International Seminar on

Ageing Society and Rehabilitation: to enable to everyone can receive rehabilitation services as necessary

February 18, 2018

National Rehabilitation Center for Persons with Disabilities
Japan

(WHO Collaborating Centre for Disability Prevention and Rehabilitation)

Program

Time & Date : 13:30～17:00, February 18 (Sun.), 2018
Venue: Tokyo International Forum (3-5-1, Marunouchi, Chiyoda-ku, Tokyo, Japan)

Facilitator: Hirotoshi Tsutsumi, Director, Department of Planning and Information, National Rehabilitation Center for Persons with Disabilities

13:30 ***Opening Address***
Yoshiko Tobimatsu, President, National Rehabilitation Center for Persons with Disabilities

13:40～ ***Keynote Lecture***
" WHO Rehabilitation 2030"
Darryl Barrett, Disability and Rehabilitation Technical Lead, Western Pacific Regional Office, WHO

14:20～ ***Presentation***

1 **"Rehabilitation and Older People-an Australian Perspective"**
Ian Cameron, Professor and Head, John Walsh Center for Rehabilitation Reserch, Sydney Medical School Norhtern,The University of Sydney, Australia

2 **"Cambodia National Ageing Policy"**
Kol Hero, Director, Department of Preventive Medicine, Ministry of Health, Cambodia

3 **"The Role of Chiba Rehabilitation Center : Moving toward an era of integrated community care"**
Katsunori Yoshinaga, Director, Chiba Rehabilitation Center, Japan

4 **"Aging of Persons with Disabilities and Health Promotion"**
Toru Ogata, Director, Center of Sports Science and Health Promotion, National Rehabilitation Center for Persons with Disabilities, Japan

Break

16:05～ ***Discussion among presenters, Q&A***

Facilitator: Hideki Yamada

General Manager of Policy Planning, National Rehabilitation Center for Persons with Disabilities

16:55 ***Closing Address***

Setsu Iijima, Director, Rehabilitation Services Bureau, National Rehabilitation Center for Persons with Disabilities

Opening Address　Yoshiko Tobimatsu

General Facilitator　Hirotoshi Tsutsumi

Mr. Darryl Barrett

Mr. Kol Hero

Mr. Ian Cameron

Mr. Katsunori Yoshinaga

Mr. Toru Ogata

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Discussion

Closing Address　Setsu Iijima

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Opening Address

Yoshiko Tobimatsu

President
National Rehabilitation Center for Persons with Disabilities

Thank you very much. I am Tobimatsu. On this cold day in February, thank you very much all for coming to participate on this seminar today. We, National Rehabilitation Center for Persons with Disabilities, are designated as WHO collaborating center for disability prevention and rehabilitation. And we support the various activities related to disability prevention and rehabilitation. And through accepting visitors and training from overseas, we're trying to disseminate the information from Japan. And one of such activities is this international seminar that we are holding every year. And for this year, our theme is *The Aging Society and the Rehabilitation*.

In Japan, more than 27% of the population is older than 65 years old. We are in a super aging society, and it's not happening only in Japan. It's been progressing in any other country. So, in Japan, under a different institution, but the so-called elderly people and the people with disability could receive the necessary rehabilitation. And by the revision of the act for the comprehensive support for persons with disabilities, even the patients with intractable diseases can take the rehabilitation, but there are different countries all over the world, and not all people can enjoy the benefits of rehabilitations.

And as a global trend, the societies are aging, so WHO's rehabilitation definition has also been changing, meaning rehabilitation is not only for the person with disabilities but for all the people who have limited living function. And it should be needed in the various different stages of their life, and it should be integrated into the medical treatment.

In today's seminar in Asia Pacific Region and in Japan, from the perspective of aging, we will be hearing the presentation on how the rehabilitation has been dealing from WHO in Australia, Cambodia, and in Japan. And we would like to think about the issues and challenges that anybody can enjoin and accessible to the rehabilitations. I hope that this seminar will be meaningful for all of you who are present today. Thank you very much.

Keynote Lecture

WHO Rehabilitation 2030

Darryl Barrett
Disability and Rehabilitation Technical Lead,
Western Pacific Regional Office, WHO

〔**Biography**〕

2016 Current position
2015 Adviser to the Australian Disability Discrimination Commissioner, Australian Human Rights Commission, Sydney, Australia
2011 Disability Inclusive Development Specialist, Department of Foreign Affairs and Trade (and the former AusAID), South East Asia and Australia
2010 Masters of Public Law
2008 Regional Coordinator/Regional Manager, Technical Unit, Handicap International Regional Office, Middle East
2007 Bachelors of Law
1996 Bachelor of Occupational Therapy

〔**Summary**〕

Health systems are improving, resulting in higher survival rates for disease and injury. This also means that people are living longer with some form of residual impairment. The rise of noncommunicable diseases and issues associated with ageing populations requires rehabilitation services to address people's health and well-being while living longer with chronic illness and impairment.

WHO is supporting countries to address these issues through strengthening and extending rehabilitation services, access to assistive technology and community-based rehabilitation.

Rehabilitation, as part of universal health coverage is also linked to WHO global efforts to ensure people have access to quality health care services without causing financial hardship. Rehabilitation interventions help people recover from illness and injury; prevents secondary or associated health conditions; and supports people to participate, be productive and fulfil meaningful life roles. As such, the availability of accessible and affordable rehabilitation plays a fundamental role in achieving Sustainable Development Goal (SDG) 3, "Ensure healthy lives and promote well-being for all at all ages".

In the Western Pacific Region, countries are at various capacities to provide rehabilitation services due to different approaches and understanding of rehabilitation; insufficient prioritization or unclear allocation of funding for rehabilitation; the lack of recognition of rehabilitation as part of universal health coverage; rehabilitation not being viewed as part of the continuum of care for the benefit of the general population; and perceptions about rehabilitation as an expensive or 'luxury' health service for high income countries.

This presentation will provide an overview of rehabilitation as part of universal health coverage, and how WHO is supporting countries to strengthen rehabilitation for all in the region.

WHO Rehabilitation 2030

Darryl Barrett

Disability and Rehabilitation Technical Lead,
Western Pacific Regional Office, WHO

Good afternoon ladies and gentlemen.

Firstly I'd like to acknowledge the National Rehabilitation Centre for Persons with Disabilities in Japan, one of our WHO Collaborating Centres and a leader in the promotion and advancement of rehabilitation in the country and in the Region. I'm speaking to you today primarily about Rehabilitation 2030, and in particular what it means for addressing future health priorities in our region.

Introduction - Rehabilitation

Rehabilitation is an essential health strategy and is necessary for people experiencing difficulties in functioning. Many people with a health condition or who experience disability who use rehabilitation services go on to be able to participate in school, work or social activities.

WHO recognises that rehabilitation is a set of interventions designed to reduce disability and optimize functioning in individuals with health conditions in interaction with their environment. As people are living longer with chronic illness and impairment, populations are ageing, and with the growing prevalence of disability in the region, the lack of coverage for rehabilitation services is concerning and requires immediate attention.

Among the recommendations in the World report on disability was the development of the WHO Global Disability Action Plan 2014-2021: Better health for all people with disability. WHO is currently supporting Member States to implement Objective 2 of the GDAP, which encourages states 'to strengthen and extend rehabilitation, habilitation, assistive technology, assistance and support services, and community-based rehabilitation'. The action plan also incorporates

the Convention on the Rights of Persons with Disabilities. The disability convention obliges States Parties to strengthen and extend rehabilitation services as a means to ensure people can attain and maintain maximum ability and participation. In particular, the convention encourages workforce development and the availability of assistive technology to ensure people who experience disability or functional limitations can receive quality and appropriate rehabilitation services.

Rehabilitation is also a key component of the Declaration of Alma-Ata (1978) which identified primary health care as key for people to be able to attain health. Recognising that health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, we must strengthen rehabilitation if this is to become a reality. In 2018, on the 40th anniversary of the Alma-Ata Declaration, it's time to address limitations in rehabilitation services that countries are experiencing, as a key mechanism for realising the 2030 Agenda for Sustainable Development.

We must consider the Sustainable Development Goals or SDGs at this time also. For at the core of the SDGs is equity, which can be achieved by promoting poverty reduction, creating environments for equal opportunity and ensuring development is sustainable. The SDGs promote a world that is fair, where everyone can participate and no one is left behind. One way that countries can achieve the SDGs, and ensure no one is left behind is through strengthening rehabilitation.

People who are typically at risk of being left behind are those who experience difficulties in functioning due to health conditions, including some people with disability. Limited functioning and disability can restrict or prohibit people from study, work, self-care, or social engagement. Rehabilitation addresses both the functional capacity of individuals, and certain barriers in their personal environment to promote independence and participation.

The global community has committed to "Ensure healthy lives and promote well-being for all at all ages" through SDG 3. A key element of ensuring healthy lives and promoting well-being is through advancing universal health coverage (UHC). In essence, UHC is a means to ensure all people have access to quality essential health care, without suffering financial hardship or undue burden. This is important for people with health conditions causing functional difficulties and those with disability in particular.

Strengthening rehabilitation services is one way to progressively advance UHC by addressing the growing unmet health needs of people who are living longer with chronic health conditions or impairment. It is important that all people have access to rehabilitation services, as part of the continuum of care. Rehabilitation is for everyone. As such, the availability of accessible and affordable rehabilitation plays a fundamental role in achieving SDG 3.

Member States have been working to improve access to rehabilitation services for people with disability, which has been important, however since the development of the GDAP, the 2030 Agenda for Sustainable Development and an emphasis on UHC, a stronger focus on rehabilitation is required to meet current and future health priorities. Without specifically addressing rehabilitation gaps in the Western Pacific Region, attainment of the SDGs and improvement in advancing UHC will be limited.

It's vital that we address the profound shortage of rehabilitation services to support people to access basic health services, and for countries to advance UHC and achieve the SDGs.

Rehabilitation 2030

A key tool for addressing challenges in rehabilitation services is Rehabilitation 2030: A call for action. For those of you who may not be familiar with Rehabilitation 2030, let me introduce you.

In February 2017, WHO convened rehabilitation experts and policy makers in Geneva to draw attention to the profound unmet needs for rehabilitation and raise a call for action.

The meeting was attended by 208 participants from 46 different countries, and drew attention from both the organization itself, and the health and development communities.

The Rehabilitation 2030 meeting was the first time a meeting focused on rehabilitation had taken place at WHO since 1958. So not for almost 60 years had WHO had a global meeting about rehabilitation.

It was attended by government representatives, health care professionals, civil society, rehabilitation organizations and disabled people's organizations. The meeting called for governments and rehabilitation stakeholders to coordinate action and establish joint commitments to raise the profile of rehabilitation as a health strategy to address 21st century health priorities relevant to the whole population, across the lifespan and across the continuum of care.

With the rising prevalence of noncommunicable diseases and injuries and the ageing population, there is a substantial and ever-increasing unmet need for rehabilitation. In many parts of the world, however, the capacity to provide rehabilitation is limited or non-existent and fails to adequately address the needs of the population.

The barriers to scaling up rehabilitation indicate a need for greater awareness and advocacy, increased investment into rehabilitation workforce and infrastructure, and improved leadership and governance structures. The magnitude and scope of these unmet needs signals an urgent need for concerted and coordinated global action by all stakeholders.

The *objectives of Rehabilitation 2030* were quite straight forward.
Firstly, to draw attention to the increasing needs for rehabilitation.
Secondly, to highlight the role of rehabilitation in achieving the SDGs.
And Thirdly, to call for coordinated and concerted global action towards strengthening rehabilitation health systems.

The meeting put on the table, some clear issues at the global level, that require addressing not only to support the development of rehabilitation services, but more importantly to support people's health and well-being. In particular, there is a clear recognition of the unmet rehabilitation need around the world, and especially in low- and middle-income countries, and that this need is profound.

We know that demand for rehabilitation services will continue to increase in light of global health and demographic trends, including population ageing and the increasing number of people living with the consequences of disease and injury.

As mentioned earlier, rehabilitation is an essential part of the continuum of care, along with prevention, promotion, treatment and palliation, and should therefore be considered an essential component of integrated health services.

Rehabilitation is relevant to the needs of people with many health conditions and those experiencing disability across the lifespan and across all levels of health care. Thus, rehabilitation partnerships should accordingly engage all types of rehabilitation users, including persons with disability. Rehabilitation is an investment in human capital that contributes to health, economic and social development because the focus of rehabilitation intervention is function, and participation.

We also know that the role of rehabilitation is instrumental for effective implementation of the Global strategy and action plan on ageing and health (2016–2020), the Mental health action plan (2013–2020) and the Framework on integrated people-centred health services, and as a contribution to the efforts of the Global Cooperation on Assistive Technology (GATE) initiative.

And while all this is known, current barriers to strengthen and extend rehabilitation in countries include:

i. under-prioritization by government amongst competing priorities;
ii. absence of rehabilitation policies and planning at national and sub-national levels;
iii. limited coordination between ministries of health and social affairs where both are involved in rehabilitation governance;
iv. non-existent or inadequate funding;
v. a dearth of evidence of met and unmet rehabilitation needs;
vi. insufficient numbers and skills of rehabilitation professionals;
vii. absence of rehabilitation facilities and equipment; and
viii. lack of integration into health systems.

There is an urgent need for concerted global action by all relevant stakeholders, including WHO Member States and Secretariat, other UN agencies, rehabilitation user groups and service providers, funding bodies, professional organizations, research organizations, and nongovernmental and international organizations to scale up quality rehabilitation. To address these global issues, a key meeting

outcome was agreement on the following 10 actions to progress and strengthen rehabilitation

These included –

1. Creating strong leadership and political support for rehabilitation at sub-national, national and global levels.
2. Strengthening rehabilitation planning and implementation at national and sub-national levels, including within emergency preparedness and response.
3. Improving integration of rehabilitation into the health sector and strengthening inter-sectoral links to effectively and efficiently meet population needs.
4. Incorporating rehabilitation in Universal Health Coverage.
5. Building comprehensive rehabilitation service delivery models to progressively achieve equitable access to quality services, including assistive products, for all the population, including those in rural and remote areas.
6. Developing a strong multidisciplinary rehabilitation workforce that is suitable for country context, and promoting rehabilitation concepts across all health workforce education.
7. Expanding financing for rehabilitation through appropriate mechanisms.
8. Collecting information relevant to rehabilitation to enhance health information systems including system level rehabilitation data and information on functioning utilizing the International Classification of Functioning, Disability and Health (ICF).
9. Building research capacity and expanding the availability of robust evidence for rehabilitation.
10. Establishing and strengthening networks and partnerships in rehabilitation, particularly between low-, middle- and high-income countries.

So really, not a lot to do at all!

Importantly the question then becomes, what relevance does Rehabilitation 2030 have in our own Region? Well, you may be pleased to know that the Regional Office for WHO in the Western Pacific is addressing this in a couple of ways.

Firstly through promoting rehabilitation as an essential health service, for all people, not as a disability-specific service.

We're working with countries in the region to support rehabilitation as part of essential packages of health care, and for ageing populations and people with mental illness.

We're also working with colleagues in HQ to promote the GATE initiative to improve access to assistive products for all people.

These will come together in a new Regional Action Plan on Rehabilitation that is being developed this year by our office. The Regional Action Plan on Rehabilitation, the first of its kind in any region of WHO, will draw on the outcomes of Rehabilitation 2030, and more importantly, will address health issues and rehabilitation concerns in our region.

The Action Plan will be presented at the WHO Regional Committee meeting in Manila in October this year, for endorsement by Member States. We are in the process of developing the action plan, and will consult with individual countries to seek their input into the plan. The Plan is important to address the issues we know exist, and that we've drawn out from our Member State Survey in 2015, looking at country capacity to implement the WHO Global Disability Action Plan.

Regional Developments

A regional action plan doesn't come without its challenges. The Western Pacific Region is a culturally and linguistically diverse area that extends from China and Mongolia in the North and West, to New Zealand in the south, and French Polynesia in the east. While some countries enjoy rapid emerging social and economic development, others isolated geographically struggle for advancing their commitment to sustainable development. The Region includes advanced economies, countries in transition from low and middle income status and small island developing states. Health systems face some particular challenges in terms of meeting the demands of emerging disease patterns, a growing ageing population, in one of the most disaster prone regions in the world. The region shares a range of issues relevant to efforts for strengthening rehabilitation services for all people. These issues have been indicated to or by the WHO Regional Office for the Western Pacific by Member States, development partners, and health care users themselves.

While rehabilitation is recognised by WHO as an essential component of UHC, it is not included as an essential health service in all basic care packages nor as a core component to essential interventions for health conditions from diseases and injuries. Efforts to reduce deaths and prevent illness and injuries are being effective and people are living longer with chronic illnesses such as cardiovascular disease, diabetes and mental illness. However, health interventions have not sufficiently included support for strengthening of rehabilitation services and access to assistive technology. In many countries in our region rehabilitation services are often under prioritized and neglected on the national health agenda. For example, only around 1 in 10 people have access to the assistive technology that they require to work, get an education, or just mobilize. People are living longer, but are less able to participate in education, work, social and community activities or simply take care of themselves. Their ability to contribute to prosperous families, communities and nations will remain limited so long as rehabilitation services are not considered as an essential health service. This is concerning also given that at some point in our lives, we will all likely experience disability directly or experience functional difficulties due to the interaction between a health condition or impairment, and barriers in our societies.

While not exhaustive, the following set of issues has been identified as key concerns related to rehabilitation services in the Region.

Rehabilitation services are of limited quality and / or not available to all people

The importance of rehabilitation to the health and well-being of populations is largely known to the rehabilitation community themselves, or to people with disability, but not necessarily to health systems planners. This is concerning considering the range of issues associated with the current state of weak rehabilitation services in many countries in the region. The Pacific Island countries experience, particularly large deficits in rehabilitation services and many governments are dealing with ongoing challenges to address this.

Community based rehabilitation (CBR) services are being adopted as a means to support access to services for people with disability, however, approaches to CBR differ in the region, with some taking a health-focus while others more broad on inclusive development. Importantly, CBR needs to be integrated into health systems to allow referral across and between community and tertiary settings, and

sufficient numbers of qualified rehabilitation professionals are required to support CBR activities but they are currently profoundly limited in some countries.

The rise of noncommunicable diseases

The rise of noncommunicable diseases is well-known in the Western Pacific Region, particularly in Pacific Island countries where diabetes and cardiovascular disease lead to further health conditions such as vision loss, stroke and amputation. The majority of the Pacific Island countries have more than 14% of the prevalence of diabetes, with the highest being Marshall islands at 29%. Trends in Asia indicate a current lower prevalence compared to the Pacific Islands countries. Functional difficulties associated with NCD are profound. The ever increasing demands that NCD place on health care and social welfare services, and loss of individual function leads to a reduction in productivity and the impoverishment of families. The links with these health conditions and people's ability to function are important to address if countries are aiming to support the health and well-being of their populations beyond medical care. Restoring function so that people who have an NCD and experience functional difficulties can still access the necessary NCD related promotional, preventative and curative health care services is vital. For example, a person who has an NCD such as diabetes may go on to develop an ulcer and subsequent amputation, impacting on their ability to function. They would then potentially face physical barriers to accessing the ongoing NCD-related health care they need due to barriers in the health care system such as inaccessible infrastructure. If the amputation reduced or removed their ability to earn a living, they may face financial barriers to accessing health care and maintaining a healthy lifestyle. This scenario would also involve family and community members who may also be impacted on because of NCDs and subsequent disabling situation. While no doubt there should be ongoing efforts to prevent NCDs, people will continue to acquire them, and go on to experience difficulties functioning. Prevention is undoubtedly important and a priority in the Region, however people currently have, and will continue to have in the foreseeable future, a range of diseases that have not been prevented despite the best efforts. For these people, the lack of rehabilitation services in the Region means they and their families face challenges to obtain health and well-being and to not be left behind.

Intrinsic capacity can decrease in ageing populations, who also require rehabilitation services as prevention of injury and illness and to overcome barriers

Health conditions associated with ageing are becoming a pressing issue in the Western Pacific region with 235 million people over 60 years old consisting of 13% of the population in the region in 2010. There are challenges related to health in responding to consequence of ageing. First, countries, especially lower- and upper-middle income countries in the region have shorter time to prepare for building systems to address health issues in relation to ageing populations compared to high income countries. The proportion of older people in the population has been increasing more rapidly than the other age groups, mostly from a fall in fertility rates and longer life expectancy. It took about 35-50 years for Australia's, Japan's and New Zealand's proportion of older population to reach 14% from 7%. Some countries however have seen the same demographic changes in less than 30 years. Second, there will be more need for health care services, including rehabilitation for the prevention of injury and illness, and the management of the consequence of diseases and injuries associated with ageing. The leading causes of morbidity for older people in the Western Pacific region are cardiovascular diseases, cancer and respiratory diseases, followed by unintentional injuries. This translates into an increase in the proportion of people with difficulties in functioning and disability, especially among women. This is related to the longer life expectancy for women compared to men. Third, functional difficulties related to limited physical capacity, especially mobility, can mean older people with limited mobility are unable to access health facilities. Infrastructure without universal design or services without reasonable accommodation become inaccessible for older people with limited functional ability.

There is a profound lack of rehabilitation workers

Globally, the rehabilitation workforce is varied. The range of professionals engaged in the provision of rehabilitation services can include specialist medical practitioners, rehabilitation nurses, physiotherapists, occupational therapists, speech pathologists, psychologists, social workers, orthotists, prosthetists, heath technicians and community-based rehabilitation workers. Many countries in our region are able to identify some types of rehabilitation workers among their health workforce, however there are many gaps across the professions. The rehabilitation workforce is limited and can be weak, contributing to the slow development of

rehabilitation services. While physiotherapy is available to some extent in every country in the region, some countries only have two therapists for the entire health system. This lack of rehabilitation staff impacts on the ability for people to recover quickly from illness or injury, transition home from health facilities. It also increases the impact of the health condition for the entire family due to the low level of function a person may live with due to lack of rehabilitation services.

Quality and appropriate assistive products are not readily available in all countries

Assistive technology is an important part of rehabilitation interventions, as many people who engage in rehabilitation may be prescribed assistive products to assist them at home, work or in the community. While high-income countries in the region reported having regulatory agencies and legislation governing the prescription of assistive products, the provision of assistive technology in a systematic manner is limited across the region. Few countries reported specific assistive technology standards. Some lower- and upper-middle income countries described legal documents referring to assistive technology, and six countries reported having an agreed list of essential assistive technologies. High income countries appear to have more complex service provider systems to meet the wide range of assistive technology needed by people with disability and those experiencing functional difficulties.

Another significant issue with the provision of assistive products in the region is procurement, which is particularly problematic in the Pacific Island countries which have relatively small populations dispersed over very large geographic areas. These issues combined with a profound under-developed rehabilitation workforce mean that appropriate assistive products are not prescribed or provided to people who need them. In the Pacific alone, with people experiencing amputations, and vision loss related to diabetes, the provision of assistive products is crucial for the health and well-being of Pacific Islanders. Without assistive products people with disability will be excluded from a range of development opportunities and effectively be left behind. These are people who have families, have jobs, go to school, vote and may otherwise be able to contribute to their communities if assistive products were available.

Increasingly, countries are addressing the need for assistive technology, but there remains limited availability of appropriate assistive technologies and

inadequate standards for provision of good-quality, safe and affordable products. Existing funding is not adequate to meet the large unmet rehabilitation needs. Assistive technology can be essential for some people experiencing health conditions.

Data on rehabilitation services are not uniformly collected or utilized to inform policy or programs

The limited availability of data related to rehabilitation service delivery is not an issue just for the Western Pacific Region. Globally data on those who need rehabilitation services and those who actually receive a service remains a major challenge. Not all countries in the region collect data on rehabilitation services. Pacific Island countries and lower middle-income countries reported limited available data on rehabilitation services.

The collection of data through administrative sources is also limited in our region. There is also scattered collection of data from other sources such as during health emergencies like cyclones or earthquakes, however, inconsistency remains in the region regarding effective data collection mechanisms. In some countries rehabilitation service data sits outside regular health system data collection mechanisms. This limits the impact of the information about rehabilitation services and health outcomes, and also limits the ability for rehabilitation services to be considered in health systems.

Health emergencies don't always consider rehabilitation services in priority interventions nor address disability issues

During a health emergency, the tragedy of loss of life is coupled with injury or illness that can contribute to disability. In addition, some people with difficulties in functioning and those with disability can be at greater vulnerability. Many people with disability or those who experience difficulties functioning prior to the health emergency can experience particular challenges such as obtaining necessary nutrition; or staying safe from violence and injury or illness. Some people will be unable to move independently or safely without assistance from family or others, or without disability related supports. Preparedness for health emergencies is relevant to the Western Pacific region where countries are prone to natural and man-made disasters, outbreaks and conflicts.

So, as you can see, significant challenges exist in our Region, if we are to address the health and well-being of all of us.

While there are clear challenges, WHO is committed to working with countries to address these, including through the development of a Regional Action Plan on Rehabilitation

During March we will develop a draft Regional Action Plan, and then from April to June we will consult with governments in our Region, seeking feedback and guidance on the plan. Then in October at the WHO Regional Committee meeting the plan will be presented for endorsement.

It will be a historical time for our region, and for all of us working in rehabilitation, in both health and non-health sectors, we will have our profiles raised, our issues public, our priorities noted and our work focused.

And echoing the call to action, I encourage you all to support the strengthening of rehabilitation in our region, and welcome your input to the action plan when it is open for consultation, and to continue your work to develop stronger rehabilitation services for all of us.

presentation

Rehabilitation and Older People - an Australian Perspective

Ian Cameron
Professor of Rehabilitation Medicine, University of Sydney
Head, the John Walsh Centre for Rehabilitation Research

〔Biography〕
Ian Cameron is Professor of Rehabilitation Medicine at the University of Sydney and leads the John Walsh Centre for Rehabilitation Research. Ian is a clinician researcher who works with older people and people with disabilities. Ian holds an Australian National Health and Medical Research Council Senior Practitioner Fellowship.

〔Summary〕
As in many higher income countries Australia has a rapidly ageing population. Investment has, in the past, been in institutionally based services for older people. These have been located in hospital based rehabilitation services and residential aged care facilities.

However for several decades recently Australian government policy has specifically encouraged older people to “age in place”. This has encouraged the development of community based services for older people and rehabilitation services outside traditional hospital settings.

These developments have been made in the context of mixed public and privately funded aged care and rehabilitation services. While the concept of “user pays” is well established there is also the acceptance of a “safety net” of services for older people with limited financial resources.

This presentation will review the structure and functioning of rehabilitation services for older people in Australia and place these in the context of service structures recommended by the World Health Organisation.

Rehabilitation and Older People,

an Australian Perspective

Ian Cameron

Professor of Rehabilitation Medicine, University of Sydney,
Head, John Walsh Centre for Rehabilitation Research

Thank you very much for that introduction. Also, thank you to Dr. Tobimatsu and colleagues from the National Rehabilitation Centre for Persons with Disabilities for the invitation to talk today. I apologize that I'm not able to speak in Japanese with you, but I have spoken to the translators, and they will, I think, do a very good job.

My topic is *Rehabilitation and Older People, an Australian Perspective*. You can see on this first slide that there's a picture of two older people who are aging successfully. They are farmers who have a very large sheep station. And they've continued that work into their 80's. That's the goal of aging and rehabilitation for older people, but unfortunately, not everyone can achieve that.

And so, this slide is my summary slide. As we all recognize, the world is an aging society. Japan and Australia have both similarities and differences when we're thinking about rehabilitation of older people, but a key principle is "aging in place". Australia also has a philosophy of user pays with a safety net. It does see rehabilitation as an essential health service. And in summary, Australia meets most of the World Health Organization standards suggested in the document as just outlined by Mr. Barrett. However, there are controversies. And we will talk about the controversies a little, and the lady here on this slide, Mrs. Campbell, will be our more detailed case study.

So, this is a slide looking at the increasing number of older people and the decreasing percentage of younger people. And so, in most parts of the world, younger children are outnumbering older people by 2015, and in higher income countries like Australia and Japan, older people already outnumber all children.

If we look at this comparison between Japan and Australia, I will just highlight a few differences. Japan, of course, has a much larger population, about six times more than Australia. The GDP per capita, life expectancy at birth, and health spending per capita are surprisingly similar. Japan has more hospital beds per thousand population and a much longer length of hospital stay. However, the numbers of beds in long-term residential facilities for older people are roughly similar. And finally, you can see that the number of people who are overweight or obese in Australia is much larger than Japan, and that, of course, is associated with health issues.

This slide summarizes some of the important consideration for health and age care systems in Australia. In summary, health and health services are mainly the responsibility of the states of Australia while age care services are traditionally the responsibility of the Australian Commonwealth Government. And so there can be conflicts between those levels of government.

Australia has had an “aging in place” philosophy for older people and for younger people with disability for that matter since the 1980’s. And this idea of “user pays” has been operating since the 1990’s. Australia has a system of universal health insurance called Australian Medicare, and that’s strongly supported by the population, but it’s important to realize that Australian Medicare does not cover age care services. It’s separate, and older people make a payment for age care services that varies according to their financial situation.

So, what does “aging in place” mean? I’m sorry the quote is so long, this is from a paper they explored what aging in place means in the Australasian region of the world. And essentially, it means the older person lives where they choose to live, which is usually their own home, and then having health and age care services come to them in their home without moving to a residential age care facility.

And our older people illustrated here on the farm achieved aging in place until the man died, and his wife had dementia. And so, without the husband there, the wife then moved into residential care after his death.

This slide is about “user pays” with a safety net. Our first female prime minister, whose name is Julia Gillard, introduced this final part of user pays. So, if older people in Australia now move to a nursing home, generally, they

need to sell their house to have enough money to pay for age care. Australia does not have long-term care insurance.

So, I'm moving on to an international perspective. I'm mindful of the timer, and so this section will need to be in summary. We can look at a range of documents that are relevant here. So, we have documents from the United Nations and the World Health Organization, some of the important documents of the United Nations Convention on the Rights of Persons with Disabilities, and these apply equally for older people and younger people.

We have the World Report on Disability that's now been available for quite a few years. It has a chapter about rehabilitation, which supports views of the ICF, a multidisciplinary approach, and particularly notes successes about older people. They give the examples of falls prevention and community participation after stroke. We have the World Report on Aging and Health, and it supports "aging in place", and notes the effectiveness of rehabilitation. And it supports the development of health systems and long-term care systems. It introduces the concept of optimizing intrinsic capacity, which essentially means helping a person as they age to maintain maximum capacity and then, if something happens to affect that capacity, then to restore it. So that's particularly Trajectory B in that figure.

As part of the Rehabilitation 2030 initiative that's been discussed by Mr. Barrett, there are a number of recommendations for rehabilitation and health systems. So, three of the four recommendations on this slide, Australia meets well. What it doesn't do so well is have both community and hospital-based rehabilitation services broadly available. Of the other four recommendations, the one that Australia does not meet so well, in my opinion, is that there are insufficient financial resources to provide adequate levels of rehabilitation services.

These concepts of rehabilitation, as had been introduced in the previous talk, these are ones from the World Health Organization. The definition of rehabilitation is evolving over the years and the World Health Organization documents define rehabilitation objectives. You can see those rehabilitation objectives are somewhat wider than the traditional objectives of rehabilitation services.

I am going to apply rehabilitation in older people principles in this case study. And just to introduce that there's a range of types of factors to consider in rehabilitation planning for older people. And it's the Point C that I've underlined that are more of a factor for older people and rehabilitation than younger people. So, these are; did the older person had a disability before the current event, the need to make sure that medical or health system factors don't make the older person worse, the need for greater liaison with family members, and also a great need for liaison and coordination with other service providers.

This is the case study that we'll fairly much finish with. So, this is Mrs. Campbell. You can see her here when she was a younger woman. She was born in 1929, so she will be 89 this year. The particular issue that we're going to talk about was that she had a high fall downstairs with a head laceration, and she couldn't get up. So, a fall related injury. And it turned out that she had a delayed diagnosis of an injury a her cervical spine vertebral subluxation and also a fracture of the left ankle. We're going to use this diagram to illustrate rehabilitation planning from the point of view of Mrs. Campbell and health professionals. And this is using this diagram is from a paper of Steiner from 2002.

So, you can see we have the health condition, which is the fall with multiple injuries. Mrs. Campbell has past health problems of epilepsy, deafness, polymyalgia rheumatica, and she'd had an episode of delirium. Using the ICF, if we think about the body structure and function problems, she had a cervical spinal fusion for her neck injury. She had the left ankle fracture. In terms of an activity limitation for her, limited ability to get to the toilet was important. And in terms of participation restriction, of course, she wondered when she could get home. Thinking about the contextual factors, from a personal perspective, she had reduced confidence due to prior illnesses. She had positive environmental factors through a supportive, highly educated husband. And they lived in retirement accommodation, meaning an apartment that was set up for older people. Thinking about the health, the rehabilitation team perspectives, initially, there was immobilization of the neck and ankle. And the limited hearing was a factor to consider. In terms of the activities that were the focus of the rehabilitation program there were restricted transfer ability, restricted self-care, and restricted mobility. And the clear participation goals were to return home to her normal home duties.

So just to summarize, after a three-week in-patient rehabilitation program, Mrs. Campbell became mobility independent, self-care partly independent and delirium did not recur. She returned home with her husband. An ambulatory rehabilitation program was offered. She said she didn't want it. She did agree to have her hearing assessed and now uses hearing aids. And in summary, she's not able to drive now, but continues her role in the church, and is supported by her husband.

So, this is pretty much my closing remarks. The rehabilitation services worked well for Mrs. Campbell after the initial delay in diagnosing what her injuries were. But the issues, from an Australian perspective, would be services might not have worked as well if she had less financial resources and also lived away from Sydney in a rural area. Australian health and age care services are not as available away from the large cities.

I will just mention this in passing. Rehabilitation services deal with the person, but sometimes rehabilitation services need to deal with systems. And I'll close there. I would like to acknowledge Professor Gwynnyth Llewellyn, who I think is known to some of you, who assisted in putting this presentation together. Thank you.

presentation

Cambodia National Ageing Policy

Kol Hero
Director, Department of Preventative Medicine, Ministry of Health, Cambodia

〔**Biography**〕

1985-91 Medical Doctor Degree, Faculty Mix of Medicine-Pharmac and Stomato-Odontology (currently called University of Health Sciences), Phnom Penh, Cambodia.

1996-98 Master Degree of Science in Epidemiology (Public Health), College of Public Health, University of the Philippines Manila, the Philippines

2002-05 Master Degree of Business Administration (Major:Management), Panhasastra University of Cambodia

2004-05 Master Degree of Business Aministration (International Hospital Management Program), HfB (Business School of Finance and Management), Frankfurt, Germany

〔**Summary**〕

The Royal Government of the Kingdome of Cambodia has committed to providing the necessary support and creating enabling environments at policy and program levels for the implementation of the National Aging Policy 2017-2030. The policy was adopted by Prime Minister “Hun Sen” in 17 August 2017 and launching in 18 January 2018.

The ultimate goal is to help older people to participate with freedom and dignity in development activities especially those related to enhancing the well-being of the elderly. Policy calls for concerted efforts by the public and private sectors as well as civil society, development partners and the network of older people’s associations spread across the country.

The guiding principles should be taken into account also during the implementation phase are: Paying adequate attention to the status of the elderly as defined by Khmer culture and traditions when addressing issues facing the elderly; Mainstreaming population ageing into all development plans and programs with full recognition of the right of older persons to participate in planning decisions affecting them; Taking into account diversity in needs of older persons resulting from differences in age,

ethnicity, religion, health status, educational level, and economic status when addressing ageing-related issues; Focusing particular attention on older women because they outnumber older men and are more vulnerable due to greater discrimination and a greater likelihood of being poor, widowed, and neglected; and implementing measures to address population ageing taking into account new ageing-related international and regional initiatives.

The policy vision is to continuously enhance and improve the quality of life of older persons in Cambodia with emphasis on ensuring them equal rights and opportunities. The two goals are first is to ensure that older persons are enabled to fully participate with freedom and dignity for as long as they wish to in family, community, economic, social, religious and political activities; and second is to ensure that younger persons are better equipped with knowledge that enables them to lead a more productive, healthy, active and dignified life in old age.

Nine strategic objectives are: ensuring financial security, health and well-being, living arrangement, enabling environment, older people association and active aging, intergenerational relations, elder-abuse and violence, emergency situation, and preparing younger generation.

Cambodia National Ageing Policy

Kol Hero

Director, Department of Preventative Medicine,
Ministry of Health, Cambodia

Thank you very much. Today, I have the honor to be here to give you the presentation data in *Cambodian National Aging Policy*. At first, I would like to say, Dr. Tobimatsu, president of the National Rehabilitation Center for Persons with Disability. Also, thank you for WHO collaboration center, WHO WPRO, WHO country of WPRO who's facilitating me to come to Japan. And also, thank you for national, international guest speaker, ladies and gentlemen.

Cambodia recently have adopted the so-called Cambodian National Aging Policy because in this area, you're supposed to speak more about the rehabilitation, but unfortunately, Cambodia rehabilitation is not really within the health system, like WHO strategy, especially for the SDG. Then, they need to include the rehabilitation within the health system. Cambodia is also making the health system available for these services, and then we are working for this. And then hopefully, we can have some kind of good therapist in the future.

So, as you can see that Cambodia National Aging Policy in the past, we have the separate ministry doing the work, the Ministry of Health, for aging within the health sector. Then the Ministry of Social Affairs working for the aging activity within the community. But currently, I've seen that most of the development partner that the donor is going to phase out, that they also want to include rehabilitation within the two sectors, that we have to work together.

So, I will speak regarding to this is my content of the presentation. I will speak the background, why the aging activity within the country is important. Then I would like to show you what the reality of aging in the country. Then also, the statement of the policy, vision, goal, and strategic objective of National Aging Policy, what the institutional structure within for the implementation, and then what the health and the well-being priority. And then we have come up with the

so-called draft *National Aging Health Action Plan* that we are still working only before, we hope to finalize soon and get some report even from the government development partner or some kind of international assistance. And we have some kind of what we are going to do next.

So, as you can see at Cambodia, we're seeing that most of the time that the people living with, like the extended family, so the parent, the grandparent is living along with the grandchildren or children, which is most, but currently, they just started to see from extended maybe to the nuclear family. So even the proportion of the older people remained lower compared to other Asian country because, you see why, because Cambodia in the past, we have some kind of civil war almost 30 years. And most of the people died during the war. And then we have older people that are getting bombed during the '80 or the '90. Then, now is the time that Cambodia population, they become older. And then that you can see, the proportion, we are continuing to rise during the next 15 or 25 years.

Then, currently, we have the so-called National Aging Policy from 2017 to 2030, and then it was adopted in the last year, August. And then we have now the work plan among the various ministries, and then we hope to finalize it by the next couple of months, then we start to implement for the whole country for the people that mostly depend on the traditional old style. And then also, currently, we have the government and the so-called National Safety Net that are led by the Ministry of Economy and Finance. We hope that the older people can have some more assistance from the government. We have the so-called social protection policy framework included within the National Safety Net from 2017 to 2030 that seek to develop a social protection system for the funding of all the groups, including older people.

This is the effect that considered now is Cambodia is pouring up for the older people that you can see the people that's age 60 and above and from 5.6% in 2000 up to 7.6% in 2013. And then the projection can be up to 17% in 2050. That's why the government of Cambodia is trying to set up before the population of older is to reach higher.

The most effect about the older people in Cambodia, because it is seen we have a long duration of war, that less people, during the people all during the period of time that they have less time to study so that not received education at all up to almost 68%. And then now, we are decreasing, the number. We have up to around

40.5%, but regarding to the proportion of men and women, we have some kind of men have more education than women. So, there is still the gap among the gender.

These are the effect number three that why the government needs to focus on the policy to protect to take care of the older people because of the proportion of the people supporting the elderly is become decreasing. So, we have 15.5 % in 1998 and down up to 9.3 % in 2030. This is that way because the population in the past, we stay together at home, but since the economy grow that the younger people are more gladly to move to work in the urban area to get more income, so that left the people stay at home alone.

This is the slide. We have some kind of a launching of the policy that you have the Prime Minister and then the Minister of the Social Welfare, and due to rehabilitation that the chair of the aging policy, National Aging Policy.

So, the vision of the National Aging Policy is to continuously, enhance and improve the quality of life of older people in Cambodia with emphasis on ensuring them equal rights and opportunities. So, whenever you do something, you have to have the vision and the mission and then the goal to make sure that we are confident to do the same.

So, the goal here, we have two main goals. To ensure that older persons are enabled to fulfill, participate with freedom and dignity for as long as they wish to in family, community, economy, social, religion and political activity. The second goal, to ensure that the younger persons are better equipped with the knowledge that enable them to lead a more productive, healthy service and dignified life in all age.

Among the nine strategies, we have developed only five because we've seen that the most priority, that's one to five. We have nine priorities. The first strategic objective is ensuring financial security, that's most important. And then health and well-being, that's the second priority. That's mostly focused that the main task for the Ministry of Health and Ministry of Social Affairs. The third strategy objective, a living arrangement. Fourth is enabling environment. Fifth, older people association and active aging. Sixth, intergenerational relationship. Seventh, elder-abuse and violence. Eight, emergency situation. And the ninth is preparing younger generation.

We select the Aging Policy within the five priorities objective that we have discussed among the different stakeholders, different ministries responsible for, that we have priority one, enhance financial security. That mostly belong to the Ministry of Economy and Finance. Priority two, that health and well-being belong to Ministry of Health and Ministry of Social Affairs. Priority living arrangement. And then four, enabling environment. And five, older people's association. We have different ministries doing the work. And then this is the institutional structure. We have the royal government of Cambodia at the top. We have the Ministry of Social Affairs and focuses on our training as the lead ministry. We have a secretary that are led by the undersecretary of state within the ministry. We have the Ministry of Health, also remember of that. We have provincial department for Ministry of Social Affairs and Ministry of Health. And we have provincial security department that we're putting activity. We have a 15- member ministry.

So I can inform you that we have Ministry of Social Affairs, Youth Rehabilitation, Ministry of Women's Affairs, Ministry of Interior, Council of Ministers, Ministry of Economy and Finance, Ministry of Labor and Vocational Training, Ministry of Health, Ministry of Religion and Cults, Ministry of Rural Development, Ministry of Education, Youth, and Sport, Ministry of Planning, Ministry of Information, Ministry of Public Affairs, Cambodia, and National Committee for Organizing National and International Festivals. We have 15 ministries working for the activity.

So, regarding to priority number two, regarding health and well-being, we need to see from the ministry perspective, we just set up the policy direction, set up the national and action plan and the strategic action plan. Then, we translate all the policy into action. So, we need to work to concentrate all the policy and activity to make it overcome the action plan and applicable for the whole country.

So that we have, first, to promote healthy aging and expand preventive health care. Second, to establish a responsive health system that is accessible and ensure quality curative the health services. And third, to meet older person's requirement for long-term care or to further address availability of adequate trained health personnel. That's the most important.

So, regarding to the action plan, we have three years. We select for the three years first because we still need some modification for the next national action plan. So, for the strategic number two that I just said, we have introducing a life course approach to healthy ageing and disease prevention at the main task of the Ministry

of Health and lead the activity in collaboration with other ministries. So, we then provide training to help prepare oneself to become healthy. This is through the health care worker. And then the rest organized through health is also related to old age, how to prevent them and promote inclusion of health issues into the investment plan, have the advocacy for other investment, strengthening partnership with NGO working on health issues, and then build partnership with other global and regional network as we come here, to learn from Japan society or maybe from Australia or especially through WHO regional ocountry office.

So, the next strategy is arranging counselling services for older people at health centers because you see that most of the people, even health care worker on the ground, they do lots of support and know how to provide counseling regarding how the old people have some kind of disease, and then one day they are looking for the services, something like that. And then enabling older people to assess the regular medical examination. So that's the most important thing because as Cambodia is, we don't have so much of the health care, unlike Japan, they have a lot from the top to the ground, but Cambodia still did a lot of improvement on the system.

And then the next strategy is establishing surveillance systems across the country for monitoring isolated and/or vulnerable older people. Because whenever we implement the activity, the action plan, we have to monitor that whether our activity, action plan is going well. So, we have to check it. Sorry. The time is limited. I just said for only the strategy. The other, you can read on the slide.

And then the other strategy is equipping health facilities providing quality health services for older people, including referral and follow-up, are the most important because even within the health system, all the health care workers, they know very well what the sign of aging or rehabilitation. We need to provide them the knowledge to train them. And then they will just provide for the knowledge to other population at the ground. So, equipping national hospital to provide comprehensive health service for older people, including a number of screening, diagnosis, and treatment that also, we set up the service for that.

Then building adequate in-patient capacity to provide comprehensive care service for older people. Expanding coverage of free quality healthcare services and providing financial assistance, if needed, to poor older persons that cannot afford paying certain medical charges. Even the Ministry of Health, they provide the free

health care services for older vulnerable people and people with disability, the young and the poor. They have their ID card. That's through their health equity fund scheme to make sure that the people can come to get the health care service at the health system.

For this one, the next step when we're going back, so here, we have to finalize the work plan within the consensus with the other ministries, especially Ministry of Social Affairs and Rehabilitation. And we continue to strengthen the institutional among the ministry, even the development partner, even everything, WHO or NGO or IO, provide the capacity building plan, the most important, because as Dr. Darryl said that only two within only one country, but Cambodia, fortunately, they have some already. We just continued to expand the capacity among the professional, among the provider.

So, the financial arrangement and allocation are the most important since government in Cambodia, we still have some kind of limited budget to provide for even within the health care system or other. National and regional cooperation and collaboration is the most important, to share best practices, to learn from each other, especially to learn from other developed country, like Japan or Australia. So, thank you very much for your attention.

presentation

The Role of Chiba Rehabilitation Center : Moving toward an era of integrated community care

Katsunori Yoshinaga
President, Chiba Rehabilitation Center

〔**Biography**〕

1980 Graduated from Chiba University School of Medicine, awarded physician's license
1988 Graduated from Chiba University Graduate School of Medical and Pharmaceutical Sciences, awarded Ph.D. in Medicine
1988 1 year of study abroad at Royal Perth Rehabilitation Hospital (Australia)
1999 Associate professor of Department of Rehabilitation Medicine, Chiba University Hospital
2001 Director of above department
2005 Current position

〔**Summary**〕

The Chiba Rehabilitation Center was established in 1981 by the Chiba prefectural government and is an institution that provides rehabilitation from the viewpoint of medical care and welfare to children/persons with physical disabilities. Currently, we provide services such as treatment for children/adults with severe disabilities since childhood and rehabilitation for adults and elderly persons with conditions caused by such a stroke, brain trauma, and spinal cord injury.

Furthermore, the center plays a central role in the prefecture through the municipally-led regional community-based rehabilitation support system proposed by the national government, which is being implemented in the Chiba prefecture since 2002. We support activities of regional support centers established in each of the nine secondary medical areas in the prefecture, and also carry out unique activities to promote community-based rehabilitation.

In Japan, the current definition of community-based rehabilitation is "all activities on which all persons, institutions, and organizations involved in living—including those involved in health, medical, welfare, and nursing care, as well as local residents—cooperate, based on the rehabilitation standpoint that ensures that disabled children, adults, and elderly persons, as well as their family members can continue to live their lives safely and comfortably in the community that they are used to." This concept closely resembles the philosophy of the "community-based integrated care system," which the Ministry of Health, Labour and Welfare (MHLW) has strongly promoted and is one of the countermeasures regarding elderly persons that it seeks to achieve by 2025. Therefore, the awareness of constructing a community-based integrated care system needs to be maintained even in the development of regional community-based rehabilitation support system in the Chiba prefecture.

The Role of Chiba Rehabilitation Center :

Moving toward an era of integrated community care

Katsunori Yoshinaga

President, Chiba Rehabilitation Center

Hello, ladies and gentlemen. Thank you very much for my introduction. My name is Yoshinaga. I come from the Chiba Rehabilitation Center in Chiba Prefecture. Well, thank you very much for invitation. I was offered this opportunity by Ms. Tobimatsu san, Ms. Tobimatsu because she thought that it would be a good opportunity for me to share with you what we are doing at the public prefectural rehabilitation center.

The title of my talk is *The Role of the Chiba Rehabilitation Center: Moving towards an Era of Integrated Community Care*. You might know that towards 2025, we are establishing the integrated health care. And really, we are working towards this integrated community care. And this is a graph that I would like to show you. It shows you how fast we're aging. Earlier, our colleagues, friends from Australia and Cambodia, talked about aging, but here in Japan, we're talking about super aging. Look at this part right here. Over 65 years of age. So, it's been around since 2000 or so. The ratio of the elderly has been growing. And in 2025, this will be when the post Second World War baby boomers will be senior citizens. So, it is quite serious that our aging, the fact of aging in the Japanese society is obvious and is not to be overlooked.

Back in 2000, the national government had noticed the super aging in Japan, and they started to take in some measures. Firstly, the national government introduced the long-term care insurance system. And secondly, rehabilitation hospital ward for those in the recovery period was implemented, was introduced in 2000. I have been now working as a rehabilitation specialist since 1980's. And I remember in those days, rehabilitation, the concept was more for disabled people. However, this rehabilitation hospital ward for those in the recovery period was introduced. More people got better recognition or

better awareness of the need of rehabilitation. And then further, the national government presented the community rehabilitation promotion and implementation summary to the prefectural governments. So really, 2000 was a year of making rehabilitation a key measure of elderly support.

Then, by integrated community care system, what am I talking about? In 2025, people who were born as the baby boomers' babies will become senior citizens. And we have to make sure that in this integrated community care system, prevention and promotion and palliation will be put together all in one together with the long-term care insurance act. As Mr. Barat mentioned, this integrated community care system includes not only the persons with disabilities but also children. And the concept is really social inclusion.
Now, having said that, I would like to show you, or I would like to share with you what we do at Chiba Rehabilitation Center. The center was established in 1981. The motto is '*Everybody will be in their own town'*. Now, you may wonder where Chiba Prefecture is. It is located in the east of Tokyo. And Chiba City is the capital of Chiba Prefecture, and our center is in the city of Chiba. The population of Chiba Prefecture is 6.2 million, and the aging rate is around 26%.

Established in 1981 by the Chiba Prefectural Government. And it is a general rehabilitation center for persons with physical disabilities, including children. And at the center, rehabilitation has been provided from the aspect of medical therapy, welfare, and occupation. It's funded by the prefectural government and also by the businesses. And at the center, we have 110 beds for adults in the recovery period and 132 beds for children and grown-up children. And many of the patients are adult patients. We have patients with stroke, brain injury, spinal cord injury, amputation, and so on. In case of children and grown-up children, they are likely to have cerebral palsy, severe motor and intellectual disabilities. And it's interesting that many of these children are now grown up, in their 30's and 40's, but they have been living or staying at the center since they were very small.

We also have the welfare division. And we have the child development support center, daycare facilities for handicapped children and disabled children and individuals. We also have the *Kouseien*, which is a facility supporting persons with disabilities aiming at participation in the society. We also have regional collaboration division, and that focuses on CBR,

Community Based Rehabilitation. I'm now working together with a prefectural government. We also have other divisions as you'll see.

Now, let me be a little more specific. I would like to highlight three aspects of what we do. One example of activities at my center is rehabilitation, especially of quadriplegics in the recovery period, for elderly in the recovery period. You can see these pie charts. This is the ward in order to prevent the increase of the bedridden elderly people. And on the left, you can see the national aggregate or national average of recovery rehabilitation wards. HBD stands for a higher brain dysfunction in CVA, cerebral vascular accident, so stroke and fracture. They account for the majority. But look at Chiba Rehabilitation Center on the right, you can see that more than half of the patients have had a stroke plus a higher brain dysfunction. And we also have a lot of patients who have had a TBI, traumatic brain injury. And further, many of our patients have SCI, spinal cord injury. If I understand right, in other countries, well, in one country like Australia, you may have SCI specialized centers in different states or provinces, but it's not that way in Japan. Our center is a public facility. And not many hospitals like ours do have a special team for patients with spinal cord injury. So, I think it is quite interesting, even noteworthy, that we have the special ward for spinal cord injury people.

Well, you may wonder why we have these many spinal cord injury patients. Well, in fact, this is quite particular or typical for Japanese people. Unlike other countries, in Japan, we have so many people who have neck troubles. And as they age, they are quite likely to have spinal cord injury just as a result of a minor fall or so.

Well, in many of these cases, spinal cord injuries with quadriplegia due to mild injuries caused by falls and so on are very common occurrences, and they are also on the rise. Well, one day, one person, a senior man might fall after drinking a lot, and that could lead to quadriplegia. Well, one day, a person riding a motorcycle might fall, and it might lead to quadriplegia.

And as far as we have looked at our data, compared to patients under 65 years of age, the elderly patients are more likely to have combined comorbidities, like internal diseases such as stroke, hypertension, diabetes, and hepatic renal function decline. And further, the percentage of patients

with a history of DVT, deep vein thrombosis treatment, at an acute phase hospital is quite high.

And what other issues do we have? In-patient FIM gain is low, and FIM efficiency is also declining accordingly. Further, the home discharge rate is low here in Japan. In other words, once the patient is discharged, he or she cannot come home because of a lack of barrier-free accommodation at home. A lot of people, more and more people are coming back, not to home, but coming back to daycare or nursing homes. And acceptance of the rising number of elderly with spinal cord injury and that rehabilitation procedures need to be established in our center as a public hospital. And we believe that we should be even more active and proactive to establish a better a higher leveled rehabilitation methodology for senior patients with spinal cord injury. We don't have that accumulated, we don't have that established methodology yet. So as a public hospital, public rehabilitation center, we are now working on compiling some literature on this.

Another example of our activities is about effort for home support in the pediatric division, addressing the increase in it. And well, look at this. I mean, well, nowadays, thanks to advancement of medicine, more and more children, severely disabled or severely ill children are able to live longer. And they can age, of course. They can get older. And at centers like ours, the severity of the diseases is getting even higher. We have around 30 respirators, and all of them are in use now.

About 30 years ago, when I was working at my center about 30 years ago, it wasn't like that. I mean, not many severely ill children were able to live long, but now, they are. Therefore, as they age, their families age as well. And so, there are more different types of care for these children, for grown-up children. And we now see a higher need for helping and supporting these family members who are also aging. And sometimes, this aging of our family members say that they can no longer take care of their children at home.

So, what we have been doing is a lot of different type of workshops. We organize and facilitate workshops for, for example, facility staff, on adulthood issues. See, they may be quite knowledgeable about taking care of senior citizens, but we also share knowledge and information about pediatric patients. We also organize workshops for schoolteachers because they might need to do

some breathing help for some students who come to their schools. And we also hold workshops for home visiting nurses. And they may be used to taking care of senior citizens or elderly patients, but they may not really know about what they should do for severely ill children. So that's another thing that we do.

Third example that I would like to share with you is about development of a community- based rehabilitation operation. And we also work in collaboration with the prefectural government. In case of Chiba Prefecture, we have developed a project of community- based rehabilitation, CBR, support system. Well, as I mentioned earlier, in 2000, the national government suggested that the respective prefectural governments should introduce CBR. And we have been working with the prefectural government in order to promote community-based rehabilitation.

Here, you can see the definition of CBR in Japan. And Mr. Cameron mentioned about aging in place. And that concept is highly valued here in Japan too. CBR refers to, which you see on this slide, and the philosophy of CBR closely resembles what we call the integrated community care.

So, we have been trying to align what we do with what is needed in the global community as well. As I mentioned earlier, our center, Chiba Center, Medical Center, I mean, Chiba Rehabilitation Center is the center of the centers. In total, we have nine centers, and they are like our satellites. And together with the Chiba Prefectural Government, we have been promoting CBR operation, and we often feedback to the prefectural government with the policy proposals. And we also support the satellite, widespread support centers, nine of them in the prefecture. We also try to map out proposals. And we make a trial of a new community rehabilitation activities. Sometimes, we would go visit a local elementary school. And we do some educational enlightenment activity targeting small children. We also have been working on aligning rehabilitation for the patients together with the rehabilitation for those who suffered a natural disaster. And we also have been trying to organize the cross-functional activities towards promoting meetings of various professionals in the community.

Well, here, you can see some pictures. In 2013, the Chiba City and also the Chiba Medical Association asked us to organize a workshop for promoting community meetings. Well, in the medical field, we are very used to get

together with people who have different specialties, but when it comes to communities, it was quite a surprise that they don't have good access and they don't have good communication or network among other specialists, people with the different types of expertise, but it is really essential and needed, so we are now trying to do more of this kind.

Now, the summary. What is the role of the Chiba Rehabilitation Center set up by the prefectural government towards the aging society? First, we provide medical rehabilitation for elderly persons with disabilities who cannot be handled at private or rehabilitation hospitals. Two, we promote efforts for home support in relation to the advancement in age of severely handicapped children and the aging of their parents. Three, we promote the operation of the CBR support system. Four, we create new operation as a comprehensive rehabilitation center towards the 2025 construction of the integrated community care system and including viewpoints on social inclusion that also includes support of the elderly children and persons with disabilities. Thank you all very much for your attention.

presentation

Aging of Persons with Disabilities and Health Promotion

Toru Ogata
Director, Center of Sports Science and Health Promotion
Director, Section for Regenerative Neuro Research, Hospital, National Rehabilitation Center for Persons with Disabilities

〔**Biography**〕

1995 Graduated from Faculty of Medicine, University of Tokyo
2004 Graduated from Graduate School of Medicine and Faculty of Medicine, University of Tokyo (Surgical Science), awarded Ph. D. in Medicine
1995 Residency, University of Tokyo Hospital
1997 Department of Orthopedic Surgery, Mitsui Memorial Hospital
1998 Emergency and Intensive Care Center, Tokyo Metropolitan Bokutoh Hospital
2000 Department of Orthopaedic Surgery, JR Tokyo General Hospital
2004 Research fellow, National Rehabilitation Center for Persons with Disabilities (NRCD)
2006 Assistant, Department of Orthopedic Surgery, University of Tokyo Hospital
2007 Senior research fellow, Research Institute, NRCD
2009–2014 Head of Department of Rehabilitation for Movement Functions, NRCD
2014 Head, Health Promotion Centre, NRCD
2016 Head, Regenerative Medicine Office (Concurrent position)
To present

〔**Summary**〕

With the improvement in medical care and welfare, the number of persons living with a disability has shown an increasing trend globally, which signifies the aging of persons with disabilities. Looking at the data of each country on the cause of mortality of persons with spinal cord injury, the proportion of cardiovascular diseases and cancers among causes of mortality has increased, along with the prolongation of life expectancy, suggesting that prevention against lifestyle-related diseases is important for disabled

persons, as well as healthy persons, in order to prolong a healthy life span. In addition, the problem of poor physical strength and obesity accompanying the decrease in activity is a risk factor leading to lifestyle diseases in persons with chronic disability, and thus, requires countermeasures. In response, the National Rehabilitation Center for Persons with Disabilities (NRCD) has developed the viewpoint of rehabilitation physical education, with the goal of helping persons with disabilities by supporting health promotion. It has implemented initiatives regarding exercise, nutrition, and living guidance for physical fitness/obesity. In Japan, community-based efforts are being made with respect to decreased motor function in elderly persons from the viewpoint of long-term care prevention, but the physical, mental, and social aspects must be kept in mind when accepting cases of the middle-aged or elderly with disabilities. It is a future task to create a network in which appropriate evaluation is carried out during the introductory stage and the relevant specialists intervene when necessary, while connecting with community resources.

Aging of Persons with Disabilities and Health Promotion

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I work as an orthopedist at a hospital. We see people with disabilities in chronic phase, and this is one of our activities in our daily practice. Just last week, I had a patient like this. A woman in her 50's, she has disabilities with both legs. She uses a cane, and she walks although deformed, but nowadays, the legs are painful, so she does not go out. And she got influenza and got worse even. And she can't walk very much anymore. What shall I do? That's the question. Well, you can't really eliminate the underlying disability or to remove the pain from the leg may be limited in case of safety. Maybe I can say to her "You have walked enough, so why don't you start using the wheelchair?" That's one option you can take, but for the next 20 years, she's going to live probably. Is that an optimal solution? Is that the only solution? That's the question that I would like to address, and I'll explain what I'm doing and also the background of those problems.

Policies in Japan is divided into acute phase, recovery phase, and maintenance / chronic phases. Getting along the 20 years after stroke, that's not rare anymore. So in this aging society, they may have new health problems different from underlying or primary diseases, like lifestyle related diseases. And compensation activities may also accelerate aging and therefore lower functioning.That's what we see. So, you can't really remove the original handicap, but at least you want to prevent or delay onsets of other diseases.

Now, let's think of spinal cord injury. Including Japan, we have the statistics from Cambodia and Australia, and onset of age is shown. Cambodia and Australia, quite often 30's and 40's. That's the frequent age of onset. But as Dr. Yoshinaga said, mainly in the 60's, but 20 years ago, it was in the 30's

that we're seeing most often in Japan. So those in their 30's and 40's, spinal cord injury, and they live for the next 20 years and longer. That's what we are seeing globally. With the people with spinal cord injury, what's the cause of death? This is a Finish study for 30 years. And they have a bigger population, about 1,647, and 490 were analyzed. And the top cause is cerebral or vascular vessels diseases. In the past, it was the infection, but with advancement in medicine, quite often that this cause is quite similar to people without disabilities.

And here's another statistic, not limited to spinal cord injury, but every three and a half years, you look at the health conditions. And this is a US study for those with physical disabilities. And you see arthritis, hypertension, cancer, the same as people without disabilities, but the onset is early, 55 to 65 years old. And risk factor, one of the biggest is BMI. Obese is a biggest issue. So, you live 10, 20 years with disabilities. Then, quite often, lifestyle related diseases are the big reason or cause that you need to address.

Our center and affiliate had this survey to look at the body weight. And on the top, you can see the overall numbers. Slim, normal, obese, over 40%, are outside the normal range. You may not be surprised. It's not so different from those without disabilities, but when you look at each institution, there are some findings. Some have many patients with very obese. Some was very much lean, or slim. It depends on the diseases that they see or specialize. So, depending on diseases, the body weight is very much relevant. So obese is a problem, but low BMI is also a problem. For the people with these disabilities, what do they think of their status? This is our survey using the health checks and questionnaire. Recently, in the past one year, what do you think is the biggest concern for you in ADL? That's the question we addressed. And you can see, outstanding answer was related to mobility, moving, transferring to cars, or climbing upstairs, up and down. So, mobility is quite often the biggest concern for those who are aging with disabilities. I explain mainly are physically handicapped, but it could be visual, hearing, or mental or various reasons. Inability or loss of ability is really a problem in activity of at least to mobility related to obese or the whole comorbidity, so it's a negative spiral that you can expect. And it may also be related to increased complications. So, you need to take action here.

At our center, for a few years, we have the center for both science and health promotion for outpatient service. The target is those who come to the

outpatient and those with physical handicap, and weight control is a problem. And the patient himself or herself think it's a problem. And we do risk assessment and also exercise nutrition guidance is provided as a service. Risk management is very important. Exercise, well, we have now the Olympics and people with disability do exercise, and there's nothing wrong with that, but there are some risks, and you need to be aware of that, particularly blood pressure, or by exercise, you may hurt a joint or bones. So, you need to have good assessment before you start programs like that.

So how that patient starts to be involved in a program? That's important. There are two main reasons for physical decline among people with disabilities. One is, as I mentioned in the first, some women and some part of the body function is significantly lower or weight gain or it's the fatigue. Overall systemic problem can be the big reason. So, there are various patterns, but quite often, how it happens is you have been bedridden for some time and pressure ulcer, and that leads to lowered energy and some malfitting of assistive devices.

There are some environmental factors, for example, change of what job or you don't work anymore, or you experience this or spouse or the parents may pass away who had been providing care to you. That could trigger lower functioning. So, if there is intervention point, we try to address them, and if there are any specific physical issues and nutrition, we try to intervene on those specific factors. When it comes to physical function, you tend to think of exercise, and you may think of sports. You may not need sports serve as high energy exercises, but for weight control or to improve physical function, you need to provide some kind of exercise for rehabilitation. So, you need to be clear about purposes. And based on the purpose of what you do, it's important that you have good level of program.

And this is for the spinal injured people and what are provided. Those with spinal cord injury, and you may think, or the patients say, "I want to play basketball". Well, basketball cannot be played for long hours. It gets very exhausting. Of course, you try to reduce body weight. You need to do this thing whether you have disability or not. You need aerobic exercises. It's not flashy, but you need to have some kind of aerobic exercise, or you try to use what is functioning so that basic metabolism is improved, and weight can be

controlled better. With that, maybe you can have some games for fun. So, you need to be clear about purposes. And it's very important in program planning.

So what level of exercise should be provided? That's also very important. This is true for people without any disabilities but the intensity of exercise. But at our center, we call this smiling pace. You can continue exercise with a smile on your face. It's not much load. It should be done easily.

So, in terms of heart rate, it's about 100 or 110, rate per minute. Now, one of the reasons for this is those who start the exercise, they do not have much exercise. If you'll start suddenly, then it's not very sustainable. Some people may feel, "I want to do more," and then gradually, you increase the amount of exercise. And together with exercise, you need to have good guidance for nutrition and meals. If you eat too much, it's not very good. And I don't have much time to talk about nutrition and meals. If the people have disability and handicaps, it's very important they eat well. And for that, you need very good guidance.

So, what are the effects? And are they really effective? What often the problem is how do you measure? Well, disabilities can be divided into small segments, but if you try to classify too much, then sample size, just small count have a good data. So, at our center we do not divide it too finely. If it's physical, it's just simple classification of standing position possible or on a wheelchair. Intellectual disabilities or elderly and in case of a physically handicapped and visual or time after onset of disease and so forth. This is a rough classification. For three months, we provide exercise and nutrition intervene, and we had some resource like this. So physical standing, and wheelchair, significantly better result after three months intervention. The body weight is lower. However, for higher brain function and a visual impairment, it was not quite significant. This is reality. The same data is also looked at from a different point.

By looking at duration of exercise, 150 minutes per week or not. So that makes a difference. If you exercise more, you have lower body weight. That's true. And weekly, 150 minutes exercise, you may think it's not sure that the body weight is lowered, but you need caution here. Those with disabilities, they come to the gym to join our program, but other than that, they do not have exercise at all, so 115 minutes is all the time they do exercise during a

week. So, this kind of program is also important, but also, you need to consider that exercise level in the day to day living.

Is exercise intervention effective? Yes, you can see that. However, caution is required. Adequate intensities and frequencies are important and also, how to select the subjects. The data I show includes some with obese or without. Of course, if you have the patient with obese, it can be more effective. So, you need to be very well-prepared to assess those points in advance.

Body weight is not the only index to show level of ADL and good functioning. And the FIM items are shown here for ADL. And you look at the FIM level, then you more or less can assess independent ADL. Instead of able to do or not, it's also important whether the patient feels concerns. So, you need to have assessment of concern level of the FIM items. Which items are cause of concern for you? That's the question we asked. Many people feel they are very worried or concerned, but after intervention, the concerns are gone. Like meals or toilet associated matters, after nutrition and exercise program, the concern is gone. It's not just they can do it or not do it, but the quality of being able to do something gets better, and that's what we need to measure.

Rehabilitation should be inclusive. That means those for the handicap and also the elderly. The reason why I separate them in my talk is those with these problems, they can't use the exsisting facilities for the elderly people, but the patients don't like it normally because of the age. So those people start having dysfunctioning in their 50's and 60's. But according to the Japanese government policy, and there are some programs and the main target there, is in their 70's and 80's. Therefore, people with physical handicaps, they don't really want to go because they feel they are too young for that. And also, accessibility is a problem sometimes in the patient side and also the therapist. So, provider side is not used to the physically handicapped, so they both feel are not quite proactive. Of course, inclusive is better, but can you do it right away? Not necessarily all the time. So, you need to be aware of that.

I mentioned body weight and also blood sampling. And body weight, you can measure objectively, so it's important, but that's not the final goal. I want to emphasize that point. To stop the negative spiral, I explained. That's very important. So, mobility and also the level of activity should be higher or maintained. And ultimately, those with disability should be able to have more

social participation. And what's important here is subjective and objective indicators to advance or to assess programs. Maybe those who have disabilities are happy, but if objective numbers do not show any improvement that's not sustainable or data may be good, but if those programs do not lead to social participation, that's not good enough. So, you need to assess both aspect.

So how do we provide or how do we plan programs for health promotion and who is doing and where do we do? There are various aspects to consider, and there are many facilities. Some are very well-equipped manpower and facilities. Some sites may not be so. So, depending on what you have and also who do you want to have joined and what's the purpose of the program, those are very important. Who is providing that support? And how do you evaluate effectiveness of the program? You need to consider those in advance as you try to provide program like this in each region or communities.

Sorry for the small letters. At our center, our efforts and programs should be more generally communicated, we think. And for each manpower and facility level, we recommend various types. And we are creating manuals for various centers in region to start. The ABCs are shown here. If it's a little difficult to have larger scale or maybe if you have manpower and you can have scalability, then you have programs like this. So easy on the left. More complicated and refined on the right. So, we explain those programs, possibilities, and we also consider human development. There are many difficulties, but the important thing is to take the first step. And you don't need a big facility to have the first step.

Safety management is important. Therefore, a manometer to measure BP is very important. And also, you need to see effectiveness. So, a scale to measure body weight on wheelchair, that's important. And if you have those, you can start. And also, quite often, walking is recommended, but intensity of exercise is very important. Even if it's walking, you can be a bit more intensified. And also, the heart rate of 100 per minute should be a good indicator for the appropriate level of exercise. So, safety management and monitoring, and also the big, important aspect is regular exercise. How you can maintain, that's very important. And quite often, persons with disability, they have to come to the program center, and you need various support associated with exercises.

This is my last slide. Objective and subjective health or perception of health should be well-balanced in providing programs. And that's important to avoid complications associated with aging. And what's the important here is to continue. With continuation is not just maintaining the numbers and not just maintaining a regular routine. And some say, "I'm not really interested in that." Therefore, for what do you do should be clear. Through these health promotion, the social participation may be moving to the next step or something new can be done, and that kind of proposal is very important. Thank you very much.

Discussion and Q&A

Facilitator Yamada: Thank you very much for your introduction. My name is Yamada. I would like to work as a moderator for this session. Gentlemen, speakers, thank you very much for your presentations. Today, we've been talking about rehabilitation as not only with persons with disabilities but also for everyone who needs that rehabilitation. And I think we have mutual agreement or understanding. The idea is to minimize the limitation of all the functions for everybody, to live his or her own life. So that they can live their lives themselves. It is true, and I think it is well understood, it might relate to how capable a country is. And these people who need rehabilitation, where they are positioned, how much, how they are prioritized. I think that relates to how one country, how mature a country is. So, in this discussion session, first I would like to raise two themes, two ideas. Maybe you can give us your comments or your thoughts on these two points. One, it's related to aging. What kind of actions, countermeasures would be really necessary for rehabilitation when it is thought about together with the aging? And next I would like to ask you your ideas, your questions about the presentations given by other speakers. So, if you have any questions or comments on other speakers' presentations, please raise them. And of course, anything in addition will be highly appreciated. Well, maybe Mr. Barrett could you answer these questions first.

Barrett: Thank you very much. Well, two interesting questions to start off. I think I'll start with the countermeasures one. On the first question you said, if I understand correctly. An important thing, and actually we were speaking about this before. Because Cameron and I were discussing the need for a language, to start with common language. One of the interesting challenges I've faced since being with WHO is that, even though we're in the one organization we seem to talk about the same things in a different way. Often when I talk to my colleagues in the aging space, in the aging policy, in the aging program area, they don't have the same concept of disability as I do. And then if I talk to my colleagues in say, communicable diseases, or even non-communicable diseases, their concept of disability is also very different.

So, the concepts of rehabilitation of disability, the language I think we really need to all be on the same page. Because at the end of the day, for both, we're talking about function and participation. We might be talking about a range of

different health conditions that underlie the function aspects the person may have, but rehabilitation is not specific for any type of health condition. It's a very broad approach to dealing with function and participation.

So, common language I think is very important. And I thought all of the presentations were very interesting, and probably close to my heart because I lived in Cambodia, is the presentation from Dr. Hero. I think it's fantastic that a government like Cambodia government is thinking about aging when there are so many challenges that face a health system like in Cambodia. I think also Cambodia has a history as many of us know, steeped in conflict. And steeped in issues such as landmines and amputations and injuries that go with that. And so, when we think of Cambodia, we don't automatically think of aging populations. And so, the advocacy and the leadership that's required from government to get aging, healthy aging on the agenda is quite an effort. I think it will be interesting to watch how Cambodia travels in dealing with aging population, because it's a less developed country, country with significant challenges, in a region that we all need to get behind and support. So, for me I think it was interesting to see and observe Cambodia's approach. Thank you.

Facilitator Yamada: Thank you. Well, speaking of Cambodia. Well, thank you for your comment Mr. Barrett. Since Mr. Barrett just mentioned something about Cambodia, may I ask Dr. Kol about your feedback. And I forgot to mention something. Well, I would appreciate you giving us your feedback for three minutes or so, so we can move on.

Kol: Okay, thank you Mr. Barrett. And for your comment about the rehabilitation in conduct of Cambodia. In the past, I had said during the presentation that rehabilitation is mostly supported by International Community and the Ministry of Health only part of that. Because after the war, even during the war, they had less ability that still, mostly the skilled people, they are already killed during the civil war. And even after the recovery from war, and still had after the war almost 30 years. So, with the concept of rehabilitation is still, as Mr. Barrett has said, is saying like computationally, the problem with the war, now as we received from the so called, like the problem with the land that come to the so called, "rehabilitation" . So, focusing on the so called non-communicable diseases.

So, the non-communicable diseases are the WHO priority, like our presentation show that at this. And then this group is the communicable diseases. So, the problem is mostly when the foundation and movement is shifted from the lower socio economic, and middle-income country recently. Even the population are so

especially the life expectancy had become shorter. The WHO said in the country is more than 60, so that the government of Cambodia is checking on the aging as the most common problem for the population. That's why they shape up the policy. That life for the all to show this day to take action. So, when the said the so called, formation of the policy belong to WHO, to work together, to bring, to build the capacity even the collaboration, cooperation that we can move the country, especially learn from the region as a whole. Maybe someday for that. Thank you.

Facilitator Yamada: Thank you very much. Now, Dr. Cameron.

Cameron: Thank you. I thought I'd talk about actions with countermeasures first. I wanted to highlight the need to recognize that an improvement of functioning is possible. Most older person develops disability that's partially reversible. So as an audience that works in rehabilitation services, we all know that and accept that. But that's not a widely held societal view. And also, when you talk to older people, it's not a widely held view in older people, at least in Australia.

And so, to illustrate that with a personal example, it's my mother who has quite a significant mobility disability. It is not severe, but it's such that she has difficulting walking up a flight of stairs now. If she can walk up the flight of stairs, she is able to visit family. And so, in terms of working to convince her that she needs to look at a mobility training program, with strength and balance components, and functional training to get her up the stairs is very difficult, because she doesn't see that it necessary.

So that's an example at a personal level, not so much broader societal issue. Reflecting on the other presentations, the key issues are similar despite very different countries, cultures, and societies. So that there's the common theme in all the talks about older people, older people particularly with acquired disabilities, and sometimes with long term disabilities. There is a well understood range of systems and services that can help those people. And so, there is a universal approach. The difficulty is that, that's not broadly available, at least in many countries.

Facilitator Yamada: Thank you. Now, Dr. Yoshinaga, what do you think?

Yoshinaga: Where rehabilitation is positioned in rehabilitation, there are maybe. Why, I can maybe talk about four things. Japan is super aging. And of course, until the very last day, we want to be in a, well, until the last day. We

hope to minimize the days of being unable as short as possible. We call it *pinpin korori* which is very lively until the last minute. But it's hard to achieve. That's the first one.

And secondly, we have to look at, we'll see what we can do with people with dementia, with cognitive disorder that many of the elderly patients have. I also hear other communities or other prefectures have some difficulty in addressing this rehabilitation issue for patients with dementia. Three, when it comes to elderly patients, we will likely to say that as much as possible this rehabilitation should be sent back to home, instead of being hospitalized for a long time. But now what is happening in Japan is even family members, and elderly patients are find it difficult to go home with care given by family members. So that's another thing.

Four, as I mentioned earlier, we're promoting integrated community care. We have a key word, citizen or *jumin* in Japanese. We often talk about people in-charge, specialists, people in prefecture government. But we don't get to talk about the citizens. What citizens can do? What we can ask citizens to do for this issue? As I work in the community, I noticed one thing. In the rural area or suburban areas, a lot of people have affection about where they live, about their community. But in big, big cities like in many places in Tokyo, it can be difficult for people to have a common mindset or common affection for where they live. I think there needs to be some effort made to create or generate this spirit of citizenship.

Facilitator Yamada: I see. Thank you very much. What we can ask citizens to do? That's quite interesting. Next, Dr. Ogata.

Ogata: Yes, as promotion of the people with disability, that was my topic. But more generally speaking, what's more important is preventative approach in rehabilitation. I think that aspect is very important. The physical function declines eventually in some people, but quite often some event triggers malfunctioning, like stroke, like falls. You need to prevent that. Of course, one of the important aspect of rehabilitation is trying to recover those functions.

But how you can prevent episodes or triggers happen from the very beginning? That is very important, also in terms of social cost effectiveness. That's important. And should that be included in our concept of rehabilitation, is that to be done in medical health care system. That choice may be up to each society, but one episode does not destroy every single in the aged. But some need care, and that is worsened by some event. How do you prevent that? That's very important.

Hospitals can't cover everything. Community-based care is very important. Health managers in Japan, we have care managers. And in some societies and countries, health centers, they have central role. So how do we develop human resources who are professionals in doing, providing that kind of care and planning?

Facilitator Yamada: Thank you very much. Planning and prevention and how to leverage community capability and resources, those were the comments that were made. Thank you very much. Soon I'd like to entertain questions from the audience. But before that, just one point that I would like to particularly take up. Mr. Barrett, I would like to get your comment on the point, and that is "rehabilitation is for everybody, regardless of economic status". I think that's one important aspect. If you are rich, of course you have many options. But those without money, then options may be limited and there are difficulties. And that's true in any country in the world. How much that should be incorporated into the policy making? How to raise priority using the public fund for rehabilitation so that it's affordable and accessible? How can we influence so that policy making is moving toward that direction? So that is also one of the missions of WHO I supposed. How to prioritize and how rehabilitation should be higher in priority and what are your efforts in this respect? I'm sure you're doing now, and what's your future outlook on this point? Thank you.

Barrett: So, a very easy question. Look, one of the things we will always struggle with is trying to address how we include rehabilitation so that people who can't afford it, even in rich countries like Japan and Australia, there are people who can't afford health care that they need. But particularly in entire countries where health systems are struggling. You have some countries in the Pacific where you might have a very limited health budget. How much of that goes on prevention versus rehabilitation? Because for a lot of countries there is already an emphasis on prevention for very, very good reasons. But that comes at a cost. And what I see in my work is that comes at a cost of rehabilitation. So, it's not an easy answer on how we find a balance between funding rehabilitation and maintaining our perspective on prevention and health promotion. One of the ways WHO is working towards addressing this is through universal health coverage. Universal health coverage you might recall is essentially where we, it's a concept of promoting essential health services that people need and that people can access good quality health care without causing them financial hardship. At the moment in our region, some countries do not include rehabilitation as part of universal health coverage. So, we have to address that. We're not saying you have

to find funding to develop national rehab systems or whatever. All we're saying is let's start by promoting the full range of universal health coverage. And then with that, we are aligning our work with the Sustainable Development Goals, because we're also saying if you want people to participate, if you want health and well-being for all people, for all ages, which is what the SDG's are about, particularly Goal 3. If you want those things, you need rehab. If you don't have rehabilitation services, people with disability, people with chronic impairment, people with chronic health conditions, people who are getting older with functional difficulties will be left behind. So yeah, it's a big advocacy effort for us.

Facilitator Yamada: Thank you very much. In Japan, as Yoshinaga-san mentioned, Dr. Yoshinaga mentioned, in 2000 nursing care insurance started in Japan. That brought the idea in terms of funding, the insurance funding should be provided so that we can support nursing care for long range. That's the system, and we have a good funding scheme. And among the menus, prevention of care is also included. But we are super aging, so it's accelerating. We have the system, but we still have the money issues. And who's going to take care and provide care? So, we have many, many issues that we need to tackle in terms of financial burdens. Maybe the rich people should have more burden. There are various discussions. Who is going to pay for that? We need good balancing act, so that we always refine our system and correct system in line with what's better. And in the super aging society, Japan has a system and making corrections as things get evolve. And I hope this can be a reference to some countries in the world.
Next, I would like to entertain questions from the floor. Anybody? If you have a question, please raise your hand.

Ito: Thank you very much for the wonderful talks. My name is Ito from Japan Physical Therapists Association. Let me talk in English. Thank you for your wonderful lectures everyone. Now our association is an organization mostly working for public interest. Especially Mr. Darryl Barrett, please suggest us what's the main role of rehabilitation professional organization. For example, what we do is work with government for the local people. But also, like a human resource development like in terms of research, academic, and some educational things as well as clinical practice. Last year, we started to somewhat expanding our international activities. In terms of aging society, what can we do in Asian region, it's going to be the main topic for our association. In this case, in terms

of rehabilitation and aging society, what could you expect the role of rehabilitation professions especially national level organization? Thank you.

Facilitator Yamada: Mr. Barrett please.

Barrett: Okay, thank you Mr. Ito for your question and thank you for your time coming today. I'm glad you could make it. Great question. Professional organizations are crucial, are essential if we want to develop rehabilitation at the national and at the regional level. So, you asked what is expected of us as a professional organization, as a national society for physiotherapy. There's a range of things. At the individual level, at the individual therapists' level, you're essentially building the confidence of therapists to be rehabilitation leaders, because many therapists when they start off and even as they go through their career, they're constantly having to negotiate their place in the pecking order of health care as I'm sure you're well aware. So, building the confidence. And that confidence comes through professional development and training, supporting clinical guideline and documentation, supporting the development of standards, patient standards, professional standards. Advocacy is a big role that professional organizations play, making sure that professionals such as physiotherapists or speech therapists, or whoever it is, is recognized and is prominent in the health care that's provided to a range of people, whether it's people with disability, older people. It's making sure that the physiotherapy voice or the occupational therapy voice is clear and is present when health care decisions about health care is being made. Because if I take some examples from my work, we have countries like, many countries in the Pacific where you don't have any professional associations. And so, the awareness of what a physiotherapist can do or does do is very, very limited. And so, in some countries, it's just starting at awareness and advocacy. And then you have other countries like Cambodia where you have an established association. And so, the awareness is there, but they still need to build the confidence of the therapists. And they're starting to work on clinical guidelines and standards. So, they've taken it beyond advocacy. So that's really broadly at a national level. At a regional level, I think there's always opportunities to look at where a more mature association like here in Japan can assist neighboring countries that are just starting off, and have an arrangement where therapists from your association can support therapists that are starting creating their own association to help build their confidence and build those processes. So, there's a range of things that you could be involved with, that's for sure.

Facilitator Yamada: Thank you very much, are there any other questions?

Nakamura: My name is Nakamura. I'm in charge of prosthetics making at National Center, and I have a question regarding what we do and the relationship to aging. Technology is advancing. For example, I make lower limb prostheses for–amputees, in which a computer is incorporated so that falls is less likely to happen. Of course, they are very costly, but I think those high functional parts should be applied for the aged. I have a question. Of course, there will be less falls and walking in safety. But some say, you should not spend so much money for the aged. Some extreme opinions like that. So, what is your opinion on that point, especially overseas because I like to get your feedback on this point. Thank you.

Facilitator Yamada: Dr. Cameron please.

Cameron: Yes. Mr. Nakamura, I'd like to comment. I also work in health research with health economists quite a lot. And so, what you've raised I think is essentially a health economic question. And so, it'd be using established methods to gain an idea about the additional quality of life that could be experienced by older people as a result of using more advanced technology. And at least in Australia, health technology is usually available it costs less than about 40,000 Australian dollars per additional year of health-related quality of life. I think you can argue on an economic basis. That's the sort of approach that's likely to be taken in Australia. I comment that the more advanced forms of prosthetic devices are generally not available to the general population in Australia by existing equipment funding schemes that will only fund more basic technology. It's only people who have compensation through work injury or some other means or are very wealthy who can pay for the advanced technologies.

Facilitator Yamada: Did that answer your question? Mr. Nakamura?

Nakamura: Well maybe that's true for the assist devices, but some says that if they use assistive devices then they may not be able to keep their physical condition. So, they should not be used. And that's what some of the professionals are thinking. So maybe we have to correct those kinds of mistaken understanding towards the assistive technology. Anything you would like to add to that?

Cameron: Sorry. I'm not sure. Am I correctly, understanding the question is that some health professionals won't recommend the technology even if it's available.

Nakamura: Yes. Maybe the criteria or the standard has not been clearly set for the application of such devices yet. Because I would think that we should proactively be using those assistive devices, but there's no clear guideline.

Cameron: That's right. There's no clear guideline. I was thinking of as a researcher, to justify the use of these advanced technologies there would have to be a benefit shown that was not too costly to obtain. So, I'm quite used to some technologies are not sufficiently effective to justify their cost at the moment. So that would apply to some types of advanced prosthetics, but not others necessarily. But it needs to be assessed in particular cases.

Facilitator Yamada: Does it answer your question?

Nakamura: Yes. Maybe not just about assistive technology, but perhaps return on investment or cost rationality has not been clearly defined yet. That's my understanding.

Cameron: I'm agreeing with your last comment.

Facilitator Yamada: Thank you very much.

Tobimatsu: To that question, if I make it more generalized, the rehabilitation with the elderly people and the rehabilitation to the people with disability who are not elder, maybe the objective would not be exactly the same, and different. So how we can get consistency is the issue perhaps. In specific, the young person with disability, how he/she can be independent and live on their own life is the objective of the rehabilitation. But if it's for the elderly how should we make them easier to live for the rest of their lives, that's going to be the objective. So maybe objective wise is somehow different. So, the patient in front you, which way you would go would make this kind of conflict of interest. But is there any kind of that contradiction in your country as well?

Cameron: I'm happy to comment. I'm sure there are different goals of rehabilitation in different age groups. So, return on investment in assisting a younger person live independently for the remaining 40 or 50 years of their life,

that's a different question to an older person living independently for a shorter time. Perhaps I can illustrate this very question in a study we've just completed and submitted for publication. So, in Australia, people who live in nursing homes who break their hip usually don't get offered a formal rehabilitation program. So, we've run a clinical trial where people from nursing homes could get a one-month multi-disciplinary rehabilitation program after their hip fracture. And that was in the nursing home, and there was a control group who received usual care. So, we showed a benefit of the rehabilitation program after a month in terms of function and mortality. But there was no difference at 12 months except a small increase in quality of life. So, the question was whether that investment of effort was worthwhile. And the answer I gave earlier to Mr. Nakamura was that in traditional health economic terms, it wasn't worthwhile. I guess I find that very hard to accept because I would hope that at least a minimal amount of rehabilitation could be offered to those patients in a higher income society like Australia. But we don't have that at the moment.

Barrett: I think for me also, we can often. I'll go back to terminology, because even though I can seem quite insignificant in my role, words matter a lot. What you say and where it's used and who uses the terminology. And I think, even when we're talking about a younger person with disability or an older person, there are significant subsets if you like, in those two very big groupings.

You have older people, say over the age of 65, who have potentially the exact same goals in terms of participation as someone who's in their 30's. I love that phrase you mentioned before about live lively until the very last minute. So, there are goals that are exactly the same even if you're an older person compared to if you were a younger person with disability. And often it's the cut-off of age that determines whether somebody is a person with disability, which is an older person with difficulties with functioning. So, it comes back to the core of rehabilitation, and rehabilitation is people centered. So, it's not about the health condition. It's about saying, "well what is it you want to do in your life, and how can we assist you in the rehabilitation process?" So, for me it's a very personalized process.

Facilitator Yamada: Thank you very much. So, does it answer your question? Anybody would like to ask a question from the floor. Yes, please.

Inoue: Thank you very much for your precious presentation. I'm from NRCD. My name is Inoue. Dr. Ogata mentioned that prevention would be regarded as rehabilitation, or the Dr. Yoshinaga mentioned about *pinpin korori* "live lively

until the day you die". So, the scale or coverage of the rehabilitation on the WHO presentation, how should we define this rehabilitation in scope? And as you mentioned in today's presentation, about the aging society in Japan. One thing is about this elderly nursing care insurance for those who need the nursing care. How we should deal with it? One fourth of the population over 65 years old need those care. But actually, what's necessary to take an attention is those three quarter of those. If for example, a retired person over 65 years old, we have to create the job that they can easily work. Or their community, the elderly people should work or have a certain role to support the community. So that might also lead to the prevention. And so, rehabilitation should also include those kind of bigger definition. That's my question. And the other question that I would like to clarify, that is in South East Asian country positioning of Japan may not be clear for us. So, if possible we would like to ask Dr. Kol, that is there any Japanese role that we can make in Cambodia? Do you have expectation toward Japan? That's my second question.

Yamada: So, Dr. Kol, would you like to answer his question, the expectation to Japan from Cambodians perspective?

Kol: Thank you very much for the question. During my presentation, I speak recently. We would like to learn from the developer, how we can proceed with taking care of the patient when their getting older or getting sick. Because Cambodia is entering the aging society from now or maybe in the future, we would like to learn how the Japanese society structure their health care system, so professionally. And then even the nursing care in the community. That's the most important that we like to learn from. Even from Australia, even guiding from the WHO, or collaboration center. And then it terms of the providing of the care system. But we also would like to learn how Japanese health care insurance, not only for the patients, it can also be for the elderly for the rehabilitation center. That problem. Thank you very much.

Facilitator Yamada: Your first question, you mentioned about rehabilitation and prevention. Would you like to make some comments Mr. Barrett?

Barrett: I'm conscious. I'll let my colleagues at the end of the table also speak about this one. But rehabilitation, and prevention is interesting because, again, some don't automatically see rehabilitation as a preventative strategy. A meeting like today with the topic of aging is the perfect example that demonstrates the

preventative function of rehabilitation. Keeping people safe while they age, keeping people healthy and active and functioning is something that is much easier for people to understand from an aging perspective than it is from a stereotypical disability perspective. Because still very much in our, at the global level, when we think about disability we often think about an image of somebody in a wheelchair, perhaps somebody who is blind, somebody who has an amputation. We have a stereotype in mind when we think of disability. When we think of aging, just about every one of us can relate to that because every day we get a little bit older. So, we know that that's us coming down the line. So, thinking about rehabilitation in terms of maintaining muscle strength or maintaining balance and coordination, maintaining mental function, environmental design for safety at home, aging in place, prescription of assistive technology, social interaction. All of those things as preventative strategies to keep us healthy and keep our well-being through the ages I think is a lot easier for people to understand in the context of aging, compared to the stereotyped disability. But I'd be keen to hear what others think about that.

Facilitator Yamada: Thank you very much. So, Professor Cameron, do you also have some comments in terms of the rehabilitation and prevention?

Cameron: I have some comments, yes. I guess I come partly from a public health background. So, in traditional public health terms I'd say rehabilitation involves secondary or tertiary prevention. So, rehabilitation is trying to help people avoid ongoing consequences of whatever's happened to them.

Facilitator Yamada: Thank you very much. Does that answer your question? Thank you. Anybody else from the floor who has a question.

Ogata: As for the word rehabilitation, and as Mr. Barrett has said that the terminology is very important. In this area, the rehabilitation actually has lots of meaning. When I talk about that, we're not really sure what type of rehabilitation that we're talking about in some cases, that's what I feel. Especially the medical rehabilitation or community-based rehabilitation. I think what they aim at or the know how or resources are different. But in WHO the definition of rehabilitation, would you be adding some terms, like sub categorize the rehabilitation? Do you have an idea on that?

Barrett: Another very easy question. I'm a bit lucky being in the regional office because we escape the responsibilities at the headquarters level to set some of these definitions. But at the Rehab 2030 meeting last year in Geneva, February, WHO produced the new definition of rehabilitation. And the focus there is reducing disability, maximizing or optimizing function in people with an underlying health condition in interaction with their environment.

So, it's very ICF relatable because of the environment. It's also very relatable to the convention on the rights of persons with disabilities, because it looks at a health condition and interaction with the environment. The health condition can be anything including an illness or injury. It can be pregnancy. It can be the effects of aging. It can be a range of different things.

So, I think the number one message is it's very broad, but WHO we wouldn't necessarily be looking at rehabilitation in context of employment for example. Because while you can very easily relate that definition of rehabilitation to employment or work rehabilitation, our focus as WHO is on health. That's our focus. Our focus is in supporting processes and health systems development. Our focus is rehabilitation in health systems, rehabilitation related to health systems, which includes often rehabilitation as it's carried out in Ministries of Social Affairs for example. Because it's still very much linked to the same types of interventions you get in health systems, as opposed to vocational rehabilitation, which is very focused on particular employment strategy.

Facilitator Yamada: Does that answer your question?

Ogata: It sounds like we shouldn't be too specific about the word rehabilitation, but I guess in Japan at least, we should have different types of rehabilitation, maybe different words, for different types of rehabilitation. But thank you.

Facilitator Yamada: Any other question from the floor? We have a few more minutes. So, let me ask a question to Dr. Kol. At the Ministry of Health and at other ministries, you said that you are having a cross ministerial discussion for rehabilitation. But for prioritization, for budgeting, what kind of issues, troubles were you faced with? For example, in Japan, we have ministry of health and labor and welfare. We have different other ministries. And all these ministries get, are allocated their budget separately. For example, if the Ministry of Health in Japan would like to do another project and get some money for that, the ministry cannot get that budget instantly. The ministry has to allocate their money, seeing what they have in their wallet. Does that make sense? But in Cambodia, in order to, for

example, if you all agree that this policy is extremely important, so let's allocate more money, more budget on that project, do you have something like that? Would you have more flexibility on allocating budget or finance on different projects?

Kol: Thank you very much for this question that is very important. We have three ministries that the government include within the elderly care, and that falls into the rehabilitation sector. But the Ministry of Health and Ministry of Welfare are mostly in the activity, doing most of the physical activity. But the ministry shares some activity not so much related to the human being. But I think now through the government, we have some kind of social safety net, social protection policy framework at the head ministry or economic planning. But in terms of the priority of the government of Cambodia, our priority in the past governments, before this era of Cambodia, we have the priority on mother and child and communicable disease.

Now some of the two previous priorities, some are already addressed. But now it's in the non-communicable disease. So, rehabilitation is also included in that activity. Needs some kind of activity in the sector. What the government now of Cambodia is thinking what the most important and includes the rehabilitation in there. We have just recently adopted launching the policy that for the Ministry of Health. We have tried to formulate a plan and submit by mid-month a year. That we'll have another meeting by next year. But we can't just be sitting down, working the plan within the ministry, to make sure that the health sector can be coming ahead. Because the people who needs some kind of rehabilitation also suffer so much in the physical activity. But we need more particular on that. And regarding the government of Japan, you would like to do some activity that would benefit the people of Cambodia, we'll be happy to come and learn from you to take some help from you. Thank you very much.

Facilitator Yamada: Thank you very much.In Japan, as I mentioned earlier, different ministries have different budgets. So, if one ministry thinks that they want to do something extra, something new, usually the ministry is told to ensure that money from their wallet. But I think all ministries concerned should try to have a plan well mapped out in advance, so they can get their budget accordingly. Well doctors, thank you very much particularly those of you who came all the way. Thank you for joining us this afternoon and I guess we are running out of time. So, if I may, I would like to conclude this session.

Ladies and gentlemen, thank you all very much, and your speakers, thank you. And would you please come back to your seats.

Closing Address

Setsu Iijima

Director, Rehabilitation Services Bureau,
National Rehabilitation Center for Persons with Disabilities

Ladies and gentlemen, thank you all very much for attending the international seminar on aging related rehabilitation. Well as mentioned, we are in Japan, living in a super-aged society. Now, the rate of elderly people is around 27%, and it is likely to go up to 40% in the very near future. And further, we are having even more elderly people living in the society. More than one fourth, more than 25% will be in their late 70's, you know 75 years old or older. And this is quite significant and quite remarkable. This is really not experienced yet by other countries. But there is some good news. When it comes to elderly people, in Japan when we reach age 60, we thought that it was the time to retire from working. But look at us. More and more people in their 60's, are doing far better. So we're now working on the possibility of changing the definition of elderly people. Seriously speaking, as we have more and more elderly people, we are having this issue of pension. Thinking of all these circumstance, the Japanese society is trying to have more elderly people living more fully until later in their life stage. And one specific characteristic of the Japanese aging society is that the speed of aging is so fast. We used to have this rate of elderly citizens, 7% to 14%. And it took us far shorter than other countries.

In other European or Western countries, it took like one century or 100 years to reach 14% from 7%. In Japan it took us only 27 years. And it's not the problem only in Japan, but also, it's going to be a major problem in other Asian countries, Korea and Singapore. They can be aging even faster than Japan. We all know the

forecast of the population and the demographics is fairly stable and fairly sure compared to other researches.

So, we know what is going to happen. Even in countries like Cambodia where aging is not that serious yet, but it is a fact, it is true that it will be an issue in the future as well. And in our region, in the Asia Pacific region, as we have more knowledge and more understanding on what can happen in aging society, I think that we can share more. I think this international seminar, we would like to keep doing this, so we can continue having information exchange and knowledge exchange. And this will remain as a big part for our center, in NRCD. And I would appreciate you all continued support on this. Thank you all very much for coming.