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Final Report:

Reablement
and Older People

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Preface: Healthy Ageing in an Enabling Society

The World Health Organization (WHO) outlines a model of healthy ageing in its 2015 World Report on Ageing and Health[i] that consists of two primary factors: an individual's intrinsic capacity, and functional ability. The evidence-based model suggests that even if an individual's intrinsic capacity is diminished, the person may still be able to do the things that matter to them if they live in a supportive, enabling environment. This reflects the concept of maximizing functional ability, which according to the WHO is the ultimate goal of healthy ageing.

Furthermore, the WHO approach suggests that it is the interplay of an individual's intrinsic capacity with the environment that maximizes the opportunity for healthy ageing. As a person's intrinsic capacity changes with age, the environment is an increasingly important factor in the domain of function of the older adult. In this context, the environment may include policies that affect health, service delivery models, and new approaches to health and social care.

This model of healthy ageing accords with a move within international social policy towards envisioning what is being called 'the enabling society'.

The enabling society will seek to harness new technology and new approaches to deliver programs and services that are more individualized, flexible and focused on long-term outcomes over a person's life… in a way that provides more efficient program delivery and more effective collaboration between governments and other stakeholders.[ii]

The reablement approach for people with compromised functional capacity in everyday life, as its name implies, is one of enablement, and is therefore very much in tune with contemporary thought around bringing changes to the way in which health and social care is delivered in the community. Based on a bio-psycho-social model, reablement supports and encourages people to gain or restore autonomy in their own space, helping them to live well in their community, with a longer-term goal of reducing their need for supportive care. In short, the goal of reablement is to "enable people to be and to do what they have reason to value".[iii]

While the reablement approach or model can usefully be employed with people of all ages who have reduced functional capacity, the focus of this report is on older people. Along the continuum of service provision, the functional capacity of older people, for example with advanced dementia, complications of diabetes, and frailty can be expected to span a spectrum from high-level clinical care to assistive living and, when symptoms are milder, to services in the home, including reablement interventions.

The report offers a synthesis of the discussion papers generated at the International Federation on Ageing (IFA) Global Think Tank (October 2015) by four working groups comprising medical specialists, scientists and researchers in their respective fields of expertise — dementia and other neurodegenerative diseases, diabetes, frailty, and technology. These international experts were brought together by the IFA and DaneAge to consider the evidence to date for the potential of the reablement model to maintain and / or improve the functional capacity of older people, to the degree that may require fewer or different services; and may even reduce the premature admission of older people to a range of institutional care. The report summarizes the fruits of these discussions in relation to perceived benefits and challenges in a reablement approach, and presents recommendations for the future.

Acknowledgements

Executive Summary

Introduction

The purpose of the enabling society is to render social policy more effective in enabling individuals to pursue their goals and achieve their full potential in life.[1] The reablement approach is part of this new policy narrative and challenges the negative discourse of ageing and age-related morbidities towards a perspective which focuses on intrinsic capacity and functional ability.

The intention of the IFA Global Think Tank and Copenhagen Summit 2015 / 2016 is to contribute to a solution-driven global public health agenda for healthy ageing whereby there is an improved awareness of the value of a reablement approach and applied technology for an increasing ageing population.

Attention focussed on the discourse on reablement and its efficacy for older people with dementia, diabetes and frailty for two main reasons. Firstly, these conditions will have an increasingly significant social and economic impact on health and social care systems in the next two decades, as millions of citizens globally will be directly or indirectly affected through personal diagnosis or the care of a loved one. Secondly, in general terms the capacity and capabilities of older people with these conditions and subsequent complications are somewhat reflective of a continuum of care and support, ranging from services in the home to assist with activities of daily living to complex clinical care and mental health interventions.

International experts in a cross-cutting exploration gathered for the Think Tank in October 2015 to examine the potential of the reablement model to affect the health and well-being of older people positively as well as to provide cost-savings in the longer term. Preparatory papers developed from a comprehensive literature review and synthesis of each respective subject area on reablement in the context of diabetes, frailty, dementia and assistive technology informed their discussions.

A series of questions about reablement were addressed during the Think Tank, including what a viable reablement model looks like; whether this approach should be adopted by stakeholders; what gaps in knowledge and practice need to be addressed; and consideration of the social, individual and global implications of this approach.

The IFA Copenhagen Summit 2016 Report summarizes the fruits of these discussions, and synthesizes themes from respective expert group papers in relation to the perceived benefits and challenges of a reablement approach, and presents recommendations for the future.

Reablement

The reablement philosophy is aligned to the new approach from the World Health Organization (WHO) Department of Ageing and Health that speaks to the interplay between the intrinsic capacities of an individual and the surrounding environmental conditions.[2]

A reablement approach aims to engage individuals in a process of identifying their own strengths and capacities when functional goals and targets are discussed during the planning stages. Older people are encouraged to focus on what they can do (safely) and what they value, instead of focusing on things that they cannot do anymore. In short, the goal of reablement is to "enable people to be and to do what they have reason to value".[3]

Reablement can be seen as both a 'philosophy' and a 'service'. The philosophy and service speak to the loss of functioning through a decline in abilities (including changes in vision and hearing) as well as following illness or injury, through focused and time-limited interventions provided in a person's home or in community settings that are often multidisciplinary in nature.

Reablement for the individual older person is an active process of (re)gaining skills and confidence in maintaining or improving function, or adapting to the consequences of declining function. It also supports the individual to remain socially engaged within the community context in a safe, culturally sensitive and adaptable way.

An Overview of the Expert Working Group Discussions

Two principal arguments were outlined by the Think Tank expert working groups for adopting a reablement approach: public health sustainability; and improved quality of life of the individual older person. In terms of the former, although more evidence is needed to draw firm conclusions studies suggest that a reablement approach is cost-effective when considering longer-term effects — that is, a reduction in home care services and reduced hospitalization for some. Similarly, in terms of promoting quality of life, a number of positive indicators were reported in studies of reablement in older people with dementia, diabetes and frailty, notwithstanding the relatively new field of research.

Gaps are clearly evident in the knowledge base about the efficacy of the reablement approach. These include a scarcity of high-quality research into how principles of reablement are implemented to actualize the goal of enhancing an individual's intrinsic capacity in combination with environmental supports to promote their functional ability. Gaps in the understanding of practice also exist such as determining changes that may be required at the organizational level in the training of health professionals and care workers. Since reablement involves working 'with' people, rather than doing things 'to' or 'for' them, a significant change in the mind-set or culture of some older people, health professionals and care workers, and family members may be required to ensure that the principles of reablement are implemented in practice.

Towards an improved understanding of the social and economic case for reablement (as a service within the continuum of 'products' to enable and support older people), systematic research is required into: the components of interventions assessed as beneficial — and in what context and with whom they are beneficial; the investment / expense impact of a reablement program; outcomes to older people, including functional status and quality of life measures; and the impact of knowledge, skills, attitudes and behaviours of older people, health professionals, caregivers, care workers and society generally regarding the potential gains of an enablement philosophy.

In sum, the reablement approach could be considered a bridge between acute and long-term health and social care systems with the potential to help align these systems and save health dollars. Reablement is also seen as a means of facilitating an individual's continuing ability to participate in, contribute to and be productive and valued in society.

Recommendations

Recommendations were broadly framed within research and implementation of the reablement approach. First and foremost, more high-quality research with large samples for all categories of outcomes is considered a priority in order to reduce the knowledge gaps concerning the system impacts and individual effects of reablement. For implementation of the reablement philosophy and for interventions to be realized, there is a need to assess the cost-effectiveness of reablement interventions as well as to develop an understanding of how best to establish services to identify, monitor and deliver appropriate and timely service.

A cross-cutting recommendation focusses on understanding the use and value of assistive technologies in a number of different ways, such as treatment aids and decision support tools, in addition to being a critical element in fully tailored interventions to help build the capacity and capability of the individual. Underpinning successful implementation is an assurance that health professionals and care workers are trained in the reablement ethos and its implementation.

Conclusion

Reablement can empower and improve the functionality of older adults and in the process reduce their need for more supportive health and social care measures. Although the evidence is still emerging and despite these challenges, positive indicators such as improvements in health-related quality of life and well-being and reduced personal home care costs permit a cautious optimism about reablement as an effective component of emerging health and social care models.

Governments and civil society alike are called upon to gain a deeper understanding of the value of incorporating the reablement approach into policies and programs to help maintain and improve the functional ability of older people with chronic conditions and to detect risk factors early, thereby avoiding further adverse consequences.

1 P Hicks, The Enabling Society, Institute for Research on Public Policy [IRPP] Policy Horizons Essay, Quebec, 2015, p.3.

2 World Health Organization (WHO), *World Report on Ageing and Health*, Geneva, 2015, pp.64-67.

3 WHO, 2015, p.28.
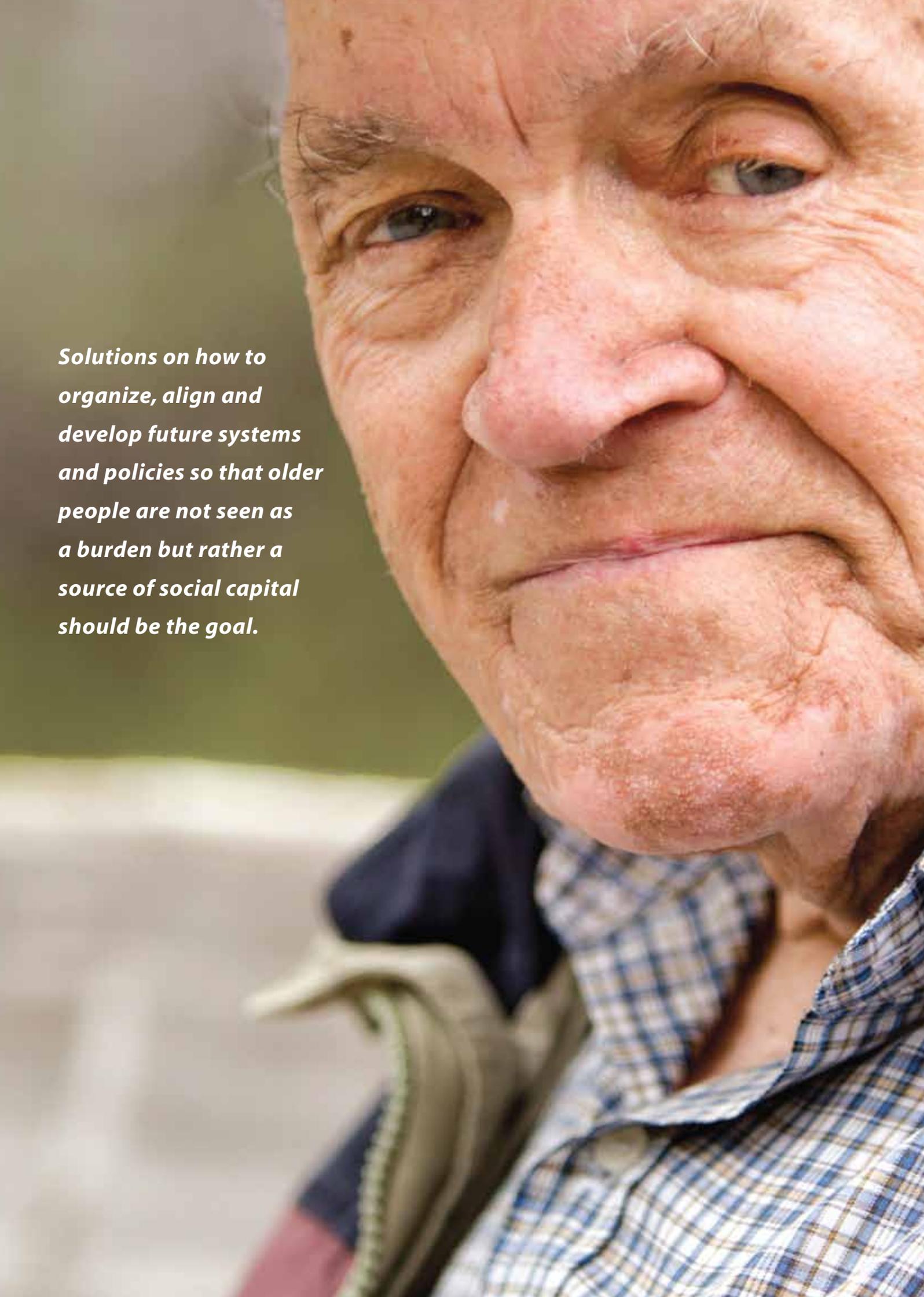
Solutions on how to organize, align and develop future systems and policies so that older people are not seen as a burden but rather a source of social capital should be the goal.

IFA 2015 Global Think Tank on Ageing: Background and Context

The unprecedented rapid population ageing in today's world is a challenging issue with serious social and economic consequences for many governments around the world. In the past ten years the number of people aged 60 years and over has risen by 178 million; and in China alone the estimated number of older people in 2012 was 180 million. [iv] Those turning 60 years of age each year worldwide is nearly 58 million, equivalent to almost two people every second and representing close to 11.5% of the total global population.

By the year 2050 this proportion is projected to nearly double to 22%, and for the first time there will be more older people than children under 15 years of age. [v] In a recent review of the present and future burden of chronic non-communicable diseases relevant to older people, Prince et al (2015) reported that almost one-quarter of the total global burden of disease (23%) is attributable to disorders in people aged 60 years and older. [vi]

The significant and increasing pressure on health and social care expenditure is a significant challenge that calls for innovative ways of thinking and acting toward an ageing population. Solutions on how to organize, align and develop future systems and policies so that older people are not seen as a burden but rather a source of social capital should be the goal.

Many western societies that have experienced the peak of population ageing are characterized by a strong discourse on active and healthy ageing. However, significant barriers still exist to the development and implementation of good public health policy on ageing. These include complex multi-morbidities, poor or no access to person-centred services, user fees, inadequate income security and social protection, as well as the prevalent misperception of the abilities, capacities and role of older people in society.

Ageist attitudes continue to limit the potential for the introduction of innovative models of health and community care.

Snapshot of Global Think Tank Themes

Over the next two decades citizens globally will be impacted directly or indirectly by the conditions of dementia, diabetes and / or frailty across their life course in an unprecedented way, either through personal diagnosis or the care of a loved one. The World Health Organization (WHO), the United Nations (UN), governments, academia, industry and non-governmental organizations have, in the recent past, had condition-specific calls for action to better understand their implications as well as how to work collaboratively in creating solutions that are transferable and replicable. The limitation of a disease-focused approach prompted the IFA and DaneAge to consider a cross-cutting process to the Global Think Tank on Ageing and subsequent Copenhagen Summit, bringing together international experts on dementia, diabetes, frailty, technology and health economics to discuss the potential of the reablement approach and model for older people from a functional rather than a diagnostic perspective.

Before examining the fruits of the discussions, it is useful to take a snapshot of the social, function and economic impact that such conditions have on individuals and their families as well as globally; and to introduce the role played increasingly by technologies in the management and care of the health of older people.

Dementia

Dementia is the greatest cause of years lost due to compromised functional capacity in developed countries and the second greatest worldwide. In 2013, there were approximately 44.4 million people with dementia worldwide, a number that is expected to increase to about 75.6 million in 2030, and 135.5 million in 2050.[vii] The total estimated worldwide cost of dementia was USD604 billion in 2010 with around 70% of these costs occurring in Western Europe and North America where population ageing has matured, making dementia one of the most expensive health conditions (both socially and economically) for society as a whole.[viii]

As an irreversible neurodegenerative condition, dementia is a leading cause of disability for older people.[ix] The progressive decline in cognitive and physical function manifests in loss of memory; problems with communication, judgment and decision-making; disturbances in motor function; and behavioural changes, and emotional effects such as depression, apathy and social withdrawal.[x] Despite the progressive decline in functioning, people can live for as long as 20 years with dementia.[xi] It is commonly believed that older people with dementia tend to live in residential care facilities, but in fact between 60% and 70% live in the community in developed countries.[xii]

Diabetes

Diabetes Mellitus is the world's fastest growing chronic disease. In 2014, it affected an estimated 387 million people around the world (43% of whom were undiagnosed), a number that is predicted to grow 205 million more by the year 2035. Of these approximately 316 million people had impaired glucose tolerance, placing them at significant risk of developing diabetes, and this group is expected to increase to 471 million by 2035.[xiii] More than 25% of people over the age of 65 years around the world have diabetes, and approximately 50% have pre-diabetes.[xiv] Both type 1 and type 2 diabetes occur in older people. Type 2 accounts for more than 90% of cases.[xv] In most high income countries diabetes is the leading cause of cardiovascular disease, blindness, kidney failure and lower limb amputation. Diabetes is an independent risk factor for the development of functional impairment and disorders of mobility, and approximately 25% of community-dwelling older adults with diabetes are frail.[xvi]

Personal and financial costs of the burden of diabetes are colossal, inciting some 5.1 million deaths and consuming some USD548 billion in health care spending (11% of the total spent worldwide) in 2013. Estimates show that 76% of global health expenditure on diabetes in 2013 was for people between the ages of 50 and 79 years.[xvii] Costs of care for older individuals with diabetes who are unable to maintain their independence are three-fold higher in the community and nine-fold higher in institutional care.[xviii]

Frailty

Frailty is considered to be highly prevalent with increasing age and confers high risk for adverse health outcomes, including institutionalization, falls, hospitalization, and mortality. It is recognized that frailty has a biologic basis, but whether it is a clinical syndrome distinct from the ageing process itself remains in question. Numerous geriatric interventions have been developed to improve clinical outcomes for frail older adults. A major obstacle to their success has been the absence of a standardized and valid method for screening those who are 'truly' frail so as to effectively target care.

A state of frailty is a key indicator of the individual's health and needs, although researchers note the complexity of defining 'symptoms of frailty' and assessing the care needs of such a heterogeneous group.[xix] Frailty impacts upon an individual's quality of life in many, often co-existent ways. These include isolation and loneliness associated with chronic illness, low energy and reduced mobility, loss of loved ones and a reduced social network; persistent low mood, affected by the factors previously described; memory problems; and a sense of reduced control over one's life resulting from increasing levels of dependency.[xx]

Assistive Technology

Assistive Technology (AT) is defined as "any item, piece of equipment or product system whether acquired commercially off the shelf, modified, or customized that is used to increase, maintain or improve functional capabilities of individuals with disabilities".[xxi] AT expands beyond such traditional devices as shower chairs and walking aids to digitally-enabled devices including mobile devices, telecom networks and software applications.

The last ten years has seen a significant expansion in the range of AT devices that are available, especially to enable older adults to maximize their function. This growth is not only driven by the changing demographics but also by the changing demands and expectations of older adults that technology will play a role in helping them to remain in their own homes and communities.

An Overview of the IFA Global Think Tank on Ageing and the IFA Copenhagen Summit

The IFA Copenhagen Summit is the Annual Meeting of the IFA Global Think Tank. This international platform is specifically convened to stimulate policy discussions with leaders and key decision makers in government, academia, business and civil society. The overall purpose of the connected events in 2015 – 2016 is to help create a solution-driven global public health agenda for improved awareness and education on the impact of targeted reablement, rehabilitation and applied technology to improve functional ability in the ageing population.

The Global Think Tank, held in October 2015, took the form of an invited-only workshop of expert academics and practitioners in age-related fields including dementia, diabetes, frailty and technology, who were asked to respond to key questions about reablement in the context of the sub-themes. There was a broad assumption that the functional capacity and capabilities of older people with these conditions are somewhat representative of a continuum of care and support, ranging from services in the home to assist with activities of daily living (ADL) to complex clinical care and mental health interventions.

Preparatory papers on reablement in the context of diabetes, frailty, dementia, technology and older people informed the experts' discussions. Each paper comprised a literature review and synthesis of the respective subject area gained from peer-reviewed journal articles and reviews for at least the past five years, together with Cochrane reviews and articles that included studies on outcome indicators of cost-effectiveness and function. The literature studied was almost exclusively written in English and encompassed research conducted in Europe, North America, Australia and the United Kingdom.

Each of the three condition-specific papers included a summary of the research around assistive technologies. The literature review search for each preparatory paper was guided by the following set of questions: What is the extent of the problem? What are the features of reablement? Which reablement interventions do and don't work? Which features are amenable to change?

The Global Think Tank experts were then invited to address a series of new questions, namely:

1. **What does a reablement model look like, including what supports are needed?**

2. **Why should a reablement approach be used by stakeholders (government, funders, individuals and caregivers)?**

3. **What are the gaps in knowledge and practice that need to be addressed for reablement to be considered a viable policy strategy?**

4. **What are the implementation challenges pertaining to each theme (dementia, diabetes and frailty)?**

5. **What are the societal and individual implications of the reablement approach globally?**

This report, which presents a synthesis of responses to these questions as well as the experts' recommendations, aims to stimulate and inform policy dialogue.

IFA Copenhagen Summit Report, 2016

Rehabilitation and Reablement

The term 'rehabilitation' warrants clarification in the context of this discussion. Rehabilitation traditionally has been regarded as a high-intensity, therapeutic, medically-directed intervention delivered within a hospital or outpatient setting, with formal assessment of function and outcomes. In contrast, reablement focuses on supporting and restoring functional ability with a goal of autonomy for the individual at home, and is an active process of regaining skills and confidence. The relatively new approach of reablement is not prompted by a specific acute event or illness but can be implemented with people who have experienced a gradual decline in their health status and functioning.

Rehabilitation is often prescribed as a response to an acute episode such as a fractured neck of femur due to a fall. However, there appears to be a growing interest in intervening 'upstream' to help older people maximize their capacity and ability to live in the community. One important thread in public and political debates of the European Union (EU) is the potential of rehabilitation for older people to be a proactive response to change in function as opposed to rehabilitation within a geriatric care model. This discourse focuses on autonomy and quality of life, as well as on the potential cost containment of public expenditure compared with a traditional model of rehabilitation, as reablement is linked to self-management and personal responsibility.

Whether it be semantics or not, it is important to describe 'reablement' in an applied way that makes sense in an already complex health and social care system. Reablement (also known as 'restorative care' in Australia, New Zealand and the USA) is quickly gaining momentum in some parts of Australia, Europe, New Zealand, North America and the United Kingdom. Reablement interventions tend to be short-term, targeted and generally low in cost and low in intensity. These services typically aim to 'help the person to help themselves': doing things 'with' people to help them maximize their independence rather than doing things 'for' them or 'to' them. Programs may be led (but not exclusively) by health professionals, such as physiotherapists and occupational therapists, with the assistance of vocationally qualified workers, and have the goal of reducing the need for home care in the future.[xxii]

The expert working groups were asked in the first instance to address the pivotal question of what a reablement model looks like (and should look like).
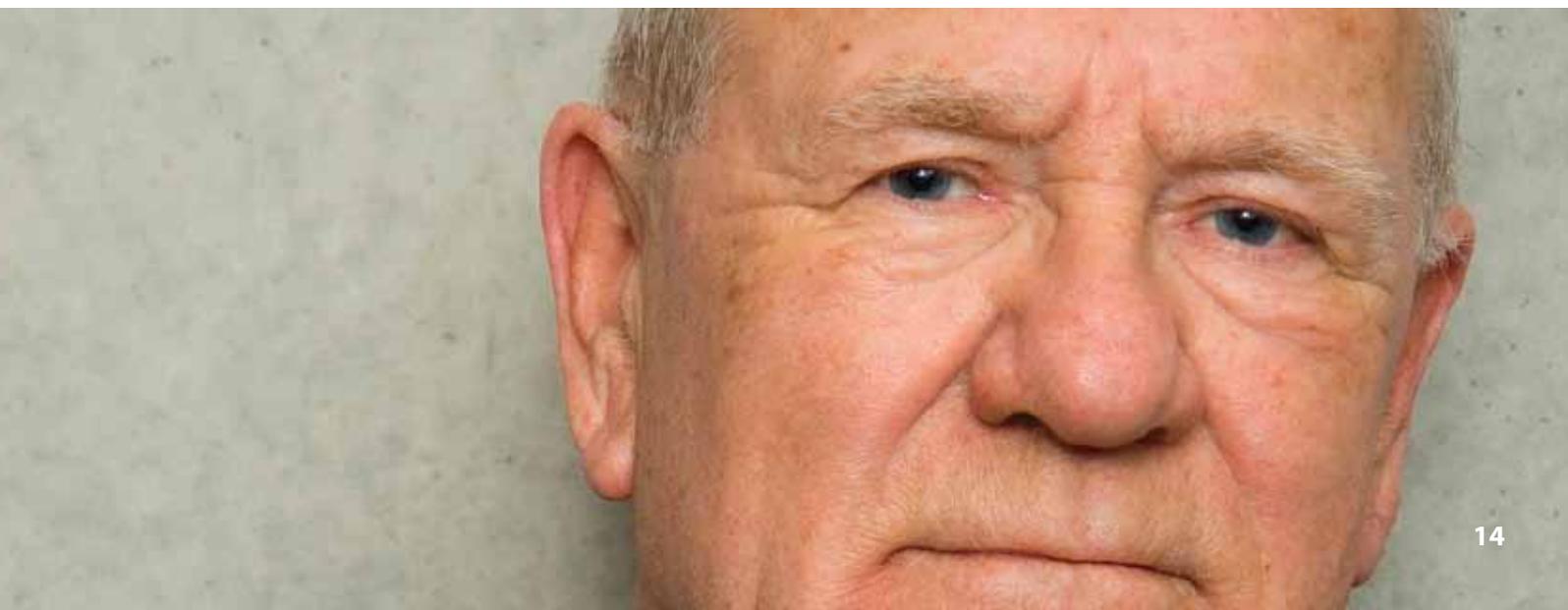
Question 1:

What does a reablement model look like, including what supports are needed?

Reablement may be seen as both a 'philosophy' and a 'service'. The philosophy encompasses targeted, relatively short-term, person-centred, goal-directed interventions addressing loss of functioning through a decline in health (including changes in vision and hearing) or a specific condition, as well as following illness or injury. The focus is on regaining or managing the impact of functional loss and promoting autonomy according to the individual's capacity. This is an active process of regaining skills and confidence through maintaining function as, for example, in activities of daily living (ADL), achieving new goals, or adapting to the consequences of declining function.

The reablement approach also supports the individual to remain socially engaged within the community context. The program and subsequent interventions need to be safe, culturally sensitive, and adaptable in all health and social care contexts. They should be practiced across all levels of service, supported by age-friendly environments and health and other public policy, and be an integral part of clinical practice guidelines, policy and service models.

Reablement services usually involve focused, time-limited (typically 6 to 12 weeks) interventions provided in a person's home or in community settings, often multidisciplinary in nature, and aim to help people regain as much functional capacity as possible. Non-pharmacological options are favoured when safe and when evidence supports their value. The effective use of assistive technology AT can enhance and improve the delivery of care and support the individual's self-management of their condition, including their physical and mental function.

Reablement service outcomes are measurable in different clinical domains and effectively integrated into existing clinical pathways that take account of the individual's personal functional goals and targets.

Reablement interventions are holistic and in tune with working towards outcomes that matter to the individual, supporting (enabling) them to do what they value in life and consulting with them in their family and local context. Although time-limited, reablement requires working at the pace of the individual with variation to input depending on their capacity and needs. It is also an iterative approach, applied in response to functional changes, and highly flexible to accommodate sometimes rapid shifts in the individual's health, cognition and therein capacity.

Reablement is not always clinician-led but requires close collaboration between the health, allied health practitioners, care workers and family involved in the service. It is important that the individual (where possible, in the case of dementia) and their caregiver(s) be involved in planning the model and also in planning their own goals and treatment and in evaluating the intervention.

Goals of Reablement

The goals of the reablement model are: to maximize functional ability throughout life including during palliative and end of life care; to support and enable the transition towards higher functional states; and to improve or maintain autonomy in the individual's environment through helping to mobilize their intrinsic capacity. Goals may relate to cognition, activity (mobility, ADL, instrumental activities of daily living [IADL] and leisure pursuits), behaviour, emotion, physical symptoms (e.g. pain), social engagement and communication.

Goals are operationalized through a careful understanding of the person's abilities, to ensure that the aims are achievable and realistic, as well as meaningful and worthwhile. Strategies to enable the person to work towards the goal are put in place, drawing on a range of evidence-based methods which may include physical training, learning or re-learning skills or behaviours (restorative methods) or finding ways around a functional difficulty (compensatory methods), including adapting the environment and/or using assistive technology.

Supports for the Reablement Model

Crucially, support for the reablement model may also require skilled workers practising in potentially new ways, as well as a changed mind-set from older people, families and care staff, all of whom may require orientation to the model and its expected outcome, including the use of appropriate AT devices.

Assistive technology is a key element of the reablement approach from both the user and the provider perspective. For older people, ATs can help to build personal capacity and capabilities toward achieving individual goals as well monitoring changes in behaviour or function which may then require adaptation of the intervention.[xiii] Independence is often aligned to self-management of one's condition and functional capacity, and there is good evidence that ATs can support this as well as be a pipeline for communication and online interaction with professionals and family.

Service providers use ATs to understand when services could be withdrawn / reduced / modified as well as to collect data on parameters that are difficult to measure. The data is then used to predict trajectories to help with decision-making; to provide new mechanisms to increase motivation and adherence to the reablement process; and to underpin interagency collaboration. There may be scope, although not well tested, to use reablement as a vehicle for older people, family caregivers and / or care staff to acquire new skills in situations where technology can help meet ongoing needs or connect people more fully with others.

There are different ways to categorize and describe the use of AT by and with older adults. The experts in technology chose a model based on function and on the needs of older people related to ensuring that function can be maintained, spanning six primary domains: mobility, safety and security, cognition, health monitoring, support in ADL, and leisure. In recent years there has been an influx of electronic technologies that help with cognition, sensory loss and frailty. These include systems that can assist older adults with dementia during self-care activities through the use of prompts,[xxiv] technologies to support safety in the home such as monitoring falls and other potential accidents,[xxv] and the use of robotics for cognitive support and training.[xxvi]

The process of designing, selecting and deploying technological solutions within the reablement model must be a collaborative effort between a multidisciplinary team of experts, including clinicians and practitioners (such as personal support workers, nurses, physicians), therapists, family and caregivers, technology designers and, most importantly, the older adult. An iterative process of research, development and design of solutions in consultation with all of these stakeholders is critical to ensure that effective and proper solutions are developed, with a focus on genuine individual needs, goals, and function in everyday life.

Question 2:

Why should a reablement approach be used by stakeholders?

Two principal arguments for adopting a reablement approach were noted by the experts, namely:

1. **Public health sustainability; and**

2. **Quality of life of the individual older person, encompassing improving and/or maintaining functional ability and autonomy, empowerment leading to confidence and self-worth, communication and social engagement, and a sense of being a valued member of the community.**

Public Health Sustainability

Reducing the need for long-term care services, as well as hospitalization and institutionalization, are key factors in helping to reduce the economic burden of countries when providing appropriate services for all, but specifically for a certain cohort of older citizens. With a rise of both expectations and life expectancy, governments are concerned with the real or perceived increase in the cost of providing consistently high-quality care to older people, especially for those experiencing health and functional declines that manifest with chronic conditions, for example, frailty, diabetes and dementia.[xxvii]

Outcomes of research studies, while indicating that more evidence is needed to draw firm conclusions, suggest a high probability that reablement is cost-effective when considering longer-term effects (i.e. a reduction in home care services and reduced hospitalization for some) as it can reduce the needs for ongoing support. [xxviii] Researchers report that a reablement model assists older people to gain or restore their functional autonomy / independence, reduces or ameliorates disability, and helps to avoid hospitalization, emergency care and institutionalization.[xxix] The results in two studies show that health and home care costs of reablement were lower than the costs of conventional home care.[xxx] The aggregated health and home care costs of the reablement group were lower by a factor of 0.83 over the two-year follow-up in a large Australian randomized controlled trial.[xxxi]

Moreover, by enhancing the individual's self-care skills and confidence to live independently or with minimal services, the time expended by clinicians and other health professionals can be optimized, thus providing a further cost-saving measure within the health system. It is also noted that 'caregiver burden' may be alleviated through a consultative, multidisciplinary reablement approach. When caregivers are educated and consulted in care planning, implementation and evaluation of progress, their levels of stress and anxiety are shown to decrease. The health and well-being of both the older person and caregiver improve along with their increased engagement with the reablement program.[xxxii] This in itself is a public health cost-saving outcome.

Older people in some cultures are considered a costly burden to society rather than a cohort where investment is made as part of a growing economy. This attitude robs communities of the opportunity to maximize the major social and economic resource that older people can offer as a contribution to society. There is also a potential loss to the economy if people of working age leave employment to assume family caring responsibilities for older family members and friends who, without this, would be insufficiently supported.

The experts in technology suggested a 'business model' approach to the delivery of the technology used for and with older adults in the community. While ATs are often currently considered to be medical devices and provided through existing health care models, many technologies useful in reablement can be regarded as 'classic' consumer products and/or electronics that can readily be purchased off the shelf.

Quality of Life

Our experts in dementia noted that it is unrealistic to assume that prevention or cure for dementias and other neurodegenerative diseases is imminent. "Consequently," (they stated) "we cannot continue with the current nihilistic view that society's only response to dementia and neurodegenerative disease is the provision of supportive care." A reablement approach supports the human rights of people with dementia and their caregivers, and focuses positively on what people can do with appropriate support and interventions. It appears to actually enable people with dementia to function at their optimal capability, and offers a proactive approach that contributes to continued well-being and the prevention of crises.

Existing evidence supports the notion that people with dementia can respond to rehabilitation interventions following significant illness or injury.[xxxiii] There is also emerging evidence that people with dementia can respond to cognitive and physical reablement strategies that aim to improve their intrinsic capacity and functional ability.[xxxiv]

Experts in the diabetes working group concluded that reablement interventions may enhance individuals' quality of life through reducing the incidence of falls, slowing age-related mobility loss and promoting both physical and emotional well-being.[xxxv] Research around reablement exercises that help to increase balance and dexterity has demonstrated a significant reduction in the rate of falls, years post the reablement.[xxxvi] It was also noted that the reablement approach can improve the control of diabetes and its associated risk factors and reduce the risk of complications, help to maintain independence and autonomy, and lead to better patient-centred care.

While the empirical evidence in reablement and older people in the context of frailty currently is not strong, the experts noted a number of positive indicators for improved quality of life among older people. Reablement can reduce dependency in terms of activities of daily living amongst home care users; and studies show that interventions focusing on functionality indicate improved activity performance and satisfaction with performance[xxxvii] and ADL. [xxxviii]

In terms of health care service use, the results in an Australian randomized controlled trial with 750 participants showed that participants in the reablement group required fewer home care hours, were less likely to be in need of nursing homes, and were less likely to be in need of emergency department treatment compared with participants in the control group.[xxxix] The latter finding was also demonstrated in a further study. [xl] People who received reablement interventions were also less likely to need personal care service,[xli] and to be readmitted to hospital.[xlii] Reablement may therefore reduce the need for home care services, as well as for other health care services.

The use of technology in a reablement model in those individuals who are considered to be frail may be one of the strongest indicators of the benefits of technological solutions, according to the experts. Attention was drawn to the long history and strong evidence of AT in supporting frail older adults to continue to live as independently as possible in their own homes and communities. While technologies have been developed and tested with populations of older people, there is still a lack of evidence or weak evidence for many interventions that aim to improve health, well-being or participation.[xliii]

Reablement for frail older adults also resulted in benefits for unskilled home care assistants. In a mixed methods study,[xliv] home care assistants working with participants in the reablement group were found to have increased job satisfaction and significantly reduced turnover compared with those working with participants in the usual care group. The study emphasized the value of enhanced coordinator support and supervision, as well as improved training and flexibility, which resulted in increased job satisfaction.

A reablement approach supports the human rights of people with dementia and their caregivers, and focuses positively on what people can do with appropriate support and interventions.

Question 3:

What are the gaps in knowledge and practice that need to be addressed for reablement to be considered a viable policy strategy?

Gaps in the Research

Reablement is a relatively new approach within the health and social care sectors which has yet to be researched to the extent and depth required to demonstrate its efficacy and cost-effectiveness unequivocally. Yet the same statement can be made about the limited evaluation of the impact of current models of support and services for older people. Gaps in knowledge of the impact across services models therefore abound.

Overall there is an absence of accepted definitions for the terms 'enablement', 'rehabilitation' and 'reablement' as they apply to chronic conditions and the subsequent functional ability of older people. There is a scarcity of high-quality research into the way in which the principles of reablement are implemented in order to actualize the goal of the older person's intrinsic capacity in combination with environmental supports so as to promote their functional ability and protect or improve their quality of life.

In understanding the social and economic business case for reablement (as a service within the continuum of 'products' to enable and support older people) experts call for systematic research into: the components of interventions assessed as beneficial — and in what context and with whom they are beneficial; the investment / expense impact of a reablement program; outcomes to older people, including functional status and quality of life measures; and the impact of knowledge, skills, attitudes and behaviours of older people, caregivers, care staff and society in general regarding the potential gains of an enablement philosophy.

Individualized programs that enable older people to improve and remain functional require their engagement. Far too little is known of their perspectives and values, particularly vulnerable populations such as those with cognitive deficits who are often excluded from research trials on the grounds of difficulty with reliable data collection and challenges with ethics approval. [xlv]

Specific to the field of reablement of older people with diabetes is the fact that a mere 1% of intervention studies related to diabetes have been carried out in people aged 70 years and older. Moreover, there is a paucity of research into community health strategies that can prevent older people with impaired glucose tolerance from developing diabetes. Since up to 80% of type 2 diabetes is preventable, this is a critical gap in the knowledge field that urgently needs to be addressed and could be part of a reablement strategy.

Gaps in Practice

There appears to be a growing acceptance of the role of reablement by health care professionals, with many managers and care workers valuing its flexibility and the more responsive way of working with older people.[xlvi] However, it cannot be assumed that the necessary cooperation and integration of systems (including the state, market, insurance systems, family, local communities, religious institutions, volunteers and other civil society actors) toward a reablement approach is simple within jurisdictional responsibilities and legal frameworks. It will be important for decision makers to consider the potential value of such an approach within the current framework of service provision to older people. The delivery of reablement programs to a large extent depends on the training and skills of care workers and health professionals, a gap which has been identified by the experts.

Experts in frailty suggested as a broad principle that attention must be paid to training and organizational development in the development of any new service models. It was noted that reablement in some settings may need a whole-of-system approach to support the shifts in mind-set and ways of working with older people.

Despite evidence that people with dementia can gain from rehabilitation following an acute event,[xlvii] current health and social care provision for people with dementia is often fragmented and limited. In addition, many existing services focus on older people with physical health problems to the detriment of those with dementia and other cognitive impairment conditions. This can sometimes be because of the time-limited nature of reablement services, whereby staff may mistakenly believe that it is not possible to 're-able' a person with dementia in a six-week intervention.

In the area of assistive technology, while many devices are commercially available (such as activity-tracking devices and apps), clinically relevant and meaningful interpretations of the data and efficacy studies of technological interventions are still needed.[xlviii] Because this field has suffered from the lack of a strong evidence base for rehabilitation and reablement applications, health care providers can be left to weigh the pros and cons of recommending these tools.

Question 4:

What are the implementation challenges pertaining to each theme?

Reablement and Dementia

In supporting an enablement philosophy for older people with dementia and other neurodegenerative diseases, there are a number of unique challenges which begin with a deep understanding and adoption of the philosophy. The new narrative needs to be about 'living well with dementia', with a focus on retention of abilities and effective adaptation to the loss of functional ability. The model must also be adaptable to different cultural contexts and situations.

Service delivery and care of people with dementia and neurodegenerative diseases must be reoriented such that reablement and rehabilitation are integrated into routine care, with the necessary reallocation of resources. In order for reablement to be sustainable, responsibility for delivery must extend beyond solely the health care system and have a community focus.

Consistent care management is important, which may best be facilitated by a case management approach. Staff require knowledge about how to assess and build upon the remaining abilities of the person with dementia, taking into consideration any co-morbidities, so training becomes a key factor. Being able to understand and improve intrinsic capacity and functional ability are essential skills for all.

Reablement and Diabetes

Introducing a reablement model into modern diabetes care needs to include strategies to alter the mind-set of care professionals away from a glucocentric model towards an individualized approach that aims to maintain functional performance with quality of life and well-being at the centre of the approach.

Challenges to implementing a diabetes reablement model begin with acknowledging the conceptual and practical differences between the reablement approach and rehabilitation. This is essential in order to change the beliefs, habits and behaviours of clinicians through education and training and clinically relevant useful practice guidelines.

The science of reablement in the context of people with diabetes must be at the heart of education and changing beliefs. For instance, there is a need to define the duration of interventions for particular reablement approaches, and to define the most relevant anticipated outcomes.

Because of the pioneering nature of this approach for people diagnosed with diabetes, it is important to promote the dialogue and research to all stakeholders through national and regional campaigns, seeking to generate new research and evidence for change in health economic models, models of care, and triangulated methods, which are key gaps at the present time.

Implementing a new model for diabetes management in different cultural settings and adapting the model to the capacity of developing under-resourced countries as well as well-resourced wealthy nations is a challenge that those pursuing the reablement model will experience.

Reablement and Frailty

The primary challenge in examining reablement in the context of frailty is that there appears little consensus from an academic perspective of the term 'frailty'. The terminology also tends to change in practice and be somewhat influenced by culture and the social and economic status of the environment. Notwithstanding these facts, the effective application of research findings to service implementation is often hampered by the vast differences in the nature and execution of models of reablement.

The pace of the policy process can be such that new ways of working are implemented so rapidly that it proves difficult to rigorously evaluate effectiveness. This is compounded by evaluations that are based primarily on small-scale experiments with often fairly short timeframes and may therefore be of limited scientific quality. However, the scientific quality of an intervention may not necessarily be the question to be answered within the practice of care setting which aims to enable an older person to choose to do what they value. This may seem a lofty goal, but clearly it is human-centred.

Too often, interventions of health and social services are not executed early enough to prevent losses in function. As a consequence, decisions about the nature and duration of services to support older people are made far too rapidly and often result in decreasing rather than enabling function. This kind of process precludes the potential benefits from the introduction of a reablement model. While acknowledging the increasing demands on care and services from many older people the panacea cannot be a premature admission to a nursing home (residential care facility).

As previously stated, the potential benefit of a reablement approach may require reorientation and retraining of professionals to practise in potentially different ways, as well as the adoption of a changed mind-set by older people, families and care staff. Existing services may 're-badge' themselves (often to attract new funding) while not offering the quintessential elements of reablement. Ensuring that services are genuinely 're-abling' in ethos is both a key policy and practice challenge.

Cultural change presents another challenge, affecting individual older people and their caregivers, paid care staff, and service providers in the following ways:

a) Some older people may experience being supported to become more independent as less familiar and therefore less comfortable than being 'cared for' via traditional care services.[xlix] For older individuals and their family caregivers, reablement may sometimes also feel less safe than traditional services.

b) For paid care staff it may be more time-consuming to implement a reablement model rather than simply 'doing to' the older person. Expecting existing staff to work in very different ways without sufficient support to reflect upon previous practice while then testing out new approaches is unlikely to be effective.

c) For some providers, reablement represents a significant challenge to existing business models. For example, a private provider may need different and enhanced financial incentives (perhaps based on a system of 'payment by results') given that the work is more intensive with the individual in the short-term.

Reablement and Assistive Technology

The argument for the development and application of technology in a reablement approach has several angles. General use versus a personalized solution may be critical in the reablement process yet it may be more expensive and less useful in other contexts. Family caregivers may need to be trained in the personalized solution, although new advanced techniques such as artificial intelligence may enable an AT device to automatically learn and customize to a user.

The affordability and cost benefit of new developments and implementation of a solution during reablement must be reasonable, not only for the individual but also for the agency that may be providing (and paying for) it.

Currently around 70% of all ATs are abandoned,[i] so it is critical to ensure that any AT used in the reablement process will be actually adopted, and its use sustained by the older adult and / or caregiver. In some instances potential users of an AT perceive a stigma associated with it. In practice this means that even if a technology has been designed to meet the goals and needs of an individual and it has been shown to be usable, it may not be used. Social acceptability must be taken into consideration in the design and implementation of ATs.

The context and environment within which the AT will be used, the duration of its use, and the work plan associated with maintaining the technology once implemented can present a challenge to the user, caregiver and care provider. Support from the family caregiver is often a prerequisite for effective deployment. Complex digital devices may require maintenance and updating — a challenge in this regard is how to manage and fund such devices within health care systems with limited budgets.

Measuring the impact of the new ATs in reablement is important in order to determine their efficacy and to support the ongoing development and use of ATs in this area of application. The concept of measurement becomes even more important as technologies are emerging that traditionally have not been used in reablement or health care systems in general (e.g. robotics, smart homes).

Ethics is a further significant challenge for AT. Privacy, confidentiality and security of personal information may be compromised with the advancement of technologies as each citizen will automatically become part of various information and communication technologies (ICT) ecosystems. The collected data will be used for analytics on outcome measures for different levels of function to optimize personalized services and generate preventative interventions. This will also enable the development of cost-efficiency and effectiveness models.

As more and more data is generated, collected, stored and shared, issues of adequate privacy, safety and security measures must be of paramount consideration. Authentication, authorization and consent become even more important — particularly for older people with diverse cultural and educational backgrounds and experiences and those with a condition (such as dementia) that manifests in decision-making disabilities. Furthermore, it needs to be borne in mind that unconditional reliance and dependency on new technologies will have far-reaching ethical and legal implications.

Question 5:

What are the societal and individual implications of the reablement approach globally?

Societal Implications

The reablement approach is part of a new narrative that challenges the negative discourse around ageing and age-related morbidities towards a perspective that focuses on intrinsic capacity, functional ability and healthy ageing. Reablement is a bridge between acute and long-term health and social care systems and has the potential to help align these systems and save health dollars.

Medical and non-medical training curricula will need to be updated to reflect the enablement philosophy, so that the professional attitude to older people is not one of 'determining placement' but rather geared to optimizing capacity and capabilities. Reablement can and should be able to be delivered in the community, in people's homes (including nursing homes and other residential facilities), supported by an age-friendly environment.

Reablement is also seen as a means of facilitating an individual's continuing ability to participate in, contribute to and be productive and valued in society.

Current and future use of technology will have significant effects on society. Socio-economically, new technologies and services will create new jobs in different sectors. For the implementation, additional skills are needed and training will be developed. With the new technologies and combined services, new service models will be created. Those models will need to be person-centred, based on empowerment and co-created with service providers. New models of revenue streams are also likely to be generated alongside or as replacements to existing ones. In this regard, public discussions on public reimbursement versus private payer will need to take place.

It is critical to appreciate that the key to success lies in understanding service and care requirements and how AT can inform health care decision-making, and ensuring that governance, management and operational systems remain flexible to adapt to the 'new' while sustaining the older models.
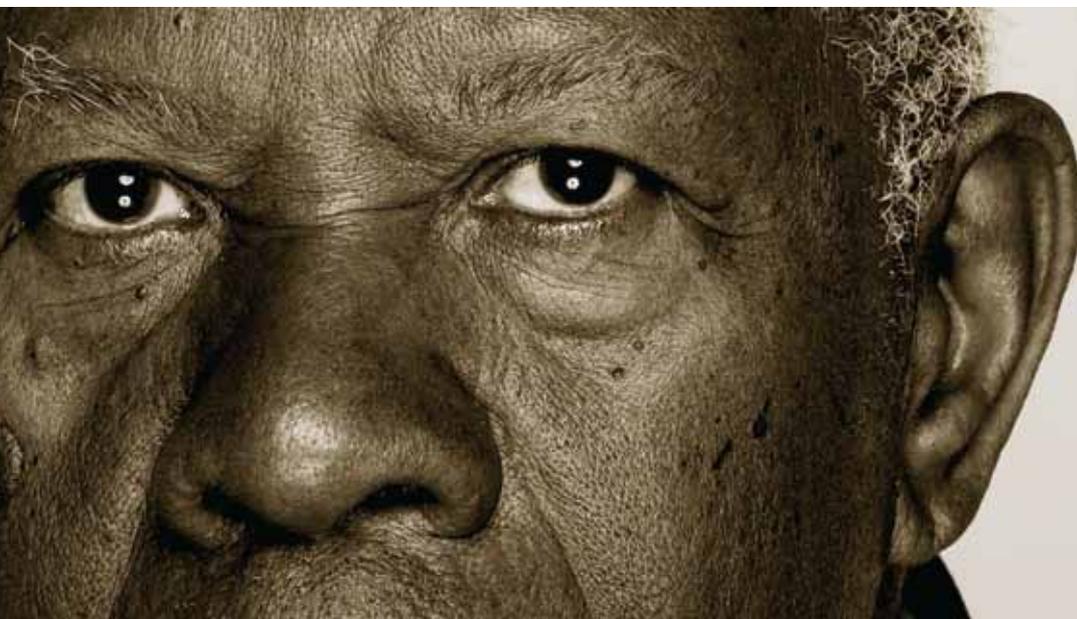
Individual Implications

The reablement philosophy is aligned to the new approach outlined in the WHO World Report on Ageing and Health that speaks to the interplay between the intrinsic capacities of an individual and the surrounding environmental conditions.

Reablement can engage individuals in a process of identifying their own strengths and capacity when their functional goals and targets are discussed during the planning stage of the intervention. They are encouraged to focus on what they can do (safely) and what they value instead of focusing on things that they cannot do anymore.

It is anticipated that a reablement approach could prevent or slow a diminishing functional trajectory, thus enabling older people to start new endeavours, complete unfinished business and plan for palliative / end of life care to the degree preferred.

ATs, and in particular those that are based on ICT, will create new ways of communication within the circle of care. However, older people who are not digitally literate — those who have not learned and have no access to ICT in general — may be further excluded from basic participation in society: The so-called digital divide. This needs to be borne in mind on a case-by-case basis when planning reablement services for individual older people.

The Global Picture

Current literature on reablement tends to draw on western / developed country health and social care systems. However, it is possible that other systems are delivering genuine reablement in practice without necessarily calling this 'reablement' or identifying specific services. In different cultures, notions of 'independence', goal-setting and being an active participant in service delivery may also be less familiar or more challenging, and there may be a stronger emphasis on inter-dependence.

There are also very different accountabilities and different assumptions regarding the respective roles of the individual, the family, the state, the market and civil society, different attitudes to professional expertise, and different service delivery models — all of which may impact on reablement.

Regarding the use of assistive technology around the globe, sharing internationally developed 'best practices' focused on the reablement model will be essential in order to gain benefits from ATs which are shown to assist functioning in activities of daily living with lower costs. Sustainability of the chosen solutions and the business cases that inform them, along with implementation challenges, should all be part of the dialogue.
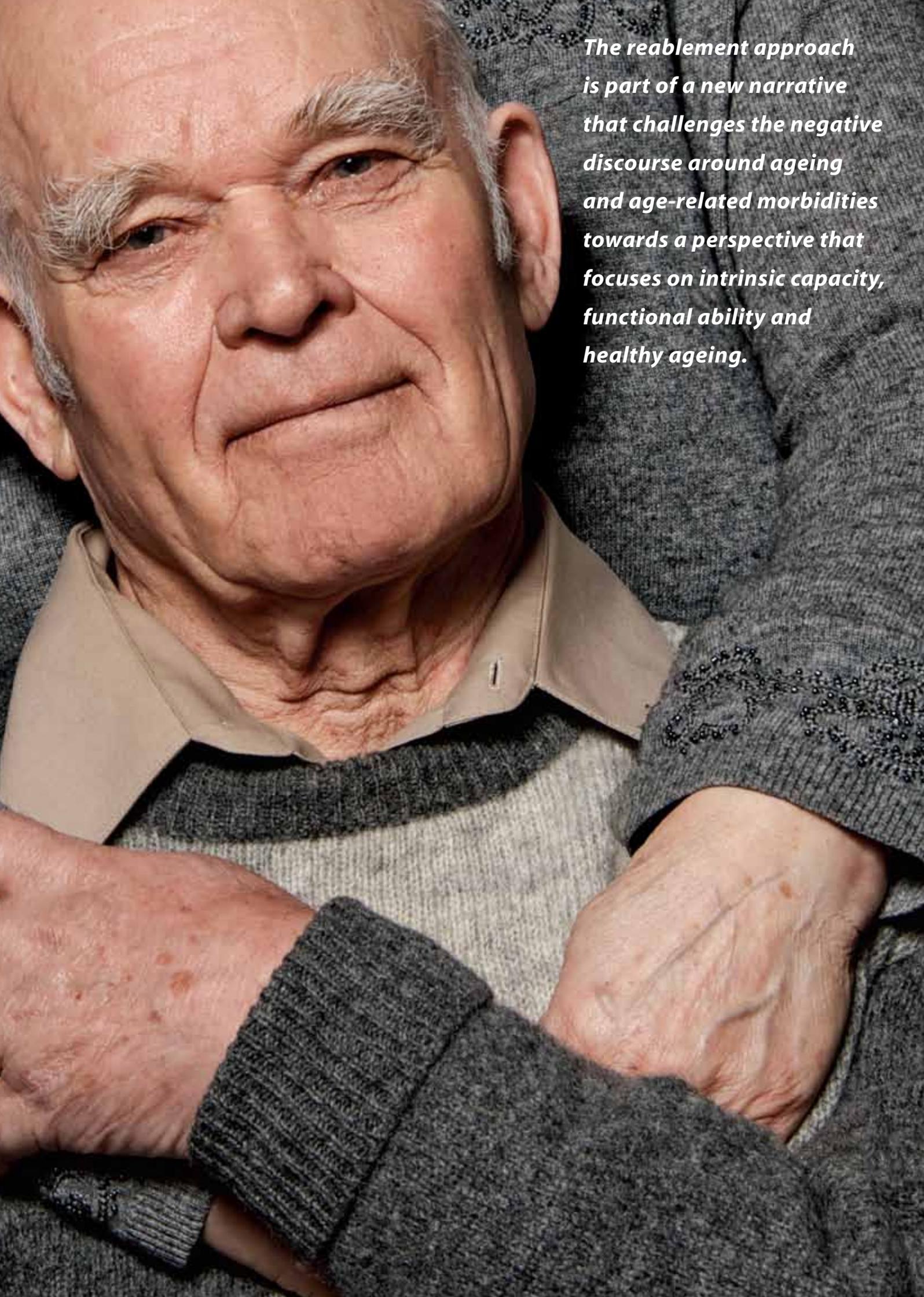
The reablement approach is part of a new narrative that challenges the negative discourse around ageing and age-related morbidities towards a perspective that focuses on intrinsic capacity, functional ability and healthy ageing.

Recommendations from the Experts

Recommendations are broadly framed within research and implementation of the reablement approach.

Reablement and Dementia Recommendations

Dedicated research is recommended into reablement for older people with dementia in the community, for the purposes of:

- establishing clear evidence for the effectiveness of the model;

- understanding how to best establish services to identify, monitor and deliver appropriate and timely reablement; and

- determining how to positively influence the knowledge, skills, attitudes and behaviors of people with dementia, caregivers, care staff and society generally regarding the potential gains of an enablement philosophy with its focus on 'living well with dementia'.

Implementation: A reorientation of service delivery and care of people with dementia and neurodegenerative diseases is imperative so that reablement is integrated into routine care, adequately resourced, and adapted to different cultural contexts and situations.

Responsibility for service delivery must extend beyond the health care system and have a community focus. A case management approach may be the best way to facilitate consistency of care management.

Attention to orientating and training staff in the reablement approach is vital so as to ensure requisite knowledge about how to assess and build on the remaining abilities of the older person with dementia, taking co-morbidities into consideration. Being able to understand and improve intrinsic capacity and functional ability are essential skills for all.

Reablement and Diabetes Recommendations

Research: Developing high-quality research into the clinical efficacy and cost-effectiveness of diabetes reablement interventions is mandatory, requiring both observational research methods and well-designed randomized controlled clinical trials. Priority research areas for intervention trials are:

- To examine the benefits of optimizing blood pressure and glycemic control using a range of outcome measures such as functional ability, quality of life, frailty, dementia, mood level, pre-disability and disability and hospital admission.

- To assess assistive technologies as treatment aids and decision support tools through a feasibility / pilot study.

- To assess the cost-effectiveness of reablement interventions.[li]

- To identify community health strategies that can prevent older people with impaired glucose tolerance from developing diabetes, since up to 80% of type 2 diabetes is preventable through strategies that reablement currently employs in the care of older people, such as changes in lifestyle, nutrition, exercise and activity and the individual's environment.[lii]

[NB. Some research gaps are being addressed by the MID-Frail Study, a European Union-funded randomised controlled clinical trial underway in seven countries comprising a multi-modal intervention assessing the functional outcomes of treatment, exercise and education programs in 1800 frail or pre-frail people with type 2 diabetes over the age of 70 years.[liii]]

Implementation:

- A model of reablement in diabetes care should be safe and culturally-sensitive, with wide application among different health care systems, and be adaptable to varying states of the disease and associated functional levels.

- The model should enable individualized care approaches, incorporate assistive technology, and allow the assessment of clinically meaningful outcomes such as changes in functional status and level of frailty, metabolic parameters such as HbA1c and blood pressure, and the cost-effectiveness of the reablement interventions.

- From the diabetes care teams there should be wider use of illness trajectories toward improved understanding of how reablement can be employed to alter the functional status of individuals with diabetes during both the acute and longer-term phases of the condition to enhance health outcomes and maintain autonomy. It is critical to increase public and health professional awareness of the importance of maintaining good functional status early in life to avoid frailty in later life.

- There is an important opportunity and responsibility to align the reablement approach with current clinical guidelines and policies of diabetes care (such as the IDF Global Guidance in Managing Diabetes in Older People [liv] or the EDWPOP and AGS guidelines [lv]) as this will enable the focus of care to remain patient-centered and maintain quality of life, well-being and patient safety as important indicators of clinical effectiveness.

- The alignment goes beyond an individual patient or system but rather points to an urgent need to highlight the importance of diabetes reablement approaches to all key stakeholders by representation to national and international diabetes societies and ageing organizations through a series of campaigns, media involvement, and health professional webinars.

- To recognize and address the reality of inequitable service provision, regionally and nationally — at the level of the individual older person with diabetes, and at the level of health care pathways or systems and transitions of care among services / systems — is both the challenge and the opportunity.

Reablement and Frailty Recommendations

Research: More high-quality research with large samples for all categories of outcomes is needed in order to reduce the knowledge gaps concerning the effects of reablement.

Implementation:

- Reablement interventions need to be individualized, person-centered and introduced to the older person in the context of their family and community. Interventions must be fully tailored to the capacity and needs of the individual.

- Staff training is crucial and based on an appreciation of changes needed to traditional practice if reablement is to be genuinely embedded.

- Support for family caregivers and volunteers to re-think traditional roles may be needed if they are to be full partners in the reablement process and contribute to its successful implementation.

- The reablement model, when built on the collective skills of the multidisciplinary team that enable professionals to deliver the kind of support they believe older people deserve, has a dual benefit. It can be cost-effective by way of providing stability in the workforce through greater job satisfaction and retention of staff; and it facilitates responsive, flexible, whole-of-person care for the older person.

Reablement and Assistive Technology (AT) Recommendations

Research, design and implementation:

- The process of designing, selecting and deploying new ATs must be a collaborative effort between a multidisciplinary team of experts, including clinicians and practitioners (personal support workers, nurses, physicians etc.), therapists, caregivers, technology designers and, most importantly, the older adult.

- The iterative process of research, development and design of ATs is critical to ensure that effective and proper solutions are developed, with a focus on genuine individual needs and goals and function in everyday life.

- The factors of usability and user satisfaction must be taken into account during the development, selection and implementation of any technological approach.[lvi] Design teams need to consider as a priority factors that motivate an older person to adopt a technology, integrate it into their lifestyle and sustain usage.

- All technologies used in reablement must be inter-operable — that is, they must be able to work together (communication and data sharing). It is also important that they can operate seamlessly with other types of 'everyday' technologies which older adults (and their caregivers) may already be using, such as cellular / smart phones and smart home systems.

- Receiving training in how to use an AT is of critical importance in reablement, particularly for older people with a condition such as dementia which may affect their ability to learn and retain new information. Health and social care professionals may also need to be trained in the use of some ATs.

- The growing number of older adults worldwide suggests a need for considering the international aspects of AT use in reablement, including research and practical assessment of how ATs may be used in under-resourced regions and countries; and how these populations can benefit from new approaches, and identifying potential difficulties in implementation and maintenance.

- It is essential to address the ethical dilemma inherent in the use of ICT in the care and management of the health of older people. With the advancement of technologies each citizen will automatically become part of various ICT ecosystems. Significant work is required to create awareness and to educate citizens on the benefits and potential risks of being part of such ecosystems, as their data is generated, collected, stored and shared.

- Ensuring adequate privacy and security measures, including refining authentication, authorization and consent as protection measures, necessitating dedicated research and the creation of consensus positions internationally. This is particularly important for older people with diverse cultural and educational backgrounds and experiences and those with a condition such as dementia.

Conclusion

Healthy ageing is defined by the World Health Organization (WHO) (2015) as the process of developing and maintaining functional ability to promote well-being in older age.[lvii] The reablement approach is part of a new narrative that challenges the negative discourse around ageing and age-related morbidities, offering instead a perspective that focuses on intrinsic capacity, functional ability and healthy ageing, and is thus closely aligned to the WHO approach.

Reablement can empower and improve the functionality of older adults and in the process reduce the need for more supportive health and social care measures. There are strong indications that a reablement approach can reduce health care costs over the longer-term.[lviii] Importantly, individuals engaged in the new model report improvements in health-related quality of life and well-being, and have reduced their own personal home care costs.[lix]

Although the evidence is still emerging, experts believe that not trying to support people to return to optimal autonomy would be counterproductive for the individual and their family as well as a poor use of finite resources. Despite the challenges identified, there is a cautious optimism about reablement as a necessary component of an effective health and social care model in many contexts and cultures.

Experts call upon governments and civil society alike to incorporate the reablement approach into policies and programs in order to help maintain and improve the functional ability of older people with chronic conditions and their risk factors early and thus avoid further adverse consequences for older people.

The reablement approach shows promise as a good practice for the continuum of functional independence to end of life care, in light of its individualized, respectful, consultative, holistic and person-centred ethos.

Appendix: IFA Global Think Tank Working Groups

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Endnotes

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IFA
INTERNATIONAL FEDERATION ON AGEING
Global Connections

The International Federation on Ageing (IFA) is an international not-for-profit membership organization founded in 1973. IFAs members are government, NGOs, industry, academia and individuals. The goal of IFA is to be the global point of connection and networks experts and expertise to influence and shape age-related policy.

The IFA has General Consultative Status at the United Nations and its agencies and formal working relations with the World Health Organization. Our membership extends to over 70 countries with a constituency representing over 60 million people.

Ældre Sagen
DaneAge

DaneAge Association (Ældre Sagen) is a national, not-for-profit membership organisation founded in 1986. DaneAge has 700,000 members and is open to all adults (age 18+). The mission of DaneAge is to fight for a society in which: all can live long and good lives, the person is more important than their age, it is possible to live and flourish on their own terms, and support and care is available for those who need it.

DaneAge is independent, non-partisan and neutral regarding party politics, religion, and ethnic origins. DaneAge has 217 local chapters across Denmark with 16,114 volunteers working in the local chapters, doing voluntary social work, providing local membership activities, local advocacy, etc. DaneAge's headquarters in Copenhagen has a staff of approximately 100 (FTE).