ERIA Project on Longitudinal Study of Aging and Health in ASEAN Countries

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Figure 1. Proportion of those aged 60 and above in Selected Asian Countries in 2015, 2040 and 2065.
# Population & % 60+ in Asian countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Population (mil)</th>
<th>% 60+</th>
<th>Longitudinal survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>China</td>
<td>1397.0</td>
<td>15.4</td>
<td>yes</td>
</tr>
<tr>
<td>India</td>
<td>1309.1</td>
<td>8.9</td>
<td>yes</td>
</tr>
<tr>
<td>Indonesia</td>
<td>258.2</td>
<td>8.1</td>
<td>yes</td>
</tr>
<tr>
<td>Japan</td>
<td>128.0</td>
<td>32.8</td>
<td>yes</td>
</tr>
<tr>
<td>Philippines</td>
<td>101.7</td>
<td>7.3</td>
<td>no</td>
</tr>
<tr>
<td>Vietnam</td>
<td>93.6</td>
<td>10.3</td>
<td>no</td>
</tr>
<tr>
<td>Thailand</td>
<td>68.7</td>
<td>15.6</td>
<td>yes</td>
</tr>
<tr>
<td>Myanmar</td>
<td>52.4</td>
<td>8.9</td>
<td>yes/no</td>
</tr>
<tr>
<td>South Korea</td>
<td>50.6</td>
<td>18.4</td>
<td>yes</td>
</tr>
<tr>
<td>Malaysia</td>
<td>30.7</td>
<td>9.1</td>
<td>yes</td>
</tr>
<tr>
<td>Cambodia</td>
<td>15.5</td>
<td>6.8</td>
<td>no</td>
</tr>
<tr>
<td>Lao People's</td>
<td>6.7</td>
<td>6.1</td>
<td>no</td>
</tr>
<tr>
<td>Singapore</td>
<td>5.5</td>
<td>17.9</td>
<td>yes</td>
</tr>
<tr>
<td>Brunei</td>
<td>0.4</td>
<td>7.1</td>
<td>no</td>
</tr>
</tbody>
</table>
Aim of the Project

- Examine well-being of older adults aged 60 and over in two countries of ASEAN: the Philippines and Vietnam (no longitudinal study)
- Focuses on health status including mental health: current health status and correlates, and changes over time if any, and determinants
- Estimate health expectancy
- Examine care needs, economic well-being, etc.
## Statistics at a glance

<table>
<thead>
<tr>
<th></th>
<th>Philippines</th>
<th>Vietnam</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>total</td>
<td>103 mil</td>
<td>93 mil</td>
</tr>
<tr>
<td>60+</td>
<td>7 mil</td>
<td>9 mil</td>
</tr>
<tr>
<td><strong>Proportion of population age 60+</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>7.3%</td>
<td>10.3%</td>
</tr>
<tr>
<td>2030</td>
<td>10.3%</td>
<td>17.5%</td>
</tr>
<tr>
<td><strong>Life expectancy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>at birth</td>
<td>68.5</td>
<td>76.0</td>
</tr>
<tr>
<td>at age 60</td>
<td>17.0</td>
<td>22.0</td>
</tr>
<tr>
<td><strong>GDP per capita</strong></td>
<td>$8,325</td>
<td>$5,957</td>
</tr>
</tbody>
</table>
Life expectancy is increasing all over the world, this doesn’t mean a healthier population (Crimmins, Hayward, & Saito, 1994; Jagger et al., 2008).

So, ensuring longer life by reducing mortality at all ages will not ensure SDG 3 (Ensure healthy lives and promote wellbeing for all at all ages).


Health Expectancy

• Summary measures of population health
  – Disability-free life expectancy, Active life expectancy, Healthy life years, Health-adjusted life expectancy, Healthy life expectancy

• Combining information on morbidity and mortality
  – dividing life expectancy into healthy and unhealthy years

• Sanders 1964; Sullivan 1966, 1971

• REVES  http://reves.site.ined.fr/en/
Health Expectancy: Definition

Life Expectancy = Healthy Life Expectancy
+ Unhealthy Life Expectancy
(Health Expectancy)

87 Years of Life = 83 Years of Healthy Years
+ 4 Years of Unhealthy Years

4 years of unhealthy years do not mean the last 4 consecutive years of life.
The World Health Report 1997

Conquering suffering
Enriching humanity

Report of the Director-General

World Health Organization
Geneva
1997
Message from the Director-General

In today’s rapidly changing world, some traditional attitudes towards human health, suffering and disability need to be urgently reviewed.

For example, infectious diseases can no longer be regarded as restricted to developing countries. This is clear from the evidence of their international resurgence and the intercontinental spread of AIDS. Nor can chronic noncommunicable diseases continue to be judged only as problems of the richer nations. They are emerging at an alarming rate in poorer regions, unwelcome additions to the infections which still flourish there.

Until now, the term for this phenomenon — the “double burden” of disease — has usually been applied only to developing countries. But it can no longer be confined to these countries alone; it has expanded into a double threat to global health. In the battle for health in the 21st century, infectious diseases and chronic diseases are twin enemies that have to be fought simultaneously on a global scale.

We dare not turn our back on infectious diseases, for they will return with a vengeance if we do. The lessons of AIDS, tuberculosis, malaria, cholera and Escherichia coli food-poisoning outbreaks must not be forgotten. In addition to the many millions of people a year who are killed by infectious diseases, hundreds of millions of others are afflicted by them. This was the theme of The World Health Report 1996.

But neither can we ignore the growing burden in suffering and disability represented by noncommunicable diseases and conditions — cancer, circulatory disease, metabolic and hormonal imbalances, mental disorders, musculoskeletal conditions — most of which are chronic; they invariably afflict the sufferer with pain and disability, for years and even decades. This, too, is the plight of hundreds of millions. Confronting these chronic conditions, and the crisis of suffering that goes with them, is the theme of The World Health Report 1997.

Health is being increasingly affected by a number of factors over which the individual has little control, and over which the conventional health sector also has little sway: social and economic circumstances, labour-saving technologies, and the information and communication revolutions. People in poorer countries are now acquiring many of the unhealthy lifestyles and behaviours of the industrialized world: sedentary occupations, inadequate physical activity, unsatisfactory diets, tobacco, alcohol and drugs. Populations in richer countries continue to live with all these risks. Problems are aggravated by the international spread of misleading information about consumer products. All these factors together will lead to a global increase in premature ill-health from chronic diseases.

Worldwide, life expectancy has increased dramatically during the last decades of the 20th century. But in celebrating our extra years, we must recognize that increased longevity without quality of life is an empty prize, i.e. health expectancy is more important than life expectancy.

Unlike many infectious diseases, the majority of chronic diseases are preventable but cannot as yet be cured. The emphasis must therefore be on preventing their onset, delaying their develop-
Message

Increased longevity without quality of life is an empty prize. Health expectancy is more important than life expectancy.
Life Expectancy and Health Expectancy

• When people live longer, quality of life becomes a central issue (Liu, Chen, Song et al., 2009).

“Increased longevity without quality of life is an empty prize.”
– The Director-General of WHO in mid 1990

• Health expectancy research, therefore, has become very important for projecting future levels of need for care and assistance (Cambois et al., 2011) in the developed regions of the world.

Two Families of Summary Measures

1 Health Expectancy
   – REVES (Réseau Espérance de Vie en Santé)
   – Theories of Predicting Future Population Health

*Quality Adjusted Life Years (QALYs)*

2 DALY-based (WHO)
   – Disability-Adjusted Life Years (DALYs)
   – The Global Burden of Disease Project
Health Expectancy in Policy

• EU: EuroStat--Healthy life years as indicator of population health
• EU: Target for a two-year increase in healthy life years at birth from 2010 to 2020
• USA: First appeared in "Healthy People 2000" as one of priorities and continued in "Healthy People 2010" and "Healthy People 2020"
• Japan: First priority to increase health expectancy for the next decades in the health promotion guideline released in 2012 by the MHLW
• WHO: DALY, DALE, HALE
HEALTH EXPECTANCY IN VIETNAM BY EDUCATION AND REGION

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¹ Institute of Population, Health and Development; ² Nihon University; ³ General Statistic Office

Regional differences in functional difficulty and disability free life expectancy (DFLE) among older persons in the Philippines

Jeofrey B. Abalos

Heather Booth

Abstract

This study aims to describe regional differences in the prevalence of functional difficulty among older persons in the Philippines. It also examines geographic differential in disability free life expectancy (DFLE) and investigates the factors associated with these differences. Data are drawn from the 2010 Philippine Census of Population and Housing (CPH) and the 2010 Philippine Life tables. Sullivan Method was employed to calculate DFLE and meta-regression models were used to examine the factors associated with regional differences in DFLE. Results show a wide disparity in functional difficulty and DFLE among older men and older women in the Philippines. Socioeconomic indicators, including poverty incidence, GDP per capita, education and urbanization, were found to be associated with geographic differences in DFLE.
Organization of the Project

• Project PI: Yasuhiko Saito
• Project Co-PI: Dr. Osuke Komazawa
  – Economic Research Institute for ASEAN and East Asia
• Local PI (Philippines): Dr. Grace Cruz
  – University of the Philippines Population Institute
• Local PI (Vietnam): Dr. Nguyen Cong Vu
  – Institute of Population, Health and Development
Longitudinal Study of Ageing and Health in the Philippines (LSAHP)

• Survey design for baseline survey in 2018
  – Nationally representative sample of 60 and over (not household survey)
  – Sample size of 6,300 persons selected by Multi-stage stratified random sampling
  – Oversampled those aged 70-79 by factor of 2 and aged 80 and over by factor of 3
  – In-person interview survey using structured survey questionnaire by tablet (proxy allowed)

• Wave 2 scheduled to be conducted in 2020
  – Exit survey: death and related information
  – Sample refreshing - may consider
Longitudinal Study of Ageing and Health in Vietnam (LSAHV)

• Survey design for baseline survey
  – Nationally representative/Provincial representative sample of 60 and over (not household survey)
  – Sample size of 6,050 persons selected by Multi-stage stratified random sampling
  – Oversampled those aged 70-79 by factor of 2 and aged 80 and over by factor of 3
  – In-person interview survey using structured survey questionnaire by tablet (proxy allowed)

• Wave 2 is scheduled to be conducted in 2020
  – Exit survey: death and related information
  – Sample refreshing - may consider
Baseline Survey

• Philippines
  – compare with 1996 and 2007 survey
  – module for the Philippines

• Vietnam
  – compare with 2011 aging survey
  – module for Vietnam
Questionnaires

• Screening by Short Portable Mental State Questionnaire (SPMSP: Pfeiffer 1975)
• Household questionnaire
• Main questionnaire for older adults
• Anthropometric measures questionnaire
• Child questionnaire
• Care giver/potential future care giver questionnaire
Household Questionnaire

- Family Structure
- Living arrangements
- Information on Surviving Children’s family
- Electricity
- Water
- Cocking fuel
- Toilet
- Asset
- Bank account
- GPS
Main Questionnaire

- Demographic attributes
- Socioeconomic status
- Intergenerational exchange
- Social network
- Loneliness
- Health behaviors
- Chronic conditions
- WG disability questions
- Sleep

- GALI
- Physical functioning (ADL, IADL, NAGI)
- Mental Health
- Vision & Hearing
- Fall
- Pain
- Dental Health
- Health Care Utilization
- Income/Pension
- Information Technology
Exit Survey

Decedent proxy Interview

• Date of death
• Cause of death
• Place of death
• Medical expenses in the last 6 months prior to death
• Relationship of main caregiver
Anthropometric and performance measurements

- Blood Pressure / Pulse
- Anthropometric Measures
  - Height
  - Weight
- Grip strength
- Gait speed
- Peak flow
- Segmental Appendicular Muscle Mass
- Functional reach
- Balance test
Adult Child Questionnaire

• relationship with older parents
• intergeneration support
  – financial support
  – in kind support
  – others
• filial piety
• Contact information
Care giver/ Potential future care giver questionnaire

- working status
- health status
- family composition
- attitude and beliefs
- kind of care providing
Demographic characteristics

- Age
- Race/Ethnicity
- SEX/GENDER

Genetics: APOE, Parents' age at death, cause of death

Physical environment: Place of residence, Type of housing, cooking fuel, type of toilet, climate, water supply

Past experience: Childhood experience, Place of birth, Place of residence when child, Past disease experience

SES
- Education
- Income
- Wealth
- Asset
- Occupation
- Work experience

Health Behavior
- Exercise
- Drinking
- Smoking
- Diet/Nutrition
- Health care Access
- Access
- Usage
- Insurance
- Social environment
- Social support
- Marital status
- Oral Health
- # of teeth
- Denture
- Chewing ability

Biological Risk
- Blood Pressure
- Cholesterol
- Glycated Hemoglobin
- Waist size
- BMI
- Leg length
- CRP
- Albumin
- IL-6

Perception of health

Social Determinants of Health

Health Outcome

(Prevalence and Incidence)

Diseases
- Conditions
- Impairments

Healthy

Death

Functional Loss

Disability

Framework for Aging Study