



World Health
Organization

DEVELOPING AN ETHICAL FRAMEWORK FOR HEALTHY AGEING

Report of a WHO meeting
Tübingen, Germany, 18 March 2017

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Executive summary

Today, people live longer than ever. The rising number of older people is leading to radical social change, including challenges for global health and health care systems. This development was addressed in the *World report on ageing and health* published by WHO in 2015, followed by the Global strategy and action plan on ageing and health 2016–2020, which provides strategies and policy options for Member States to support people in living not only longer but also healthier lives. These documents indicate that some issues of healthy ageing require conceptual and ethical exploration. For this purpose, a scoping meeting was organized by WHO on 18 March 2017 at the University of Tübingen, Germany. Various experts in the fields of bioethics, gerontology, public health and other social and medical sciences were invited. This report presents the content of the presentations and summarizes the achievements of the meeting.

Participants agreed on the first steps towards an ethical framework for healthy ageing. The target groups of the framework are the older persons themselves and the stakeholders responsible for their health and well-being, such as family members, professional carers, institutions, communities and local and national

governments. All are responsible for contributing to ensuring conditions that help older people do and be what they value. These conditions are shaped by many considerations, including changing expectations of medical care in older age, a just allocation of medical resources, ensuring real possibilities for the participation of older people in social life, promoting an age-friendly environment that supports the functions valued by older people, ensuring the absence of discrimination and abuse in both personal relations and social structures, and having a deep understanding of the life-course, especially the meaning of older age, and respect for its special existential dimensions.

An ethical framework could increase awareness of these issues, help to reshape moral and social attitudes to old age and provide a tool that could be applied consistently by various stakeholders. The meeting was convened to identify the elements of such an ethical framework.

1. Background

According to the WHO *World report on ageing and health* (1, p. 3), the number of people over the age of 60 is expected to double by 2050. This will result in radical societal change. Dr Margaret Chan, the former Director-General of WHO, said,

today, most people, even in the poorest countries, are living longer lives. But this is not enough. We need to ensure these extra years are healthy, meaningful and dignified. Achieving this will not just be good for older people, it will be good for society as a whole.

This statement summarizes the starting-point of the meeting. A global increase in average life expectancy is a major achievement, but the risk and the burden of chronic diseases rise with increasing age (1, p. 39) and can contribute to negative stereotypes and discrimination of older people. It will be crucial to maintain good health throughout the life-course and prevent diseases if older people are to engage in meaningful activities. In so far as chronic diseases in advanced age cannot be fully prevented, the health needs of older people must be met, such as in long-term care, to protect their dignity. And, as Dr Chan rightly highlighted, only if the lives of

older people are healthy, meaningful and dignified will society as a whole benefit from their full potential.

In order to ensure that adults live not only longer but also healthier lives, the Sixty-ninth World Health Assembly adopted in May 2016 a comprehensive Global strategy and action plan on ageing and health 2016–2020 and a related resolution (2). This strategy is based on the 2015 *World report on ageing and health* (1). Its aim is for every country to commit to action on healthy ageing. Some of the fastest demographic changes are occurring in low- and middle-income countries. Promoting healthy ageing, including addressing age discrimination in various forms, and building systems to meet the needs of older adults will be sound investments in a future in which older people have the freedom to be and to do what they value and to develop and maintain “the functional ability that enables well-being in older age” (1). In addition, the Health Assembly requested WHO to prepare an action plan on dementia, and this has been approved by the Executive Board.

The *World report on ageing and health* (1) lists seven basic abilities of older people

that should be respected: to meet basic needs, to learn, to grow intellectually and socially and make decisions, to be mobile, to build and maintain relationships and to contribute to society. In the context of health, each of these abilities raises diverse issues that require conceptual and ethical exploration. Immediate issues are those associated with dementia, assistive medical technology, use of digital media in the care of older people and intergenerational ethics. The entire range of issues should be explored in order to construct an appropriate ethical framework for stakeholders including decision-makers, care providers and carers, so that they can decide on the most urgent, important issues for further analysis. For this purpose, a meeting was organized in March 2017, with the support of colleagues at the University of Tübingen, Germany and Age International. The meeting was attended by leading philosophers of health, well-being and ageing and experts in the fields of bioethics, gerontology, public health, health promotion, human rights, sociology and psychology. The meeting was held immediately after a workshop organized by the University of Tübingen on 16–17 March 2017 on the ethics and theory of healthy ageing in order to identify areas for further research.

The objective of the meeting was to discuss the need for and the potential structure of an ethical framework to promote the ethical values and principles of the World report that would: best respond to the challenges of health during ageing and in old age; contribute to

decreasing discrimination of older people; strengthen the rights-based agenda for improving the health of the ageing population; and support policy-makers in devising and implementing strategies for healthy ageing. A further aim was to identify topics in the area of ageing that require additional ethical guidance. While some areas stand out immediately, such as health care rationing, assistive devices and healthy environments, others might be identified and eventually prioritized for further elaboration. While well-known ethical frameworks in clinical practice, research and in public health exist and could be used as a starting point for developing a framework for healthy ageing, the important differences and nuances relevant to ageing must first be identified and explored.

The report is structured to reflect the agenda, describing the content of the presentations of invited experts and general points raised during the discussions. The last section provides a summary of the discussions, identifies open questions and proposes actions that could be taken by stakeholders, such as decision-makers, care providers, carers, communities and certain population groups.

2.

Presentations by experts

2.1 The starting-point: *The world report on ageing and health* and the Global strategy

Ritu Sadana, of the Ageing and Life Course Department at WHO, introduced the meeting by presenting the key messages in the *World report on ageing and health* and the recently approved Global strategy on the same topic.

She recalled the rising number of older people worldwide and noted that gains in extra years are not only a prolongation of individual lives but also result in demographic transitions, with fundamental implications for both societies and individuals. The predictable changes will affect not only demographic statistics but also the relationships among individuals, groups and cohorts; they will indirectly reshape images of old age and attitudes towards older people. New commitments to and expectations of older people and of society will be made. With new technology, older people may achieve new functions and contribute differently to society, although they are also likely to become vulnerable in new ways. Awareness of the chances and the

threats of the future development of society should lead to measures to provide older people (as well as other generations) a fair chance for pursuing a good life.

The health of older people is key to ensuring mutual benefits for both older and younger generations. Poor health in older people has negative implications not only for them but also for their families and carers and for society as a whole. If the extra years gained are spent in good health, older people may have the opportunity to contribute to society and to do what they value. The *World report on ageing and health* states that “Comprehensive public health action on population ageing is urgently needed. This will require fundamental shifts, not just in the things we do, but in how we think about ageing itself” (1). The report includes a framework to foster healthy ageing, built around the new concept of “functional ability”. Investing in the support of functional ability will bring valuable social and economic returns in terms of both the health and the well-being of older people and their continuing participation in society.

The report proposes three areas for action, which will require fundamental shifts in the

way society thinks about ageing and older people.

- Make the places we live in friendlier to older people.
- Realign health systems to the needs of older people. This will require a shift from systems designed for curing acute disease to systems that also provide continuing care for the chronic conditions that are more prevalent in older people.
- Develop long-term care systems to reduce inappropriate use of acute health services and to ensure that people live their last years at home and with dignity. Families should therefore be given professional support in providing care. Thus, women, who are often the main carers of older family members, are freed to play broader roles in society.

The report proposes several means to achieve these objectives. It notes, however, that, although the health needs of older people are fairly consistent throughout the world (1), preparedness to meet them and how they are delivered varies among and within countries, depending on socioeconomic development, the degrees of inequity and inequality in the country and current policies in this area.

2.2 Ageism as a form of discrimination

A major challenge to achieving the objectives described above is ageism, a form of discrimination against individuals or groups on the basis of their age. “Ageism” was first described by Robert Butler (3) in an analogy to sexism and racism; it has been suggested that it is the most neglected of the three.

Ageism can be seen as a process of systematic stereotyping of and discrimination against people because they are old, just as racism and sexism accomplish this for skin colour and gender. Old people are categorized as senile, rigid in thought and manner, old-fashioned in morality and skills (4).

Mira Schneider currently at the Ethox Centre, University of Oxford, United Kingdom, introduced ageism, summarizing the key concepts and the findings of research. She pointed out that people may express idealized positive attitudes to old age but in everyday life act according to hidden negative attitudes towards older people (5). A comparison of perceptions in various countries showed that many people consider that older people are not adequately respected, especially in high-income countries (6), and lack of respect for older people has been diagnosed empirically in these countries (7). Discrimination against older people is often based on pervasive negative stereotypes and on implicitly (subconscious) or explicitly (conscious) held views on cognitive, affective and

behavioural stereotypes. Implicit and explicit ageism is well established in health care settings: health care professionals commonly hold more negative attitudes towards older patients (8). Older people generally receive less screening and preventive care, poorer management and treatment and are the subjects of less research because of their age (9).

Ageism can be externalized (e.g. by younger people towards older people) or internalized (by older people towards themselves). In the latter case, older people may feel that they are a burden and perceive their lives as less valuable because of their age; they are therefore at higher risk for depression and social isolation. Ageism can manifest at the micro level (intrapersonal and interpersonal), meso level (community and society) and macro level (instructional and policy) (10). At the micro level, internalized ageism has been associated with reduced life expectancy and higher rates of mortality and morbidity, as negative self-stereotypes appear to modify the severity of and recovery from morbidity in older age (11–13).

2.3 Abuse of older people

In his presentation, Yongjie Yon, WHO Regional Office for Europe, emphasized the vulnerability of older people to abuse. “Elder abuse” has been defined by WHO as “a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person” (14). It can take the form of psychological, physical, emotional, sexual or financial abuse, or neglect, which can be passive or active. Passive neglect, which is very common, consists of unintentional failure to provide the necessary care, such as nutrition, medication or cleaning. Active neglect is intentional disregard of older people. Elder abuse, especially psychological and financial, is a major, worldwide public health problem (15). It constitutes a violation of human rights (8).

There are promising interventions for preventing elder abuse (16), including interventions by carers, money management programmes, helplines, emergency shelters and dedicated multidisciplinary teams. Elder abuse is not necessarily the result of evil intentions. In some cases, it is due to a poorly considered value judgement, e.g. on the priority of safety over the autonomy of an older person, due to a perception that the older people in general lack appropriate judgement, i.e. implicit ageism.

2.4 Ageism in medical research

Antonio Cherubini, University of Perugia, Italy, gave another clear example of explicit and implicit ageism, which is the exclusion of older people from medical research. Medical journals regularly report the results of randomized clinical trials (e.g. on heart failure, hypertension, Alzheimer's disease, colorectal cancer and depression) from which older patients are excluded by an explicit upper age limit and various other criteria (17). Their exclusion is regularly justified for pragmatic reasons (18): older people are a heterogeneous group, so that it is difficult to interpret the study results; it is more difficult to obtain their consent than that of younger patients; older people are at higher risk of becoming sick or immobile during a trial, compromising their continuing participation and resulting in a higher drop-out rate. The inclusion and continuing participation of older people in research is often associated with higher costs in terms of time and other elements, e.g. transport. Their higher risk for adverse drug effects, which are related to changes with age, and the higher prevalence of multimorbidity and consequent polypharmacy are also used to justify their exclusion.

Geriatricians are calling for the inclusion of older people in clinical trials, as the results of trials performed in younger populations are not necessarily applicable to older people because of differences in physiology, multimorbidity and polypharmacy and in their lifestyles and

values. Their exclusion from such trials may result in inappropriate prescriptions, waste of resources and adverse events, as many drugs and nonpharmacological interventions have not been tested to determine whether they affect age-related problems like falls, cognitive function, frailty and multimorbidity. This is an example of implicit ageism, which has negative implications not only for the individuals concerned but also for health care and society. To reduce discrimination of older people in clinical research, a European Union-funded project, PREDICT, produced a "Charter for the rights of older people in clinical trials" (17), which has been widely endorsed by gerontological and geriatric associations as well as nongovernmental associations such as Age Platform.

2.5 How non-western societies conceptualize ageing and health

Kavita Sivaramakrishnan, Columbia University, USA, pointed out that non-western societies are coping with two developments at the same time: ageing and rapidly changing social structures (19). Formerly agrarian economies are no longer sustainable, and older people are unfamiliar with the new social structures; some even actively oppose modernity.

Economic modernity has resulted in migration away from the family and hence a breakdown of traditional family relationships and family solidarity. Women go to work and are unable to care for the

older people in their families. The family remains important as a social institution but has a different meaning. It is no longer the large family, with several generations, including grandparents, uncles and others, living together, but is a nuclear family, consisting of an adult couple and their children. Traditionally, support for older parents was part of family life. Sons earned money and paid for health care (there was no health insurance), while daughters-in-law cared for the older people. Today, the system has changed: supporting older parents is still an important cultural expectation, but it has become more difficult, especially when the offspring are employed far away, unemployed or underemployed. Even well-employed adults have to decide how to support both their children and their older parents. The changes are occurring too fast for the older generation, which has therefore been unable to prepare or adapt itself to the new conditions of life. This generation is frequently the loser in this competition and often has to take a back seat.

How can the problem of caring for older people be solved? The rapidity of the change in structures challenges solutions; besides, western solutions are not readily applicable to African and Asian populations. One possibility is to support the traditional family care concept, with some modifications. Caregiving family members could receive professional assistance and support for informal long-term care, such as paid leave from work, with government subsidies. This solution would respect valuable

family relationships but ignores poverty and migration. Informal care will not be adequate to manage all the long-term care needs of older people. Another possibility would be to extend the formal care system, for instance by training traditional health care workers in long-term care. These services would not replace the family totally but would fill gaps left by nonprofessional carers. One problem is that professional carers usually act only in the formal sector, whereas some older people are not covered by health insurance and are “invisible” to the authorities, slipping through the institutional framework of formal solutions. The combination of the two solutions that is appropriate for communities and societies and covers everybody in need will depend on the social and cultural structure in each setting.

2.6 Age-related rationing and priority-setting in health care

Hans-Jörg Ehni, University of Tübingen, Germany, presented an overview of ethical justifications for age-based rationing of health care and their shortcomings. Age-based rationing rests on the premise that population ageing leads to an increase in health care costs and an increase in the proportion of health care resources spent on older people. Therefore, some ethicists have argued that, under certain conditions, chronological age can be used as a morally permissible criterion for rationing health care. This has generated

extensive discussion. Two arguments are frequently used to justify use of chronological age to ration health care:

- maximizing utility and
- “fair innings”.

Maximizing utility

This argument is based on a utilitarian calculus for health care. The utility of the resources spent on health care should be maximized, for instance measured as quality-adjusted life-years (QALYs). As older people have a shorter average life expectancy than younger people, giving priority to younger people will maximize the QALYs. This calculation could be amended by assuming that older people have a lower quality of life and therefore the QALYs of an older person should be rated lower. As older people have fewer expected life-years, they lose in comparison with younger adults (e.g. QALYs, and see the critique of Nord et al. (20)). Both assumptions – shorter life expectancy and poorer quality of life – can be used to justify setting age thresholds for particularly cost-intensive treatments. The argument of maximizing utility has, however, several weaknesses. Judgements about age are based on negative stereotypes. The argument ignores individual differences and considers that older people are uniform in all respects (even with regard to expected life years). Additionally, this argument negates the equal moral value of all human beings and emphasizes morally irrelevant differences.

Fair innings

The fair innings argument refers to justice. It is based on the moral intuition that death is always a misery but in young years is also a tragedy, i.e. even worse. Therefore, the lives of older people should not be prolonged at the cost of the lives of younger people. For example, Daniel Callahan argues (21) for a threshold of 70 years, which he considers to be a “natural human life span” that would allow a sufficiently fulfilled life. For the proponents of this theory, the priority in health care for people below the age of 70 should be to avoid premature death; for those over 70, the focus should be on palliative care. This argument also has weaknesses. First, there is no agreement on the length of a natural, sufficiently satisfying life. Furthermore, the underlying concept of “a good life” is not convincing, as it assumes that people over 70 do not have truly valuable years of life because they have reached an objective threshold of satisfaction.

Norman Daniels has proposed another version of the fair innings argument: the prudential life span account (22). This argument is based on the assumption that rational distribution of resources throughout the life-course would give priority to younger people, as they wish to reach old age. This is a contractarian argument based on the preferences of older people themselves. It therefore appears to avoid ageism and negative stereotypes of old age. The argument, however, also has several problems. First, it is not clear that everyone would

distribute resources for health care throughout the life-course in the same way. Secondly, the general argument is too indeterminate to justify a decision to ration and should be amended by additional assumptions.

As these different ethical arguments for justifying age-based rationing fail or are at least problematic, alternative strategies to reduce rising health care costs may be preferable. As the highest costs in any person's life are usually generated during the last year of life and many people prefer not to be treated aggressively at any cost, limiting life-prolonging treatment according to individual preferences might be an acceptable strategy. Another strategy would be to focus on healthy ageing and disease prevention throughout the life-course in order to prevent chronic illness in late life.

2.7 Prevention and early detection of clinical conditions in older people

Medical care focuses primarily on disease. This may have been justifiable in the nineteenth century, when acute illnesses were the main concern of the medical fraternity. Today, however, the incidence of chronic illnesses and non-specific complaints is increasing, due not only to an actual increase in incidence but also to better diagnostic ability. Matteo Cesari, University of Toulouse, France, pointed out in his presentation that, by using better diagnostic instruments, we

can detect more abnormalities or detect them at an earlier stage; however, there is no evidence that all "abnormalities" must be treated. Some may be irrelevant for patients, especially for older people, or diagnostic instruments or algorithms may produce misleading empirical data because the normal physiological values of older people vary widely. Thus, in high-income countries, older people undergo more diagnostic tests and, consequently, appear to need more health care, even though their physiological and functional capacities are within the normal range.

In contrast, some conditions, such as frailty, are not diagnosed as diseases but should be considered just as relevant for medical care and prevention. Frailty is a health state related to ageing in which multiple body systems lose their reserves and the risk for developing dependence and death increases (23). The individual body parts may not be diseased, but lack of reserves makes the body vulnerable. Older people must therefore receive comprehensive geriatric assessments, focusing on function rather than on disease.

Thus, a health care system for older people is inadequate if it is based on a "single disease" or "chronological age" approach without taking into account the complexity of biologically aged people. We should shift to novel, integrated models of care that focus on meaningful outcomes for patients, such as function instead of disease.

2.8 Establishing long-term care systems in low-resource settings

Long-term care infrastructure has been established in several countries to change the focus on disease and to provide care for frailty and the other special health needs of older people. Puangpen Chanprasert, Ministry of Public Health, Thailand, presented an example of good practice in Thailand, a low-resource setting. The national plan, law, policy and integrated implementation of long-term care in Thailand have been organized at all institutional levels: national, provincial, district and community. At the national level, the Older Person Act entered into force in 2003, a national committee for older people was established, and a second national plan was introduced in 2009. The national policy and guideline provided criteria and an implementation strategy for use at provincial and district levels, including evaluation of implementation, monitoring and supervision. At community and sub-district levels, health funds finance the long-term care infrastructure. Integrated care is provided in existing facilities by volunteers, health professionals, care managers, carers, an older persons' club and civil society. Several ministries cooperate and network at all levels. A pilot project was conducted, and several good models for implementation were chosen in preparation for extension of the programme. Although establishment of long-term care in Thailand is a success, several problems remain: volunteers have

multiple, unclarified roles; the reporting system could be improved; and the quality of training for carers is still a challenge.

2.9 An ethical framework for dealing with dementia

Julian Hughes, Nuffield Council on Bioethics, United Kingdom, presented the report of the Council on dementia (24), which identifies areas of concern for carers of people with dementia and for the people with dementia themselves. As most of the concerns were ethical, the Council published an ethical framework, which has six main components: a case-based approach to ethical decisions; beliefs about the nature of dementia; beliefs about the quality of life with dementia; the importance of promoting the interests of both persons with dementia and those who care for them; the requirement to act in accordance with solidarity; and recognizing the "personhood", identity and value of people with dementia. These components provide a helpful framework for tackling the ethical problems that may arise in caring for a person with dementia. Strech et al. (25) highlighted specific ethical issues that arise in the context of dementia, including difficulties associated with an inability to make decisions, which characterizes all cases of dementia at some time.

3. Towards an ethical framework for healthy ageing

The presentations and discussion highlighted several situations and cases in which healthy ageing is a challenge for both individuals and society. Although ageism and the related issue of elder abuse are clearly unethical, they are so entrenched and ubiquitous in society that their relevance as fundamental barriers to promoting healthy ageing policies and health care might not be appreciated. An ethical framework to address these challenges adequately and consistently is therefore both timely and necessary. The framework could build on the ethical principles contained implicitly or explicitly in the *World report on ageing and health* (1), which addresses the specific health needs of older people and how they can be met by states, societies, institutions, communities and health care systems. In the first chapter, the authors refer to basic ethical values and principles, including individual diversity, inequity, stereotypes and the rights of older people. Individual freedom, equality, non-discrimination and human rights are ethical and legal concepts relevant to these topics. The section "Towards an age-friendly world" describes a comprehensive approach to ensuring the well-being of older people that encompasses five basic abilities. An

ethical framework for healthy ageing would include the relevant ethical principles described in the *World report* systematically and, if necessary, complement them with other frameworks, as discussed at the beginning of the meeting.

The participants described a number of ethical frameworks that cover areas broader than ageing and health. Beauchamp and Childress (26) introduced four principles for general biomedical dilemmas, framing ethical analysis of clinical issues and issues in medical research. Frameworks for public health ethics are more closely related to healthy ageing, but they are still not specific enough to the problems of old age, because the ageing population introduces the issues of intergenerational fairness and resource allocation, which must also be addressed.

The participants discussed the Nuffield Council ethical framework for dementia in detail. As dementia is most prevalent in old age, some of the principles in the framework have been recognized as applicable to healthy ageing. The approach of the framework to normalization of people with dementia and their carers was considered a good

example, and participants commended the way in which the dementia framework had been developed, which could be applied to an ethical framework for healthy ageing. Fear of losing one's memory and cognitive functions, which are strong determinants of identity and autonomy, are major concerns during ageing. Nevertheless, the ethical framework on dementia was considered too specific for all the issues of healthy ageing. Although dementia affects many older individuals, it is only one of many chronic diseases that are more prevalent in older people. An ethical framework for healthy ageing should also include a life-course approach to include the overall social changes in an ageing society, which, understandably, was not part of the dementia framework. Furthermore, the relationships between people with dementia and their carers may differ substantially from those between older people in general and their relatives or their society.

The ethical framework for healthy ageing should apply to all the individual and social challenges of older people and should provide a transparent approach to decision-making, to answer questions like: Who is accountable for which actions? What autonomy do older people have? Which moral rules should guide interventions and justify them? The focus on "healthy ageing" should not divert attention from other areas of care that are important for older people, including those in very advanced age, such as long-term care, prevention and management of disability in old age, an age-attuned, friendly health care environment and, once people reach the end of their lives, appropriate end-of-life care.

4. Specific issues in healthy ageing

For an ethical framework, special attention should be paid to the gerontology of older people's life and health as well as to their social roles and functions. The *World report on ageing and health* (1) contains a substantial body of such knowledge. Referring to the report and to other additional sources, participants at the meeting identified a number of core issues of older age concerning health, comprising physical, mental and social issues and specific existential issues that occupy many older people as a result of their life course. In this part of the report, we summarize the achievements of the meeting and identify open questions and areas for further research.

4.1 Definition of old age: the subject of the framework

Before discussing the problems of older people, a definition of the "older person" is required. Various thresholds have been established by the scientific community. The statistical analysis in the *WHO Report on ageing and health* is based on studies in which 60, 65 or 70 years was used as the threshold. Demographers

and sociologists now often distinguish a third age range, 65–80 years ("younger old") and a fourth group of 80 and older ("older old") (27). Participants commented that chronological age is too simple a way of defining groups of older people, particularly in view of global differences in health and life expectancy. The definition of older people used in the *World report* (1) is "a person whose age has passed the average life expectancy at birth for that country". It also describes the diversity of older people, as chronological age alone does not sufficiently reflect the problems of a particular age group. Some people are very physically fit until a very advanced age and are not limited in any physical functions, while others have severe consequences of ageing, including physical and mental decline and disability before they reach the proposed threshold. As biological ageing is a result of an accumulation of a wide variety of molecular and cellular damage over time, biological age might be informative about the health of individuals; however, there is no reliable biomarker of biological age.

Chronological age plays a crucial role in the social support systems in many countries, such as the age threshold

for pensions; however, chronological age is also a possible trait for social discrimination: people who retire because of their chronological age may be accused of contributing less to society (or less than they could) than working people. Demographers have suggested that the average life span be used to define age groups instead of the same threshold for different people and societies. But, this could be too simplistic.

The participants recognized that a definition of old age should be discussed. The definition would influence how people think about older people and their specific needs, which social stereotypes are supported, who is left out and how older people see themselves. The question is not only which chronological threshold should be selected (60 or 70 years or more) but finding the best criteria of old age in different contexts (e.g. chronological, biological, social or subjective age) and taking into account the implications of the choice. How this should be done remains an open question. An ethical framework should not only propose a definition but also include the moral trade-offs that are made when selecting one threshold over another.

4.2 Medical care of older people

While there is general agreement in the scientific community about the goals of medical care, three questions were posed at the meeting.

Can age-based rationing be justified on the basis of projections that older age groups will require a steeply rising, disproportionate amount of health care and health care spending? There is public and scientific discourse on limiting expensive health care for older people. The participants discussed two of the best-known arguments for such limitations and for excluding older people from full health care coverage: maximizing utility and fair innings. Participants supported equal health care coverage for all, including older people, according to their medical needs and not according to age. The demand for age-based rationing might be tempered by the fact that questions of rationing arise in practice more between older people than between younger and older patients. Nevertheless, there is evidence that health care is rationed on the basis of age (28). Other ways of decreasing health care costs that would be preferable to rationing include reducing waste, promoting prevention and examining the reasons for the high cost of end-of-life care, taking into consideration the preferences of the older persons themselves. The consensus of the participants was a valuable outcome of the meeting. An ethical framework on healthy ageing should include the moral reasons for a model of resource allocation for this group that includes guidance on which trade-offs are ethically acceptable and which are not.

How can the participation of older people in clinical research be increased in order to ensure appropriate medical technologies and care models? The established ideal

of medical research is the single-disease model, in which means are sought to treat the disease as a unique entity. This model is fundamentally flawed for application to older people, many of whom suffer from more than one condition (29). Participants argued against this ideal model, as most older persons in the real world are usually treated for a number of conditions, thus necessitating knowledge about polypharmacy and the effects of different treatments on multiple diseases and on the person (30). The concepts that guide medical research should be changed; and, despite practical difficulties, most, ideally all, older people should be able and empowered to participate in studies. An ethical framework should make the normative reasons for changing the established one-disease orientation more explicit and include the ethical consequences of alternative approaches and an alternative taxonomy of outcome. Older people are also systematically excluded from clinical research by the age limits commonly used as exclusion criteria in trial protocols. Such age limits are another sign of negative stereotypes of old age, as they imply that people over a certain age might not be healthy enough to be included in a trial. A related point is that the taxonomy of outcomes typically used in clinical trials is mis-specified when there is multimorbidity. Investment in the taxonomy of outcomes should be pursued if such research is conducted. Research methods should also be adapted to take into account the diversity of older subjects, and not vice versa, i.e. the denial of diversity and homogenization of

all older people towards healthier ones, who are easier to study with current methods.

How can the established approach to medical care, which stresses disease-related outcomes such as morbidity and mortality, be changed into the more appropriate approach of life goals that are more relevant for older people, such as autonomy and quality of life? The participants not only questioned established research concepts but also the goals of therapy in old age. Sometimes, the best available medical care does not meet the needs of older people, as they may find it more acceptable to live with a certain disease or with suboptimal physiological values as long as they have intrinsic capacity than to undergo extensive treatment. The current focus on diseases and related outcomes, such as morbidity and mortality, should be replaced by a focus on outcomes that are more relevant for older people, such as the ability to continue to do what they value (e.g. mobility, meeting basic needs, learning and taking decisions) and thus preserving or improving their quality of life.¹ The framework should elaborate these outcome criteria. Abilities, however, remain to be defined. Enhancing the abilities of older people does not mean that they have to perform more or better in general human functions. Objective or universally accepted definitions of “normal” or “optimal” functioning are

1 Several instruments are available for measuring outcomes such as function and quality of life, e.g. measures of ability to perform activities of daily living and the 36-item short form survey (SF 36) of the Rand Corporation.

of limited validity in older age because subjective expectations and socially accepted functions change. The framework should take a critical position towards general terms like “normality”. Older people’s interest in certain functions may differ from that of younger patients. Older patients may have good reason to value a different sort of performance, such as their social role, memories and existential issues, which may play a more important role in their lives than in those of younger patients, who may be more interested in e.g. physical performance. An ethical framework should outline the values that physicians might consider when discussing health or medical conditions with older people, such as the functions that should be given priority in decision-making and how well they should be able to perform them. As different people value different things and may wish to give greater priority to the same health problem, older patients should not be considered a uniform group.

Similarly, treatment of every single morbid condition may be the wrong goal. Instead, targeting the problems that limit valued abilities the most might be appropriate. Not treating every diagnosed disease can be considered a responsible act of identifying priorities rather than maleficent negligence. The appropriate ethical justification is that withdrawing or withholding treatment is motivated not by an intention to ration treatment for older people but by respect for the complexity of their medical conditions and an understanding that healthy ageing is possible even when the person is not free

of disease and disability. This normative attitude is implicit in the WHO *World report on ageing and health* (1), which defines healthy ageing as “developing and maintaining the functional ability that enables well-being in older age”. This attitude nevertheless requires better, fuller elaboration.

A focus on actual capacities and abilities does not, however, justify a minimalist approach to physical and mental health. Function may be endangered by overall low performance of the body, described as frailty. As frailty is a condition that confers a high risk for severe health conditions, falls and injuries, it should be considered an indication for preventive measures, even if there is no health condition that would legitimate a direct medical intervention and functional ability is not severely limited. Denying acceptable support to older people to sustain their functional ability could be interpreted as maleficence.

The discussions at the meeting focused mainly on high-income countries. Participants identified traditional and ideological obstacles to applying ethical principles of medical care to older people and gave examples of the enduring dilemmas. The development of an ethical framework could systematize the arguments and facilitate decision-making in the face of conflicting values and different socioeconomic conditions, such that the perspectives of high-, middle- and low-income countries and different cultures are adequately addressed.

4.3 Shaping the environment: enhancing the abilities of older people

The participants observed that “healthy ageing” as defined in the WHO report is focused on ability (physical and mental; a person is “dis-abled”) and the physical and social environment and the adequacy of the latter in enabling people to do what they have reason to value. These reflect the capability approach and the idea of social justice, with constraints imposed on individuals by the environment. For example, several limitations in older age can be mitigated not only by good medical care but also by a conducive environment, such as age-friendly pedestrian paths and open spaces for recreation. The quest for an age-friendly environment is a positive contribution to health; it includes support for functioning and autonomy and mitigation of negative health risks due to poor living conditions and other social determinants.

Participants argued that it is unethical to deny an age-friendly environment for older people, as it is as crucial as health care for their functioning. Ensuring the mobility of older people, age-friendly communication technologies and the support of the social environment, such as family carers, were mentioned as examples of positive environmental contributions to the health of older people. Health of older persons can be enhanced by changing the environment according to their health needs.

This is not a new idea. People have always adapted their environment to their needs. Somewhat newer is the idea that ageing societies should reshape their environment, their social living spaces, to the needs of older people and to general life-course needs. Especially in older age, people experience a decline in their capacities. In order to maintain a life of dignity and autonomy, they depend on a supportive environment, such as transport with easy access, parks with benches and places for recreation and accessible health care institutions, in addition to the special needs of more disadvantaged older people, such as wheelchair-accessible paths and lifts. Human rights and equity would be violated by exposing people with special needs to the environmental standards of healthy young adults (see the United Kingdom Disability Discrimination Act (31)). The participants agreed that equity demands that more be done for disadvantaged older people so that they can take part in social life. Various stakeholders have a role to play. If older people have such support, they can continue to be active and contribute to their community; this is part of the broader notion of health. An age-friendly environment is a requirement for human rights and equity, because it allows older people to do and be what they value.

Some older people do not recognize threats to their health from environmental health hazards and make risky choices. Family members, carers and social institutions can diminish or lower the risk factors by changing the living conditions of older people and limiting their free

choice. An important ethical question in this context is the degree to which the autonomous choices of older people should be influenced by family members, carers or social institutions, and whether and under which conditions older people should have special protection against environmental health risks. Environmental health risks can do more than influence decisions about the autonomy of individuals, as they often have a structural dimension. For example, discrimination based on age is often built into politico-economic structures, such as institutions that have a meritocratic perception of people's value based on their age. In this respect, discrimination against older people by their social environment has been described as a particular concern and a form of abuse. An ethical framework on healthy ageing should address all these issues.

4.4 Acting in a complex system

Societies that wish to promote universal, equal application of human rights and equity for all people can take various courses of action. Any combination of solutions for the care of older people has advantages and drawbacks. A number of initiatives that address some of the most urgent issues in care of older people include the example of long-term care practice in Thailand (section 2.7) and the WHO Global network of age-friendly cities and communities, which has included more than 250 cities and communities worldwide since 2010 (32). Some

problems are addressed by health care institutions and others by social workers or families. The participants agreed that recent developments in the care of older people had led to inappropriate segregation of care, resulting in coexisting over- and under-supply in various dimensions of care, with an over-supply of care for some needs and an under-supply for others.²

Harmonization of services is a high priority, as public health specialists must orchestrate the creation of a supportive social and technical environment for the needs of older people. Decision-makers and strategic actors who want to reduce inappropriate use of expensive health care services and help families to spend their resources in an "efficient way" often sense an ambiguity, however, as "appropriate" services must also respect the cultural traditions of a community. The first chapter of the *World report on ageing and health (1)* stresses that "more of the same will not be enough".

The experience in Thailand of long-term care planning is an excellent example of a complex institutional answer to the needs of older people, even with few resources. The country integrated professionals in various fields, nonprofessionals and family members into care for older people. Although few resources are required, the example is not easy to transfer to other countries and cultures. Further research

2 The over-supply of carers for people with minor restrictions in activities of daily living and the under-supply for instance of carers for mobility, incontinence and feeding has been verified, especially in the western context. See reference (33).

should be conducted on the extent and conditions in which the experience of one country can be transferred to another with a different health care system, another culture and, potentially, another legal framework, and the underlying ethical values and normative assumptions should be analysed.

Participants suggested further that, in stating underlying values and normative assumptions, researchers should be aware of the continuous changes in the values of modern societies. Families have traditionally been important in providing care for older people, but the availability of younger family members in modern society is limited by urbanization and mobility for work reasons, and they have less intense relationships and contact with their older relatives. Furthermore, the care of older people requires more and more professional knowledge, which may disqualify family members from becoming carers. Nevertheless, emotional relationships and better knowledge of the life history and personal values of older people, despite changing social structures, make family members important carers. Societies should find a balance between helping family members to provide care and easing their burden by making professional care available. Decision-makers should consider the importance of bilateral support between generations. The ethical framework should address respect for the principle of intergenerational solidarity in the modern world and what this would require from different actors in practice.

4.5 Existential dimension of older age: a life-course approach

An ethical framework to address the particular needs of older people must include a reflection on the possible meaning of old age for a flourishing human life and the conditions that this phase of life represents for a good human life as a whole. This relates on the one hand to different gerontological concepts of ageing well, such as “successful”, “active” or “healthy” ageing; on the other hand, it relates to the conceptions of different cultures about the meaning of old age, such as intergenerational transfer of knowledge or experience, reflection on and fulfilment of a life's achievements and reflections on human finitude. The importance of health and functioning for older people should be understood in this more general context. A harmonious system of care is built on a clear understanding of what it means to be old. Although the needs and health challenges of older people are diverse and heterogeneous, old age has some consequences that should be considered in all systematic decisions. There is extensive literature on the physical and mental processes of old age, but determining what older people really need and what is important for them requires a comprehensive evaluation that includes the social and existential dimensions of life in older age.

Cultural and social expectations of age-related norms shape our life-course, our opportunities and our behaviour. Some are

codified, such as the legal requirement for education in childhood, the minimum age for marriage, the maximum age for some jobs and the age of retirement. Other age-related norms are not regulated legally but are culturally deeply rooted (34), for example, in most western societies, adults are expected to live independently from their parents, to live in a partnership and to have children after a certain age. Individuals who do not meet these social expectations sometimes have to give extensive justifications.

Older people also have culturally rooted life-course expectations. In most parts of the world, they are expected to dress and behave in an age-appropriate manner (35); and they are assumed to have certain capacities and to lack others. In certain eastern societies, such as India, older people are expected to give up family and social responsibilities and “retire” from active life. The main expectations and assumptions are subject to traditional stereotypes: old age is sometimes characterized as conferring special wisdom, knowing how to achieve a long life, being interested in the past and particularly not in the future, being burdened by new technologies and being unable to change deep-rooted habits. Such traditional age-related stereotypes often lack an empirical foundation and do not respect the diversity of older people. Stereotypes and social acceptance do not change automatically as older people change. In ageing societies, especially in those that enjoy better health, the social images and roles of older people have changed. They are able to participate and to shape everyday social life, and they

also change their life expectations. The first years after retirement are increasingly years full of activity, and postponing some important life goals to this phase of life appears to be rational. In later years, if biological functions become more limited, older age may provide an opportunity for self-reflection, deeper understanding and re-interpretation of one’s history. This can result in life fulfilment, authenticity, the realization of deeply subjective values, re-evaluation of earlier occurrences in life and religious and spiritual experiences (36). Some of these reflections are manifested and supported in the form of social and cultural expectations, while others are not.

Old age has some distinct aspects, such as increasing confrontation with the limits of life, approaching death, managing health issues, changing social and family roles and a personal relationship to diminished bodily capacity. These life-course changes shape not only the activities of older people but also their relationships with other generations, their strengths and weaknesses, their needs and their power when encountering other generations.

As the traditional roles and meanings of older age change, philosophical, anthropological and social research should address the new meaning of old age in the life-course and its consequences for our societies (37).

4.6 Reshaping social attitudes towards older age

Changes to everyday practice often require changes to general attitudes. In some previous discourses, older age has been framed as the period of life when people require costly care and cannot contribute to the national economy; therefore, they are a burden on society. This makes older people into scapegoats, by setting an unfair framework (38). First, it contrasts older people as a cohort with the rest of society (exclusion), judges older people in an overall manner (ignoring diversity) and exposes them to discrimination. Secondly, it regards this period of life as dominated by a need for care. All people need some care, even if older people usually require not only a different kind but also more care than younger people. But being cared for does not dominate life in older age. The kind of care and how much care older people need depend on several inherited, cultural, environmental and social conditions and not only on chronological age. Thirdly, the frame considers mainly economic functions and monetary contributions as valuable. Evaluations of contributions to society should include non-economic values, such as relationships, life experience, wisdom, reflectiveness and sources of identity (e.g. through family history). Older people can contribute to some of these values in precious ways.

Human rights protect all people with no difference according to age or other individual properties. Equity, equality and nondiscrimination are basic principles that guide our ethical reflection about every human being. The frame described above negates these principles. To overcome the weaknesses of the frame, countries and communities should find a culturally appropriate frame for older age that reflects the true qualities of older people in the present time and an appreciation of their value.

5. Conclusions

Participants at the WHO meeting contributed to designing a framework for ethics in healthy ageing, using the *World report on ageing and health* to find appropriate principles, interpretations and justifications. The aim of the meeting was to initiate discussions on international ethical guidance for decision-makers, care providers and carers that could be adapted and adopted nationally. The discussions focused on ethical problems arising in the context of the health needs of older people, how to define them, how to reflect differences between individuals and cultures, the appropriate social and medical services for older people and examples of good practice. The participants identified many ethical issues and topics related to ageing and health that should be addressed systematically. They agreed that the *World report* was a good starting-point for an ethical framework but should be complemented by a systematic approach to addressing the association between those principles and additional ones such as solidarity and reciprocity. The systematic approach could also include the ethical issues addressed at the meeting to illustrate possible difficulties in use of the strategies proposed in the *World report* and

comparable strategies on ageing and health. The framework should include questions such as, how should societies treat older people? Do older people have any special claims or obligations due to their age, and, if so, why? How should resources be allocated to achieve the goal of universal health coverage? What guidance can be given to policy-makers about acceptable and unacceptable trade-offs in resource allocation? Is there inequality among older people that demands social action? How should intergenerational justice be understood? What aspects of the quality of life of older people in different societies and cultures raise concern about fairness or injustice? An open, transparent, rational discussion of these questions and their normative implications presupposes philosophical and ethical reasoning. Such reasoning will also strengthen the case for a rights-based approach, as proposed in the *World report*. The meeting did not attempt to supply definite solutions or objective statements but suggested topics for further discussion and confirmed certain issues, basic values and principles that should guide further research and action.

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Annex 1. Agenda

Time	Title	Speaker
08:30–09:00	Introduction and background	
09:00–09:30	Presentation of the World report and the Global strategy on ageing and health	Ritu Sadana (by Webex)
Ageism and issues related to ageism		
09:30–09:45	Ageism, an introduction	Mira Schneiders
09:45–10:00	Elder abuse is 'fraud' with ethical tensions	Yongjie Yon
10:00–10:15	The exclusion of older people from health research and its consequences	Antonio Cherubini
10:15–10:45	Moderated discussion	Sridhar Venkatapuram
10:45–11:00	Coffee break	
Socio-economic policies influencing care and support to ageing populations		
11:00–11:15	How societies conceptualize ageing. Global diversity in conceptualization of ageing	Kavita Sivaramakrishnan
11:15–11:30	Age-related rationing and priority setting	Hans-Jörg Ehni
11:30–12:00	Moderated discussion	Sridhar Venkatapuram
12:00–13:15	Lunch	
Health system approach to ageing		
13:15–13:30	Prevention and early detection of clinical conditions in older people	Matteo Cesari
13:30–13:45	Establishing long-term care systems in low resource settings	Puangpen Chanprasert
13:45–14:15	Moderated discussions	Hans-Jörg Ehni
Caring and carers		
14:15–14:30	Creative care for caregivers in the community: the evidence from India	Amit Dias (by Webex)
14:30–14:45	Dependence and caregiving in older age: Nigeria experience	Richard Uwakawa
14:45–15:15	Moderated discussion	Rachel Albone
15:15–15:30	Coffee	
Clinical, medical and health issues related to ageing		
15:30–15:45	Dementia and ethical issues	Julian Hughes
15:45–16:15	Moderated discussion	Alessandro Blasimme
Defining an ethical framework		
16:15–17:15	Potential elements of an ethical framework for ageing and well-being. What values and principles. Moderated discussion	Sridhar Venkatapuram
17:15–17:30	Wrap up and next steps	

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