



**World Health Organization**

**World Health Survey: Study on Global Ageing (SAGE)**

26-27 August 2004

Venue: National Institute on Aging, Room GW525C, Bethesda, MD, USA

*Draft Agenda*

<p><b>26 Aug</b></p>	<p><b><u>Session 1:</u></b></p> <p><b>8:30-12:30</b></p> <p><b>Item 1: Opening remarks, Objectives of meeting and expected outcomes</b>  <b>Chair: Maxine Weinstein</b></p> <ul style="list-style-type: none"> <li>• Introductory remarks NIA</li> <li>• Introductory remarks WHO</li> <li>• Background of WHS and current status</li> <li>• Background of SAGE – aims and objectives, challenges and opportunities</li> <li>• Links between survey and demographic surveillance data (e.g., INDEPTH sites)- Jane Menken</li> <li>• Linkages to and Lessons from HRS – David Weir</li> </ul> <p><b>Item 2: Preliminary results from the WHS</b>  <b>Chair: Jane Menken</b></p> <ul style="list-style-type: none"> <li>• Quality assessment of the WHS – strengths and weaknesses</li> <li>• Substantive results from the WHS with a focus on the 50+</li> </ul>	<p><b><u>Session 2:</u></b></p> <p><b>13:30-17:00</b></p> <p><b>Item 3: Design issues for the SAGE</b>  <b>Chair: Eileen Crimmins</b></p> <ul style="list-style-type: none"> <li>• Sampling</li> <li>• Sociodemographic measurement challenges</li> <li>• Issues in Longitudinal follow up studies – Barry Popkin and Jane Menken</li> <li>• Biomarkers and performance tests <ul style="list-style-type: none"> <li>○ Biomarkers – Teresa Seeman</li> <li>○ Performance tests – Doug Ewbank</li> </ul> </li> <li>• Impact of HIV/AIDS – Jane Menken</li> </ul>
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27 Aug	<p><b><u>Session 3:</u></b></p> <p><b>9:00-12:30</b></p> <p><b>Item 4: Proposed draft of SAGE questionnaire and section by section review</b>  <b>Chair: Doug Ewbank</b></p> <ul style="list-style-type: none"> <li>• Overview of questionnaire modules</li> <li>• Individual questionnaire <ul style="list-style-type: none"> <li>○ Vignettes – Arie Kapteyn</li> <li>○ Valuation – Josh Salomon</li> <li>○ Subjective well being – Daniel Kahneman</li> <li>○ Life events</li> <li>○ Social capital</li> <li>○ Economic Activity – Jim Smith</li> <li>○ Coverage and Responsiveness</li> <li>○ Time Use</li> <li>○ Other topics</li> </ul> </li> </ul>	<p><b><u>Session 4:</u></b></p> <p><b>13:30-17:00</b></p> <p><b>Item 4 (continued): Proposed draft of SAGE questionnaire and section by section review Chair: WHO</b></p> <ul style="list-style-type: none"> <li>• Household questionnaire <ul style="list-style-type: none"> <li>○ Household roster</li> <li>○ Expenditure, Consumption</li> <li>○ Permanent Income measure</li> </ul> </li> </ul> <p><b>Item 5: Next steps</b></p> <ul style="list-style-type: none"> <li>• Pilot of SAGE questionnaire</li> <li>• Selection of countries for follow up</li> <li>• Implementation of first follow up</li> <li>• Linkages with INDEPTH, SHARE</li> <li>• Possible linkages with other surveys, e.g., Indonesia, GCC countries</li> <li>• Other methodological studies</li> </ul> <p><b>Item 6: Conclusion</b></p> <ul style="list-style-type: none"> <li>• Review of timetable</li> <li>• Publication plan</li> <li>• Next AG meeting – venue, dates</li> <li>• Continuation application</li> </ul>
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There will be 2 coffee breaks, 10:30-11:00 and 15:00-15:30, and a lunch break, 12:30-13:30, each day. A dinner will be hosted by WHO at LaMiche restaurant on Thursday night starting at 19.00.

## **WHO STUDY ON GLOBAL AGEING AND ADULT HEALTH**

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**World Health Organization**



## **The WHO Study on Global Ageing and Adult Health**

August 2004

### **Background**

The changes in demographic dynamics causing an ageing world will perhaps become the most important dynamic affecting families and societies throughout the world. The processes and implications of population ageing have been well documented in developed countries, but not as well in most developing countries, particularly in Africa. While the average median age of populations are increasing in all regions of the world, the resulting impact is of particular concern for developing countries where social and health systems safety nets are not as well developed or exclude older persons (UN Pop Div, 2002 Revision).

This demographic shift precedes the emerging health transition, and where resources for addressing demographic and health problems in developing countries have been focused on issues of more immediate concern for a majority of people who are not yet old. However, as the proportion and number of older persons grows, the composition of burden of disease shifts. The very tip of the health transition has been exposed – information from our best estimates based on available data indicate a double or triple burden of disease (WHO 2000). Continued high morbidity and mortality rates from communicable diseases, high and increasing rates of non-communicable diseases, increasing rates of group III conditions plus the impact of poverty and HIV/AIDS. Access to fewer resources and life-long hardships, combined with marginalization in older age, leaves a traditionally vulnerable population at greater risk of poor health and lower levels of well-being.

Yet the empirical understanding of the health state of older persons – morbidity and mortality – and a equitable system to address needs, remains limited. A global effort to improve the information available about health status and systems for persons aged 18 and older was initiated by WHO through the World Health Survey (WHS). This will result in an empirical base to improve our understanding of how to combat the contributors to poor health (diseases, poverty and inequities), as it affects the processes and results of ageing because it includes persons in older age groups. A strategy which promotes working with countries in three main areas has been initiated: 1) accessing and utilizing available country data (see WHO MDS Project outputs, including indicators); 2) conducting primary data collection and methodologies (WHO Study on Global Ageing (SAGE)); and, 3) contributing to improvements in the health care and information systems (see Health Metrics Network). In the context of WHO's overall health and development strategy, a country-focused approach for data collection has been initiated through the WHS.

**Creating a platform and cohort for follow-up: World Health Survey respondents**

As a means to address the lack of information on older persons, the WHS was used as the platform for both methodological development and data collection. All 71 participating WHS countries collected data on the health and well-being of older adults (see Table 1).



Table 1. World Health Survey agreed and final sample size by country

Country	Sample Size	Test cases received	Country	Sample Size	Test cases received
Australia	1750	1754	Luxembourg	720	700
Austria	1000	1055	Malawi	5000	5304
Bangladesh	5903	5552	Malaysia	5000	6040
Belgium	1000	1012	Mali	5000	4285
Bosnia and Herzegovina	2000	1028	Mauritania	4000	3857
Brazil	5000	5000	Mauritius	5000	3888
Burkina Faso	5000	4825	Mexico	40000	38746
Chad	5000	4662	Morocco	6000	5000
China	4000	3993	Myanmar	5000	3588
Comoros	5000	1759	Namibia	5000	4250
Congo	5000	2497	Nepal	8700	8688
Côte d'Ivoire	5000	3184	Netherlands	1000	1091
Croatia	1100	990	Norway	1000	984
Czech Republic	1000	935	Pakistan	10000	4463
Denmark	1000	1003	Paraguay	5000	5143
Dominican Republic	4500	4534	Philippines	10000	10078
Ecuador	5000	4660	Portugal	1000	1030
Estonia	1000	1012	Russian Federation	5000	4422
Ethiopia	5000	4938	Senegal	5000	3226
Finland	1000	1013	Slovakia	2000	2519
France	1000	1008	Slovenia	1250	655
Georgia	5000	3000	Spain	8000	6364
Germany	1000	1259	South Africa	2500	2352
Ghana	5000	4009	Sri Lanka	5500	6732
Greece	1000	1000	Swaziland	5000	3121
Guatemala	5500	4770	Sweden	1000	1000
Hungary	1500	1419	Tunisia	4160	5069
India	10000	9762	Turkey	6000	11220
Ireland	1000	1014	Ukraine	3000	2853
Israel	1000	924	United Arab Emirates	1750	1180
Italy	1000	1000	United Kingdom	1000	1200
Kazakhstan	4500	4496	Uruguay	3000	2988
Kenya	5000	4417	Viet Nam	5000	4174
Lao People's Democratic Republic	4464	4893	Zambia	5000	3901
Latvia	1000	856	Zimbabwe	5000	4100

## WHO Study on Global Ageing (SAGE)

The WHO Study on Global AGEing (SAGE) is developing a strategy and instrument to collect household data on persons aged 50 years and older in eight countries. Data collected will include self-reported assessments of health linked to anchoring vignettes for improved comparability across individuals, communities and populations; measured performance tests on a range of different domains of health; biomarkers; and introduction of a longitudinal study design to allow for dynamic examination of changes in health expectations and experiences over the life course and investigation of compression of morbidity in aging populations.

## Primary objectives:

1. To obtain reliable, valid and comparable data on levels of health for older (50+) adult populations;
2. To examine patterns and dynamics of age-related changes in health using longitudinal follow-up of survey respondents; and
3. To improve comparability of self-reported measures through measured performance tests and vignettes, (and conduct biomarker tests for selected health domains in sub-groups).

## Additional objectives:

- To generate large enough cohorts of older (50+) adult populations and comparison cohorts of younger populations;
- To follow-up of survey respondents over a period of 5-10 years to address issues of intermediate outcomes, monitor trends, examine transitions and life events, address relationships between determinants and health and health-related outcomes;
- To develop a methodology for health examination surveys and link survey data to data from sentinel sites;
- Build linkages with other national and cross-national ageing studies such as SHARE and ELSA; and,
- Provide the evidence to engage all stakeholders, including national policy makers, in addressing issues of health of the older persons.

Preliminary descriptive results from the main WHS are listed in Table 2 below.

Table 2. Respondent characteristics from the main WHS\* by demographic characteristics and country\*\*

Country	Households & respondents			General characteristics respondents 50+						
	N	N 50+	% of HH with 1+ person aged 50+	% M	% urb	% married	% widowed	% no educ	% higher educ	% not working
China	3993	1397	58	49	47	79	18	22	17	64
Ghana	4009	1127	46	44	28	54	26	53	3	22
India	9762	2492	59	50	25	71	24	55	12	54
Mexico	38746	11009	44	43	75	62	24	0.3	10	63
Morocco	5000	1335	52	45	49	66	28	82	4	71
Russian Fed.	4422	2300	68	31	82	44	41	1	52	71
South Africa	2352	437	41	43	--	54	20	26	17	67
Zimbabwe	4100	890	41	38	15	58	34	29	2	78

\* not including oversample; \*\* countries participating in SAGE

Step 1: Based on the initial sample sizes for the WHS, we had projected that six of these eight countries might have low numbers of older adults, so as a first step in SAGE, we supported an oversample of respondents aged 50+ years in five countries. In the sixth, China, we continue to negotiate the inclusion of SAGE or modules of the questionnaire into their National Health Survey. Additional respondents were added to the five countries that had not yet completed data collection as part of the main WHS implementation to obtain a total sample size of respondents aged 50+ of at least 2000 (except South Africa where we negotiated for a sample size of 1500, see Table 3). The final choice of countries for the SAGE follow up will be made based on the initial analysis of the baseline data and available resources in discussion with the Advisory Group meeting.

Table 3. Preliminary oversample and main WHS results, respondents 50+ by country

Country	OVERSAMPLE			MAIN	Overall
	Men	Women	Total, 50+	Total, 50+	Total, 50+
China*	-	-	-	1397	1397
Ghana	469	430	899	1127	2026
India	-	-	-	2492	2492

<b>Mexico**</b>	-	-	-	11009	11009
<b>Morocco</b>	366	388	754	1335	2089
<b>Russian Federation</b>	186	278	464	2300	2764
<b>South Africa</b>	495	715	1210	437	1647
<b>Zimbabwe</b>	685	1262	1947	890	2837
<b>Totals</b>	2201	3073	5274	20987	26,261

\* We are currently negotiating with colleagues in China to link SAGE to their National Health Survey.

\*\*We will select a sample of respondents from Mexico for longitudinal follow-up.

These data will form the baseline cohort for follow-up and the results will be used to inform further data collection and methodological advances. We are planning on following-up a sub-set of respondents younger than 50 years of age using a 1:2 or 1:3 ratio.

Step 2: Data collection for the main WHS and oversample has been completed. Data has been cleaned for a majority of the countries, while the process continues for the remaining countries.

A full analysis of all data from the WHS is ongoing to assist with the further development of SAGE. A psychometric analysis has been conducted to assess the overall performance of the questionnaire; further analyses will demonstrate any differences between younger and older respondents. These preliminary results will be presented at the second meeting of the SAGE Advisory Group in August 2004. A full analysis of data from all 71 countries will provide a baseline for comparisons. Separate analyses of the eight countries and individual countries are ongoing. Some preliminary descriptive results are presented in Tables 4 and 5.

Table 4. Self-rated health based on response to the question: "In general, how would you rate your health today?", by sex, age group and country

Age groups	Female								Male							
	18-34		35-49		50-59		60+		18-34		35-49		50-59		60+	
SR health responses*	Mean	%bad	Mean	%bad	Mean	%bad	Mean	%bad	Mean	%bad	Mean	%bad	Mean	%bad	Mean	%bad
<b>China</b>	1.2	1	1.3	1	1.5	3	1.9	9	1.1	0	1.2	1	1.4	2	1.7	4
<b>Ghana</b>	1.4	4	1.6	6	1.8	9	2.2	17	1.3	2	1.4	3	1.6	8	2.0	14
<b>India</b>	1.6	8	1.9	13	2.1	17	2.6	31	1.4	5	1.6	8	1.8	13	2.2	20
<b>Mexico</b>	1.3	2	1.4	4	1.6	7	1.9	11	1.2	1	1.3	2	1.4	4	1.7	9
<b>Morocco</b>	1.8	12	2.0	18	2.4	26	2.8	37	1.5	6	1.6	9	1.9	16	2.3	25
<b>Russia</b>	1.4	3	1.6	5	1.8	7	2.5	22	1.3	2	1.5	3	1.6	5	2.3	16
<b>South Africa</b>	1.5	6	1.8	8	2.1	15	2.2	19	1.5	4	1.5	6	1.7	8	2.1	15
<b>Zimbabwe</b>	1.4	5	1.7	9	1.9	12	2.1	18	1.3	3	1.5	6	1.7	9	2.1	17

\* mean is average of scores: 1=very good, 2=good, 3=moderate, 4=bad, 5=very bad; "% bad" are those respondents rating 4 or 5.

Table 5. Percentage of respondents who report diagnosis, treatment prescribed and treatment received for select chronic conditions, by country.

	*N 50+	Arthritis			Angina			Diabetes		
		%Diag	%Treated	%Received Med/Trmt	%Diag	%Treated	%Received Med/Trmt	%Diag	%Treated	%Received Med/Trmt
<b>China</b>	1397	24.6	18.8	10.6	4.9	4.4	5.2	3.6	3.5	2.7
<b>Ghana</b>	1127	15	14.1	8.6	8	6.7	3.1	2.1	2.1	1.6
<b>India</b>	2492	37.2	25	11.2	14.5	11	7	6.2	5.3	3.3
<b>Mexico</b>	11009	11.3	8.4	5.2	5.4	4.6	3.5	8.2	7.6	5.1
<b>Morocco</b>	1335	34.4	34.5	9.4	10.1	9.4	3.7	9.1	7.3	6.9
<b>Russia</b>	2300	32.1	29.7	18.7	38.1	37.5	36.4	4.8	4.4	3.4
<b>SouthAfrica</b>	437	10.1	27	19.9	2.5	14	11.9	8.7	20.6	18.5
<b>Zimbabwe</b>	891	13	9	3.9	9.9	7.3	2.9	1.9	1.7	0.8

\* only continuous age used in the calculations -this table includes only respondents from main WHS.

Step 3: We are shifting our mindset from primarily testing of new theoretical and methodological constructs of health, to one of more practical application of best practices and new, novel innovations tested in other settings over the next five to 10 years. In addition to these results and analysis of the performance of the WHS questionnaire, a critical review of 16 different studies on ageing was conducted as a means to identify commonalities and best practices for inclusion in SAGE.

The primary investigators and a group of SAGE advisors met in December 2003 to sketch out some broad suggestions for the scope and content of SAGE (report available). The assessment tools and modules for SAGE are being developed for review at a second advisory group meeting (August 2004) and a country collaborators meeting (September/October 2004). The choice and composition of countries will be finalized after the advisory group meeting. As a result of the first advisory group meeting and review of ageing studies, a draft set of modules was developed as outlined below.

#### Draft questionnaire modules

##### A) Household

- Roster and demographic characteristics (plus better determination of true age)
- Household income, expenditures and assets
- Migration and housing
- Household and intergenerational transfers

##### B) Individual

- Work history and time use
- Health state descriptions and vignettes
- Risk factors
- Chronic conditions
- Health care coverage and responsiveness
- Social integration, social capital and well-being
- Biomarkers (sub-set of respondents)
- Measured performance tests (sub-set of respondents)

#### Other key issues to be considered for inclusion in SAGE:

- economic activity and pensions, life events, impact of HIV/AIDS, mortality measurement and cause of death determination;
- address local concerns / methodological issues through focused studies, e.g. caregiving burden in sub-Saharan Africa; problems in age-reporting in developing countries; households and migration; and,
- cross-national - follow-up strategies and methods; larger samples in current countries; consider fewer countries; time period between data collection waves; linkages with national and local data collection efforts (e.g. INDEPTH); logistics for longitudinal follow-up; vignette methodologies and validation.

Step 4: A draft questionnaire will be finalized after the August 2004 meeting. A round of pretesting and piloting of a draft questionnaire will be conducted at the end of 2004 in two or three countries. A smaller study of vignette validation (testing the performance of the health state description questions, vignettes and

measured cognitive performance tests in an older adult population) is currently ongoing in one country and results will be ready for review by the end of October 2004.

Step 5: Implementation of the first round of follow-up is planned for early 2005.

Linkages:

Simultaneously, we are currently developing an abbreviated aging and older adult health module to be used in other data collection efforts (such as demographic surveillance field sites (e.g. INDEPTH) and SHARE. SHARE has added the health state descriptions module and vignettes to their data collection instrument and has piloted that tool.

Ten INDEPTH field sites have expressed interest in linking to SAGE. Our goals are to develop common measurement strategies where possible and develop methods to link surveillance to survey data. New modelling and sampling techniques will be developed as a result of the collaboration. We hope to borrow the strengths from INDEPTH field site surveillance experiences to inform and improve our survey exercises.

The SAGE study offers a unique opportunity for further methodological development work as listed below:

- 1) small area analyses – Given that sample sizes will be limited by costs, in order to develop robust estimates for parameters of interest, we will borrow from techniques developed for small area analysis for sub-population estimates by sociodemographic characteristics and geographic distribution (including sub-national estimates).
- 2) mortality rate estimation techniques and causes of death in this population need to be improved especially in the developing world. Given that sample sizes in surveys will be insufficient to provide robust estimates, linkages with other vital registration methods or sample registration surveys will be sought.
- 3) attrition in cohort studies with longitudinal follow-up will always be a concern. We will ensure that SAGE survey design and analytic techniques are informed by the current state of the art and offer an opportunity to develop new methods.
- 4) distribution of health and health related outcomes in this population, especially across sociodemographic gradients in developing countries, offers an opportunity to assess equity issues with novel techniques.
- 5) improvements in the measurement of self-related health states and morbidity will be made using measured performance tests and biomarker data. Techniques to adjust for biases in self-report will be developed.

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## **World Health Survey Study on Global Aging**

**Technical Consultation, 14-15 October 2003, Cambridge, MA, USA**

### **Meeting Report**

#### **Introduction**

The first technical consultation for the World Health Survey Study on Global Aging (SGA), sponsored by the National Institute on Aging and hosted by the Harvard Center for Population and Development Studies, was held on 14-15 October 2003 in Cambridge, Massachusetts. The meeting brought together a group of experts in the study of aging, including core investigators from major survey programmes focusing on older adults, retirement and aging. The overall objective of the meeting was to seek expert advice on the content of the survey instrument to be used in the SGA, and the design and implementation of the longitudinal follow-up component and validation study on methods to improve comparability of survey measurement.

#### **Background**

The World Health Survey (WHS) Programme was launched by the World Health Organization to develop a range of valid, reliable and comparable survey modules that could be used by national health information systems to fill critical information gaps. The Minimum Data Set (MDS) Project on Aging and Older Adults in sub-Saharan Africa was initiated by WHO for the purpose of establishing a valid and reliable source of health information on the sub-population aged 50+ years and to fill critical data gaps. The Study on Global Aging is intended to extend the current WHS Programme and the MDS Project to provide an enhanced focus on aging populations, through collection of high quality household data on persons aged 50 years and older, including self-reported assessments of health linked to anchoring vignettes for improved comparability across individuals, communities and populations; the addition of key survey items with demonstrated validity and reliability from a review of multiple surveys and consultation with experts; measured performance tests on a range of different domains of health; enhancing the depth of data available from the WHS by linking to ongoing demographic surveillance fieldsites where feasible through an aging module; and introduction of a longitudinal study design to allow for dynamic examination of changes in health expectations and experiences over the life course and investigation of compression of morbidity in aging populations.

The specific aims of the project are:

- To obtain reliable, valid and comparable data on levels of health on a range of key domains for older adult populations;
- To examine patterns and dynamics of age-related changes in health using longitudinal follow-up of survey respondents, and to investigate socio-economic consequences of these health changes;

- To supplement and cross-validate self-reported measures of health and the anchoring vignette approach to improving comparability of self-reported measures, through measured performance tests for selected health domains.

The SGA project will involve two additional rounds of data collection in eight countries where the WHS baseline surveys were completed in 2003: China, Ghana, India, Mexico, Morocco, Russian Federation, South Africa and Zimbabwe. These follow-up surveys among samples of at least 2000 older adults in each site will use a specialized aging module that includes selected components of the standard WHS instrument, supplemented with additional items chosen for specific focus on older adults and aging.

### **Meeting Objectives and Agenda**

The meeting opened on 14 October with welcoming remarks and introductory comments from Colin Mathers, from the World Health Organization. Richard Suzman, from the National Institute on Aging, emphasized the strong commitment of NIA to promoting collaborative work on aging research through linkages between major projects, and the importance of developing the content and design of the WHS SGA to allow continuity and comparison to other survey programmes supported by NIA. Somnath Chatterji presented a summary of the World Health Survey modules and preliminary results on the oversample of the over-50 population in the eight countries participating in the SGA.

The second session focused on questions relating to the design and content of an aging module, with presentations from investigators leading other major aging studies.

Axel Börsch-Supan described the Survey of Health, Ageing and Retirement in Europe (SHARE), including details on the development of the survey instrument, challenges of coordinating comparable measurements in multiple sites, and technical innovations in SHARE such as the development of a specialized computer programming platform for creating multiple country and language versions of a common instrument.

Abhijit Banerjee presented an overview of the Integrated Family Survey in Udaipur district of Rajasthan in northwestern India, which includes both interviews among members of 1000 households in 100 villages and a survey of health facilities serving those villages. The study is designed to measure health status and its determinants, characterize health-seeking behavior and examine the quality of health care delivery in this district.

Michael Hurd described key features of the Health and Retirement Study that might be considered for inclusion in the WHS SGA, including the use of an exit interview in which a surviving household member provides proxy responses for a respondent who has died since the last interview round, and the elicitation of subjective survival probabilities, which have been examined as potential predictors of mortality.

The following session focused on the use of anchoring vignettes, which included an introduction to the vignette approach by Josh Salomon, followed by a description of the vignette study on health-related work limitations in the Dutch CentERpanel

survey, presented by Arie Kapteyn. Findings from the study pointed to systematic differences in vignette ratings by age, sex and health conditions, and provide a starting point for planned further investigations of framing effects in vignette responses and comparisons with a similar U.S. sample.

In general discussion, the existing WHS questionnaire was considered critically to identify components that might be excluded from the aging module for follow-up interviews as well as important areas where additional items relating to adult health and aging that should be added to the core WHS instrument for the SGA. Detailed points raised during this discussion are presented in the next section.

Discussion on 15 October focused on the range of measured performance tests for specific health domains that might be used in the cross-validation study of self-reported health assessments and anchoring vignettes; and implementation issues for the SGA, specifically (1) the need for continuing expert advisory input as the study proceeds; (2) timeline for instrument development, translation, cognitive interviewing and pilot testing in the study sites; and (3) the formal mechanisms for ensuring that the data collected in this study will be made available expeditiously to the broader research community.

### **Key Discussion Points**

Discussion of additions to and deletions from the core WHS module for the aging module to be applied in this study related to a number of different areas:

#### 1. Measurement of relevant socio-economic variables

There was extensive discussion on the measurement of consumption, expenditures and permanent income, the relative advantages of including survey items on each, and the relationships between the different measures. Questions were raised regarding the validity of overall consumption question vs. more detailed questions on specific items or categories. The difficulty of assigning dollar values to goods in non-monetized settings was mentioned.

Several proposals were made for the addition of items on various sources of income and assets, including pensions, transfers, availability of credit, sale of assets, remittances from family members abroad.

Other socio-economic variables that were proposed as possible additions included food scarcity, child-care and social status.

#### 2. Possible exclusions from the existing WHS instrument

Proposals for items in the standard WHS instrument to be excluded from the aging module included:

- Health system goals
- Health state valuations
- Responsiveness (part)



- Child mortality
- Selected risk factors (e.g. child health)
- Health occupations

It was also considered whether vignettes should be included in the follow-up surveys. Arguments in favor of including vignettes point to the possibility of examining changing expectations and norms for health over time, but the time cost of including vignettes demands consideration of more parsimonious alternatives, e.g. including vignettes on only a subset of respondents, or for selected domains only.

### 3. Measured performance tests for the vignette validation study

A range of different issues regarding the inclusion of measured performance tests were discussed. A distinction was made between measured tests that might be used as correlates of mortality risks (grip strength was discussed as an example) vs. those that could be used in the cross-validation study to calibrate self-reported items on specific health domains and provide a means of evaluating the performance of the anchoring vignette approach to improving comparability of self-assessments.

There were four domains (of 8 in the WHS) for which calibration tests were proposed, including vision, mobility, cognition and self-care. Of these, self-care is one that was not mentioned in the original project proposal but might be amenable to measured performance tests, for example, of fine motor function. Two other points were made in this discussion: (1) that NIA has supported the development of a Short Physical Performance Battery for which an instructional CD-ROM is available; and (2) that there will be a meeting in December that brings together survey researchers who currently include performance measures or plan to include them in future surveys.

### 4. Proposed innovations

There were two major areas in which novel research avenues were proposed:

- (a) Understanding variation in activities of daily living among older adults in diverse settings

One proposal for innovative new research was to develop methods for generating time-use logs across sites in order to better characterize relevant activities by older adults, toward the end of obtaining better measurements of the impact of health conditions on limitations in functioning.

A related discussion concerned addition of measures of how difficult daily life is (proximity to water, etc.) which can be used to assess the overall impact of a given functional limitation.

- (b) measurement of life satisfaction and well-being

Inspired in part by challenges in understanding and interpreting cross-country differences in self-reported satisfaction, there are ongoing research activities supported by NIA to investigate methods for unpacking self-assessments of

well-being and life satisfaction, to measure positive affect in addition to more traditional measures on depression, worry and anxiety, and to explore biomarkers of affective states that can be used to better understand the relationship between affective experiences and reported satisfaction.

### **Recommendations and next steps**

1. A scientific advisory committee should be established and consulted in the development of the survey instrument, design of the longitudinal follow-up study and in the phases of study implementation.
2. The importance of data sharing was reiterated, and it was noted that this requirement has been mandated by the governing body of WHO for the World Health Survey in general and also written explicitly in the contracts for data collection for the SGA.
3. In order to proceed with development of the aging module for the SGA, certain preliminary analyses of the baseline WHS data will be useful, particularly relating to questions on appropriate measures of socio-economic status.
4. Existing instruments should be reviewed in order to select additional items for inclusion in the aging module. Surveys that should be considered include the Health and Retirement Study, Wisconsin Longitudinal Study, English Longitudinal Study on Ageing, Integrated Family Surveys in South Africa and Udaipur, Mexican Health and Aging Study, Indonesian Family Life Survey, Survey of Health, Ageing and Retirement in Europe, and others as recommended by the scientific advisory committee.
5. A proposed timeline for next steps in the study is the following:
  - Development of draft aging module to be circulated for comments (December)
  - Incorporation of comments in revision of instrument (January-February)
  - Translation and cognitive interviews for new items (February-March)
  - Completed draft aging module (March)
  - Pilot testing of aging module, including test-retest (April-May)
  - Finalization of instrument (May-June)

### **Addendum**

Discussions following the meeting pointed to two promising avenues for collaborative efforts relating to the WHS aging study.

The first is ongoing work led by Daniel Kahneman and colleagues to develop meaningful measures of life satisfaction and well-being that allow comparisons across countries and over time. A brief battery of questions for measurement of well-being will be proposed for addition to SHARE and for consideration in the WHS aging module.

17 Oct. 05

The second is the recent initiative on adult health and aging launched by the INDEPTH network as an extension of its work on mortality and causes of death. The possibilities for building substantive links to the content of the WHS aging study will be considered by the INDEPTH site leaders as the adult health modules to be included in the health and demographic surveillance systems of INDEPTH take shape.

**World Health Survey Study on Global Aging  
Technical Consultation, 14-15 October 2003  
Cambridge, MA, USA**

**Agenda**

Tuesday, October 14, 2003

08.45-09.00 Breakfast

09.00-10.30 **Welcome and Introduction**

Overview of World Health Survey – Somnath Chatterji

Purpose and objectives of the WHS Study on Global Aging,  
aims of technical consultation – Colin Mathers

10.30-11.00 Coffee Break

11.00-12.30 **Design of an aging module**

*-Key components for longitudinal study*

*-Content of major aging survey studies*

*-Experiences in designing multi-country aging studies*

SHARE – Axel Börsch-Supan

Integrated Family Survey – Abhijit Banerjee

HRS – Michael Hurd

12.30-13.30 Lunch, Harvard Faculty Club

13.30-15.30 **Vignettes and vignette validation study**

Vignettes overview – Josh Salomon

Findings from the Dutch CentERpanel – Arie Kapteyn

15.30-16.00 Break

16.00-18.00 **Group discussion on aging module content**

19.30 Dinner, *Grafton Street*

**World Health Survey Study on Global Aging  
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**Agenda**

Wednesday, October 15, 2003

- |             |  |
|-------------|--|
| 08.30-09.00 | Breakfast  |
| 09.00-10.00 | <b>Discussion: measured performance tests for cross-validation study</b> |
| 10.00-11.30 | <b>Discussion: study design, implementation, data dissemination</b>      |
| 11.30-12.30 | <b>General discussion, recommendations and next steps</b>                |

**World Health Survey Study on Global Aging  
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