Bangkok Recommendations

Community-Led Approaches and Innovations for Better Care Systems, and Community Resilience toward an Inclusive Silver Economy

2026 | Bangkok, Thailand

"The Bangkok Recommendations envision ageing societies in which people of all generations are supported by integrated, inclusive, rights-based, and sustainable systems that promote dignity, autonomy, participation, resilience, and wellbeing across the life course. They affirm that communities are not only beneficiaries of policy, but also active partners in translating national and regional commitments into locally responsive action. They promote community-led and people-centred approaches to prevention, long-term care, caregiver support, workforce development, sustainable financing, ethical innovation, climate resilience, and evidence-informed implementation. They also advance an inclusive silver economy that expands opportunities without deepening inequality, recognising older persons as rights-holders, contributors, workers, caregivers, community members, and co-producers of solutions, while strengthening intergenerational solidarity and shared responsibility across society."

Executive Summary

The Bangkok Recommendations on *Community-Led Approaches and Innovations for Better Care Systems, and Community Resilience toward an Inclusive Silver Economy* emerged from the International Conference and Workshop held from 6–8 May 2026 in Bangkok, Thailand. The conference served as a multi-stakeholder platform for policy dialogue, technical exchange, and collaborative learning on how ageing societies can strengthen care systems, support community resilience, and promote an inclusive silver economy. The Recommendations reflect the collective insights of policymakers, practitioners, researchers, civil society actors, development partners, community representatives, private-sector stakeholders, and international and regional organisations.

The Bangkok Recommendations are grounded in the recognition that population ageing is not only a demographic trend, but a structural transformation affecting health systems, social protection, labour markets, families, communities, financing arrangements, infrastructure, technology, and governance. Across the Asia-Pacific region and beyond, ageing is unfolding alongside digital transformation, artificial intelligence, urbanisation, migration, climate risk, labour informality, care deficits, workforce shortages, fiscal constraints, and widening inequalities. These intersecting transitions require ageing policy to move beyond fragmented and sector-specific responses toward integrated systems that connect care, resilience, financing, workforce development, innovation, governance, and evidence.

The overarching vision of the Bangkok Recommendations is to support ageing societies in which people of all generations—older persons, caregivers, families, children, youth, working-age adults, and communities—are supported through integrated, inclusive, rights-based, adequately financed, and sustainable systems. These systems should promote dignity, autonomy, participation, resilience, and wellbeing across the life course. The Recommendations affirm healthy ageing as a life-course process grounded in human rights, equity, gender equality, intergenerational solidarity, and the principle of leaving no one behind. Particular attention is given to older persons experiencing poverty, disability, social isolation, displacement, frailty, cognitive decline, or other forms of vulnerability.

The Recommendations also advance an inclusive silver economy that expands opportunities without deepening inequality. This approach recognises older persons not only as care recipients, but also as contributors, workers, caregivers, mentors, volunteers, entrepreneurs, community leaders, rights-holders, and co-creators of solutions. Innovation is understood broadly, not only as digital technology or market growth, but also as social innovation, service redesign, community-led care models, financing mechanisms, workforce models, assistive technologies, age-friendly environments, and institutional reforms that generate public value. The silver economy should therefore be inclusive, ethical, affordable, accessible, human-centred, and oriented toward dignity, equity, and public value.

The Bangkok Recommendations identify several future risks that ageing societies must address proactively. Rising care needs may widen care gaps if community-based systems are not strengthened. Workforce shortages and care labour vulnerabilities may undermine the sustainability of ageing and long-term care systems. Fiscal and financing pressures may constrain equitable access to care and increase household financial burdens. Digital transformation and AI may deepen exclusion if they are not designed and governed inclusively. Climate risk, disasters, and environmental vulnerability may disrupt care continuity and community wellbeing. Social isolation, ageism, and weakening intergenerational solidarity may erode participation, trust, and social cohesion. Inequality accumulated across the life course may intensify vulnerability in later life. Fragmented governance and weak implementation capacity may prevent policy commitments from translating into practical support.

At the same time, population ageing creates important strategic opportunities. Longevity can be reframed as a platform for inclusive social and economic innovation. Older persons can be recognised as rights-holders, contributors, and co-producers of future solutions. Community-led systems can be institutionalised as local platforms for integrated care, trust, and resilience. Digital transformation can strengthen human-centred care when guided by equity, accessibility, privacy, human oversight, and community trust. Prevention and healthy ageing can be embedded across the life course to reduce avoidable dependency and improve wellbeing. Intergenerational solidarity can be strengthened as social infrastructure for cohesion, learning, and mutual support. The care economy can be professionalised as a foundation of decent work, gender equality, and local development. Age-friendly and climate-resilient communities can be advanced as shared public goods that benefit all generations.

The Bangkok Recommendations are organised around four substantive themes.

- The first theme, *Community-Led Care and Long-Term Care Systems*, calls for community-led care to be recognised as a core component of ageing policy and long-term care systems, rather than as a residual, informal, or charitable response. As populations age, care needs are increasingly complex and extend beyond severe dependency or institutional care. They include early functional decline, chronic disease management, rehabilitation, mental wellbeing, dementia-related support, caregiver stress, social isolation, and continuity of care across home, community, primary care, hospital, rehabilitation, and institutional settings. Integrated community-led care models should link health care, social care, long-term care, rehabilitation, mental health, social protection, and caregiver support. Priority actions include developing integrated models, improving continuity of care, mapping services and resources, using data and digital tools responsibly, supporting prevention and early intervention, strengthening community organisations and older persons' associations, establishing clear care pathways, expanding community-based long-term care, and including long-term care explicitly within universal health coverage and social protection frameworks.

- The second theme, *Care Workforce, Standards, and Safeguarding*, recognises that care systems cannot be sustained without a capable, supported, fairly treated, and adequately supervised workforce. Workforce development should encompass formal care workers, social workers, health personnel, community workers, volunteers, and informal and family caregivers. The current challenge is not only a shortage of caregivers, but also the fragility of the care workforce model itself. Many care systems continue to depend heavily on unpaid family care, volunteers, and under-recognised community actors, including older volunteers who are themselves ageing. The Recommendations call for a strategic shift from viewing care primarily as voluntary service or family obligation toward recognising care as skilled, valued, and socially necessary work. Priority areas include recognising and supporting informal and family caregivers; strengthening multidisciplinary collaboration; updating quality standards and accreditation systems; developing flexible remuneration and employment models; establishing competency frameworks; improving workforce planning; expanding training, supervision, and professional development; institutionalising safeguarding systems; and registering small care units and caregivers within linked local authority and health systems. Safeguarding is essential to prevent abuse, neglect, exploitation, discrimination, abandonment, unsafe working conditions, and rights violations affecting older persons, caregivers, volunteers, and care workers.
- The third theme, *Sustainable Financing and Resource Mobilisation for Community-Led Care*, emphasises that community-led care and long-term care require predictable, equitable, and sustainable financing. Ageing societies cannot rely only on unpaid family care, out-of-pocket payments, short-term projects, or fragmented local resources. Financing should be treated as a social investment in demographic resilience, healthy ageing, household financial protection, gender equality, intergenerational equity, and fiscal sustainability. The Recommendations call for dedicated financial support for informal and family caregivers, including allowances, subsidies, training, mental health support, respite care, pension-related measures, and social protection where feasible. They also recommend establishing dedicated pooled financing mechanisms for community-led care and services, drawing on public, private, philanthropic, and development partner contributions under public oversight. A further priority is dedicated financing for workforce capacity building, upskilling, reskilling, supervision, certification, and career development. Financing reforms should reduce overreliance on out-of-pocket payments and unpaid family care, while linking resources to care needs, service standards, provider accountability, outcome monitoring, and equity safeguards.
- The fourth theme, *Community Resilience, Age-Friendly Environments, and Climate Risk*, positions resilience as part of everyday community life, not only emergency response. Older persons, especially those living alone, with disabilities, in poverty, or in climate-exposed areas, may face heightened risks from heatwaves, floods, air pollution, pandemics, and other shocks. Ageing policy must therefore be linked to climate adaptation, disaster preparedness, housing, transport, urban planning, public health, and local resilience systems. Age-friendly and climate-resilient environments benefit not only

older persons, but also children, persons with disabilities, caregivers, families, workers, and communities as a whole. Priority actions include strengthening inclusive communication and early warning systems, supporting care continuity during emergencies, promoting accessible transport and public spaces, improving housing and shelter systems, strengthening community-based preparedness, and expanding intergenerational spaces and programmes that reduce isolation and strengthen mutual support.

The four themes are supported by three cross-cutting enabling factors. First, innovation, digital transformation, AI, and the inclusive silver economy should be guided by ethics, accessibility, affordability, transparency, privacy, equity, human-centred design, and public value. Second, governance, partnerships, and implementation mechanisms should strengthen coordination across sectors, institutions, and levels of government, while ensuring accountability and meaningful participation. Third, data, research, evidence, and learning systems should guide policy design, implementation, monitoring, evaluation, and adaptation. Evidence systems should assess not only whether programmes work, but also for whom, under what conditions, at what cost, and with what implementation requirements.

The Bangkok Recommendations are intended to serve not only as a statement of shared priorities, but also as a basis for sustained collaboration, policy translation, and implementation support. Proposed follow-up actions include establishing a regional community of practice; producing and disseminating knowledge products; supporting technical exchange and peer learning; translating the Recommendations into practical policy tools; encouraging country- and locality-level adaptation; and strengthening implementation learning across institutions and countries. These actions should be practical, sequenced, and adaptable to different country contexts, institutional mandates, and levels of available resources.

In conclusion, the Bangkok Recommendations call for a shift from fragmented, reactive, and underfinanced responses to integrated, anticipatory, inclusive, and resilient systems of support. Communities are placed at the centre of implementation, but communities cannot carry responsibility alone. Effective ageing systems require public responsibility, sustainable financing, a skilled and protected workforce, strong local governance, accountable partnerships, inclusive innovation, and reliable evidence. By advancing community-led care, decent care work, sustainable financing, age-friendly and climate-resilient environments, and an inclusive silver economy, ageing societies can protect dignity, strengthen solidarity, and create shared value across generations.

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1. Preamble

The Bangkok Recommendations emerge from the International Conference and Workshop on "Community-Led Approaches and Innovations for Better Care Systems, and Community Resilience Toward an Inclusive Silver Economy," held from 6–8 May 2026 in Bangkok, Thailand. The conference was convened as a multi-stakeholder platform to advance policy dialogue, technical exchange, and collaborative learning on how ageing societies can strengthen care systems, support community resilience, and promote an inclusive silver economy.

The conference was jointly hosted by the Department of Older Persons, the College of Population Studies, Chulalongkorn University, the Thai Health Promotion Foundation, and the Ageing Innovation Expo Thailand (by KRS Xpansion). It was co-hosted by a consortium of United Nations agencies and international and regional organisations, including the United Nations Population Fund (UNFPA), the United Nations Human Settlements Programme (UN-Habitat), the Asian Development Bank (ADB), the Alliance on Longevity in Asia-Pacific (ALAP), the Tsao Foundation, the ASEAN Centre for Active Ageing and Innovation (ACAI), the ASEM Global Ageing Center (AGAC), the Foundation for Older Persons' Development (FOPDEV), the Health Systems Research Institute (HSRI), the National Health Security Office (NHSO), the Chulabhorn Royal Academy, the National Institute of Development Administration (NIDA), the Labour Research and Coordination Research Unit, College of Population Studies, Chulalongkorn University (CU-COLLAR), and the Chulalongkorn University Platform for Aging Research Innovation (Chula ARI). These partnerships reflected a shared recognition that population ageing is a cross-sectoral transformation requiring coordinated responses across policy, research, practice, financing, innovation, and community action. The World Health Organization (WHO) also provided technical contribution to the conference and the development of the Recommendations, particularly through its normative guidance on integrated care for older people, including the ICOPE framework, and the Global Strategy on Human Resources for Health: Workforce 2030. These WHO frameworks and standards helped inform the thematic architecture of the Recommendations, especially in relation to community-led care, workforce development, safeguarding, and universal health coverage.

The Bangkok Recommendations were circulated, reviewed and refined by the hosts, co-hosts, and collaborating partners, in order to ensure that the final Recommendations reflect a shared understanding, collective ownership, and common commitment to advancing inclusive, resilient, and community-centred care systems. The review process was also intended to support alignment across institutional mandates, regional priorities, and implementation pathways, while preserving the open and collaborative spirit of the conference. The Bangkok Recommendations are therefore presented as a living and inclusive framework. The Recommendations remain open to collaboration with interested

stakeholders, including national and local governments, United Nations agencies, regional organisations, academic and research institutions, civil society organisations, community networks, professional bodies, private-sector actors, and development partners committed to advancing healthy ageing, long-term care, community resilience, and an inclusive silver economy.

The Bangkok Recommendations are organised around four substantive themes: community-led care and long-term care systems; care workforce, standards, and safeguarding; sustainable financing and resource mobilisation for community-led care; and community resilience, age-friendly environments, and climate risk. These themes are supported by three cross-cutting enabling factors: innovation, digital transformation, AI, and the inclusive silver economy; governance, partnerships, and implementation mechanisms; and data, research, evidence, and learning systems.

2. Overarching Vision

The Bangkok Recommendations recognise that population ageing is reshaping societies across the Asia-Pacific region and beyond, while interacting with digital transformation, artificial intelligence, urbanisation, migration, climate risk, labour informality, care deficits, workforce shortages, and fiscal constraints, requiring ageing policy to move beyond sector-specific responses toward integrated systems that connect care, resilience, financing, innovation, governance, and evidence.

The Bangkok Recommendations *reflect* the collective insights generated through keynote addresses, thematic dialogues, analytical labs, innovation exchange, and cross-sector discussions among policymakers, practitioners, researchers, civil society actors, development partners, community representatives, and private-sector stakeholders, and provide a shared direction for strengthening community-led care systems and advancing resilient, inclusive, and sustainable ageing societies.

The Bangkok Recommendations *envision* ageing societies in which older persons, caregivers, families, and communities are supported by integrated, inclusive, adequately financed, and locally responsive systems that promote dignity, autonomy, participation, resilience, and wellbeing across the life course.

The Bangkok Recommendations *affirm* healthy ageing as a life-course process grounded in human rights, equity, gender equality, intergenerational solidarity, and the principle of leaving no one behind, with emphasis on prevention, health promotion, social protection, supportive environments, and particular attention to older persons experiencing poverty, disability, social isolation, displacement, frailty, cognitive decline, or other forms of vulnerability.

The Bangkok Recommendations *affirm* the importance of an inclusive silver economy that expands opportunities without deepening inequality; promotes innovation without excluding those with limited access; and recognises older persons not only as care recipients, but also as contributors, rights-holders, workers, caregivers, community members, and co-producers of solutions.

The Bangkok Recommendations further *underscore* the critical role of local governments and sub-national institutions in translating national commitments into locally responsive actions, while strengthening coordinated engagement among national governments, United Nations agencies, regional organisations, academic and research institutions, civil society organisations, community networks, older persons' organisations, professional bodies, private-sector actors, development partners, and local communities across sectors and levels of governance.

This vision places communities at the centre of implementation while recognising that communities cannot carry responsibility alone. Effective ageing systems require public responsibility, sustainable financing, a skilled and protected care workforce, strong local governance, accountable partnerships, inclusive innovation, and reliable evidence to guide action. The realisation of this vision also depends on workforce systems that are aligned with community-led care and long-term care models; equipped with competencies that respond to local care needs; distributed equitably across urban, rural, and underserved areas; and supported through decent working conditions, legal recognition, supervision, and continuous professional development.

3. Definition

"Community" refers to a group of people connected by place, shared identity, common interests, lived experience, social relationships, or shared exposure to particular risks and resources. In the context of ageing and care, a community is not only a geographic locality, but also a network of older persons, caregivers, families, local organisations, service providers, volunteers, and institutions that shape everyday wellbeing, access to support, and social participation. This definition recognises both formal and informal assets, including local knowledge, trust, mutual aid, and community-based organisations (National Institute for Health and Care Excellence [NICE], 2016[1]; UNICEF, 2020[2]).

[1] National Institute for Health and Care Excellence. (2016). *Community engagement: Improving health and wellbeing and reducing health inequalities* (NICE Guideline NG44). https://www.nice.org.uk/guidance/ng44
[2] UNICEF. (2020). *Minimum quality standards and indicators for community engagement*. UNICEF Middle East and North Africa Regional Office. https://www.unicef.org/mena/reports/community-engagement-standards

"Community-led approach" refers to an approach in which communities are not merely consulted or mobilised to implement externally designed programmes, but are meaningfully involved in identifying needs, setting priorities, designing responses, delivering support, monitoring progress, and adapting solutions. It requires shared decision-making, local ownership, co-production, accountability, and partnerships between communities and formal systems. In ageing policy, a community-led approach means positioning communities as active partners in prevention, long-term care, caregiver support, social participation, resilience, and inclusive innovation, while ensuring that public systems remain responsible for financing, quality, equity, and rights protection (WHO, 2017a[3]; Wallerstein & Duran, 2010[4]).

"Community-led care" refers to an organised set of health, social care, rehabilitation, long-term care, preventive, and support services delivered as close as possible to where people live, through coordinated action among older persons, families, caregivers, community organisations, local governments, health and social care providers, volunteers, and civil society. It aims to maintain functional ability, dignity, autonomy, wellbeing, social participation, and ageing in place, while ensuring timely referral and continuity across home, community, primary care, hospital, rehabilitation, and institutional settings where needed (WHO, 2017b[5], 2025[6]). In the Thai context, community-led care also reflects household, community, local, and network-based arrangements, supported by public systems, community actors, and rights-based approaches to long-term care (ADB, 2020[7]; Rodngern et al., 2025[8]; Tantuvanit, 2021[9]). It should be inclusive, adequately financed, evidence-informed, and supported by clear standards, workforce capacity, safeguarding, and accountability.

"Community resilience" refers to the collective capacity of communities, institutions, and local systems to anticipate, prepare for, withstand, respond to, recover from, and adapt to

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[3] World Health Organization. (2017a). *WHO community engagement framework for quality, people-centred and resilient health services*. World Health Organization. https://iris.who.int/handle/10665/259280

[4] Wallerstein, N., & Duran, B. (2010). Community-based participatory research contributions to intervention research: The intersection of science and practice to improve health equity. *American Journal of Public Health, 100*(S1), S40–S46. https://doi.org/10.2105/AJPH.2009.184036

[5] World Health Organization. (2017b). *Integrated care for older people: guidelines on community-level interventions to manage declines in intrinsic capacity.* World Health Organization. Geneva. https://iris.who.int/handle/10665/259280

[6] World Health Organization. (2025). Integrated care for older people (ICOPE): guidance for person-centred assessment and pathways in primary care, second edition. Geneva. https://iris.who.int/server/api/core/bitstreams/7516b015-e205-43d1-883f-01f2c31af261/content

[7] Asian Development Bank. (2020). *Country diagnostic study on long-term care in Thailand*. Asian Development Bank. https://www.adb.org/sites/default/files/publication/661736/thailand-country-diagnostic-study-long-term-care.pdf

[8] Rodngern, K., Prasitsiriphon, O., Osatis, C., & Bhula-or, R. (2025). *Advancing rights-based long-term care in Thailand: Toward inclusive and equitable care systems*. In ASEM Global Ageing Center, *Care and the human rights of older persons*. ASEM Global Ageing Center. https://asemgac.org/board/view?bd_id=pb01&wr_id=558

[9] Tantuvanit, N. (2021), 'Home and Community-led care: Household, Community, Local and Network Long-term Care for Older People', in Lorthanavanich, D. and O. Komazawa (eds.), Population Ageing in Thailand Long-term Care Model: Review of Population Ageing Practices and Policies, Vol. 2. ERIA Research Project Report FY2021 No. 06b, Jakarta: ERIA, pp.21-50. https://www.eria.org/uploads/media/Research-Project-Report/2021-06/Vol-2_07-Chapter-3-Home--and-Community-based-Care_Long-term-Care-Model.pdf

shocks and stresses, including disasters and pandemics, while protecting dignity, wellbeing, rights, and continuity of support for all people, especially those most at risk. It is the process of developing the capacity of place-based ageing communities to manage risk through collective action and the building of various community assets (Tsao Foundation, 2022)10. It includes social connectedness, local leadership, trusted communication, inclusive participation, risk-informed planning, accessible infrastructure, coordinated health and social care, public health preparedness, infection prevention and control, disaster risk reduction, and mechanisms for learning and adaptation (Norris et al., 2008[11]; UNDRR, 2015[12]). In ageing societies, community resilience must recognise both the vulnerabilities and contributions of older persons, including their roles in mutual support, local knowledge, preparedness, care continuity, public health response, disaster preparedness, and recovery (HelpAge International, 2019[13]; UNESCAP, 2022[14]).

"Healthy ageing" refers to the process of developing and maintaining the functional ability that enables wellbeing throughout older age. It reflects the interaction between individuals' physical and mental capacities and the environments in which they live, recognising that people age differently and that supportive policies and communities are essential to promoting dignity, participation, and quality of life for all older persons. (WHO, 2019)[15].

"Long-term care" refers to the continuum of health, personal, social, and supportive services provided over an extended period to people who experience, or are at risk of experiencing, significant declines in physical or mental capacity and are unable to fully manage daily activities independently. Its primary purpose is not only to treat illness, but to maintain functional ability, autonomy, wellbeing, quality of life, and dignity, while ensuring that people can continue to exercise their basic rights and participate meaningfully in family and

[10] According to the Tsao Foundation, community resilience is built through: (1) Risk Management, addressing environmental and social stressors at individual, community, and national levels by coping, adapting, or transforming risk generation. (2) Collaborative Capacity Building, where members work in tandem with older persons to strengthen "assets" across three domains: individual, community, and macro-level. (3) Key Processes, including community engagement, shared decision-making, and narrative preservation. This framework aims to protect older persons who may lack the capacity to face growing risks independently. https://tsaofoundation.org/ilcs-community-resilience/framework

[11] Norris, F.H., Stevens, S.P., Pfefferbaum, B., Wyche, K.F. and Pfefferbaum, R.L. (2008), Community Resilience as a Metaphor, Theory, Set of Capacities, and Strategy for Disaster Readiness. American Journal of Community Psychology, 41: 127-150. https://doi.org/10.1007/s10464-007-9156-6

[12] United Nations Office for Disaster Risk Reduction. (2015). *Sendai Framework for Disaster Risk Reduction 2015–2030*. UNDRR. https://www.undrr.org/quick/11409

[13] HelpAge International. (2019). *Age inclusive disaster risk reduction: A toolkit*. HelpAge International.

[14]United Nations, Economic and Social Commission for Asia and the Pacific (ESCAP) (2022). Climate Change and Population Ageing in the Asia-Pacific Region: Status, Challenges and Opportunities. https://www.unescap.org/sites/default/d8files/knowledge-products/Climate_Change_policy_paper_20220509.pdf?utm_source=chatgpt.com

[15] World Health Organization. (2019, March). *Decade of healthy ageing 2020–2030: First progress update, March 2019*. https://cdn.who.int/media/docs/default-source/documents/decade-of-health-ageing/decade-healthy-ageing-update-march-2019.pdf?sfvrsn=5a6d0e5c_2

community life (World Health Organization, 2015[16], 2021[17]). Long-term care includes assistance with activities of daily living, such as bathing, dressing, eating, mobility, toileting, and medication management, as well as social support, rehabilitation, care coordination, and support for family and informal caregivers. It may be delivered through both formal and informal arrangements, involving families, communities, paid care workers, health professionals, and social care systems across home, community-based, residential, and institutional settings.

"Inclusive silver economy" refers to an economic and social development approach that recognises population ageing as a source of opportunity for innovation, employment, care, services, housing, finance, technology, lifelong learning, and community development, while ensuring that these opportunities do not deepen inequality or exclusion. It goes beyond viewing older persons only as consumers and recognises them as workers, entrepreneurs, caregivers, mentors, volunteers, rights-holders, community leaders, and co-producers of solutions (European Commission, 2018[18]; UNFPA, 2012[19]; World Bank, 2016[20]). An inclusive silver economy should support dignity, autonomy, participation, decent work, healthy ageing, and access to long-term care, while ensuring affordability, accessibility, gender equity, digital inclusion, and public value.

"Innovation" refers to the development, adaptation, and responsible use of new or improved ideas, practices, services, technologies, financing models, governance arrangements, and community-based solutions that generate public value and improve wellbeing in ageing societies. In the context of the Bangkok Recommendations, innovation is not limited to digital technology or market-based products. It includes social innovation, service redesign, integrated care models, community-led solutions, AgeTech, assistive technologies, AI-enabled tools, workforce models, financing mechanisms, and institutional reforms that strengthen dignity, autonomy, care quality, inclusion, resilience, and participation (OECD/Eurostat, 2018[21]). Innovation should be ethical, affordable, accessible, evidence-informed, and human-centred, with safeguards for privacy, equity, transparency, and accountability. In ageing societies, innovation should also reframe longer lives as a source of

[16] World Health Organization. (2015). *World report on ageing and health*. World Health Organization. https://www.who.int/publications/i/item/9789241565042

[17] World Health Organization. (2021). *Framework for countries to achieve an integrated continuum of long-term care*. World Health Organization. https://www.who.int/publications/i/item/9789240038844

[18] European Commission. (2018). *The silver economy: Final report*. Publications Office of the European Union. https://publications.europa.eu/resource/cellar/2dca9276-3ec5-11e8-b5fe-01aa75ed71a1.0002.01/DOC_1

[19] UNFPA. (2012). *Ageing in the twenty-first century: A celebration and a challenge*. United Nations Population Fund. https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA-Exec-Summary.pdf

[20] World Bank. (2016). *Live long and prosper: Aging in East Asia and Pacific*. World Bank. https://openknowledge.worldbank.org/bitstreams/b6e668c0-21e3-505d-abb6-77b93975b5de/download

[21] OECD & Eurostat. (2018). *Oslo manual 2018: Guidelines for collecting, reporting and using data on innovation* (4th ed.). OECD Publishing. https://doi.org/10.1787/9789264304604-en

creativity, productivity, inclusion, and social transformation, rather than only as a policy challenge (Bhula-or & Sawang, 2026[22]).

"Intergenerational solidarity" refers to relationships, systems, and practices that strengthen mutual respect, learning, care, cooperation, and shared responsibility across age groups. In ageing societies, it requires moving beyond viewing older persons only as recipients of support and recognising reciprocal contributions among children, youth, working-age adults, and older persons. Intergenerational solidarity can be advanced through family, community, school, university, workplace, and civic platforms that enable younger generations to understand the needs, rights, capacities, and lived experiences of older persons (United Nations, 2002[23]). Practical examples include service-learning, school-to-community engagement, university-community partnerships, community service days, intergenerational learning spaces, digital mentoring, volunteer programmes, and care-related experiential learning. Such approaches can reduce ageism, strengthen social cohesion, support community-led care, and build shared commitment to inclusive and resilient ageing societies (Chen & Phanumartwiwath, 2025[24]; WHO, 2023[25]).

4. Guiding Principles

The Bangkok Recommendations are guided by the following principles:

(1) **Community-centred implementation:** National and regional commitments on ageing should be translated into locally accessible systems, services, and support. Communities should function as practical platforms for prevention, care coordination, long-term care, caregiver support, social participation, resilience, and local innovation, grounded in human rights, social justice, and the principle of leaving no one behind.

(2) **Rights, dignity, and participation:** Older persons should be recognised as rights-holders and active members of society, not only as dependents or service users. Policies and services should protect dignity, autonomy, privacy, safety, human rights, non-discrimination, and meaningful participation in everyday life and during emergencies.

(3) **Integrated and life-course approaches to care:** Care systems should link prevention, health promotion, primary care, rehabilitation, social care, long-term

[22]Bhula-Or, R., & Sawang, S. (2026). *Grey matters: Innovation for an aging world*. Springer Singapore.
[23]United Nations. (2002). *Political declaration and Madrid International Plan of Action on Ageing*. United Nations. https://www.un.org/esa/socdev/documents/ageing/MIPAA/political-declaration-en.pdf
[24]Chen, I., & Phanumartwiwath, A. (2025). University-community partnerships for sustainable health: Insights from public health school's community day of service. *International Journal of Sustainability in Higher Education*. Advance online publication. https://doi.org/10.1108/IJSHE-04-2025-0283
[25] World Health Organization. (2023). *Connecting generations: Planning and implementing interventions for intergenerational contact*. World Health Organization. https://www.who.int/publications/i/item/9789240070264

care, social protection, and community support across the life course. This requires moving from fragmented and reactive responses toward coordinated systems that support healthy ageing, early intervention, continuity of care, and ageing in place, intergenerational solidarity, gender equality, and shared responsibility for care.

(4) **Meaningful participation and co-production:** Older persons, caregivers, civil society, local governments, volunteers, care workers, and community actors should participate meaningfully in the design, delivery, monitoring, and improvement of policies, services, and programmes. Participation should be institutionalised through formal mechanisms so that lived experience informs planning, implementation, quality assurance, and accountability, with particular attention to voice, agency, representation, and the inclusion of women, persons with disabilities, and marginalised groups.

(5) **Equity and inclusion:** Policies should prioritise older persons with disabilities, those living alone, low-income groups, informal workers, migrants, stateless persons, rural populations, and those affected by disasters or social exclusion. Equity requires both universal minimum support and additional assistance for those facing higher risks, greater care needs, or weaker access to services, using an intersectional approach that recognises how age, gender, disability, income, migration status, ethnicity, location, and health status shape unequal risks and opportunities.

(6) **Sustainability and scalability:** Community-led models should move beyond short-term pilots toward adequately financed, accountable, and scalable systems. Sustainability requires predictable budgets, pooled and progressive financing, clear service packages, defined institutional responsibilities, workforce capacity, and quality standards, as well as transparent governance, fiscal responsibility, and long-term investment in inclusive care infrastructure.

(7) **Decent work, caregiver support, workforce protection, and strengthened care workforce wellbeing:** Care systems require a capable, fairly supported, adequately supervised, and protected workforce. Formal care workers, social workers, health personnel, community workers, volunteers, and informal caregivers should be supported through training, supervision, decent working conditions, role clarity, safeguarding systems, and career pathways, with attention to labour rights, occupational safety and health, fair remuneration, gender equality, protection from violence and harassment, and recognition of unpaid care work.

(8) **Inclusive, ethical, and human-centred innovation:** Digital tools, AI, AgeTech, and assistive technologies should be inclusive, ethical, accessible, affordable, and locally appropriate. Innovation should support human-centred care, independence, safety, service coordination, and resilience, while protecting privacy, consent, transparency, data security, and equity, and should be guided

by accessibility, universal design, digital inclusion, accountability, and protection from bias or discrimination.

(9) **Age-friendly, climate-resilient, and enabling environments:** Ageing policy should be linked to climate adaptation, disaster preparedness, housing, transport, urban planning, public space, and local resilience systems. Age-friendly environments should support mobility, accessibility, social participation, continuity of care, and protection during shocks, including disasters, pandemics, extreme heat, floods, air pollution, and other climate-related risks.

(10) **Evidence-informed policy, learning, and accountability:** Data, research, and learning systems should guide policy, adaptation, investment, and accountability. Measurement frameworks should include functional ability, wellbeing, caregiver burden, social participation, service coverage, costs, workforce ratios, quality assurance, digital inclusion, and resilience indicators, with data disaggregated by age, gender, disability, income, location, migration status, and other relevant markers of inequality to strengthen transparency, accountability, and rights-based monitoring.

5. Future risks and Opportunities

The future risks and opportunities outlined in this section were identified through multi-stakeholder deliberations during the conference, reflecting the insights of policymakers, practitioners, researchers, civil society actors, development partners, community representatives, and private-sector stakeholders. These discussions highlighted that population ageing will unfold alongside wider social, economic, technological, environmental, and governance transitions. While these changes could intensify care needs, workforce pressures, financing constraints, inequality, digital exclusion, climate vulnerability, and social isolation, they also create strategic openings to redesign institutions, financing arrangements, technologies, labour systems, and community platforms for greater inclusion, resilience, and sustainability. This section therefore presents future risks and opportunities not as separate challenges, but as interconnected areas for anticipatory action. It underscores the need to strengthen community-led care systems, invest in prevention and innovation, recognise older persons as contributors, and build partnerships capable of translating shared commitments into practical implementation.

Key Future Risks

(1) **Rising care needs may widen care gaps if community-based systems are not strengthened.** Longer life expectancy, changing family structures, smaller households, migration, and increased female labour force participation may reduce the availability

of unpaid family care while increasing demand for long-term care, rehabilitation, dementia care, support for cognitive impairment, and community-based support. Care gaps may widen if partially dependent, homebound, persons with disabilities, older persons with dementia or cognitive impairment, socially isolated older persons, and older persons living alone remain outside formal assessment and support systems. Future care demand will not be limited to severe dependency, but will increasingly include early functional decline, cognitive decline, dementia-related care needs, mental wellbeing, caregiver stress, social isolation, and the need for continuity of care across home, community, hospital, rehabilitation, and institutional settings where needed. If systems remain reactive rather than anticipatory, these needs may accumulate until families, communities, and public services are unable to respond in a timely and equitable manner.

(2) **Workforce shortages and care labour vulnerabilities may undermine the sustainability of ageing and long-term care systems.** Ageing societies may experience shortages of health workers, social care workers, community-led care workers, and trained caregivers. Cross-border migration of care workers and the uneven geographic distribution of care labour may further exacerbate workforce shortages, especially in rural, remote, low-income, and rapidly ageing communities. At the same time, reliance on migrant care workers without adequate labour protection, skills recognition, social security, fair recruitment, and safe migration pathways may create new vulnerabilities within the care workforce. Without improved working conditions, training, supervision, decent pay, and career pathways, care systems may become increasingly fragile. A particularly serious risk is that many current caregivers and volunteers are themselves ageing, while younger people may not see caregiving as a viable or attractive career because of low pay, training costs, weak professional recognition, and limited advancement opportunities. If caregiving remains dependent on underpaid or unpaid labour, or on poorly protected migrant and informal care workers, the system may become unsustainable as existing volunteers retire and care needs increase. This may result not only in labour shortages, but also in uneven care quality, burnout, weak safeguarding, and declining trust in care systems.

(3) **Fiscal and financing pressures may constrain equitable access to long-term care and community-based support.** Expanding health, social protection, pension, and long-term care needs may place increasing pressure on public budgets. If financing systems are not planned early, households may face higher out-of-pocket costs and deeper inequalities in access to care. Inadequate financial protection may expose individuals and families to catastrophic household expenditure and increase the risk of poverty and impoverishment associated with care needs. Financing risks are also governance risks: without clear definitions of community-led care, agreed service packages, defined institutional responsibilities, and minimum quality standards, financing may remain fragmented and ineffective. A further risk is the emergence of unequal care quality, where those who can pay are able to access better services, while low-income

older persons depend on incomplete public provision, unpaid family care, or short-term projects. If financing remains short-term, fragmented, or project-based, long-term care may develop unevenly across territories and population groups.

(4) **Digital transformation and AI may deepen exclusion if they are not designed and governed inclusively**. Digital tools, AI, telehealth, assistive technology, interoperable data systems, and digital platforms may improve care coordination, early detection, referral, monitoring, caregiver support, and access to services, particularly in underserved areas. However, digital transformation may also exclude older persons, caregivers, and communities with limited connectivity, digital literacy, affordability, language access, or disability-inclusive design. Risks include fear, low trust, privacy concerns, online scams, uneven access to devices, and insufficient digital support for older persons and frontline workers. AI may also introduce new risks if used without transparency, accountability, human oversight, ethical standards, data protection, and safeguards against bias. AI should support human-centred care and decision-making, not replace professional judgement, community trust, or face-to-face support. Without inclusive governance, digital transformation may widen existing inequalities instead of reducing them.

(5) **Climate risk, disasters, and environmental vulnerability may increasingly disrupt care continuity and community wellbeing.** Older persons, especially those living alone, with disabilities, in poverty, or in climate-exposed areas, may be disproportionately affected by heatwaves, floods, air pollution, pandemics, and other shocks. Ageing policy must therefore be linked to climate adaptation and disaster preparedness. The absence of integrated, accessible, participatory, and agile governance is a major risk. Fragmented public administration, weak coordination, limited frontline training, inaccessible infrastructure, and unclear responsibility during emergencies can leave older persons without timely support. Climate risk should therefore be treated as a care continuity issue, affecting medication, food, transport, assistive devices, home visits, evacuation, communication, and psychosocial support. If ageing systems are not integrated into climate and emergency planning, older persons may remain invisible in preparedness, response, recovery, and adaptation measures.

(6) **Social isolation, ageism, and weakening intergenerational solidarity may erode wellbeing, participation, and community trust.** Loneliness, social exclusion, and age-based discrimination can undermine wellbeing, participation, and trust. Ageing societies must actively promote intergenerational exchange, social participation, and positive narratives of ageing. Social isolation is also linked to mobility, transport, public space, digital access, community design, and the decline of informal neighbourhood support. If older persons are treated mainly as passive beneficiaries rather than rights holders, contributors, mentors, workers, volunteers, and knowledge holders, ageing societies may lose important social resources and weaken community resilience. The risk is therefore not only individual loneliness, but also the weakening of social

infrastructure that connects people across ages, households, institutions, and communities.

(7) **Inequality across the life course may intensify vulnerability and exclusion in later life.** Disadvantages accumulated over the life course—through poverty, informal work, limited education, disability, migration status, gender inequality, or exclusion from services—can deepen vulnerability in later life. Ageing policies must therefore address structural inequalities before and during old age. Older persons in the informal sector, poor and middle-income communities, persons with disabilities, people living alone, and those in rural or remote areas face compounded risks. These inequalities can be intensified by fragmented financing, unequal local capacity, lack of digital access, and care systems that do not sufficiently recognise unpaid caregivers, especially women and younger family members. If ageing policy focuses only on later-life services without addressing cumulative disadvantage, future systems may reproduce rather than reduce inequality.

5.2 Key Future Opportunities

(1) **Longevity can be positioned as a platform for inclusive social and economic innovation.** The opportunity is to reframe longevity not primarily as a burden, but as a development agenda that can stimulate institutional redesign, social innovation, and public value. Ageing creates opportunities for new models of care, housing, transport, finance, digital services, lifelong learning, prevention, rehabilitation, and community-based support. With the right policy choices, longevity can become a source of innovation, productivity, solidarity, and public value. The silver economy should be developed in ways that are inclusive, affordable, ethical, and oriented toward public value. Innovation should not be narrowly defined as technology or market growth, but should include social innovation, community-led care models, caregiver support systems, age-friendly products and services, assistive technologies, digital learning, and financing approaches that expand access while protecting equity. This framing can help countries move from a narrow focus on demographic pressure toward a broader agenda of inclusive development, social investment, and systems innovation.

(2) **Older persons can be recognised as rights-holders, contributors, and co-producers of future solutions.** The strategic opportunity is to move from a beneficiary-centred model of ageing policy to a participation-centred model. Older persons can contribute as workers, mentors, caregivers, volunteers, community leaders, entrepreneurs, and knowledge holders. Policies should recognise these roles and create space for meaningful participation. Their lived experience can strengthen the design, delivery, and monitoring of policies, services, and technologies. Older persons can support peer networks, share local knowledge, participate in disaster preparedness, mentor younger generations, contribute to community monitoring, and co-design services

and technologies that better reflect lived realities. Such participation can improve policy legitimacy, strengthen community trust, and ensure that future ageing systems reflect lived experience rather than institutional assumptions alone.

(3) **Community-led systems can be institutionalised as local platforms for integrated care, trust, and resilience.** The opportunity is not only to strengthen community activities, but to build durable community care platforms that connect national policy with everyday support. Strong communities can connect care, prevention, social participation, local innovation, mutual support, and disaster response. Community-led approaches offer opportunities to build trust, responsiveness, and continuity of care close to where people live. They can serve as practical bridges between national policy and daily life by linking older persons' associations, local governments, volunteers, health centres, civil society, faith-based groups, family caregivers, and community centres into more coordinated, inclusive, and locally responsive care and resilience ecosystems. These systems can turn communities into active engines of healthy ageing, preparedness, and social connection. This opportunity is especially important because community systems can connect formal services with informal support, making care more responsive to local needs and everyday realities.

(4) **Digital transformation can be governed as enabling infrastructure for inclusive and human-centred care**. The opportunity is not simply to introduce more technology, but to create digital ecosystems that support human relationships, service coordination, accessibility, and accountability. If designed responsibly, digital tools, AI, telehealth, assistive technology, and data systems can improve care coordination, early detection, referral, monitoring, caregiver support, and access to services, particularly in underserved areas. Digital tools can also support emergency alerts, health monitoring, caregiver reporting, training, service navigation, and continuity of care. When combined with human support and community trust, digital transformation can extend the reach, quality, and continuity of care without replacing human relationships. Digital transformation can therefore become a means of strengthening human-centred care, rather than a substitute for face-to-face support, professional judgement, or community trust.

(5) **Prevention and healthy ageing can be embedded across the life course and across sectors**. The strategic opportunity is to shift ageing systems upstream, from responding to dependency after it occurs to preventing or delaying avoidable decline throughout the life course. Investing earlier in health promotion, education, decent work, social protection, and enabling environments can reduce later-life vulnerability and care dependency. A life-course approach offers long-term returns for individuals, families, communities, and public systems. Prevention should be positioned as part of community-led care, not only as health promotion. It should include chronic disease management, falls prevention, nutrition, physical activity, mental wellbeing, early detection of functional decline, caregiver self-care, social participation, and safe environments that enable ageing in place. This can help ageing societies reduce future

dependency, improve quality of life, and ease pressure on families, communities, health systems, and long-term care systems.

(6) **Intergenerational solidarity can be strengthened as social infrastructure for cohesion, learning, and mutual support.** The opportunity is to translate intergenerational solidarity from a broad value into concrete institutions, spaces, and programmes. Ageing societies can create new opportunities for intergenerational learning, shared spaces, mutual support, and community participation. These approaches can reduce ageism and strengthen social cohesion. Older persons' clubs, schools, universities, workplaces, and community centres can be reimagined as intergenerational learning and service platforms, where older persons share knowledge and younger people contribute digital skills, volunteer time, creativity, and companionship. Such spaces can reduce loneliness, build mutual respect, and strengthen informal support networks before, during, and after shocks. Intergenerational solidarity can therefore become a practical resource for care, resilience, learning, and community renewal. This approach can help societies maintain connection, reciprocity, and mutual responsibility across generations as demographic structures change.

(7) **The care economy can be professionalised and recognised as a foundation of decent work, gender equality, and local development.** The strategic opportunity is to transform care from a largely invisible social obligation into a recognised, skilled, protected, and fairly compensated field of work. This care economy extends beyond caregivers alone and includes social workers, community health workers, health personnel, rehabilitation workers, care coordinators, volunteers, and other community-based actors who support prevention, care navigation, social participation, and continuity of care. Practical reforms, including tiered training, blended learning, annual reskilling, career pathways, fair remuneration, caregiver registration, supervision, safety protocols, and professional recognition, can strengthen this wider workforce. These measures can improve care quality, strengthen safeguarding, reduce workforce shortages, and create meaningful employment, especially in local communities. Recognising the care economy also supports gender equality by valuing work that has often been unpaid, informal, or under-recognised, while opening pathways for inclusive local employment, intergenerational solidarity, and more resilient community-led care systems. Investing in the care economy can therefore advance decent work, gender equality, local economic development, and sustainable care systems at the same time. This opportunity is particularly important for linking ageing policy with labour policy, skills development, gender equality, and inclusive local economic development.

(8) **Age-friendly and climate-resilient communities can be advanced as shared public goods.** The opportunity is to align ageing policy, climate adaptation, disaster preparedness, urban planning, transport, housing, and public health around a common agenda of accessible and resilient communities. Age-friendly and climate-

resilient environments benefit not only older persons, but also children, persons with disabilities, caregivers, families, workers, and communities as a whole. Investments in accessible transport, safe crossings, parks, shelters, community centres, universal design, early warning systems, heat-risk preparedness, flood response, clean air measures, and local resilience planning can improve everyday wellbeing while preparing communities for future climate and social shocks. Climate-responsive ageing policy can therefore strengthen both care continuity and community resilience. These investments create co-benefits across generations by improving safety, accessibility, health, social participation, and preparedness for all. This opportunity positions ageing policy as part of a wider public-goods agenda that benefits all generations while improving preparedness for future shocks.

6. Thematic Recommendations

Theme 1: Community-Led Care and Long-Term Care Systems

Community-led care and long-term care systems are essential to ensuring that ageing societies can respond to rising care needs in ways that are accessible, coordinated, equitable, and sustainable. As populations age, care needs are no longer limited to severe dependency or institutional care. They increasingly include early functional decline, chronic disease management, rehabilitation, mental wellbeing, dementia-related support, caregiver stress, social isolation, and continuity of care across home, community, hospital, rehabilitation, and institutional settings. At the same time, smaller households, migration, changing family structures, and increased labour force participation among women are reducing the availability of unpaid family care. These shifts make it necessary to strengthen community-based systems that support older persons to live with dignity, autonomy, and security in familiar environments, while ensuring that families and caregivers are not left to carry care responsibilities alone.

The Recommendations therefore call for community-led care systems to be understood as part of a broader care continuum. Community-led care should not be treated as a residual, informal, or charitable response, but as a core component of ageing policy and long-term care systems. Integrated models should link health care, social care, long-term care, rehabilitation, mental health, social protection, and caregiver support, drawing where appropriate on existing frameworks such as the WHO Integrated Care for Older People (ICOPE) approach. These models should support prevention, recovery, ageing in place, care transitions, and continuity of care. They should also be connected to self-care, family support, and community support, recognising that older persons, households, local actors, and formal systems all have complementary roles. While palliative care and end-of-life care are increasingly important in

ageing societies, they were not a central focus of this conference. They may therefore be acknowledged as part of the wider care continuum for future policy dialogue, especially in relation to dignity, choice, and support at the final stage of life, without expanding the scope of this theme beyond community-led and long-term care systems.

A key recommendation is to develop integrated community-led care models that bring together multiple sectors, actors, and service levels around shared pathways and accountability. These models should be supported by governance mechanisms that align health services, social care, local government, community organisations, older persons' associations, volunteers, and family caregivers. They should also be informed by evidence on care needs, functional ability, service coverage, outcomes, and local resource availability. Resource and service mapping should be encouraged so that older persons, caregivers, care managers, and community actors know what services exist, where they are located, who is eligible, and how support can be accessed. Such mapping can also help identify service gaps, duplication, and areas where additional investment is required.

Continuity of care is another core element. Older persons should not be lost between services after hospital discharge, changes in functional status, emergency events, caregiver breakdown, or transitions between home, community, rehabilitation, and institutional care. Care managers, shared protocols, referral tracking, and follow-up systems can help ensure that older persons receive timely and coordinated support. Digital care records and interoperable referral systems may strengthen coordination, provided that they are accessible, secure, and accompanied by human support.

Digital tools, AI, assistive technologies, and AgeTech can improve care coordination, service navigation, emergency response, caregiver training, rehabilitation, and independent living. However, these tools should support—not replace—human-centred care. Their use must be guided by privacy, consent, transparency, affordability, accessibility, and protection from bias or exclusion. Digital systems should be co-designed with older persons, caregivers, and frontline workers, and should be evaluated for usability, equity, and contribution to care quality.

Prevention and healthy ageing should be strengthened at the community level. Priority areas include chronic disease management, prevention and control of infectious diseases, falls prevention, nutrition, physical activity, mental wellbeing, cognitive health, early identification of functional decline, caregiver self-care, social participation, and the promotion of healthy lifestyles across the life course. These efforts should seek to maintain intrinsic capacity and functional ability, delay frailty and care dependency, and enable older persons to remain active, connected, and independent for as long as possible. Prevention should be recognised as an integral component of community-led care rather than being confined to health promotion alone, requiring coordinated action across health, education, social protection,

local government, and community organisations, together with supportive environments that facilitate healthy choices and ageing in place.

Community organisations, older persons' associations, local governments, and volunteers are critical partners in care delivery because they are close to local realities and can build trust, responsiveness, and outreach. However, they should not be treated as substitutes for formal public responsibility. Their roles should be formally recognised and supported through financing, training, supervision, safeguarding, role clarity, and professional back-up. Social innovation, care cooperatives, community enterprises, and volunteer networks can contribute to care systems when properly resourced and supervised.

Clear care pathways are also necessary. These should cover outreach, screening, eligibility and needs assessment, referral, care planning, case management, follow-up, and review. Pathways should include active older persons, homebound persons, partially dependent persons, bedbound persons, persons with disabilities, persons with cognitive impairment, and socially isolated older persons. A "no wrong door" access system should also be promoted through multiple trusted entry points, including local governments, health facilities, older persons' associations, civil society organisations, volunteers, community leaders, telephone channels, and digital platforms. This can reduce exclusion among people who may not know where to seek help or who face mobility, literacy, or digital barriers.

Community-based long-term care and caregiver support should be expanded through home-based care, day care, respite care, assistive devices, psychosocial support, caregiver training, care leave, and links to social protection. Caregivers, both formal and informal, should be supported through standardised training systems that include basic, intermediate, and advanced skills; dementia care; disability support; safeguarding; communication; self-care; and home-based care competencies. Finally, long-term care should be explicitly included within universal health coverage (UHC) and social protection frameworks, supported by sustainable financing, minimum service guarantees, targeted assistance for vulnerable groups, and reliable data on costs, care needs, service use, and household financial burden.

All ten proposed measures are listed in Table 1, with the top three priority measures identified. The first priority measure is to develop integrated community-led care models linking health, social care, long-term care, rehabilitation, mental health, social protection, and caregiver support, as this provides the system architecture for coordinated and person-centred care. The second priority measure is to improve continuity of care across home, community, primary care, hospital, rehabilitation, and institutional settings, ensuring that older persons are supported through transitions and not lost between services. The third priority measure is to use data, digital tools, resource and service mapping, and assistive technologies to support human-centred care, while safeguarding equity, accessibility, privacy, and community trust.

Table 1. Ten Proposed Measures for Theme 1: Community-Led Care and Long-Term Care Systems, with Top Three Prioritisation

No.	Proposed Measure	Priority Level	Detail
1	**Develop integrated community-led care models linking health, social care, long-term care, rehabilitation, mental health, social protection, and caregiver support.**	****	Establish the foundation for coordinated, person-centred care by designing community-led care models as a continuum aligned with existing frameworks, including the WHO Integrated Care for Older People (ICOPE) approach. Models should support prevention, recovery, ageing in place, and transitions across home, community, hospital, rehabilitation, and institutional settings. This requires governance mechanisms that align health, social care, local government, and community actors around shared roles, accountability, interoperable information systems, digital coordination tools, and evidence on care needs, functional ability, service coverage, and outcomes.
2	**Improve continuity of care across home, community, primary care, hospital, rehabilitation, and institutional settings.**	***	Care managers should monitor transitions, especially after hospital discharge, changes in functional status, emergency events, or caregiver breakdown. Continuity of care requires shared protocols, case management systems, and clear accountability across providers. Digital care records, referral tracking, and follow-up systems can reduce the risk that older persons are lost between services. Evidence should be collected on hospital readmissions, delayed follow-up, rehabilitation outcomes, and user experience to improve care transitions.
3	**Use data, digital tools, and assistive technologies to support—not replace—human-centred care.**	***	Digital systems can improve referral, monitoring, emergency response, training, and service navigation, but must be accompanied by digital literacy, privacy safeguards, and accessible design for older persons and caregivers. Ethical governance is essential to ensure privacy, consent, transparency, data security, and protection

			from bias or exclusion. Digital tools should be co-designed with older persons, caregivers, and frontline workers, and should be evaluated for usability, equity, affordability, and impact on care quality. AI and digital transformation should strengthen human relationships, professional judgement, and community trust rather than replace them.
4	**Strengthen community level prevention, self-care, family support, and early intervention as part of community-led care and long-term care systems.**	**	Priority areas should include chronic disease management, falls prevention, nutrition, physical activity, mental wellbeing, early detection of functional decline, caregiver self-care, and healthy lifestyle promotion across the life course. Community-level prevention should be promoted as part of the care continuum and linked with self-care capacities, family support systems, and accessible local services. This recognises that older persons, families, caregivers, and communities play complementary roles in maintaining functional ability, wellbeing, independence, and ageing in place. Innovation can support prevention through telehealth, mobile screening, health promotion platforms, assistive technologies, community-based monitoring, and locally accessible information on available services. Governance mechanisms are needed to link prevention across health, education, social protection, local government, family support networks, and community organisations. Evidence systems should track functional ability, wellbeing, social participation, self-care practices, family and caregiver support, and preventable care needs across the life span.
5	**Strengthen community organisations, older persons' associations, local governments, and volunteers as partners in care delivery.**	*	Strengthen trust, responsiveness, and local outreach by recognising community actors as essential partners in care delivery. Community actors should be supported through financing, training, supervision, safeguarding, role clarity, and professional back-up, rather than being treated as substitutes for formal services. Governance arrangements should formally recognise their roles while ensuring that statutory responsibility remains with public systems.

			Social innovation, care cooperatives, community enterprises, and volunteer networks can expand support when properly supervised and resourced. Learning systems should document which community models are effective, scalable, and equitable across different contexts.
6	**Establish clear care pathways covering outreach, screening, eligibility and needs assessment, referral, care planning, case management, follow-up, and review.**		Clarify how older persons and caregivers are identified, assessed, referred, supported, followed up, and reviewed across the care continuum. Pathways should include active, homebound, partially dependent, bedbound, persons with disabilities, persons with cognitive impairment, and socially isolated older persons. Resource and service mapping systems should be developed, maintained, and regularly updated so that older persons, caregivers, families, care managers, and community actors know what services exist, where they are located, who is eligible, what eligibility requirements apply, what referral pathways are available, and how support can be accessed. These systems should also help identify gaps in service coverage, accessibility, workforce capacity, financing, and future investment needs. Digital referral systems, shared assessment tools, service directories, and interoperable data platforms can support smoother navigation across services, while governance arrangements should clarify responsibility for each stage of the pathway. Research and monitoring should identify where people are being missed, delayed, or unable to access available support.
7	**Promote a "no wrong door" access system through multiple trusted local entry points.**		Improve access for older persons, caregivers, and vulnerable groups by ensuring that support can be reached through multiple trusted local entry points. These should include local governments, health facilities, older persons' associations, civil society organisations, volunteers, community leaders, and digital or telephone channels. This measure depends on governance and partnership mechanisms that connect formal

			services with community-based actors. Digital and telephone channels should be inclusive, affordable, accessible, and supported by human assistance so that older persons with low digital literacy are not excluded. Data should monitor whether vulnerable groups are effectively accessing services.
8	**Expand community-based long-term care and caregiver support.**		Promote dignity, independence, ageing in place, and caregiver wellbeing by expanding community-based long-term care and support services. Services should include home-based care, day care, respite care, assistive devices, psychosocial support, caregiver training, care leave, dementia support, and links to social protection. Dementia support should include early identification, referral, cognitive stimulation, behavioural and psychosocial support, dementia-friendly home and community environments, and practical guidance for family caregivers. Assistive technologies, AgeTech, caregiver applications, and digital training platforms can support care quality and reduce caregiver burden when designed around real user needs. Governance systems should connect caregivers with health centres, social protection schemes, dementia services, respite care, and community organisations. Data on caregiver burden, service utilisation, dementia-related needs, and unmet care needs should guide planning and resource allocation.
9	**Strengthen caregiver support, practical care guidance, and community-based assistance for families and informal caregivers**		Support systems for family and informal caregivers should be integrated into community-led care and long-term care pathways, while detailed workforce training, certification, and professional recognition should be addressed under the care workforce theme. Caregiver support should

			include practical guidance on home-based care, dementia care, disability support, safeguarding, communication, self-care, and the use of assistive devices. Community-led care teams, local governments, health facilities, older persons' associations, and civil society organisations should help connect caregivers to information, respite care, psychosocial support, referral pathways, and social protection where available. Digital tools, caregiver applications, telephone support, and local service directories can improve access to guidance and reduce caregiver burden, provided that they remain accessible and supported by human assistance. Evidence systems should monitor caregiver burden, unmet support needs, service use, and the effectiveness of community-led caregiver support.
10	**Include long-term care explicitly within Universal Health Coverage (UHC) and social protection frameworks.**		Ensure that community-led care and long-term care are recognised as core system functions within UHC and social protection frameworks. This should include sustainable financing, minimum service guarantees, and targeted additional support for vulnerable groups. The measure requires system-level governance alignment across health financing, social protection, labour, local government, and ageing policy. Strategic purchasing and pooled financing should be informed by reliable data on costs, care needs, service utilisation, and household financial burden and the risk of catastrophic expenditure and impoverishment associated with care needs. Innovation and private-sector engagement may complement public financing, but should be guided by equity, affordability, quality, and public value.

Note: The ranking was determined by participants during the conference deliberations. A four-star ranking (****) indicates the first-ranked priority; a three-star ranking (***)

indicates the second-ranked priority; a two-star ranking (**) indicates the third-ranked priority; and a one-star ranking (*) indicates a measure that was selected and explicitly mentioned during the conference discussion. Measures without a star ranking were also selected through the facilitated discussion process, but were not assigned a specific ranking by participants.

Theme 2: Care Workforce, Standards, and Safeguarding

Care systems cannot be sustained without a capable, supported, fairly treated, and adequately supervised workforce. Workforce development should encompass formal care workers, social workers, health personnel, community workers, volunteers, and informal and family caregivers.

The Recommendation under this theme places strong emphasis on recognising and supporting informal and family caregivers as an integral part of the care system, while also strengthening multidisciplinary collaboration, quality standards, remuneration models, competency frameworks, workforce planning, training, safeguarding, registration, and digital coordination. Workforce, standards, and safeguarding are closely connected: a care system that lacks sufficient workers; clear roles; fair pay; quality standards; and protection mechanisms cannot provide safe, reliable, or dignified care.

Effective care workforce development requires cross-sectoral and cross-ministerial governance. Local administration systems play a critical enabling role because sub-district and municipal structures can serve as deployment platforms for community-led care workers and volunteers; civil registration and household records can support population-based workforce planning and identification of older persons at risk; and local emergency management functions determine how care workers, volunteers, and support services are deployed during disasters and other crises. Workforce planning should therefore involve health, social development, local administration, civil registration, labour, education, and disaster management actors, with coordination mechanisms that align workforce registration, referral pathways, service mandates, emergency roles, and accountability across institutional boundaries.

The current challenge is not only the shortage of caregivers, but also the fragility of the care workforce model itself. In many communities, care continues to depend heavily on volunteers, including older volunteers and Village Health Volunteers, many of whom are themselves approaching older age. Recruiting younger people remains difficult because caregiving is not yet widely regarded as an attractive, secure, or recognised career, particularly where remuneration is low, training costs are high, and career progression is limited. In some contexts, trained caregivers move from public or community-based systems

to private providers because of better pay and working conditions, creating instability in community-led care provision. These patterns indicate the need to move beyond short-term or voluntary arrangements toward a more structured, protected, and sustainable care workforce system.

A strategic shift is therefore required from viewing care primarily as voluntary service toward recognising care as skilled, valued, and socially necessary work. This shift should be supported by legal recognition, skill-based progression pathways, fairer remuneration, annual reskilling, and clearer registration mechanisms linking care units, local authorities, and hospitals. This does not imply reducing the role of volunteers. Rather, it means ensuring that volunteerism is properly supported, protected, trained, supervised, and connected to professional systems. Volunteers, community workers, and informal caregivers should be treated as essential contributors to care systems, while public authorities retain responsibility for standards, financing, protection, and accountability.

Recognising and supporting informal and family caregivers is essential to the sustainability of community-based and long-term care systems. Unpaid care remains a core part of care provision, yet it often remains invisible, under-supported, and unequally distributed, particularly among women, young people, and family members who may reduce their participation in education, employment, or income-generating activities because of care responsibilities. Support for informal and family caregivers should include practical training, respite care, counselling, peer support, flexible work arrangements, and feasible financial or social protection measures. Such measures can reduce burnout, support emotional wellbeing, improve care quality, and ensure that families are supported without being left to carry care responsibilities alone

Multidisciplinary collaboration should be strengthened across health, social care, local government, civil society, volunteer networks, and community-based organisations. Care needs are increasingly complex and require coordinated responses across medical, social, psychosocial, rehabilitation, community engagement, and local welfare systems. A strong local coordinator or care manager can help link health and social care, map community assets, organise referrals, and support social prescribing. Social prescribing can connect older persons and caregivers with elderly clubs, spiritual and cultural activities, peer groups, learning spaces, local support networks, and community-based services that reduce isolation and strengthen wellbeing. Such coordination should be supported by clear referral pathways, shared information systems, and agreed roles among local actors.

Quality standards, accreditation systems, and service assurance mechanisms for community-led care should be updated and strengthened to support safe, reliable, person centred, coordinated and continuous care. Standards should define minimum service expectations, care worker roles, care hours, caregiver-to-client ratios, safety requirements, referral responsibilities, outcome indicators, client feedback mechanisms, and continuous quality

improvement processes. In lower-resource settings, a tiered approach may distinguish between core minimum standards and aspirational standards, enabling progressive improvement without excluding communities that are not yet fully resourced. Standards should apply across public, private, civil society, and community-based providers, while allowing adaptation to local contexts and levels of capacity.

Flexible remuneration and employment models should be developed to make caregiving more viable, attractive, and sustainable. Low pay, unstable work, and limited career prospects undermine recruitment and retention. Flexible models may include full-time, part-time, per-case, and community-based arrangements, while ensuring that flexibility does not lead to informality, insecurity, or weak labour protection. Appropriate remuneration should reflect levels of skill, responsibility, complexity of care, travel time, and supervision requirements. These measures are necessary to strengthen recruitment, improve retention, and support the professionalisation of care work.

Competency frameworks should be established for community-led care workers, social workers, volunteers, and related personnel. These frameworks should clarify the skills, responsibilities, boundaries, and referral roles of different actors within the care system. Competencies should cover health, social, psychological, cultural, communication, safeguarding, digital, logistical, referral, emergency response, and caregiver self-care dimensions. Caregiver self-care should be recognised as part of quality assurance, as burnout prevention affects both caregiver wellbeing and the safety and continuity of care. Clear competency frameworks can also support progression pathways, role clarity, supervision, and stronger links between community-based and formal care systems.

National and local care workforce strategies should guide workforce supply, distribution, retention, remuneration, working conditions, burnout prevention, career pathways, and gender equity. Workforce planning should be based on realistic forecasting of care demand, local workforce availability, skill mix, demographic change, and rural-urban disparities. The workforce required for any community cannot be determined separately from the service delivery model that the community is expected to implement. The number, distribution, and competencies of care workers needed will depend on whether services are home-based, centre-based, residential, outreach-based, or integrated across settings; whether they include case management, social prescribing, rehabilitation, dementia care, disability support, or caregiver respite; and whether services are expected to operate during emergencies. Countries and local governments should therefore conduct joint “service model–workforce mapping” exercises as a foundation for workforce planning. Continued reliance on ageing volunteers is not sustainable without stronger support, protection, and integration with formal systems. Care workforce strategies should estimate future needs for care workers, social workers, case managers, public health nurses, rehabilitation personnel, care coordinators, and trained volunteers, while addressing legal recognition, migration, retention, professional progression, and equitable distribution across local areas.

Education, training, supervision, and professional development should be strengthened to respond to increasingly complex care needs. Training should cover person-centred care, dementia care, disability inclusion, safeguarding, rights, communication, referral, emergency response, and practical home-based care. Training systems should include basic pathways, longer professional pathways, blended learning, practical assessment, annual curriculum review, and regular reskilling and upskilling. Supervision should include regular check-ins, clinical or technical guidance, peer support, workload management, user-friendly reporting systems, and developmental support rather than inspection alone.

Safeguarding systems should be institutionalised to prevent abuse, neglect, exploitation, discrimination, abandonment, and rights violations. Safeguarding must protect older persons, caregivers, volunteers, and care workers. Home and community-led care may involve risks related to harassment, unsafe working conditions, unclear accountability, abuse, neglect, exploitation, and uncertainty about responsibility when problems arise. Safeguarding should therefore include clear care plans, registration mechanisms, team-based protocols where feasible, confidential reporting channels, referral systems, and links with hospitals, local authorities, and social protection systems. It should also address digital risks, including scams, misinformation, and misuse of personal data.

Small care units and caregivers should be registered within linked local authority and hospital systems to strengthen accountability, safety, referral, supervision, and data continuity. Registration can help clarify who provides care, where services are delivered, what level of support is being provided, and which institution is responsible for oversight. Registration mechanisms should be practical, proportionate, and supportive, rather than punitive or overly burdensome. Digital tools may also support reporting, training, monitoring, referral tracking, scheduling, and communication, provided that they are simple, accessible, affordable, and accompanied by practical support for workers and volunteers with limited digital skills.

Community assets may also be mobilised to strengthen workforce support and social prescribing, where appropriate and feasible. Communities may identify local services, spaces, activities, and support mechanisms that benefit both older persons and caregivers, including transport support, community centres, peer groups, health promotion activities, and locally available welfare or service benefits. Dedicated funding for workforce capacity building, upskilling, and reskilling may also be explored, including community-based or older-person-led mechanisms where appropriate, provided that these are transparent, accountable, equitable, and complementary to public responsibility.

The three priority proposed measures provide a practical pathway for strengthening sustainable financing and resource mobilisation for community-led care. First, dedicated allocations should recognise and support informal and family caregivers through allowances, subsidies, training, mental health support, pension-related measures, and social protection.

Second, a dedicated pooled fund should provide predictable financing for community-led care and long-term care services, drawing on public, private, philanthropic, and development partner contributions under public oversight. Third, a special budget should support workforce capacity building, upskilling, and reskilling, ensuring that financing reforms are matched by the human resources required to deliver safe, equitable, and sustainable care. Together, these priorities position care financing as a social investment in demographic resilience, healthy ageing, gender equality, household financial protection, intergenerational equity, and fiscal sustainability. The full set of ten proposed measures is listed in Table 2.

Table 2. Ten Proposed Measures for Theme 2: Care Workforce, Standards, and Safeguarding, with Top Three Prioritisation

No.	Proposed Measure	Priority Level	Details
1	**Recognise and support informal and family caregivers through training, respite care, counselling, peer support, flexible work arrangements, and feasible financial or social protection measures.**	****	Recognise unpaid care as a core function of community-based and long-term care systems. Informal and family caregivers should be supported through practical training, respite care, counselling, peer support, flexible work arrangements, and feasible financial or social protection measures. Where appropriate, governments and relevant institutions should explore whether social protection budgets or related financing mechanisms can support caregiver training, stipends, respite services, and other forms of caregiver assistance, particularly for low-income households and those with high care burdens. Such support can reduce burnout, improve care quality, and help prevent women, young people, and family carers from being pushed out of education, employment, or income-generating activities because of unpaid care responsibilities.
2	**Promote multidisciplinary collaboration among health workers, social workers, care workers, local governments, civil society, volunteers, and community-based organisations.**	***	Strengthen coordination among professionals and community actors involved in care delivery. Multidisciplinary collaboration should connect health care, social care, rehabilitation, local welfare, civil society, and community-based

			support. A designated local coordinator or care manager should help link services, map community assets, organise referrals, and support social prescribing. This can reduce fragmentation, improve continuity of care, and connect older persons and caregivers with local services that reduce isolation and strengthen wellbeing.
3	**Strengthen accredited international quality standards, accreditation systems, and service assurance mechanisms for community-led care to enhance quality, accountability, and workforce mobility.**	**	Strengthen clear minimum expectations for safe, reliable, person-centred, and accountable community-led care. Standards should define care worker roles, care hours, caregiver-to-client ratios, safety requirements, referral responsibilities, outcome indicators, client feedback mechanisms, and continuous quality improvement processes. Accreditation and service assurance mechanisms should apply across public, private, civil society, and community-based providers, while allowing adaptation to local contexts and progressive improvement in lower-resource settings.
4	**Create flexible remuneration and employment models for caregivers, including full-time, part-time, per-case, and community-based arrangements.**	*	Develop remuneration and employment models that make caregiving more viable, attractive, and sustainable. Low pay, unstable work, and limited career prospects undermine recruitment and retention. Flexible models may include full-time, part-time, per-case, and community-based arrangements, while ensuring that flexibility does not lead to informality, insecurity, or weak labour protection. Payment should reflect skill levels, care complexity, travel

			time, supervision requirements, and the social value of care work.
5	**Establish competency frameworks for community-led care workers, social workers, volunteers, and related personnel.**	*	Clarify the skills, responsibilities, boundaries, and referral roles of different actors within community-based and long-term care systems. Competency frameworks should cover health, social, psychological, cultural, communication, safeguarding, digital, referral, emergency response, logistical, and caregiver self-care competencies. They should also support role clarity, supervision, quality assurance, and progression pathways. Clear frameworks can strengthen coordination between community-based actors and formal health and social care systems.
6	**Develop national and local care workforce strategies covering workforce supply, distribution, retention, remuneration, working conditions, career pathways, and gender equity.**		Develop workforce strategies based on realistic forecasting of current and future care needs, workforce availability, skill mix, demographic change, and rural-urban disparities. Strategies should address supply, distribution, retention, remuneration, working conditions, career pathways, gender equity, migration, and legal recognition. Continued reliance on ageing volunteers is not sustainable without stronger support and integration with formal systems. Workforce strategies should make caregiving a recognised career with fair pay, legal support, and skill-based progression.
7	**Strengthen education, training, supervision, and professional development in person-centred care, dementia care, disability inclusion, safeguarding, rights,**		Strengthen capacity building to prepare care workers, volunteers, and related personnel to respond to increasingly complex care needs. Training content and worker competency profiles should be explicitly derived from the service delivery models that governments and

	communication, referral, and emergency response.		communities intend to implement. A 'training needs analysis' process should be conducted at national and local levels, mapping each service function (home-based care, case management, dementia care, day care, rehabilitation, emergency response) against the competencies required, and identifying gaps between current worker skills and service model requirements. This analysis should inform curriculum design, training provider selection, and certification standards. WHO recommends adopting a competency-based training approach. Training should include basic pathways, longer professional pathways, blended learning, practical assessment, annual curriculum review, and regular reskilling and upskilling. Content should cover person-centred care, dementia care, disability inclusion, safeguarding, rights, communication, referral, emergency response, and home-based care. Supervision should be supportive and developmental, not limited to inspection.
8	**Institutionalise safeguarding systems to prevent abuse, neglect, exploitation, discrimination, abandonment, and rights violations.**		Place safety, dignity, and rights at the centre of care systems by institutionalising safeguarding mechanisms for older persons, caregivers, volunteers, and care workers. Safeguarding should prevent and respond to abuse, neglect, exploitation, discrimination, abandonment, and rights violations. It should include clear care plans, caregiver registration, team-based protocols where feasible, confidential reporting channels, referral systems, and links with hospitals, local authorities, and social protection systems, including protection during home visits.
9	**Register small care units and caregivers within linked local authority and hospital systems.**		Strengthen accountability, safety, referral, supervision, and data continuity by registering small care units and caregivers within linked local authority and hospital systems. Registration can

			clarify who provides care, where services are delivered, what level of support is being provided, and which institution is responsible for oversight. It can also reduce risks for both care recipients and caregivers during home-based care. Registration systems should be practical, proportionate, supportive, and not overly burdensome.
10	**Use digital tools to reduce administrative burden and improve coordination, while ensuring training and support for older caregivers and frontline workers.**		Use digital tools to support reporting, training, monitoring, communication, referral tracking, scheduling, and service coordination, while reducing administrative burden. Digital systems should be simple, accessible, affordable, and accompanied by practical support for older caregivers, volunteers, and frontline workers with limited digital skills. Technology should strengthen supervision, communication, and human-centred care rather than create additional reporting burdens or exclude workers and caregivers who require non-digital or assisted access.

Note: The ranking was determined by participants during the conference discussion. A four-star ranking (****) indicates the first-ranked priority; a three-star ranking (***) indicates the second-ranked priority; a two-star ranking (**) indicates the third-ranked priority; and a one-star ranking (*) indicates a measure that was selected and explicitly mentioned during the conference discussion. Measures without a star ranking were also selected through the facilitated discussion process, but were not assigned a specific ranking by participants.

Theme 3: Sustainable Financing and Resource Mobilisation for Community-Led Care

Sustainable financing and resource mobilisation are essential for transforming community-led care from fragmented initiatives into reliable, equitable, and scalable systems. Financing for community-led care and long-term care should be understood as a social investment for demographic resilience, not only as a care-sector financing issue. As populations age, care needs increasingly extend beyond health services to include long-term care, home-based support, assistive devices, respite care, caregiver support, rehabilitation, mental health services, social protection, and community-based coordination. Without predictable

financing, older persons and households may face rising out-of-pocket costs, while families, particularly women and younger family members, may absorb care responsibilities without adequate recognition, compensation, or support. Sustainable financing is therefore not only a fiscal issue; it is also a matter of equity, social protection, gender equality, care system resilience, healthy ageing, household financial protection, reduced unpaid care burden, intergenerational equity, demographic resilience, fiscal sustainability, and public accountability.

The central financing challenge is that many community-led care initiatives remain dependent on short-term projects, local discretion, voluntary contributions, or household resources. This creates uneven access across localities and can leave vulnerable groups without timely support. In some areas, effective pilot models end when project funding expires because they are not embedded into regular public budgets or linked to long-term financing mechanisms. In other settings, community-led care remains underfinanced because service packages, eligibility criteria, institutional responsibilities, and purchasing arrangements are not clearly defined. Financing gaps can therefore result in service fragmentation, unequal care quality, delayed access, and increased financial hardship for households with high care needs.

The Recommendations under this theme call for financing systems that recognise care as a shared responsibility among public institutions, households, communities, employers, private providers, philanthropic organisations, and development partners, while ensuring that public systems retain responsibility for equity, standards, oversight, and accountability. Financing arrangements should be designed to protect households from catastrophic care costs, reduce overreliance on unpaid family care, and ensure that community-led care is accessible to those most at risk. This requires a combination of direct support, pooled financing, targeted subsidies, social protection measures, local resource mobilisation, and strategic purchasing based on evidence and outcomes. These financing reforms should also be linked to broader social and economic outcomes, including healthy ageing, labour force participation, gender equality, intergenerational fairness, community resilience, and long-term fiscal sustainability.

Dedicated financial support for informal and family caregivers should be established as part of sustainable long-term care and social protection financing. Such support may include caregiver allowances, training subsidies, respite support, mental health services, emotional wellbeing services, pension-related measures, assistive device support, and targeted top-ups for vulnerable households. Financing should be linked to care needs assessment, caregiver burden, household vulnerability, disability status, and existing social protection mechanisms. Both digital and non-digital channels should be available to ensure that older persons, caregivers, and vulnerable households can access benefits without exclusion.

A dedicated and predictable pooled financing mechanism for community-led care and related support services should also be considered. Such a fund may combine public resources, private-sector participation, philanthropic contributions, and development partner support, while maintaining public oversight, transparency, and accountability. It could support home-

based care, day care, respite care, assistive devices, service navigation, community-led care coordination, and local innovation. Clear rules should define eligible services, contribution mechanisms, equity safeguards, reporting requirements, and monitoring arrangements to ensure that pooled financing complements, rather than replaces, public responsibility.

A special budget for workforce capacity building, upskilling, and reskilling is also required to ensure that care financing supports implementation capacity. Financing should support certification, supervision, career development, and practical training for formal care workers, community-led caregivers, care managers, volunteers, and related health and social care personnel. Public–private partnerships may expand training capacity and technical expertise, but public financing, national standards, accreditation, and targeted support for underserved areas remain necessary to ensure equity, quality, and consistency across localities.

Fiscal measures should also be explored to recognise the economic value of unpaid caregiving. Tax reductions, deductions, credits, exemptions, or rebates may reduce financial pressure on households that provide substantial unpaid care. However, such measures should be designed with equity safeguards, since low-income households may have limited taxable income and may benefit more from direct transfers, caregiver allowances, or social protection benefits. Tax relief should therefore be considered as one instrument within a broader package of caregiver support and household financial protection.

Equity-oriented financing mechanisms should guarantee a minimum package of community-led care while providing additional support for low-income older persons, persons with disabilities, older persons living alone, informal workers, migrants, and households with high care needs. Reliable data on unmet need, care costs, income, disability, service use, and location should guide targeting. Payment and administrative systems should protect privacy, transparency, and non-discrimination, while ensuring that complex or high-need cases are not excluded.

Fast-track funding mechanisms should be introduced to reduce administrative delays, simplify service navigation, and provide timely support for older persons, persons with disabilities, caregivers, and vulnerable households. These mechanisms should be linked to clear eligibility criteria, care needs assessments, referral pathways, case management systems, and local care plans. They should also be coordinated with health financing, social protection, disability support, local welfare funds, and community-led care systems. National guidelines, transparent approval processes, monitoring systems, and non-digital access channels should safeguard equitable access.

Financing reforms should also reduce overreliance on out-of-pocket payments and unpaid family care. Financial protection should cover care services, assistive devices, transport, respite care, and caregiver support where appropriate. Governance mechanisms should clarify the respective roles of the state, families, communities, employers, and private

providers in financing and delivering care. Data on caregiver burden, income loss, care-related expenditure, and gendered impacts should inform policy design.

Effective community-led care models should move from short-term pilots to system financing by being embedded into national and local budget frameworks. To prevent effective models from ending when pilot funding expires, governments and partners should establish transition plans from pilot implementation to institutional financing, including scale-up criteria, budget lines, lead agencies, co-financing arrangements, and timelines for integration into routine service delivery. Models should be assessed for affordability, scalability, equity, cultural fit, public value, and implementation readiness.

Strategic, evidence-based financing and outcome-oriented accountability should guide long-term investment. Funding should be linked to clearly defined care packages, service standards, provider accreditation, and measurable outcomes. Purchasing should prioritise prevention, home and community-led care, caregiver support, rehabilitation, and continuity of care. Data on costs, workforce needs, service use, functional ability, caregiver burden, user experience, equity, efficiency and outcomes should guide budget decisions. This approach can help ensure that long-term care financing generates public value by improving wellbeing, protecting households, supporting caregivers, strengthening workforce capacity, and sustaining care systems over time.

The three priority directions identified through the ranking process point to a practical financing pathway. First, dedicated allocations should recognise and support informal and family caregivers through allowances, subsidies, training, mental health support, pension-related measures, and social protection. Second, a dedicated pooled fund should provide predictable financing for community-led care and services, drawing on public, private, philanthropic, and development partner contributions under public oversight. Third, a special budget should support workforce capacity building, upskilling, and reskilling, ensuring that financing reforms are matched by the human resources required to deliver safe, equitable, and sustainable care. All ten proposed measures are listed in Table 3.

Table 3. Ten Proposed Measures Theme 3: Sustainable Financing and Resource Mobilisation for Community-led care, with Top Three Prioritisation

No.	Proposed Measure	Priority Level	Implementation Rationale
1	**Establish a dedicated financial mechanism to recognise, compensate, and support informal caregivers and allowances subsidies, training and mental health**	****	Establish dedicated a financial mechanism for informal and family caregivers as part of sustainable long-term care and social protection financing. Measures may include caregiver allowances, training subsidies, respite support, mental health

	support, pension and social protection		services, pension-related support, assistive device support, and targeted top-ups for vulnerable households. Financing should be linked to care needs assessment, caregiver burden, household vulnerability, disability status, and existing social protection mechanisms. Both digital and non-digital channels should be available to ensure equitable access.
2	**Introduce a dedicated pooled fund for community-led care and services through public–private partnerships, including philanthropic contributions.**	***	Create a dedicated and predictable pooled fund to finance community-led care and related support services. The fund may combine public resources, private-sector participation, philanthropic contributions, and development partner support, while maintaining public oversight, transparency, and accountability. Financing should support home-based care, day care, respite care, assistive devices, service navigation, community-led care coordination, and local innovation. Clear rules should define eligible services, contribution mechanisms, equity safeguards, and monitoring requirements.
3	**Provide dedicated financing for care workforce capacity building, upskilling, and reskilling through public–private partnerships.**	**	Allocate dedicated financing for workforce capacity building to support a sufficient, skilled, fairly supported, and sustainable care workforce. Funding should support upskilling, reskilling, certification, supervision, and career development for formal care workers, community-led caregivers, care managers, volunteers, and related health and social care personnel. Workforce financing should cover pre-service and in-service training, blended and digital learning platforms, supervision systems, competency assessment, certification processes, and workforce data systems. Public–private partnerships may expand training capacity and technical expertise, while public financing, national standards, accreditation, and targeted support for underserved areas are needed to ensure equity and quality. Financing mechanisms should include explicit provisions for

			underserved geographic areas and gender-responsive support, including subsidised training for female caregivers, informal caregivers, and community-based workers who cannot attend centralised courses because of care responsibilities, travel costs, time constraints, or limited access to training facilities.
4	**Introduce tax reduction policy for the family with unpaid caregivers**	*	Explore tax relief and related fiscal measures for households providing substantial unpaid care. Such measures can recognise the economic value of family caregiving and reduce financial pressure on households supporting older persons with care needs. Tax deductions, credits, exemptions, or rebates should be designed with equity safeguards, as low-income households may have limited taxable income. Complementary measures, such as direct transfers, caregiver allowances, or social protection benefits, may be needed to reach the most vulnerable households.
5	**Prioritize equity and inclusion financing mechanism to ensure access for vulnerable groups**	*	Prioritise equity-oriented financing mechanisms to ensure that vulnerable groups can access community-led care and long-term care services. Financing should guarantee a universal minimum package while providing additional support for low-income older persons, persons with disabilities, older persons living alone, informal workers, migrants, and households with high care needs. Data on unmet need, care costs, income, disability, service utilisation, and location should guide targeting, while payment systems should protect privacy, transparency, and non-discrimination.
~~**6**~~	**Introduce a fast-track funding mechanism for long-term care, community-led care, and related support**	*	Establish fast-track funding mechanisms to reduce administrative delays, simplify service navigation, and provide timely support for older persons, persons with

	services to improve access and service navigation.		disabilities, caregivers, and vulnerable households. These mechanisms should be linked to clear eligibility criteria, care needs assessments, referral pathways, and local care plans. They should be coordinated with health financing, social protection, disability support, local welfare funds, and community-led care systems. National guidelines, transparent approval processes, monitoring systems, and non-digital channels should safeguard equitable access.
7	**Reduce overreliance on out-of-pocket payments and unpaid family care.**		Reduce dependence on out-of-pocket payments and unpaid family care by strengthening shared responsibility for long-term care financing. Financial protection should cover care services, assistive devices, transport, respite care, and caregiver support where appropriate. This is particularly important for women and younger family members whose education, employment, or income may be affected by caregiving responsibilities. Governance mechanisms should clarify the roles of the state, families, communities, employers, and private providers in financing and delivering care.
8	**Move from short-term pilots to system financing by embedding effective community-led care models into national and local budgets**		Institutionalise effective community-led care models by integrating them into regular national and local budget frameworks, rather than relying on time-limited project or pilot funding. Financing should move toward predictable system financing through medium-term expenditure frameworks, UHC-related financing, local government plans, and social protection systems. To prevent effective models from ending when pilot funding expires, governments and partners should establish clear transition

			plans from pilot implementation to institutional financing, including agreed scale-up criteria, budget lines, lead agencies, co-financing arrangements, and timelines for integration into routine service delivery. This requires clear lead institutions, budget holders, implementation partners, and accountability arrangements. Pilot models should be assessed for affordability, scalability, equity, cultural fit, public value, and implementation readiness before being adapted, financed, scaled, or discontinued.
9	**Establish financial protection mechanisms to prevent catastrophic care costs for older persons and households.**		Establish financial protection mechanisms to prevent long-term care needs from leading to catastrophic expenditure and impoverishment, thereby pushing older persons and households into poverty or debt. Measures may include subsidies, fee waivers, capped co-payments, caregiver allowances, assistive device support, and targeted top-ups for vulnerable groups. Financial protection should be linked to social protection, disability support, pension policy, health financing, and local welfare mechanisms. Data systems should identify households facing high care costs and groups at risk of financial hardship.
10	**Strengthen strategic, evidence-based financing, and outcome-oriented accountability for community-led care.**		Strengthen strategic and evidence-based financing by linking funding to clearly defined care packages, service standards, provider accreditation, and measurable outcomes. Purchasing should prioritise prevention, home and community-led care, caregiver support, rehabilitation, and continuity of care. Governments should use data on costs, workforce needs, service utilisation, functional ability, caregiver burden, user experience,

			equity, efficiency, and outcomes to guide budget decisions. Safeguards should ensure that high-need populations and complex cases are not excluded from services.

Note: The ranking was determined by participants during the conference discussion. A four-star ranking (****) indicates the first-ranked priority; a three-star ranking (***) indicates the second-ranked priority; a two-star ranking (**) indicates the third-ranked priority; and a one-star ranking (*) indicates a measure that was selected and explicitly mentioned during the conference discussion. Measures without a star ranking were also selected through the facilitated discussion process, but were not assigned a specific ranking by participants.

Theme 4: Community Resilience, Age-Friendly Environments, and Climate Risk

Ageing societies require communities that are not only care delivery platforms, but also safe, accessible, inclusive, and resilient to future shocks. Climate risk, disasters, urbanisation, displacement, social isolation, and inequality should therefore be addressed as core components of ageing policy. A central challenge is that public administration often remains fragmented, with limited coordination across institutions, fragmented governance and limited coordination across institutions, insufficient frontline training, and gaps in accessible infrastructure and services. Ageing societies therefore need integrated, accessible, participatory, and agile governance systems that can respond effectively to urbanisation, climate change, and the changing needs of older populations.

The priority is to build age-friendly and climate-resilient communities that protect older persons during emergencies, support ageing in place, strengthen social participation, and ensure continuity of care before, during, and after shocks. Resilience should be understood broadly. It is not limited to disaster response, but also includes mobility, housing, access to health and social services, social connection, digital inclusion, public communication, emergency preparedness, local governance, and the ability of older persons to participate as active contributors in community life.

Several interconnected challenges need to be addressed. First, many older persons face limited accessibility in urban infrastructure, including transport, public spaces, and communication systems. Even where infrastructure exists, older persons may not be able to use it because of low literacy, poor communication, distance, cost, or lack of confidence. Second, access to health and social services remains uneven. Rural communities may have

fewer services, while urban communities may have weaker social connections despite better physical access to facilities. Third, older persons are particularly vulnerable during floods and other disasters, especially where disaster management skills, responsive planning, and inter-agency coordination remain weak.

Age-friendly environments should therefore be treated as resilience infrastructure. Public transport, walkable streets, safe crossings, parks, markets, community centres, health facilities, shelters, and housing are not only amenities; they determine whether older persons can remain active, maintain relationships, access care, and stay safe during emergencies. Walkability, green spaces, public parks, exercise areas, recreational programmes, bikeability, and active transport initiatives can all contribute to healthier, more connected, and more resilient communities.

Universal design should be embedded across both urban and rural planning. This means designing environments that are usable by older persons, persons with disabilities, caregivers, children, and the broader population. Practical issues matter: the time older persons need to cross roads, the availability of seating and shade, toilet access, lighting, ramps, clear signage, safe public transport, and easy access to health and social services. Age-friendly planning should be linked to housing, transport, land use, public health, social protection, and climate adaptation, rather than treated as a separate welfare activity.

Continuity of care during shocks is a core resilience priority. Floods, heatwaves, pandemics, economic crises, displacement, and service disruptions can interrupt medication, food, assistive devices, caregiving, transport, social support, and medical follow-up. Community resilience systems should therefore include local registries of older persons at risk, continuity plans for home and community-led care, pre-positioned resources, emergency transport arrangements, accessible shelters, backup communication systems, and clear referral protocols. Community-led care mechanisms, health volunteers, local caregivers, integrated monitoring systems, and early warning tools should be connected so that vulnerable populations are not left unsupported during crises.

People most at risk should be identified before emergencies occur, taking into account country contexts and existing national mechanisms. It should also be recognised that any person may become vulnerable when exposed to hazards, depending on the nature, intensity, and duration of the emergency. At-risk groups may include, for example, older persons living alone, persons with disabilities, people with dementia, care-dependent persons, those without family support, older persons living in informal settlements, and those in flood-prone, remote, or poorly connected areas. Identification systems should not be limited to administrative registration. They should combine local knowledge, community mapping, health and social service data, volunteer networks, and regular home visits. Privacy and dignity must be protected, while data systems should remain practical enough to support timely and coordinated response.

Community resilience should also address social isolation. Public transport enables mobility and social participation, while community centres, parks, and shared public spaces can reduce loneliness. Intergenerational spaces are especially important. Traditional older persons' clubs can be reframed as resource centres, experience centres, or intergenerational learning spaces where older persons share knowledge and younger people contribute digital skills, volunteer time, and social connection. Such spaces can support recreation, lifelong learning, health promotion, AI and digital literacy, community service, and mutual aid.

Digital technology can strengthen resilience when it is inclusive and trusted. Older persons should have opportunities to learn about AI and digital technology, not only as users of care services but also as active participants in digital society. The positive potential of technology includes alerts, communication, health monitoring, digital learning, care coordination, and connection during emergencies. However, technology must not exclude older persons with low digital confidence or limited access. Public alert systems for air pollution, disasters, and extreme weather show how technology can support public communication, but accessible language, trust, and multiple communication channels remain essential.

Local governance capacity is the enabling condition for age-friendly resilience. Local governments need authority, budget, technical capacity, trained personnel, data, and coordination mechanisms to integrate housing, transport, health, social services, disaster risk reduction, and community engagement. In many settings, local governments may lack personnel with specific expertise in ageing, while national plans may not translate effectively into responsive local action. Strengthening local capacity therefore requires training for frontline staff, practical planning tools, inter-agency protocols, community participation mechanisms, and clearer accountability.

Finally, resilience planning should recognise older persons as rights holders and contributors, not passive beneficiaries. Older persons can support peer networks, transmit local knowledge, assist in preparedness planning, participate in community watch systems, mentor younger generations, and contribute to social cohesion. Addressing ageism is therefore part of resilience. Communities that value older persons' experience, protect their rights, and enable participation will be better prepared for future shocks.

The three priority proposed measures identified through the ranking process point to a practical pathway for strengthening age-friendly and climate-resilient communities. First, inclusive digital and communication systems should be used to support early warning, emergency alerts, care coordination, health monitoring, and social connection, while maintaining non-digital channels to avoid exclusion. Second, intergenerational spaces and programmes should be strengthened to promote social participation, mutual support, digital inclusion, lifelong learning, and community cohesion across age groups. Third, age-friendly housing, transport, public spaces, health facilities, markets, shelters, and community centres should be promoted as core resilience infrastructure that supports mobility, accessibility, safety, service access, and ageing in place. Together, these priorities position resilience as part

of everyday community life, not only emergency response. All ten proposed measures are listed in Table 4.

Table 4. Ten Proposed Measures Theme 4: Community Resilience, Age-Friendly Environments, and Climate Risk, with Top Three Prioritisation

No.	Proposed Measure	Priority Level	Implementation Rationale
1	**Use inclusive digital and communication systems for early warning, alerts, care coordination, and social connection.**	****	Digital and communication systems can strengthen resilience through disaster alerts, health monitoring, service coordination, and social connection. These systems should be affordable, accessible, multilingual where needed, disability-inclusive, and supported by trusted local intermediaries and human assistance. Multiple communication channels, including non-digital options, should be maintained to avoid exclusion. AI and digital systems should be governed by safeguards on privacy, consent, transparency, data security, and protection from bias or misuse.
2	**Strengthen intergenerational spaces and programmes that promote social participation, mutual support, and community cohesion.**	***	Intergenerational spaces can strengthen social connection, mutual support, and community cohesion among older persons, younger people, families, and community members. Older persons' clubs, schools, universities, and community centres may be developed as intergenerational learning and resource platforms. These spaces can support lifelong learning, digital inclusion, health promotion, peer support, cultural exchange, volunteerism, and mutual aid. Local planning, sustainable financing, and partnerships with civil society and education institutions are needed to sustain such models.
	Promote age-friendly housing, transport, public spaces, health	**	Age-friendly environments improve accessibility, safety, mobility, service access,

No.	Proposed Measure	Priority Level	Implementation Rationale
3	**facilities, markets, shelters, and community centres.**		and community participation. Housing, public transport, walkways, parks, green spaces, markets, shelters, health facilities, and community centres should be treated as core resilience infrastructure. Age-friendly design should be integrated into urban and rural planning, local budgets, and public service delivery. Evidence should be collected on accessibility, transport barriers, use of public spaces, social participation, and the effects of age-friendly environments on wellbeing and resilience.
4	**Apply universal design and accessibility standards in urban and rural planning.**	*	Universal design ensures that environments are usable by older persons, persons with disabilities, caregivers, children, and the wider community. Planning should address crossings, ramps, seating, shade, toilets, signage, lighting, transport access, evacuation routes, and safe movement during emergencies. Universal design should be embedded in planning regulations, infrastructure investment, building standards, public procurement, and disaster shelter design. Monitoring systems should assess whether accessibility standards are implemented in practice, not only adopted in policy.
5	**Integrate ageing into climate adaptation, disaster preparedness, emergency response, and local resilience planning.**	*	Ageing should be integrated into climate adaptation, disaster risk reduction, health, social protection, housing, transport, and local development plans. Planning should recognise both the specific risks faced by older persons and their capacities to contribute to preparedness, response, and recovery. This requires coordination among local governments, disaster management agencies, health and social care providers,

No.	Proposed Measure	Priority Level	Implementation Rationale
			housing and transport authorities, civil society, and community organisations. Risk maps, early warning systems, and vulnerability data should inform preparedness and response.
6	**Ensure continuity of care during shocks such as floods, heatwaves, pandemics, economic crises, displacement, or service disruption.**		Continuity of care should be maintained during shocks, including access to essential care, medication, assistive devices, food, transport, communication, and psychosocial support. Local continuity plans should include emergency referral arrangements, backup caregivers, accessible shelters, emergency transport, follow-up after shocks, and support for those dependent on regular care. Clear protocols, designated lead agencies, pre-positioned resources, and coordination between health, social care, local government, volunteers, and emergency responders are required. Non-digital access should remain available.
7	**Develop local systems to identify and support older persons most at risk, including those living alone, persons with disabilities, care-dependent persons, and those without family support, while also promoting an enabling environment for active older persons to support frail older persons and persons with disabilities.**		Local systems should identify older persons and other community members facing the greatest risks, while creating community conditions, norms, and support mechanisms that encourage active older persons to contribute to peer support, mutual care, and assistance for frail older persons and persons with disabilities. Identification should combine administrative data, community mapping, volunteer networks, local knowledge, and regular home visits, with safeguards for privacy, consent, dignity, and data security. Local registries, vulnerability mapping, and disaggregated data should guide timely action. Older persons' associations, volunteers, active older persons,

No.	Proposed Measure	Priority Level	Implementation Rationale
			and community organisations should be linked to referral and response systems.
8	**Build local governance capacity for age-friendly and resilience-oriented planning.**		Local governance capacity is essential for assessing needs, coordinating partners, mobilising resources, and implementing age-friendly and resilience-oriented strategies. Local governments require clear mandates, budget authority, technical tools, trained personnel, ageing expertise, inter-agency protocols, data systems, and accountability mechanisms. Partnerships with universities, civil society, older persons' groups, professional bodies, and the private sector can strengthen planning and implementation quality. Capacity-building should support both routine community development and preparedness for climate, health, and social shocks.
9	**Address loneliness, ageism, and social exclusion through community initiatives, public communication, and inclusive local planning.**		Loneliness, ageism, and social exclusion are risks to wellbeing, participation, and community resilience. Older persons should be recognised as rights-holders, knowledge holders, volunteers, mentors, workers, caregivers, entrepreneurs, community leaders, and co-producers of solutions. Community initiatives and public communication should challenge ageism, promote positive narratives of ageing, and strengthen participation. Data on loneliness, discrimination, social connectedness, and participation should guide interventions, while inclusive local planning should ensure access to community life.
10	**Strengthen frontline disaster and resilience capacity for local**		Frontline personnel, volunteers, and caregivers should be equipped to support older persons before, during, and after

No.	Proposed Measure	Priority Level	Implementation Rationale
	personnel, volunteers, and caregivers.		shocks. Training should cover disaster preparedness, evacuation support, continuity of care, disability inclusion, communication with older persons, psychosocial support, and compassionate person-centred response. Capacity-building should combine formal instruction, simulation exercises, community drills, digital learning tools, and peer learning. Governance mechanisms should clarify roles among health facilities, local governments, volunteers, frontline workers, and emergency responders, supported by monitoring and after-action reviews.

Note: The ranking was determined by participants during the conference discussion. A four-star ranking (****) indicates the first-ranked priority; a three-star ranking (***) indicates the second-ranked priority; a two-star ranking (**) indicates the third-ranked priority; and a one-star ranking (*) indicates a measure that was selected and explicitly mentioned during the conference discussion. Measures without a star ranking were also selected through the facilitated discussion process, but were not assigned a specific ranking by participants.

7. Recommendations for Cross-Cutting Enabling Factors

The following enabling factors cut across all thematic areas and are essential for translating shared commitments into practical implementation. They recognise that community-led care systems, workforce development, sustainable financing, and resilience-building cannot be advanced through isolated interventions. Rather, they require an international obligation mechanism, supportive innovation ecosystems, coordinated governance, inclusive partnerships, reliable evidence, and continuous learning. These enabling factors therefore provide the foundation for strengthening implementation capacity, aligning institutional roles, mobilising resources, and ensuring that ageing societies can respond to present and future needs in ways that are inclusive, accountable, and sustainable.

The Bangkok Recommendations therefore call for these enabling factors to be treated not as separate technical issues, but as system-wide conditions for implementation. Innovation must be guided by equity and public value; governance must clarify responsibilities and sustain partnerships; and data and learning systems must support evidence-informed decision-making, accountability, and adaptation. Together, these enabling factors can help

ensure that recommendations are translated into practical actions at local, national, and regional levels.

Enabling factor 1: Innovation, Digital Transformation, AI, and the Inclusive Silver Economy

This enabling factor reflects the event's focus on innovation, AI, digital transformation, AgeTech, and the inclusive silver economy. It also connects with discussions on the longevity economy, investment opportunities, and innovation exchange. The Recommendations encourage governments, partners, communities, and private-sector actors to promote innovation that strengthens care quality, inclusion, autonomy, participation, resilience, and wellbeing, while ensuring that technological and market-based solutions do not widen existing inequalities.

Innovation should be understood not as technology alone, but as the responsible development of social, institutional, financial, digital, and service-delivery solutions that improve wellbeing, care quality, independence, and inclusion. Digital tools, AI, assistive technologies, and AgeTech can support care coordination, service navigation, telehealth, caregiver support, emergency response, monitoring, rehabilitation, and independent living. However, innovation must be guided by equity, affordability, accessibility, privacy, transparency, and human-centred design. Digital transformation should therefore be accompanied by safeguards for data protection, informed consent, algorithmic accountability, non-discrimination, and meaningful human oversight. It should also be supported by digital literacy, accessible design, multilingual communication where needed, and non-digital alternatives for older persons and caregivers who may face barriers to technology use.

Innovation should also include social and institutional innovation, such as community-led care models, social prescribing, caregiver support systems, intergenerational learning spaces, pooled financing arrangements, integrated referral pathways, and new partnerships between public systems, communities, academia, civil society, and private-sector actors. These forms of innovation are particularly important because many challenges in ageing societies cannot be solved by technology alone. They require trust, coordination, financing, standards, and sustained local implementation capacity.

The inclusive silver economy should not treat older persons only as consumers. It should recognise older persons as workers, entrepreneurs, caregivers, mentors, volunteers, community leaders, knowledge holders, and co-producers of solutions. Private-sector engagement can contribute to care, housing, finance, technology, and services, but it must be governed by clear safeguards to protect affordability, quality, dignity, and public value. Accordingly, the inclusive silver economy should be developed in ways that expand opportunities without deepening exclusion. Investment should prioritise products, services,

and systems that are accessible, affordable, ethical, and responsive to the needs of diverse older persons, including those with disabilities, low income, limited digital access, or high care needs.

Enabling factor 2: Governance, Partnerships, and Implementation Mechanisms

This enabling factor serves as the bridge between recommendations and action. Community-led care, workforce development, sustainable financing, and resilience planning cannot be implemented through isolated programmes or single-sector action. They require governance systems that align ministries, local governments, civil society, academia, development partners, professional bodies, private-sector actors, and communities around shared outcomes and accountability.

The Recommendations call for governance arrangements that clearly define institutional roles, decision-making authority, financing responsibilities, implementation mechanisms, and accountability structures. This is particularly important because ageing, care, resilience, and the silver economy cut across multiple sectors, including health, social development, labour, finance, local government, housing, transport, disaster management, education, digital development, and urban planning. Without clear coordination, responsibilities may remain fragmented, services may overlap or leave gaps, and communities may be expected to carry responsibilities without adequate resources or statutory support.

Effective governance should reduce fragmentation, clarify institutional responsibilities, support decentralised implementation, and institutionalise participation by older persons, caregivers, frontline workers, and community organisations. It should also identify lead institutions, establish implementation mechanisms, and sustain collaboration beyond the conference through working groups, communities of practice, policy dialogues, technical exchanges, and joint projects.

Participation should be structured, continuous, and meaningful, rather than limited to consultation. Older persons, caregivers, community actors, and frontline workers should be involved in the design, implementation, monitoring, and improvement of policies and services. Their lived experience can help identify access barriers, service gaps, safeguarding concerns, and practical solutions that may not be visible through administrative systems alone.

Partnerships should be governed by clear principles of transparency, equity, accountability, and public value. Private-sector and philanthropic engagement can support innovation, financing, service delivery, infrastructure, and technology, but should not replace public responsibility for equitable access, quality assurance, and rights protection. Similarly, community organisations, older persons' associations, volunteers, and civil society actors

should be recognised as essential partners, while being adequately supported through financing, training, supervision, and clear referral mechanisms.

Implementation mechanisms should translate broad recommendations into actionable workplans, including lead agencies, timelines, resource requirements, coordination platforms, monitoring indicators, and reporting arrangements. Follow-up structures may include thematic working groups, regional learning platforms, communities of practice, joint research initiatives, and pilot-to-scale mechanisms. These arrangements can help sustain collaboration beyond the conference and ensure that shared commitments lead to concrete implementation.

Enabling factor 3: Data, Research, Evidence, and Learning Systems

This enabling factor recognises data, research, evidence, and learning systems as central to effective policy design, implementation, monitoring, and accountability. While these elements are reflected across the Recommendations, presenting them as a dedicated enabling factor strengthens the credibility and operational value of the Bangkok Recommendations for policy, research, and implementation audiences. It also reinforces the need for feasible, comparable, and policy-relevant measurement frameworks that capture functional ability, wellbeing, caregiver burden, social participation, service coverage, costs, workforce ratios, quality assurance, digital inclusion, and resilience indicators.

Ageing policy and community-led care systems must be guided by reliable data, implementation research, outcome measurement, and continuous learning. Without evidence, countries cannot identify unmet needs, allocate resources fairly, monitor quality, evaluate innovation, or scale effective models. Learning systems should therefore support regular feedback from communities, older persons, caregivers, frontline workers, service providers, and local governments, ensuring that policies and programmes can be adapted to changing needs, implementation realities, and emerging risks.

The Recommendations encourage countries and partners to strengthen integrated data systems that can identify care needs, service gaps, household financial burdens, caregiver stress, workforce shortages, accessibility barriers, and climate-related vulnerabilities. Data should be disaggregated, where appropriate, by age, sex, disability, income, location, living arrangement, migration status, care dependency, and other relevant characteristics. Such data are essential for targeting support, monitoring equity, and ensuring that older persons who are homebound, living alone, socially isolated, disabled, care-dependent, or exposed to disaster risks are not missed by formal systems.

Evidence systems should also support implementation learning, not only retrospective evaluation. This means collecting information on what works, for whom, under what conditions, at what cost, and with what implementation requirements. Community-led care

models, digital tools, financing mechanisms, workforce interventions, age-friendly environments, and resilience strategies should be assessed for effectiveness, equity, affordability, scalability, cultural fit, and public value. Findings should be used to improve programme design, guide budget decisions, support strategic purchasing, and determine whether pilot models should be adapted, scaled, institutionalised, or discontinued.

Data governance is equally important. Information systems must protect privacy, consent, dignity, and data security, while remaining practical enough to support timely action. Digital systems should not exclude people with low digital literacy, limited connectivity, disability-related barriers, language barriers, or lack of access to devices. Administrative data, community mapping, service directories, local registries, qualitative evidence, and participatory feedback should be combined to provide a more complete understanding of needs and implementation realities.

Finally, learning systems should promote regional cooperation and shared knowledge across countries and institutions. Ageing societies in Asia and the Pacific are progressing at different speeds and under different institutional conditions. This diversity creates opportunities for comparative learning on community-led care, long-term care financing, caregiver support, digital inclusion, workforce development, social prescribing, age-friendly environments, and climate resilience. Regional learning platforms, joint research, technical exchanges, and communities of practice can help countries adapt promising models, avoid repeating common challenges, and develop evidence-informed implementation tools.

8. Recommendations for Systematic Follow-Up Actions

The Bangkok Recommendations are intended to serve not only as a statement of shared priorities, but also as a basis for sustained collaboration, policy translation, and implementation support. Follow-up actions should be practical, sequenced, and adaptable to different country and institutional contexts. They should also preserve flexibility, allowing governments, local authorities, academic institutions, civil society organisations, older persons' organisations, development partners, and private-sector actors to contribute according to their mandates, expertise, and available resources. The following proposed actions provide a structured pathway for moving from conference deliberation to continued cooperation, policy uptake, technical support, and implementation learning.

1. Establish a regional community of practice to sustain technical exchange and peer learning.

A regional community of practice should be established to maintain collaboration on community-led care, long-term care, care workforce development, sustainable financing,

age-friendly environments, climate resilience, digital inclusion, and the inclusive silver economy. The platform should support regular knowledge exchange, sharing of implementation tools, dissemination of research findings, and peer learning across countries and institutions. It may operate through periodic online meetings, thematic working groups, shared repositories, and regional learning events. Participation should include policymakers, practitioners, researchers, local governments, civil society, older persons' organisations, community-based organisations, professional bodies, and development partners.

Potential responsible entities may include regional organisations, United Nations agencies, academic and research institutions, government agencies, national and regional non-governmental organisations, professional networks, and older persons' associations.

2. Produce and disseminate knowledge products to translate the Recommendations into policy-relevant messages.

A conference synthesis report should be prepared to document the key discussions, thematic findings, actionable measures, stakeholder inputs, and proposed follow-up priorities. In addition, a concise policy brief should be developed to communicate the core messages of the Bangkok Recommendations in an accessible and action-oriented format for decision-makers. These knowledge products should distinguish between regional priorities, national policy implications, and local implementation considerations. They should also highlight practical examples, implementation gaps, and areas requiring further technical cooperation. Dissemination should target relevant local, national, ASEAN, Asia-Pacific, and global policy platforms.

Potential responsible entities may include conference hosts and co-hosts, academic institutions, rapporteur teams, United Nations agencies, regional organisations, policy research institutes, government sectors, civil society organisations, and development partners.

3. Identify demonstration sites and develop practical tools for implementation.

Demonstration sites or learning cases should be identified to show how the Recommendations can be applied in real-world settings. These may include community-led care pathways, caregiver support systems, workforce models, pooled financing arrangements, age-friendly environments, climate-resilient communities, digital care coordination and service navigation, social prescribing, and inclusive AgeTech solutions. Demonstration sites should include both well-resourced and lower-resource settings, including rural, remote, and climate-exposed communities. Practical tools should also be developed, such as care pathway templates, resource mapping tools, vulnerability assessment templates, safeguarding protocols, workforce competency frameworks, financing assessment tools, digital inclusion guidelines, and monitoring indicators.

Potential responsible entities may include local governments, community-based organisations, national government agencies, universities, research institutes, national NGOs, older persons' associations, health and social care providers, professional bodies, and private-sector or social enterprise partners.

4. Support joint research, implementation studies, and evidence-based learning.

Joint research and implementation studies should be encouraged to generate evidence on what works, for whom, under what conditions, at what cost, and with what implementation requirements. Priority topics may include community-based long-term care, caregiver support and burden, care workforce needs, sustainable financing, social protection for caregivers, digital inclusion, social prescribing, age-friendly environments, climate resilience, and the contribution of older persons as co-producers. Studies should examine not only outcomes, but also implementation process, feasibility, equity, affordability, governance arrangements, workforce requirements, and scale-up conditions. Findings should inform policy design, budget decisions, implementation tools, and regional learning.

Potential responsible entities may include universities, research institutes, government research agencies, United Nations agencies, regional organisations, national NGOs, civil society networks, development partners, local implementers, and community stakeholders.

5. Convene follow-up dialogues, monitor progress, and mobilise partnerships for implementation.

Follow-up technical dialogues or workshops should be convened to review progress, identify implementation barriers, refine tools, and maintain momentum. These may focus on integrated care pathways, caregiver support, long-term care financing, workforce standards, digital care coordination, climate-resilient ageing, safeguarding, social prescribing, or implementation measurement. A light-touch monitoring and learning mechanism should also be established, using periodic progress notes, shared case studies, and annual or biennial learning exchanges. Resource mobilisation should support tool development, training, research, technical assistance, and pilot adaptation, while ensuring transparency, equity, affordability, and public value.

Potential responsible entities may include host and co-host institutions, government agencies, regional bodies, United Nations agencies, academic institutions, professional networks, national NGOs, community-based organisations, development partners, philanthropic organisations, private-sector actors, and social enterprises.

9. Conclusion

The Bangkok Recommendations affirm that ageing societies require integrated, inclusive, and community-centred systems that support dignity, care, participation, resilience, and wellbeing across the life course. They recognise that population ageing is not only a

demographic transition, but also a social, economic, institutional, and community transformation requiring coordinated action across sectors and levels of governance.

The Recommendations call for a shift from fragmented and reactive approaches toward institutionalized community-based delivery platforms that connect health and social care, long-term care, workforce development, sustainable financing, age-friendly and climate-resilient environments, responsible innovation, governance, and evidence-informed implementation. Such systems should enable older persons to live with autonomy and dignity, support families and caregivers, strengthen community resilience, and ensure that care and support are accessible to those most at risk.

The Recommendations do not prescribe a single model. Rather, they provide a flexible framework that may be adapted by countries, localities, institutions, and communities according to their contexts, capacities, mandates, and priorities. Their value lies in offering a shared direction for strengthening community-led care systems, advancing inclusive silver economy approaches, and building resilient ageing societies through practical, equitable, and sustainable action.

Moving forward, the implementation of these Recommendations will require sustained cooperation, policy translation, resource mobilisation, evidence generation, and partnerships across government sectors, local authorities, civil society, academia, professional bodies, communities, development partners, and the private sector. Through collective and context-sensitive action, the Bangkok Recommendations can contribute to ageing societies that are more inclusive, resilient, equitable, and better prepared to ensure that no one is left behind.

For more information & the full report & E-FILES

https://bangkokrecommendations.netlify.app/

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