National Consultative Ethics Committee for Health and Life Sciences REPORT ON AGEING

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In the last few decades, average human life expectancy has progressed faster than was ever the case before in the whole history of mankind. In France, it is already an accepted fact that as early as 2010, there will be more people over 60 than there will be under 20. There were 11 million people over 60 in 1990, but by 2015, the total will be 16 million. As of 1997, half the women and a quarter of the men can hope to reach the age of 85. Longevity will continue to advance.

This fact will represent a major problem for our society in the next few decades... but not of a purely economic nature. The **ethical dimension** should also be examined.

If appropriate measures are not taken in the near future, there might well be an intensification of the isolation and exclusion which now affect many elderly people in our society.

CCNE considered that giving careful thought at this point to the theme of **ageing** was part of its mission.

PART I : FACTS TO CONSIDER

I - Increasing longevity

1 - International situation

Average human life expectancy in the Western world in one century has progressed from 47 to 79 years. Around 2010, this figure will be 85.

The principal characteristic of our society at the close of this century, is the growing number of aged and very aged people (1).

It is not just in industrialised countries that this process can be observed. It also exists and is accelerating in developing countries. The consequences of the increase in longevity will be

a progressive global population change. This is one of the fundamental basic facts of humanity's near future. This progression will be the fastest in the history of mankind.

Between 1900 and 2100, the population of the world will have increased by 700%, from 1.6 billion to 11.5 billion people, i.e. an increase of 10 billion people.

In 1950, the total population of the world was 2.5 billion. In 1970 - 3.7 billion. In 1994 - 5.6 billion. In 1999, the figure will be 6 billion, and by 2050 - 10 billion, according to the United Nations prospects document (2). The fraction of the population over 60 years of age which was only 128 million in 1950 (5.1%) will total 419 million in the year 2000 (6.8%). This proportion will increase in the first half of the 21st Century, and will be 14.7% of the world's population by 2050, i.e. 1.5 billion people over 65, or more.

The fraction of population which is over 80 will increase from 13 to 137 million people by 2025. The growth factor will be 3 for over sixties and 10 for over eighties. This will be a significant trend in every continent.

But it should be said that variation will be uneven globally (3, 4). This is the case for gender differences : between 1950 and 2000, life expectancy for women has increased by 20 years, and by 18 years for men. The difference between men and women is 3 years in Asia and Africa, 7 years in North America, and 8 years in Europe. Despite medical and scientific progress, men continue to live on average 7 or 8 years less than women. Moreover, a shorter life expectancy now in Africa and greater population growth than in the rest of the world should be the subject of special attention.

As regards developed countries, all the population studies published in the last 20 years report on a regular increase in the average life expectancy of men and women (about 3 months a year) with a constant gender difference, which leads to the following projection, in numbers of years (5) :

	Women	**Men**
1990	81	72
2030	88	79
2050	90	82

Another point which should be emphasised is that the increase in the numbers of elderly people will be far from compensated by the arrival of new children to constitute the working force of future generations.

2 - In France

As regards the French population, as mentioned above, a very large number of people may now reach 85, so that women can hope to live a further 6.4 years, and men 5.2 years. In other words, in 2010 there will be more people over 60 than there are under 20, with a particularly large increase in the 75 to 79 year old age group. As of 2025, 25% of French population will be over 60 and 40% will be 50 or more.

3 - Reports to consider (7) : Thirty years of "Policies for the Elderly"

The above data clearly shows the foreseeable consequences for society of the "longevity revolution" (5).

There is every justification for ethical reflection on the subject.

Such reflection needs to be a follow up of consideration and proposals made in France for

over thirty years on the subject of old age policies, which led to three successive official reports which so far have been the substructure for policies to solve problems associated with old age.

- A report by the "Study Committee on problems of the elderly", referred to as the LAROQUE report, 1962 (8).

- A report by the "Joint Group for the study of problems relating to the elderly", by the Planning Commission (Commissariat Général au Plan) (preparatory work for the 1971-1975 VIth Plan), referred to as the QUESTIAUX report, 1971, (9).

- A report called "Ageing tomorrow" by the group on Prospects for the Elderly (preparation of the VIIth Plan), referred to as the LION report, 1982 (10).

Despite the quality and pertinence of their conclusions, these official reports do not seem to have attracted all the attention they deserved. Moreover, although they were predictable, the consequences of longevity do not seem to have been recognised for what they are : one of the major problems of our society for coming decades.

II - Physiological process of ageing

Ageing is a process which, over the years, changes healthy adults into fragile individuals whose competence and energy reserves diminish as regards most physiological systems so that they become more vulnerable to many diseases and therefore more likely to die in the near future.

The process of ageing is as mysterious to us as used to be those of heredity or infection, and as to a large degree remain those of differentiation, growth, and cancer, because there is still uncertainty about where research should be aimed to define primary causes and possibly find remedies.

The physiological process of ageing takes place simultaneously but not necessarily in parallel to chronological ageing. The difficulty in defining ageing in biological terms as opposed to how easy it is to describe pure longevity which is chronological, becomes very obvious when observing differences between individuals of the same age or when trying to find markers to systematise the modalities of ageing, although no one is likely to have doubts as to who is 90 and who is 20. A man suffering from osteoporosis with no fractures, or from atheroma without angina, or with a hypertrophic but non cancerous prostate, ages well physically speaking, even without any significant mental impairment if there are no cerebral pathologies. And yet, his skin, his muscles, his defective sight and hearing, all bear witness to his age. The damage that age inflicts develops gradually throughout a lifetime, and various factors prevent or aggravate the process.

Ageing is not specific to the later part of a life. It is a programmed sequence of continuous biological mechanisms which follow each other at various rates - development, maturity, senescence - which progress naturally and constantly for all living things. Ageing is a part of intrinsic mechanisms which seem to be due to genetic determination and be inevitable, and also of extrinsic circumstances which are clearly related to the environment in the broadest sense of the word and which can therefore be improved and optimised (13-17). In any event, the human species is one which provides for its members a very long post-productive life which, remarkably, in the last century has steadily lengthened, probably because humans have managed to control and adapt their living conditions. They have modified what can be called broadly the environment, including hygiene, care, the habitat, food and behaviour, although of course the 20th century has been somewhat erratic in this respect ! How far can this go ? Based on reasoning derived from observation of laboratory animals, such as the effect of a restricted dietary intake which prolongs the life span of rodents and

non humanoid primates, the question arises of whether our species will be able to greatly outlive the span attributed so far to our genetic heritage.

1 - Intrinsic ageing mechanisms

Although longevity appears to be "inheritable" to some extent, the search for genes which code ageing has been unsuccessful so far. Some workers have grouped under the name of gerontogenes, genes which could participate in some decisive way to ageing. They distinguish between genes involved in the process of cellular division, those concerned with apoptosis, and those which are only expressed tardily (15, 18, 19).

Among the facts which point in the direction of certain genetic mechanisms, are the familial forms of early-onset Alzheimer-type dementia (20) which represent about 10% of cases. Most of these familial forms for which the earlier symptoms appear before the age of 65, would seem to be associated with a mutation of presenilin 1 , of which the gene is sited on chromosome 14. In other families, about 10% of them, the disease seems to be connected to a mutation of the gene of a precursor of the beta-amyloid protein sited on chromosome 21. A gene for apolipoprotein E, on chromosome 19, has an effect on the risk of dementia of the habitual sporadic late-onset Alzheimer-type disease. The risk would appear to be multiplied by 10 for carriers of the epsilon 4 allele of this gene.

Another point is the similarity between amyloid plaques found in Alzheimer disease dementia and the deposits found in trisomy 21 carriers, whose premature ageing is a known fact (21). However premature senility syndromes, such as Werner's syndrome, contrast with what one would expect in a simple acceleration of normal ageing : neurodegenerative diseases, cardiovascular complications, and cancers, are different.

Gene products regulate many physiological events which may play a role in the ageing process if circumstances favourable to their expression occur. Thus, several epigenetic mechanisms are thought to be involved in ageing and its pathological manifestations. One of the more thoroughly explored reactions is the generation of oxygenated free radicals against which the defences of the body weaken with age and fall prey to nutritional imbalance (22). Increased activity on the part of certain proteolytic enzymes which deteriorate cellular constituents are the source of aggravating phenomena which accelerate the decline in certain functions that contribute to the appearance of pathologies. Every function has its own specific speed of decline of which the fastest is in elastic tissues. Deterioration of elastin and of its cellular interaction contribute to the onset of pathologies such as arteriosclerosis or pulmonary emphysema (23).

To sum up our knowledge so far, there is no evidence of a longevity "clock", with overall control of DNA alteration, crossing-over alkylation and other post transductional chemical modifications of proteins, changes in composition and operating mode of cell membranes, of mitochondria, of neurotransmitter and hormone synthesis, of organic metabolism, etc... Genes of which a mutation enables a modification of longevity in some primitive animals have been discovered recently; however, identification by cloning of the proteins expressed suggest that frequently (or always ?) these are homologous compounds of regulating proteins (receptors/enzymes) which are known to play an extremely important role in the metabolism of higher animals (for example an enzyme for phosphorylation of inositol, the insulin receptor). This also would incline to considering life expectancy as very directly dependent on nutritional functions which are themselves quite obviously connected to the nature of the environment.

Thus, despite published correlations - which are not demonstrations - no central single hypothesis seems to be in the offing for defining "gerontogenes", if this is to mean genes whose fundamental, primary, and specific function is to regulate the life span of an organism.

2 - Extrinsic ageing mechanisms :

The rapid increase of average life expectancy since the beginning of this century suggests that extrinsic factors may play a major role. The human genome would be hardly likely to change considerably in so short a time lapse. Improvements in general living and working conditions with better nutrition, habitat, domestic heating, clothing, hygiene and the regression of pandemics, and medical advances, are thought to be responsible for a gain in longevity. Interaction between the environment and the genome seems to play a major role in the ageing process. Because of the large number of intrinsic and extrinsic factors which enter into the ageing process and associated diseases, the speed of decline of physiological functions is very uneven and variable. This reflects both the "gene lottery" and the variable life styles of different individuals. It is therefore worthwhile to act on the environment to lighten the burden of age and iron out inequalities as far as is possible.

In fact, there is little doubt that relative ageing and resistance to ageing are linked to social and economic levels, and to the degree and length of education, which underlines the beneficial and preventive worth of progress and education.

3 - In other words and by way of conclusion to the above, we do not know at this time whether a genetic system specifically concerned with regulating longevity, either in animals or human beings, actually exists. The importance of a certain number of physico-chemical processes with metabolic significance, which consequently are governed by the environment in the broadest sense of the word, that is by ecology, climate, diet, hygiene, and social and cultural dimensions, are gradually being discovered. This shows just how important are living conditions, in particular nutrients and behavioural factors. These processes are influenced decisively by neuro-hormonal mechanisms in the body, so that research must be done on modes of regulation, and on therapy aiming to compensate or stimulate neuro-hormonal functions which have deteriorated over the years (17, 24-26). Recent research on the epidemiology, prevention and cure (of for instance menopause, osteoporosis, hypertension, diabetes, cerebral functions) point the way to fundamental research and trials directly applicable to human beings. In fact, there are already indications that several components of ageing, both normal and pathological, can be prevented or treated to achieve more successful ageing in a greater number of cases. Research on the subject is essential.

4 - Chronological evolution and biological boundaries

In spite of progress in the quality of life of the very old, progress in life expectancy seems to be curbed by a biological limit which is the inevitable consequence of an accumulation in tissues and cells of unrepaired lesions. In many cases, end-of-life is characterised by disease, the emergence of multiple disorders, varying degrees of dependency, and frequently extreme solitude (22).

However, an invulnerable boundary has yet to be set, and since the end of the 80s, the age of death has been advancing. At this point, more than 75% of deaths take place after the age of 65 years, 60% after 75 years, and as much as 30% after 85 years. This development should continue for at least several decades and neither duration, nor therefore, extent can be predicted. Women are more concerned than men since almost 43% of them die after the age of 85 years, whereas for men the figure is only 20%.

III - Disability-free life expectancy

The asymmetric development of chronological age and of the expression of biological evidence of ageing is the reason why an increase in disability-free life expectancy (DFLE) can be observed. In France, DFLE is advancing faster than longevity itself, for men in

particular.

As a consequence, the increase in longevity is a reason for considering the **quality of life** *of the elderly who are still happily unencumbered by ailments connected to ageing*. This is a majority. Although in the 1970s the trend was to provide nursing homes or other residential facilities for the over 70 age-group, the gradual improvement of disability-free life expectancy is such that the general rule now is to keep the elderly in their own homes as long as is at all possible. The 600,000 persons living in an institutional setting for the elderly (as of December 31st, 1994) represent 6.4% of the population aged over 65 years and 13.3% of the over 75 (27), although various forms of home care to cope with incipient or temporary infirmities must also be provided. According to INSEE (Institut National de la Statistique et des Etudes Economiques - official French statistics bureau) (28), only 11% of persons over 60 who are not in care are physically dependent, and 1.7% of them need help in everyday life. Figures are respectively 28% and 4.5% for those over 80 still living at home.

However, the consequences on these elderly but still mobile people of *isolation and solitude* brought about by the shattering of traditional family units in which the older generation still played a useful and active role, must be emphasised. It is also a pity that city planers failed to provide the possibility for the elderly of continuing to live near their children, albeit in conditions which allow for, as they should, the characteristics of different generations.

One cannot but underline that this is a real problem for our society and bound to increase in severity because solitude, a feeling of uselessness, and social disinvolvement are factors which accelerate the manifestations of ageing. Remedies presently provided by associations and self-help groups for the elderly should not be underestimated, despite the fact that the purely recreational nature of some activities appear to a large number of those concerned to be rather childish, lacking in prestige, and regressive.

Maintaining a proper social commitment is one of the conditions for a continuation of personal expression by the elderly, and maintaining a high quality of life.

IV - Disability and dependency

1 - The end of freedom from disability

The end of freedom from disability is dominated by manifestations of senescence of the cerebral functions, in particular memory, cognition and perception, and of cardio-vascular and locomotive functions. Movement, expression and participation in the life of society become limited, and in combination to a greater or lesser degree with various chronic or recurring diseases, the elderly gradually enter into disability and dependence.

As an example, a European study (EURODEM) which incorporates a French study (PAQUID) (20), estimates the occurrence of Alzheimer's Disease at 1% between 65 and 70, and about 15% after 85.

In 1995, out of 8 million people of 65 and over, almost 700 000 suffered from severe disability which made them dependent on someone else in everyday life. Up to 2010, growth of that population should be limited. In 2020, probable figures should be in the region of another 100000 or 200000 more. It must be noted however that an increase in disability-free life expectancy and the indisputable effects of prevention of deterioration factors of various capacities, relational in particular, would tend to delay the age when dependency appears and so maintain some stability in dependency figures. Improvement of health compensates copiously for the effect of an ageing population. Onset of dependency is deferred and there is no significant increase in the length of time spent in a state of dependency (28).

When **physical and/or psychological dependency** appear on the scene, there are two fundamental consequences (29). On the one hand, considerable expense which plunges a number of people into being economically dependent on their families or on the community; and on the other hand, since they lose their autonomy and therefore their freedom of decision about the organisation of their everyday life, they may become dependent on decisions made for them by others, which are frequently arbitrary even though they may seek to be benevolent.

The family environment is a factor which conditions the possibility of home care. In this respect, the importance of the carer must be underlined. Mainly, these are elderly wives and daughters. Several enquiries have demonstrated that the elderly represent 35% of the volume of informal assistance and nearly 50% in the case of home care.

Daughters provide the main body of various kinds of help and care given to elderly parents and in-laws. Since an increasing number of middle-aged women are in productive employment, it stands to reason that women in their working years are going to be less available and that therefore in the future the numbers of family carers will dwindle. Furthermore, wives or daughters caring for older dependants will themselves be elderly and in need of support (30).

2 - Home care

Home care socially supportive services which supply nursing and hygiene care by medical prescription to dependent elderly people (31), were created with the aim of preventing or deferring admission to nursing homes. By the end of 1996, 1547 such services provided capacity for 5650 individuals. 70% of them are managed by the private non-profit making sector. Nearly 50% of beneficiaries are 85 and over and the same proportion are severely disabled both physically and mentally. Mostly, care is purely nursing and non-technical. Here again, the family environment plays a major role in the effectiveness of the system. However, it must be noted that only one dependent elderly person in every seven living at home, benefits from the system.

3 - Admission to a nursing home

When dependency increases, or when it becomes impossible to continue home care, an **institution** is the next step (32). At this time, it is estimated that 360000 people aged 65 and over, are dependent and reside in an institution, i.e. 63% of residents (on 31st December, 1994, 600000 people were residents, with an average age of 83, of which 48% are 85 and above).

Confronted with the financial or psychological difficulties which their state of health, or their admission to hospitals or to nursing homes, creates for their families, some people lose the will to live and choose what could be called an "altruistic suicide".

It should be noted that France has the unenviable privilege within the European Community of having the largest number of suicides in the over 75 age group. Motives are isolation, solitude, depression after bereavement of mainly elderly widowers who are less able than their wives of coping with a situation which is frequently aggravated by sickness or infirmity.

4 - Distress and attitudes

Ethics demand that everyone be assured of receiving adequate care, excluding both therapeutic neglect and unjustified therapeutic aggressivity.

- Therapeutic neglect

A frequent cause is the absence of diagnosis as illustrated by remarks such as "at that age, should we really inflict all these tests on him/her ?" or "at 90, surely diagnosis is pointless!" (56).

This amounts to ceasing to bother treating for ailments in spite of the fact that a cure is possible and could improve the quality of life. This negative attitude may certainly induce premature death, but is even more likely to make end-of-life harder to bear.

- Therapeutic aggressivity

Palliative care and the various forms of end-of-life counselling should now replace therapeutic aggressivity. The medical team managing such cases must therefore be fully aware of the specific nature of multiple pathologies afflicting the elderly dependent population. Desirable attitudes should be closer to preserving or restoring "quality of life" than to adopting futile and heroic therapeutic options. Nor should it be forgotten that in old age, even in extreme old age, the ailing and dependent must retain mastery of decisions concerning them as long as their mental health makes that a working possibility. Although refusing therapy is a choice which must be respected, there must be awareness that solitude, a harsh or impersonal environment - very different from what is recognised as desirable in the attitudes and climate prevailing in gerontology wards - may well be conducive to refusal of care equating suicide.

V - End-of-life (1)

Death has changed its venue (35, 36). Increasingly, people die in an institution and less frequently at home. This migration is a social revolution which happened very swiftly. Reasons are better access to health care, greater faith in medical effectiveness, but above all, urbanisation, smaller homes, individualism, breakdown of the family, and consequently isolation and solitude for the elderly.

In 1991, 70% of deaths in the over 65 age-group occurred in hospitals or other institutions (50%), clinics (10%), or nursing homes (10%). After 85, 15% of deaths occur in nursing homes. This progressive "institutionalisation" has led to an increase in the medical component of death and the risk of inappropriate care and futile cost when it takes place in a medical and scientific environment where death is usually viewed as a technical failure.

An effort to spare the elderly from dying in places which are uninterested would be welcome.

At this time, we have accumulated medical, therapeutic, psychological, and institutional knowledge which can really improve, physically and psychologically, the conditions in which elderly people die.

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These are the facts on which CCNE based its ethical considerations.

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PART II : ETHICAL CONSIDERATIONS AND GUIDELINES

I - Reducing the inequalities of ageing

1 - Retirement, a social devaluation

The importance of the social and economic factors connected to employment policies must be underlined (38, 39). Social protection as it has developed in France, has made access to "retirement" a fundamental social right. The claim to pension rights of a wage earner when he ceases work, rights which are both deferred wages and evidence of solidarity between generations, can be denied by none. There is also the perfectly legitimate possibility of claiming early pension rights for those whose working life started very early or whose occupation was particularly stressful.

Nevertheless, and independently of any economic consequences, granting earlier retirement rights across the board (as was conceded in the 80s) has effects which cannot be ignored on the composition of society.

Making a certain age the rule for claiming full pension rights sets a symbolic threshold for entering into "retirement", a word which is identified wrongly with "old age" (12). Meaning the impossibility of practising an occupation, retirement in collective judgment is the point of entry into old age and triggers a negative social definition of that time of life. Old age is a time for rest and not for work, and the "senior citizen" someone who can no longer work i.e. a pensioner (40). The fact that in order to benefit from pension rights, gainful employment must cease, reinforces this conviction which is insufficiently attenuated by the 25 hours a month of paid activity which are tolerated. Moreover, the recent option of "pre-pension" rights which further reduce the age when gainful employment ceases altogether for people who are still physically and intellectually capable of working, accelerates the process of exclusion from the world of productivity and accentuates a modification of the social definition of old age.

To accept that in 2015, 40% of the population will be aged 50 or more, in no way corresponds to the notion that 40% of the population is unfit for work.

Yet, that which devaluates in the eyes of society "the elderly" leads to an acceleration of the ageing process which is not a little influenced by attitudes, opinions, and the outlook of others.

There is still nevertheless an identification of the "three ages of life" as being : youth as a time to mature and learn, adulthood during which knowledge and experience gained are exploited, and retirement - old age - a time for rest from the efforts of adult activity. Quite obviously, this view is now totally divorced from reality (41, 42).

The distribution of work over the life cycle has changed radically in the last twenty years. Youngsters enter the labour market later because they go to school longer and have difficulty in finding employment. Activity after the age of 55 is following a sharp downward trend in Europe and in North America. Working life is truncated at both ends and is now mainly the prerogative of median age-groups .

This dramatic drop in professional activity after 55 has been observed since the 70s in France and all other industrialised countries except Sweden and Japan. The age-group 60-64 were the first to be affected, but there is now significant extension to the 55-59 age-group, so that ageing workers are progressively excluded from the labour market (43).

CCNE is well aware that choosing to lower the standard retirement age for wage earning

workers is part of an effort to facilitate access to the labour market for younger age groups. But there is some concern regarding the risk for society of creating artificial age groups and setting them against each other. A balanced society is built on the social relationships between all of its members. There is already evidence in our society today of a deterioration of the fundamental social relationships within the family or between spouses. By depriving a section of a society's active members of the self-esteem procured by employment, there is perhaps a risk of triggering a process of exclusion or discrimination which could be at variance with Human Rights.

The fact that some categories of workers are allowed to draw pension rights and then go on to another wage earning activity (as is the case for instance for military personnel), which in itself is totally blameless, is also an example of the inequalities the present regulations give rise to. If this is a good system for some, why not apply it to others ?

CCNE fully acknowledges that an individual cannot claim a position or exercise authority beyond the legal age set for those functions. But it wishes to emphasise that there is no direct and confirmed connection at present between lowering the age of retirement and job creation. Efforts should therefore be made to avoid creating unnecessary conflict between age groups.

CCNE notes that financial support which grandparents give to children and grandchildren is increasing, and therefore reintroduces the issue of the direct role in society played by the elderly.

Finally, lowering the age of retirement does nothing to solve the question of the use to which knowledge and experience accumulated by retirees could be put.

Voluntary work solves only some of the problems, which demonstrates that there is a need to rethink and enhance the role of voluntary work in our society. There must be some form of recognition, appropriate status, and proper legitimacy.

Another point to underline is that although the notion of "retirement age" applies to wage earners, it is far from doing so for craftsmen, tradesmen, and a great many self-employed persons. But, on the contrary, cases of **premature ageing** have been observed in recent years among the long-term unemployed or the jobless who have become social outcasts, as had been observed long ago in prison inmates and similar populations.

Ethics surely dictate a lessening of the inequalities of ageing.

2 - Ageing in the eyes of public opinion

One is bound to notice in the media and advertising material an **excessive representation of youth** and emphasis on everything connected to youth and its attributes, a "dominance of youth syndrome" which prompts thinkers or salesmen to bow down to the "young is beautiful" concept (36) and which taken to extremes is sometimes expressed as a kind of "anti-old racism". As it happens, pensioners spend a great deal of their time absorbing information, communication, culture, media material. They see an image of themselves which lowers their self-esteem.

Knowing that today's population forecasts will be tomorrow's reality, the image of ageing in public opinion (37) must be considered as an ethical concern of our time.

This means that thought should be given now to the importance of educating the young on the management of their health, their understanding of advice on preventive health measures, their attitude to old-age and to times past, their relationship with their grandparents and more generally their place within their family and of that family in the passing of time and in society.

3 - Forgetting the economic role of "senior citizens"

Immediately after World War II, the " *most pressing"* objective in the LAROQUE report (8) was to "guarantee (to each older person) *sufficient resources to live decently ".* On the whole, there is no disputing that this is so. There are numerous examples of elderly people better off with their pensions than they ever were before. These cases are frequently observed in a rural environment so that there is now access to culture (travel, visits, etc.) which was previously denied. This is also frequently true of retired wage earners.

Recently, various marketing sectors have accurately diagnosed the situation and are now targeting a category they have created, the latest version of "senior citizens", i.e. elderly but active and dynamic persons, generally endowed with positive and favourable characteristics. The market contributes to their emergence among the various categories of consumers who are sought after, motivated and wooed, in particular to win them over to technology and services (44) which could enable them to access new forms of individual life styles in a post industrial society, providing of course that social policies and rigid administrative procedures do not deny them that access.

4 - Demographic imbalances and risks of inequity

There is cause to fear that the present situation, which is the result of solidarity between generations, may become untenable in the future because of demographic imbalances which endanger the financial equilibrium of pension schemes, as the active to inactive population ratio deteriorates. A report called "Ageing tomorrow" (10) had drawn attention to inauspicious population developments by the year 2000. It underlined the importance of any measures aiming to preserve demographic equilibrium. It must be recognised that no genuine political and social measures to that effect were taken in France, and also that positive results of truly motivating measures taken in Sweden were only temporary (39).

According to the **White paper on pensions** (45) published in April 1991 with a preface by Michel ROCARD who was Prime Minister at the time, even if fecundity were to return promptly to the replacement level, even if there was an upturn of activity in the older age-groups in the next century, and even if unemployment fell swiftly, the burden of pensions to be financed in 2040 at rates which remain at their present level, would suffer a 50% increase in their proportion to GDP in 1990. Given no change in population, by 2010, supplementary financing needs would amount to 8 contribution units for the general pension scheme, and 11 units for the scheme specific to the civil service (46).

By law dated 22nd July, 1993, on the subject of pension schemes and safeguarding social protective mechanisms, "aims to preserve existing basic rights and solidarity systems and also guarantee equity between generations called upon to contribute to an effort to contain pension expenditure". As of now, updated information reveals a foreseeable risk of intra and inter generation inequity (47).

It would perhaps be wiser to pursue wealth sharing courses which dissociate activity and solidarity.

II - Prevent and manage dependency

To consider that a group of elderly people partially deprived of resources is an inescapable fact would contradict the ethical requirement of preventing the effects of ageing since we are now able to do so.

1 - Prevention, as a factor of disability-free life expectancy

Although further increases in life expectancy are limited by biological boundaries, disability-free life expectancy (DFLE) can be increased by active prevention of harmful and cumulative

consequences of minor disabilities or transient disease (48). However, for this to be so, discerning health care is required.

a) Up to the age of 75-80, in the *absence of infirmity*, elderly people suffering from some well defined pathology within the range of a clinical speciality, should be treated in the **healthcare mainstream** like any other patient regardless of age.

b) In cases where several pathologies coincide with existing loss of autonomy, or when there is a **risk of losing autonomy** because of concomitant pathologies, prescribing management by a **specialised geriatric unit** is advisable. This should also be the case, whatever the pathology, for patients over 80.

c) Management in a geriatric unit, or an emergency geriatric unit, or at the very least referring to geriatricians, is essential to evaluate the functional status of sick elderly patients so that steps can be taken to initiate **prevention of dependency**. In this respect, the importance and effectiveness of management of the very early signs of Alzheimer type dementia must be emphasised.

Effectiveness of prevention has now been demonstrated by all the specialised geriatric units, but unfortunately, there are still only very few of these so that a majority of "sick elderly people" are still treated elsewhere, and many of them are unsuitably treated... Ordinary untrained care, however compassionate, can be inadequate or deficient, so that only too frequently it brings about an aggravation of the ageing process. Simply leaving aged patients lying in bed, or motionless, can render them unable to walk. When nutrition is inadequate, depending on the ailment, cachexia can ensue. When care is technically correct but lacking in those relational qualities which are essential for elderly patients, depression may be the result. Inappropriate behaviour such as treating them like children, and depriving them of the stimulus of information, may lead to psychological disconnection. An older person who has now become an invalid begins to feel guilty about being alive. Whereas appropriate care would have kept these elderly patients autonomous (55), they join the group of " *dependent persons*".

2 - Support : special compensation for dependency

The law N° 97-60 dated January 24th 1997 created a "special compensation for dependency" (*PSD- Prestation Spécifique Dépendance*) and is for society a first step in the direction of taking account of the social and economic consequences of "dependency". It can only be considered as a first step, but there is no disputing its symbolic importance. It only covers at this time 300000 people whereas there are 700000 truly dependent persons. It is paid in kind, diminishing according to individual means and makes a more rational appraisal of the degree of dependency. Local departmental authorities run the system which seeks to optimise available resources by dual co-ordination of personal assistance and supply of services (49, 50). However, many adverse reactions followed the implementation of the PSD and initial evaluation results. According to a study performed at the request of the Commission for Social Affairs of the Senate (51), the system can only become effective if it provides the means for individual preventive measures to combat dependency. In fact, PSD is only for highly dependent old people whose score on the AGGIR evaluation grid is 1, 2, or 3, whereas the less dependent whose score is 4 are those who would best benefit from measures to prevent an aggravation of dependency. Furthermore, those who are highly dependent at level 3, but whose resources are slightly too high to qualify, in particular because of an appreciation of their assets, get not help at all.

3 - For a public health approach

Another point worthy of notice is that the definition of dependency as "needing help to accomplish everyday tasks" as it appears in French legislation differs from the definition adopted by the Council of Europe (52, 53). Dependent persons are described as those who

"for reasons **connected to loss of physical, psychological, or intellectual autonomy**, require substantial help to satisfy specific needs arising out of the accomplishment of everyday tasks". Thus, independently of age, the factor causing dependency, a disease, an affection, or multiple pathologies, do not appear in French definitions.

2 *The essential considerations of public health are in this way dismissed from French deliberations, whereas a public health approach would better serve the cause of preventing dependency.*

Such an approach is bound to relate to a discussion of the involvement of the French sickness insurance scheme which so far has not even been mentioned. The question of when long-term health care insurance takes over from ordinary sickness insurance was never raised.

In this respect, French legislation differs from recommendations N° R (94) of October 9 and 10, 1994, of resolution 1008 (1993) of the Parliamentary Assembly of the Council of Europe, and from recommendation 1254 (1994) of the above Assembly. It must be said that despite these recommendations, member countries of the Community approach these problems very differently (54). Solutions already found to problems of ageing in the French population and those which may be expected after an objective examination of French society could well be contradicted by our European commitments. Perhaps ageing should be included in subjects for subsidiarity.

This situation, to which must be added disparities in the way departmental authorities grant PSD as regards conditions for qualifying and effectiveness, constitute the negative side of the 1975 law which dissociates health and social matters, and decentralising legislation which confers responsibility for social issues to departmental authorities, whilst health remains a State prerogative. Several possibilities for co-ordination of these activities which are provided by the May 1966 decrees, should be actively implemented to improve the efficiency of dependency assistance and the prevention of dependency.

4 - The proximity approach

CCNE has no hesitation in recommending a proximity approach in providing assistance to dependent persons. It would be unethical to deny that dependent elderly persons should be helped appropriately and efficiently close to where they have spent their lives and where their friends and families reside.

There is no justification for refusing to renovate for that purpose certain facilities originally designed for short-stay hospitalisation which have become superfluous or obsolete, and to provide suitable advanced training courses for staff employed there.

III - Developing geriatric medicine

A purely "social" approach to ageing so far, explains the gaps in teaching and research in geriatric medicine. Immediate remedies must be sought.

1. Teaching geriatric medicine

There must be an intensification of *specific* education for medical staff, para-medical staff, and social workers who will be caring for an increasing number of elderly people. Whereas many decades ago, the specificity of care required for children led to the identification of a specific discipline, paediatric medicine, it is surprising to find that public health problems connected to the pathology of age and of the ageing process which are very noticeable have not yet inspired French academic circles to define and recognise a discipline called geriatric medicine. It is still taught, as a poor relation in the eyes of many, as part of "internal

medicine". Training is scattered in the midst of various university degrees or campaigns for the ongoing education of general practitioners. Recognition must be given to the major role played in this respect by professional organisations and associations such as the National Geriatric Foundation (*Fondation Nationale de Gérontologie*).

If the elderly are looked after by physicians who are specially trained in geriatric medicine, it will be beneficial to the elderly first and foremost, but also to the entire community in particular as regards a reduction in the expense of medication. Excess consumption of drugs by the elderly (61) is also at present a public health problem. Preventing and avoiding self-medication, refraining from over-abundant or duplicate prescriptions would be among the first benefits and yet strictly comply with Article 8 of the Code of Deontology.

2 - Geriatric research

Geriatric research is also a necessary priority if one takes account of the importance for society of the present increase in longevity which will be a major public health problem in the near future . *"Multidisciplinar research on ageing and dependency"* was on the list of priorities of the "1987 charter" (57). This must include *clinical* research based on evaluation, *fundamental* research of the phenomena involved in ageing, and research in the *social sciences* (58, 59). Research procedures and modalities will have to be adapted accordingly. Credits will need to be granted. Validation of protocols and updating training courses will follow.

The lack of interest for geriatric research on the part of major research institutions is to be deplored. It is true that a great many laboratories and individual researchers are interested in ageing, but apart from in the neurosciences, they are very dispersed. In this connection, the important consequences for future society of some of the ongoing research if it succeeds in maintaining memory and mental activity in old and even very old people (60) cannot be too highly stressed. Recent epidemiological research, both preventive and curative (for example as regards the menopause, osteoporosis, hypertension, diabetes, cerebral activity) suggest fundamental research and trials directly applied to human beings. Indeed, there are indications as of now that several components of ageing, either normal or pathological, can be prevented or treated so that "successful ageing" can occur more frequently.

However, it must not be forgotten that research and particularly therapeutic research, on aged dependent patients is extremely difficult. Truly geriatric therapeutic controlled trials, need to be designed to include real elderly patients.

Furthermore, when aged dependent persons suffering from Alzheimer type senile dementia are involved, comparative controlled therapeutic trials raise specific problems of consent (59, 60). Modifications to legislation to cover these specific situations, with due regard to ethical points already made by CCNE, would seem necessary.

Restrictions on geriatric research programmes based on the argument that results will contribute to increase longevity and therefore accentuate demographic imbalance, are unacceptable.

Medical ethics put an obligation on physicians and researchers to seek progress in preventive and curative methods which retard death. There is an ethical obligation on our society to opt as a priority for preventing the deterioration of the quality of life of the elderly, and for keeping them autonomous, and thereby maintain human dignity.

It would therefore not be acceptable to dispute the usefulness to the community of research on the deterioration of the quality of life and on dependency in particular, which implies research on aged dependent persons, on the grounds that they themselves might not derive any personal benefit from such research (64).

Conclusion :

From a collective issue to a geriatric programme of action -

As we have seen, there are now possibilities of managing humanely and effectively the manifestations of ageing and these lead to a reappraisal of the relationship between biological ageing and demographic ageing.

It is possible to believe in a longer life span and still retain an optimistic view of the health of our oldest citizens. In the future, our old people will be in better health at a comparable age, but they will also be even older and there will be more of them (4).

As regards the community, the issue will be played out in a race between "biological youthfulness" and demographic ageing.

In 1953, there were 200 people over 100. In 1988, there were 3000. Estimates for today would be about 4 to 5000. Soon there will be tens of thousands (55, 56). Extreme old age inevitably requires assistance. Although the very old in 2050 will be in better shape than their 1951 counterparts, there will still be a public health problem, and probably also a problem of society.

It is of course possible that if the issue of "collective choices" was raised, there would be some voices to question the "use to society" of these very old people, however free of infirmity they might be. If that were so, it would have to be opposed in the name of the following absolute ethical principle : each and every human being commands the utmost respect, independently of age and of the consequences which age has on physical and mental health.

That being so, arguments using economic constraints as an alibi, in favour of no diagnosis or limiting certain forms of care by administrative measures, would be contrary to every ethical principle. Age, even extreme old age, must simply be one of the parameters used to assess an individual's state of health. It cannot be a discriminating parameter (62). CCNE has already clearly expressed its opinion on this point (63).

Taking into account demographic data, now clearly identified, and consequences for society of the foreseeable ageing of the population, CCNE suggests that a ***geriatric programme for action should be developed and implemented as a matter of priority with a view to solving quickly and efficiently the difficulties arising out of the multiplicity and intricacy of regulations, authorities and structures concerned.***

Summary

Average life expectancy is growing faster than at any other time in history : this generalised fact represents a major problem for society. The problem must be broached from an ethical angle.

Several notable facts deserve attention. Growth in life expectancy requires a continuation and an adjustment of the "old age policies" of the last thirty years. Progress in knowledge concerning the physiological processes involved in ageing, and their intrinsic and extrinsic mechanisms, despite the maximum biological boundary, would encourage a consideration of present and possible extensions of disability-free life expectancy, and a firm attitude regarding management of those who are dependent or who have reached the end of their lives.

The above leads to ethical guidelines based on the three following areas :

- First of all, seek to reduce the inequalities of ageing which lead to inequity : social

devaluation which accompanies legitimate access to retirement; negative images generated by ageing ; ignoring the positive economic role for the family and society played by senior citizens ; danger of inequality because of growing demographic imbalance between age groups.

- Then, implement the ethical demands of prevention and management - in terms of public health - of dependency due to ageing. To do that, excessive compartmentalisation (due to the 1975 law) between health care and social care must be eliminated, and a reinforcement of the proximity approach to care.

- Finally, develop actively education and research in geriatric medicine, in clinical terms, the social sciences, and fundamental research.

It is possible to believe in a longer life span and still retain an optimistic view of the health of our oldest citizens. As regards the community, the issue will be played out in a race between biological youthfulness and demographic ageing, which leads CCNE to suggest that a geriatric programme for action should be implemented as a matter of priority with a view to solving the difficulties arising out of the multiplicity and intricacy of regulations, authorities and structures concerned.

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63- CCNE , Rapport sur "Progrès technique, santé et modèle de société : la dimension éthique des choix collectifs ", n° 57, 1998

64- CCNE , Rapport et recommandations sur "Consentement éclairé et information des personnes qui se prêtent à des actes de soin ou de recherche", n° 58, 1998

Annexes

1. Background : the three reports on old age policies

I - Commission d'étude des problèmes de la vieillesse (1960)

Président, Mr. Pierre LAROQUE

Rapport LAROQUE, 1962 (2)

..." l'effort au profit des personnes âgées, sacrifiées au cours des quinze dernières années (1945-1960) doit recevoir durant la période prochaine une priorité permettant de rétablir l'équilibre aujourd'hui rompu à leur détriment".

..." le problème le plus pressant est de garantir à chacun des ressources qui leur assurent une vie décente".

..." toute solution qui conduirait de quelque manière que ce soit à une ségrégation des personnes âgées doit être formellement condamnée".

..." l'âge normal d'ouverture du droit à une pension vieillesse est de 65 ans".

..." le maintien, à tous égards souhaitable des personnes dans un logement individuel doit nécessairement s'accompagner d'un important effort d'action sociale".

... L'aide médicale à domicile avec traitements ambulatoires ou "hôpitaux de jour" doit être développée sous contrôle, ainsi que la réadaptation fonctionnelle.

... Lorsque vient le moment où la santé ou le milieu de vie se détériore, il faut alors songer à l'hébergement collectif ... Le seul critère d'admission devrait être l'état de santé : il faut cesser de mêler valides et grabataires.

II - Intergroupe pour l'étude des problèmes relatifs aux personnes âgées

Commissariat général au Plan

Préparation du VIè Plan, 1971-1975

Président, Mme Nicole QUESTIAUX

Rapport QUESTIAUX, 1971 (3)

... un double objectif : "répondre aux besoins actuels d'une population d'un âge donné, agir sur les actifs d'aujourd'hui pour leur préparer une meilleure vieillesse".

..." l'amélioration des connaissances statistiques est l'une des priorités de la politique de vieillesse".

..." l'abaissement de l'âge de la retraite n'est pas une garantie contre le chômage".

..." c'est faute d'information que la société française accepte pour ses citoyens les plus âgés, la grisaille d'une vie quotidienne que le rapport a tenté de décrire".

..." aucune étude spécifique ne paraît avoir été conduite en ce qui concerne les besoins des personnes âgées et les conditions dans lesquelles l'avance en âge influe sur ceux-ci".

..." Faire en sorte qu'une personne âgée ne dispose pas de ressources inférieures à un revenu minimum. Ce revenu devrait être défini en fonction de la satisfaction des besoins et être lié au revenu des actifs. L'effort collectif en faveur de la vieillesse vise à assurer à chacun une proportion normale de son propre revenu d'activité".

..." La population âgée est pauvre et inactive. La disproportion entre ses ressources et ses besoins de logement est considérable".

Le rapport dresse la liste des principes qui devraient servir de base à une politique du logement.

Les équipements sanitaires sont peser sur le VIè plan :

"Le besoin d'un hébergement collectif médicalisé demeurera important pendant le VIè plan en raison de l'inadaptation quantitative des équipements actuels...du fait de l'accroissement de la population âgée, notamment du nombre des grands vieillards ; ... un hébergement fera croître dans des proportions importantes les besoins en personnel médical et paramédical"... Tout médecin devrait recevoir une formation gériatrique intégrée dans le cycle des études médicales.

... Il ne faut pas oublier "la charge que représentent pour la Sécurité Sociale les personnes hospitalisées en service d'aigus, de chroniques ou de gériatrie pour des raisons sociales non médicales".

III - Groupe "Prospective personnes âgées"

Commissariat général au Plan

Préparation du VIIIè Plan, 1981-1985

Président, Mr. Robert LION

Rapport "Vieillir demain" 1982 (4)

..." Le caractère principal d'une politique de vieillesse c'est de concerner la société toute entière et non pas les seules personnes âgées".

... La France va inventer le concept d'une vieillesse active, autonome et intégrée cependant que le grand âge devient une réalité sociale d'ampleur nationale.

... Si le "statut social de retraité" qui suit le "statut d'actif" s'inscrit dans le schéma de la succession des âges, le couperet de l'âge légal de la retraite est brutal. Il s'accommode mal du décalage fréquent entre l'âge chronologique et les capacités ou les souhaits.

... La vieillesse ne doit pas être assimilée à la retraite et celle-ci doit être distinguée du chômage.

... La crise économique dénature le problème de la vieillesse.

... Les recommandations de la Commission Laroque et celles de l'Intergroupe du VIè plan ont été très peu prises en compte quand elles visaient l'organisation sociale.

... Il convient de donner à la population vieillissante et âgée un choix de vie plus libre dans un meilleur cadre d'échanges et de relations entre les générations.

... une "pédagogie du vieillissement".

... La limitation d'un vieillissement prématuré et de l'incidence des maladies liées à l'âge relèvent autant de mesures de prévention sanitaire et médicale tout au long de la vie que de la lutte contre la pauvreté.

... Les modalités des retraites doivent être réaménagées sur de nombreux plans.

2. Demographic data

3. Law n° 97-60 dated January 24th, 1997. Specific care for dependent persons.

4. AGGIR evaluation grid for loss of autonomy

Notes

1. (the working group discussed at length the subject of "end-of-life" of the elderly. Since a new working group on this subject has recently been designated, it was suggested that the subject be separated from this report).

2. **Laroque P.** (prés.) 1962, Politique de la vieillesse, Paris, la Documentation Française, 438 p.

3. **Questiaux N.** (prés.) 1971, rapport du groupe de travail pour la préparation du VIè plan (1971-1975), Paris, la Documentation Française, 333 p.

4. **Lion R.** (prés.) 1980, vieillir demain, rapport du groupe de travail pour la préparation du VIIIè plan (1981-1985), Paris, la Documentation Française, 270 p.