (a) *"family members"*, (b) *"network of friends"*, and (c) *"civil society members"* at large [8]. The author (of this work) makes special mention here that contribution of these sections of the population makes difference, as they are health care providers who

Figure 2.
"Active and Ageing Across the Life Course" in Europe model. [Source: Sheffield University (year of publication not mentioned). "Futurage: A Road Map for European Ageing Research". Sheffield, United Kingdom: Department of Sociological Studies, Sheffield University (Acessed on April 10, 2021 from: https://www.age-platform.eu/sites/default/files/Research-briefing_futurage.pdf)].

truly understand the health concerns due to their close connections (and prolonged interactions) with aged people in course of social living.

7.2.2 Evidence in support of statement

In support of programme undertaken in response to 2nd priority area named "Health and Long-Term Care Systems Fit for Ageing Population", the author presents here the example of Approach to Geospatial Modeling (AGM) initiative which was undertaken in Australia. As a part of this project (AGM), an effort was made to select and ascertain health and aging demand (in terms of *"community needs"*) and supply (in terms of *"social infrastructure available"*) indicators. Further, these indicators have been mapped on the basis of publicly available data projected for the years 2025 and 2040. Furthermore, the programme implementers used trend data and current state data in order to determine assumptions about projected future: (a) *'demand'*, and (b) *'supply'*. It is interesting to note that the resulting maps enable to illustrate both the level of current and projected demand and supply. Most importantly, this exercise enabled find out the gaps that prevail in provisions of social infrastructure by local government area (LGA). The AGM initiative considered three focus areas, namely:

a. Aging Well,

b. Chronic Diseases, and

c. Mental Health.

It is pertinent to note that these three focus areas were selected (and scoped) based on these three parameters: (a) scale and burden of disease, (b) level of publicly available information, and (c) potential need for reform. It was found that within each area of focus, there are a range of measures that can be used as indicators of demand (or need). It is important to note that this approach provides summary of key infrastructure for health and aging in Australia. This list, however, is not a comprehensive. This is because of the fact that in Australia, many state (and local community) initiatives exist that are beyond the scope of this project to map in their entirety. In terms of outcomes of the initiatives of the AGM, it has been observed, in broad terms, that there are also key programmes and services that the project managers might be aware of. But the fact remains is that they (programmes and services) have not been able to map the required indicators due to the lack of sufficient publicly available data (that needs to be made available by the LGA). Most importantly, in terms of lessons learnt, it has been noted that continuation of the current health and aging models (like LGA) would require significant investment. This aspect is significant in order to meet the projected demand for infrastructure in years 2025 and 2040 in view of the fact that most obvious gaps remain in "aged care social infrastructure" [10].

7.3 Strategic priority Area-3

7.3.1 Statement: supportive environments

This aspect (of environments that are conducive and supportive) is important priority area. The author makes points that initiatives aimed at building (and creating) *supportive environments* is promising development. This type of promising development is reflection of network of cities and communities that: (a) interact

with each other in meaningful way, and (b) cooperate among themselves. This working mechanism creates age-friendly (and supportive) environments [8].

7.3.2 Evidence in support of statement

In the context of strategic priority area-3 (named Supportive Environments) the author of this policy paper herewith makes mention of Senior Friendly Communities Project (SFCP). For the purpose of this work, description on SFCP initiative has been presented under following sub-headings, as outlined below:

A. *Introduction to the SFCP Initiative*: In order to improve the lives of people suffering from dementia and old-age depression, local authorities in parts of the WHO European Region have started undertaking initiatives aimed at combining public health and various social services. The ultimate outcome of the SFCP project is to: *"better support the active and healthy ageing of their senior communities"*. Also, there was emphasis on highlighting an initiative in the Meuse-Rhine Euroregion (EMR). It is important to note that the Senior Friendly Communities Project (SFWP) aims build upon the WHO global and European strategies and action plans on healthy aging and the Age-friendly environments in Europe (AFEE) framework. This framework attempts to (a) design policy tools; and (b) trains local policy-makers in strategy development, local public health interventions, cross-border collaborations, and people-centred approaches for the care and well-being of their elder populations [11].

   It is important to note that the project (SFCP) is implemented by the EMR Foundation. The EMR Foundation supports cross-border cooperation between professionals and organizations engaged in maintaining, promoting and improving public health for residents of the EMR. The cooperation, as outlined above, is tailored to the needs of older people and utilizes an integrated approach that combines health and other municipal services (adapted to the specific needs of the local community). Notably, The EMR cross-border region includes parts of Belgium, Germany and the Netherlands [11].

   Further, local authorities and the communities they serve have a key role to play in developing and implementing *"evidence-based interventions"* (in order to improve the well-being of people with dementia and old-age depression, and their informal caregivers). It has been found that as elsewhere in the European Region (EU), the EMR initiative has an aging population and an increasing prevalence of dementia (about 2%) and old-age depression (about 25%). Notably, with an overall population (of about 4 million people), Policy makers, local authorities and health professionals are working towards improve the lives of their elder communities [11].

B. *Key Activities*: It is pertinent to note the key activities municipalities can choose from include: (1) multiple strategy workshops for local policy-makers on how to develop a strategic plan focusing on local public health campaigns, inter-sectorial action and cross-border collaboration that contribute to the well-being of people with dementia and old-age depression; (b) training of well-being coaches who work closely with primary care physicians; (c) outreach activities offered by trained volunteers to socially isolated older people; (d) educational sessions on aging, positive health, communicating with people with dementia and on empowering family caregivers; (e) creation of local social networks of older people; (f) education in primary schools on

dementia and depression; (g) cultural activities that include the themes of dementia and depression; and (h) online support tools for informal caregivers [11].

In the Netherlands, e. g., family physicians in the city of Kerkrade are working to identify patients in need of social support. When such patients are identified, doctors offer services provided by well-being coaches. These coaches are volunteers who are trained to support people at risk of old- age depression. Social workers in the Netherlands are also tasked with coordinating teams of volunteers trained to provide telephone support to socially isolated people, who are then contacted every 3 days, or every week, to follow up on their needs and to prevent social isolation. Further, In Euskirchen, Germany, police officers, public transport personnel, fire fighters and shop owners are being trained to communicate with people who have early dementia. In Belgium, municipalities are developing neighborhood groups and networks of older people to improve their social inclusion [11].

C. *Project Assessments and Activities*: The project usually begins with a baseline capacity assessment, which is available in Dutch, English, French and German, and is carried out in each participating municipality. The local community then usually selects a number of activities, which reflect their needs. Support is provided throughout the project to help municipalities implement the activities chosen. Finally, after the initial implementation process, a second assessment is performed to develop a 5-year sustainability plan. Notably, the project euPrevent Senior Friendly Communities receives support from Interreg Euregio Meuse-Rhine with means coming from the European Regional Development Fund [11].

7.4 Strategic priority Area-4

7.4.1 Statement: strengthening research and the evidence base

The author opines that *strengthening research and the evidence base* should form part of strategic priority area. Policy makers and collaborative partners should strives to:

a. further improve the evidence for policy, and

b. facilitate dissemination and exchange of knowledge (which is especially needed to fill gaps in comparable data).

Findings of research studies must be disseminated and exchanged among stakeholders and researchers. Most importantly, knowledge transfer should continue to be key in projects for HA, including at the local levels [8].

7.4.2 Evidence in support of statement

Here, the author presents example of the Longitudinal Study of Aging and Health in the Philippines (LSAHP) in support of priority area-4 (named Strengthening Research and the Evidence Base). It is pertinent to note that the LSAHP is the first study, which is research and evidence-based in nature, that was undertaken in the Philippines in the year 2018. It is multi-actor longitudinal study on aging [12]. Data and information for the study were collected from:

a. older Filipinos,

b. their caregivers, and

c. adult children.

Under the LSAHP project, the 2018 baseline data provides comprehensive information on the health, economic status, and overall well-being of a nationally representative sample of older Filipinos aged 60 and older. It is pertinent to note that these data are considered as valuable resource for the crafting of evidence-based policies and programmes for aging population in the Philippines. With regard to objectives, the LSAHP aimed to (1) investigate the health status and well-being, as well as their correlates, of Filipinos aged 60 years and over; and (2) assess and ascertain the determinants of health status and transitions in health status and overall well-being. This initiative (LSAHP), which is part of a comparative study of the Philippines and Viet Nam, is funded by the Economic Research Institute for ASEAN and East Asia (ERIA). The ERIA is an international organization established in Jakarta, Indonesia in the year 2008 by a formal agreement among Leaders of 16 countries in the East Asian region. It aims to conduct research activities and make policy recommendations for further economic integration in the East Asia. The ERIA works very closely with both the ASEAN Secretariat and 16 research institutes to undertake and disseminate policy research under the three pillars. They are: "Deepening Economic Integration". The LSAHP is implemented by the Demographic Research and Development Foundation, Inc. [12].

8. Section-2: priority interventions

Four Priority areas, as outlined above, form the basis for priority interventions. These interventions are prominent in national or subnational plans related to healthy aging. Worldwide, evidences are growing about effectiveness and contribution of interventions to the sustainability of health and social policies for aging population. The evidence-based policies provide a foundation for the further strengthening of international exchange and knowledge transfer for ensuring HA for all [8]. The author herewith suggests four priority areas in which interventions are needed for the purpose of furthering well-being of elderly population. They are: (a) prevention of falls, (b) promotion of physical activity, (c) public support for informal care giving (with a focus on home care), and (d) geriatric and gerontological capacity building among the health and social care workforce. Description on how these priority interventions enable HA, across the regions of the globe, is presented below:

8.1 Fall prevention

In terms of health risks among older people, findings of the research studies undertaken across the regions of the globe are suggestive of the fact that the risk of falls increases steadily with aging process. More specifically, older women are more vulnerable than older men. Two contributing factors for this trend, according to medical professionals, is that women (a) tend to have less muscle strength, and (b) are more likely to have osteoporosis. In addition, it is pertinent to note that fall-related injuries during old age are more likely to be severe. Doctors have reported that once injured, older people are more susceptible to longer-lasting ill health (or hospital) stays, with fatal complications of various types. Again, in terms of

expenses to be incurred towards treatment, *"fall-related injuries"* (mainly *"hip fractures"*) involve considerable amount of costs for two medical aspects, namely, (a) *"hospital admissions"*, and (b) *"rehabilitation interventions"* [8]. In terms of other factors responsible for fall and related injuries, reasons include (a) muscle weakness, (b) balance disturbances, (c) previous history of falls, and (d) multiple medication. Scientific and convincing evidences drawn from research studies indicate that *"most falls are preventable"*.

At this juncture, the author of this paper make a specific point herewith that some of the *"preventive measures"* tend to be *"cost-effective"* (or *"cost-saving"*). Importantly, there are *"good-practice examples"* of how fall prevention strategies can be successfully implemented in different settings, when supported by enabling public policies [8].

In terms of viable and non-medical interventions needed to prevent fall resulting health complications among older people, appropriately designed advocacy initiatives have been found to be effective. This will, however, require multi-sectoral approach. For instance, combination of creating and raising awareness of risk factors, exercise programmes, physical therapy and balance retraining have potential to reduce (a) falls, and (b) number of injuries per fall. It is for this reason that many countries, today, have designed and implemented programmes aimed at home safety assessments. It has also been discovered that scientific modification in home exercises by trained professionals can also reduce incidents of falls and other related injuries. Some developmental projects have, in place, more specialized preventive measures for high-risk groups of older people. Preventive measures advice (for instance, wearing of hip protectors) makes difference in case of fall prevention among older people. In this context, what is of utmost significance is that prevention of falls is prominent in quality management programmes for HA for all in various settings [8].

8.2 Promotion of physical activity

It has been found that physical activity is one of the strongest predictors of HA. Several groups of medical professionals suggest that regular physical activities, in moderate volumes, help older people promote mental, physical and social well-being. Also, such activities enable them to prevent: (a) *'illness'*, (b) *'injury'*, and (c) *'disability'*. In support of this research statement, the author of this work makes statement that those sections of people who are physically fit when they enter into old age, tend to stay healthier for longer time. One should also note that physical activities among older people is beneficial not only in preventing diseases, but also in (a) *"lowering the risk of injuries"*, (b) "improving mental health", (c) *"further improving cognitive function"*, and (d) *"enhancing social involvement"* [8].

8.3 Public support for informal care giving (with a focus on home care)

With aging population, witnessed in several nations and regions of the globe, older people (with functional limitations of various types), from different social-settings, need support with the activities of daily living. What is alarming in this context is that the growing prevalence of dementia will further increase the demand for this support. Thus, public support for informal care giving (with a focus on home care) is one aspect that requires special attention in initiatives aimed at HA for all [8].

Demographers and researchers (including the office of the WHO) have found that in many of the European countries, most care (in terms of hours) is provided mostly by women informally at home settings. This phenomenon is witnessed even

in countries that have well-developed publicly supported elderly care sectors in place. The author of this work advocates that public support for informal care giving is one of the most important public policy measures that needs to be taken in order to ensure future sustainability of health and social care in aging populations [8]. The fact remains is that this type of informal care, with a focus on home care, is a response to multiple disorders. It requires an evolving and tailored combination of six considerations, namely,

a. *acute care,*

b. *rehabilitation,*

c. *chronic disease management,*

d. *social care,*

e. *dementia care*, and

f. *palliative care* [8].

Another important dimension of policy for public support for informal care giving that requires intervention from policy makers and all involved stakeholders is that where these services are available, they (a) are often fragmented, and (b) may be prohibitively expensive. *Further*, many of the older people, with chronic health or social care needs, opt for living at home. They prefer to remain independent at home, as long as possible, over the alternative of *"assisted living"* in institutional settings [8]. However, it should be noted that without public support, caring for a relative or friend can result in:

a. reduced workforce participation,

b. higher risk of poverty, and

c. long-term loss of employment opportunities for the care giver [8].

Furthermore, lack of support can also have a negative impact on the relationship between care giver and recipient. Also, it can potentially lead to (a) mental and other health problems, (b) the social isolation of both parties, and (or) (c) elder maltreatment. Although most public funding of long-term care is still provided through institutions, in some countries in the European Union region, long-term care provided at home is seen as a preferred and cost-effective alternative to care provided in a nursing home or other facility. In these countries, it has become an important component of publicly funded services [8].

8.4 Geriatric and gerontological capacity building among the health and social care workforce

Gerontological capacity building among the health and social care providers is key in ensuring HA for all. In this context, it is pertinent to note that significant progress in geriatric education has been made in many countries over the years. Geriatrics, today, has become a full-fledged recognized specialty in medical schools: at both undergraduate and postgraduate teaching levels, including as a part of continuous training of health care staff at medical institutions in various parts of the

world. However, the progress made in this direction has been uneven. But the growing number of very old population in some nations and regimes has made it urgent to further strengthen national and sub-national capacity for training in geriatrics and gerontology. It has also become necessary to promote a stronger profile for geriatric training, including cross-specialty training. What is more alarming is that the greatest challenges are still gaps in the geriatric knowledge of general practitioners and other health care practitioners, *on the one hand*, and insufficient specialist training and a shortage of specialists in geriatrics itself, *on the other* [8].

9. COVID-19 response to ensure healthy lives and promote well-being for all at all ages

As outlined in previous sections by the author, ensuring healthy lives and promoting well-being at all ages is essential to SD. There are, therefore, several challenges associated with health that need to be addressed, especially in view of aging population. In addition to this, the globe is confronted with another health crisis: COVID-19. This pandemic is (a) spreading human suffering, (b) destabilizing the global economy, and (c) upending the lives of countless number of people around the globe. It is important to note that before the pandemic (COVID-19) emerged, notable progress was made in improving the health conditions of millions of people. However, the current health emergency poses added global risk. It has shown the critical need for health preparedness at all levels, and in all countries [13].

In addition to the initiatives undertaken by the United Nations Development Programme (UNDP), the WHO has been leading the global effort to tackle COVID-19 crisis, in the form of coordinating global efforts. In terms of COVID-19 response, the WHO (in collaboration with its collaborating partners) has come out with the *"Strategic Preparedness and Response Plan"* (SPRP). The SPRP envisages the public health measures that countries need to respond to COVID-19 health crisis. Again, the Strategy (the SPRP) provides guidelines for the public health response to COVID-19 (at national and sub-national levels). Also, it (SPRP) highlights the coordinated support that is required from the international community to meet the challenge of COVID-19 [13].

The COVID-19 Solidarity Response Fund has been institutionalized. The Fund supports work of the WHO work in order to: (a) track and understand the spread of the virus, (b) ensure patients get the care they need, (c) ensure frontline health workers get essential supplies and information, and (d) accelerate research and development of a vaccine and treatments for all who need them.

Notably, the WHO, together with partners, also provides guidance and advice for elderly people to look after their mental health during the COVID-19 pandemic. Aged people (including older adults) are at increased risk of being infected with the COVID-19 [13].

10. Summing up

The discussion presented above highlights need for ensuring HA in line with SDGs. Several deliberations have taken place at national and international platforms on this subject area. Also, the conceptual framework of Decade of Healthy Aging (2021–2030) has come into existence. All these developments have resulted in desired commitments and strategies, including plan of action: both at policy (macro) and ground (micro) levels. However, there many crucial gaps in

'knowledge' and *'capacity'*. This fact emphasizes need for "capacity-building" in areas where programme implementers have (a) either *'failed'*, and/or (b) *"achieved little success"*. Several initiatives are underway throughout the world for *'bridging'* and '*narrowing'* the gap. In this very context, the author of this work specifically points out that several of the initiatives DO NOT have in-built scientific mechanism to measure or evaluate the outcomes in exact terms. For instance, one can come across instances wherein an organization has: the objective of reaching out to 100 college student population with messages on *"what society at large should do to care for those older people living in isolation"*. The author states that:

a. Above should not be objective (in true programme management terms). Rather, it (this action/initiative) should be looked at as: *"means of achieving HA"*.

b. Several of the initiatives (if not all) DO NOT aim to quantify the outcomes in QUANTIFIABLE TERMS (QTs). The term QTs, according to the author, should enable the project managers and project evaluators to match *'objectives'* with *'outcomes'*. This will enable one to know both "success and failure areas", including the extent. This, *in turn*, should necessarily enable both project managers and project evaluators (including policy makers and other involved stakeholders) to identify the areas and exact means (or strategies) to make improvements.

In view of very specific statements made above by the author, there is need to propose "time-bound" Programme of action (PoA) in the area of HA. Such PoAs should necessarily envisage following two key aspects: (a) availability of resources, including resource support from collaborating agencies (working at local, national, international, and inter-governmental levels); and (b) locally prevailing socio-economic and demographic profile.

In order to ensure that above outlined aspects form the integral part of the initiatives aimed at ensuring HA for all, the author suggests, in this paper, that those responsible for implementation at the actual ground/community levels programmes propose "time-bound projects" (TBPs). Such TBPs, in the context of mega cities (which are demographically characterized with, among other factors, huge population base), should envisage two significant considerations: (a) *resource support that will be actually available at the time of programme implementation*, and (b) *likely hindrances that may come up*. In the absence of ascertaining answer to these questions on needed resource support and likely obstacles, initiatives aimed at HA for all may not yield desired outcomes [14].

Author of this paper has outlined above concrete actions that are required if the Decade [UN Decade of Healthy Aging (2021-2030)] is to be a success (in terms of HA for all). However, the priority areas should be left open to series of dialogs and consultations among: (a) expert, and (b) stakeholders [15]. *Most importantly*, (a) POAs needs to commence immediately, and (b) actual project implementation is possible ONLY through collaboration with many key partners. The author outlines that: Policy coherence and equitable impact will only be achieved if there is coordination and integration between the stakeholders and actions. Actual implementation of the POAs require resourcing (that may sound like: *"investments"*).

At this juncture, it is important to outline that the emergence of UN Decade of Healthy Aging (2021–2030) is a significant development. This initiative (2021–2030), sought to be undertaken, in global collaboration, is aligned with the last ten years of the SDGs that brings together all partners (including governments, civil society, international agencies, etc.) to improve the lives of older people, their

families, and the communities they live in. Health for all is need of the hour, as populations around the world are aging at a faster pace (than in the past). This demographic transition will have an impact on almost all aspects of society in relation to aging process [16]. To sum up, there is need for life-course approach to aging. This calls for protecting and promoting the rights of older adults in the implementation of the 2030 Agenda [17].

The author briefly presents here the strengths and limitations of this study. In terms of strengths, this paper has extensively researched into strategic interventions that need to be taken by the providers of health care, policy makers and other stakeholders involved in order to ensure HA all, in the context of SDGs that are set to be met by the year 2030. Most importantly, this research work has also looked into selected relevant initiatives that have been undertaken, at both macro and micro levels, in various countries. The initiatives have been quoted in support of each strategic intervention that the author has suggested in this work (in view of general and specific objectives). Based on findings and data analysis, significant lessons have been leant (that are briefly outlined above). With regards to limitations, the author has outlined very few and selected actual initiatives undertaken in various parts of the globe in support of each suggested strategic intervention. Many more projects on HA for all have been implemented, over the years, by developmental agencies (including national governments, and inter-governmental agencies), across the regions of the globe. However, the author could not incorporate all of them, mainly because of space limitation that was suggested. Selection of initiatives that form part of this study (chapter) was made by the author, using research wisdom, including envisaging consultations with demographers in the network of the author. However, this does not, in any way, undermine the significance of this research work. Quoted initiatives are ample demonstration of need for interventions needed in the area of HA for all, including for meeting SDGs in timely manner.

None of us should forget that investments in a future that enables people to live longer and healthier lives are key. Also, it is significant for policy makers to ensure that they have the opportunity to contribute to the society, so that THEY ARE NOT BE LEFT BEHIND). These two aspects are key to creating societies that respect elderly population [18].

Acknowledgements

The author gratefully acknowledges the support of his wife, Anjila Santosh Mishra, in authoring this research paper. Although she does not possess required subject knowledge & expertise, she has life experiences (which is outcome of non-formal learning). I say that she provided cherished comments on my work on commitments for SDGs & HA for all, & that her contributions are treasured.

DOI: http://dx.doi.org/10.5772/intechopen.97674

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