Ageing – a growing (health) challenge with ethical consequences: Advice from the World Health Organization

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The overarching message is optimistic: with the right policies and services in place, population ageing can be viewed as a rich new opportunity for both individuals and societies (Margaret Chan, 2015: vii).

Abstract

This article is focusing on ageing populations and hence elderly or geriatric communities evident across the world. The World Health Organization (WHO) predicts that elderly population growth will result in almost double the number from the current number of elderly people by 2050. The emerging question in this study is what we can learn from the WHO's handling of ageing. A follow-up question is how the answers to this question can be used in ethical guidelines for geriatric care. These observations contributed to the research question for this study: What contribution can the WHO commentaries and guidelines make towards ethics guidelines for geriatric care? To give effect to the research question, is it important to understand the consequences of an ageing world. The outcome of the qualitative research results is framed into ethics guidelines for geriatric care. The research results are presented within the context of public health. Public health has to do with the improvement in the quality of a population's health and well-being. A

Christian medical ethics perspective will contribute to this debate. This perspective is necessary as global guidelines are by nature religious neutral but should still be implemented. This implementation can be influenced by the Christian view on healthcare. The proposed guidelines are accompanied by a professional ethics approach.

Abstrak

Hierdie artikel fokus op die wêreldwye verskynsel van ouerwordende gemeenskappe en dus ouer of geriatriese gemeenskappe. Die Wêreld Gesondheidsorganisasie (WGO) voorspel dat die aantal ouer mense sal verdubbel teen 2050. Die vraag is wat kan ons leer van die WGO se hantering van oudword. 'n Opvolgvraag is hoe hierdie antwoorde gebruik kan word in die etiese riglyne vir geriatriese sorg. Hierdie waarnemings het tot die volgende navorsingsvraag vir hierdie studie gelei: Watter bydrae kan die WGO kommentare en riglyne maak tot die etiese riglyne vir geriatriese sorg? Om aan hierdie vraag aandag te gee, is dit belangrik om die gevolge van 'n ouerwordende gemeenskap te verstaan. Die uitkoms van die kwalitatiewe navorsing word as etiese riglyne vir geriatriese sorg aangebied. Die navorsingsresultate word in die konteks van publieke gesondheid aangebied. Publieke gesondheid het te doen met die verbetering van die kwaliteit van 'n bevolking se gesondheid en welwese. 'n Christen medies-etiese perspektief dra tot die debat by. Hierdie perspektief is nodig omdat globale riglyne 'n godsdiens neutrale aanslag het maar nog steeds geïmplementeer moet word. Hierdie implementering kan deur 'n Christelike perspektief op gesondheidsorg beïnvloed word. Die voorgestelde riglyne word teen die agtergrond van 'n professionele etiek aangebied.

Keywords:

Ageing; Ethics; Geriatric community; Public health; Social determinants

Sleutelwoorde:

Etiek, Geriatriese gemeenskap, Oudword, Publieke gesondheid, Sosiale determinante.

1. Background

In its 2015 Report on Ageing and Health, the World Health Organization (WHO) stated that for the first time in history, most people will reach 60 years of age and older. It is predicted that by 2050 the world population older than 60 years will nearly double from 12% to 22% (WHO, 2015:43). In 2019 a similar projection was forecasted (WHO, 2019:2).

The WHO uses 60 years as indicator of older population growth and therefore as criterion to identify the age category for older people. The same approach has been taken in other reports on ageing (WHO, 2017a, WHO, 2017b, WHO, 2019). Normally three groups of old age people are defined: the *young-old* (60-74 years); the *old-old* (75-84 years) and the *very-old* (85 years and older). Vulnerability due to health, social, economic, environmental, and political reasons, is a growing challenge especially amongst geriatric people who are represented in a rising ageing and consequently elderly or geriatric community.

WHO (2015:28,30) proposes *functional ability* and *healthy ageing* as meaningful interventions to combat the process of growing old. Chan (2017:113) refers to these interventions as the "new narrative for healthy ageing." The importance of geriatric care is further observed in her comment that the WHO moved the health needs of the elderly from the "back burner" to the "full heat of attention" (Chan, 2017:113).

From these reports can be concluded that a growing ageing and consequently an elderly or geriatric community will place more demands on the already challenged health, social and public services. This, in turn, will put more strain on the elderly or geriatric community.

As this study is directed at all groups of older people, the generic terms used for people older than 60 years of age are "geriatric people" (plural) and "geriatric person" (singular). "Geriatric community" (singular) is used to refer to a group of older people. In this study reference will be made to the geriatric person, people, or community for consistency unless a specific reference is made to elderly or ageing which may have a different interpretation.

The emerging question is *what can we learn from the WHO's view of ageing?*

2. Focus of the study

At the end of her tenure (2007-2017) as Director-General for the WHO, Margaret Chan (2017) published a report on the developments in public health during this period. She emphasised the growing role *social determinants* can play to improve public health. The new thinking is that social determinants, and not physical challenges only, contribute to health. The WHO confirms in various reports that health is influenced by more factors than physical illness only (WHO, 2015, 2017a, 2017b, 2017c and 2018). Aspects such as living conditions, food and water, social interface, and availability of healthcare influence general health. Wilkinson and Marmot (2003:10) confirm that health follows the social gradient.

The downside of Chan's comment is that social factors can also negatively influence quality of health and well-being of communities. Such a negative impact will increase the *vulnerability* of a community. Ethical challenges are often associated with vulnerability. This is particularly evident in the geriatric community.

The COVID-19 pandemic underlines the vulnerability of the geriatric community. For the foreseeable future is geriatric care grounded in a COVID-19 world. Based on the experiences during COVID-19, Fisher, Suri and Carson's (2022) argue in favour of a new approach to global health security and measures of preparedness. Their comment is particularly relevant for the geriatric community as this community is a community at risk due to health and social challenges as were evident during the pandemic.

Armocida, Ussai, Pavlovych, Valente, Missoni, Pistis, Lauria, Bustreo and Onder (2022) refer to the older people as "forgotten victims" in the Ukrainian humanitarian disaster. They observe the contradiction between recognising older people as a vulnerable group in the conflict with Russia but that this group is not considered to be a priority for humanitarian assistance. They argue that humanity and impartiality should always exist.

These observations identify the **research question** for this study: *What contribution can the WHO's commentaries and guidelines make towards* ethics guidelines for geriatric care?

The outcome of the qualitative research results will be framed into ethics guidelines for geriatric care. The research results will be presented within the *public health* context. In general, public health has to do with the improvement of the quality of a population's health and well-being (Lategan, 2021:25-26). Public health is always directed towards promoting humanity. Service delivery and a moral basis can therefore not be removed from promoting strategies

and taking preventive actions (Lategan, 2021:25). It is for this reason that the proposed guidelines will be accompanied by a *professional ethics* approach.

By presenting these guidelines in a public health ethics framework, the advantage is (a) that the framework can be useful to doctors, healthcare workers, health managers and administrators and (b) can be a valuable addition to the more known healthcare ethics, medical ethics, and bioethics which each have a different scope. Medical and bioethics' focus are on *cure*, is individual as defined by the doctor-patient relationship and deal with decisions on matters of life and death. Healthcare ethics is directed at *care* for the patients and public health ethics concentrates on *prevention* of illness and disease. Medical or bioethics, however, is generally used in ethics discussions on people's health.

A Christian medical ethics perspective will contribute to this discussion. This perspective is necessary for two reasons. *Firstly*, is there a long tradition of Christian medical ethics and bioethics. *Secondly*, global guidelines are by nature *neutral* but should still be *implemented*. This implementation can be influenced by the Christian view on patients, vulnerable communities, and healthcare.

An obvious limitation in this study is that a *scoping review* of the relevant WHO documents on ageing were done and not a *systematic review*. The intension of a scoping review is to provide broad-based perspectives on the research topic opposed to a systematic review addressing the complete set of records on a particular topic. For this paper is a scoping review considered as sufficient as it provides a baseline perspective on a particular topic (Sucharew and Macaluso, 2019:416-417).

To give effect to the research question, is it important to understand the consequences of an ageing world.

3. World Health Organisation on the consequences of an ageing world

The WHO's comments on ageing should be read against its understanding of health. The WHO's seminal definition of health is "a state of complete physical, mental and social well-being and not merely the absence of the disease or infirmity" (WHO, 1946). This understanding is echoed by the United Nations' Sustainable Development Goal (SDG) 3, namely "To ensure healthy lives and promote well-being for all at all ages" (SDG, 2015: Goal 3).

In dealing with ageing, the WHO (2015:28,30) promotes the concept of *healthy ageing* to raise awareness of the healthcare challenges experienced by elderly people, on account of inequalities and social determinants, but also in relation to the ongoing improvement of health equity. Healthy ageing is defined as "the process of developing and maintaining functional ability that enables well-being in older age" (WHO, 2015:28). The focus on healthy ageing is through raising awareness of inequalities, importance of social determinants and the continuous improvement of health equity.

Two concepts, (a) *functional ability* and (b) *environments*, are important for healthy ageing.

Functional ability is referred to as "the health-related attributes that enable people to be and to do what they have reason to value" (WHO, 2015:28). The report goes on to say that functional ability is inclusive of (a) the intrinsic capacity of the individual, (b) relevant environmental characteristics, and (c) the interactions between the individual and these characteristics.

Environments refer to those factors that form the context of an individual's life. Broadly speaking, these are (a) home, (b) communities, and (c) the broader society. These factors are further identified as livelihoods, relationships, attitudes and values, health and social policies and their supportive systems, and the services that result from implementing these policies (WHO, 2015:29).

Healthy ageing calls for healthy behaviours. Healthy behaviours can be put into effect by supportive ethical guidelines to strengthen the positive effect of social determinants on the health of the geriatric community. The intention of healthy ageing is, proverbially, to add "years" to "health." Healthcare and socio-economic support are important instruments to deliver on healthy ageing. However, regardless of the nobility of this approach to ageing, is it not without potential ethical dilemmas.

At least three noteworthy realities can create ethical dilemmas. These developments are:

(a) the growing awareness of mental health diseases such as dementia,
(b) the cost of healthcare, and
(c) the current COVID-19 pandemic.

The promotion of healthy ageing depends largely on *healthcare provision* and *practice*. A growing ageing population will have a big impact on the provision of healthcare (National Institute on Aging and the WHO, 2011:22). The impact goes beyond the mere administration of resources such as human

and financial resources, infrastructure, equipment, and medicine required to deliver healthcare. An ageing population will also influence family life, work, and elderly people's place in the community (National Institute on Aging and the WHO, 2011:20-22, WHO, 2020). The World Report on Ageing and Health (WHO, 2015) emphasises the effect a growing ageing community will have on health and health systems and confirms the workforce and budget consequences of such a population growth.

The consequences for a growing ageing society are influenced by the way ageing is perceived, the implementation of available policies steering the needs of an ageing population, and the effectiveness of service delivery to an ageing population (cf. WHO, 2020). The apparent inability of the South African healthcare system to deal with the ageing population is further problematised by the difficulty in finding a working definition of an older person in Africa. It is evident that a single definition such as chronological age or social, cultural, or functional markers cannot be used due to demographics, economic activity, and cultural practice. Hence, a combination of chronological, functional, and social definitions is proposed. Consequently the approach to geriatric communities in Africa cannot be understood in the same way as, or treated similarly to, other geriatric communities around the world (WHO, 2015: 94-95).

An ageing population should not be viewed as negative at all. Several reports, such as the Global Health and Aging Report (National Institute on Aging and the WHO, 2011) and the Report on Ageing and Health (WHO, 2015), identify the ongoing increase in life expectation as the reason for a continuous population growth resulting in higher numbers of elderly people. The increase in life expectation is generally due to the improvement in health and living conditions, increased access to healthcare services, improved healthcare delivery, better policies and (relatively) supportive budgets (National Institute on Aging and the WHO 2011: 2, WHO, 2015: 10).

The review of relevant WHO reports on ageing will assist in identifying ethics guidelines for geriatric care that can be used within public health.

Before these guidelines can be presented, it will be useful to return to the value public health can add to this discussion. The next section presents the case.

4. Will a public health ethics framework assist?

The WHO's definition of public health is overarching and emphasises preventative strategies in health promotion and disease deterrence. In the 1988 "Future of Public Health" document, the emphasis was placed on what healthcare practitioners can do, hence the following definition: "The field of public health is concerned with health promotion and disease prevention throughout society. Consequently, public health is less interested in clinical interventions between health care professionals and patients, and more interested in devising broad strategies to prevent, or ameliorate, injury and disease" (WHO, 1988:13).

The need for a public health ethics framework for ageing was identified by the WHO's (2017a:11-12) comment that the detail of such a framework should be worked out for a specific healthcare system. The need for this framework is further informed by the important role that public health plays in healthy ageing and the quality of health and well-being, given the growing ageing population.

Additional to the necessity for a public health ethics framework, was Nunes' (2015:218-42) summative study of 28 European Union (EU) and 12 other countries outside the EU's Bioethics and Ethics Councils' documents and opinions on ageing and elderly people. From her study, seven principles and bioethical elements were identified. These principles and elements are:

- respect for human dignity, regardless of the stage of life,
- recognition of the individual's unique situation relevant to ageing,
- freedom of one's decisions,
- acknowledgement of elderly people's vulnerabilities,
- ethical commitment and social responsibility in monitoring the elderly,
- no age discrimination, and
- guidance to attain integral good and quality of life.

The Global Strategy and Action Plan on Ageing and Health (WHO, 2017b:23) promotes the role of ethics by stating that: "Ethical guidelines are needed to guide governments and stakeholders at all levels, to address competing demands for resources, and to develop more inclusive approaches that optimize the functional ability of every person."

The WHO Report on Developing an Ethics Framework for Healthy Ageing shares a similar comment: "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" (WHO, 2017a:11).

This Report (WHO, 2017a:4) recommends three major changes:

(a) the physical environment should be friendlier to geriatric people,
(b) realign health systems to the needs of geriatric people, and
(c) develop long-term care systems to improve quality of health and living for geriatric people.

A review of WHO reports on ageing (WHO, 2015, 2017a, 2017b and 2020) to give guidance on the development of ethics guidelines in public health for the geriatric community, leads to four broad-based conclusions:

- There is an ongoing population growth of older people due to improved life expectancy. This has resulted in growing geriatric communities.
- There is a need to address geriatric healthcare in the context of public healthcare due to the reality of increased life expectancy, palliative care, growing mental health challenges and the challenges of affordability and sustainability.
- Social determinants will have an uncontested impact on the health of the geriatric community. Three major social determinants relevant for this study were identified:
  * Limited *resources* to support quality of health and well-being.
  * *Isolation* from family and community structures.
  * The *conflicting roles* of being on retirement but having to earn an income to make ends meet; being a grandparent and substitute parent at the same time and being vulnerable, often with limited support from social and personal communities.
- The evident absence of refined ethical guidelines in geriatric care based on the framework for healthy ageing.

With the confirmation that ethics guidelines can contribute to the improvement in the quality of the geriatric community's health and well-being, the next section will attend to the WHO's contribution to the ethics of geriatric care.

5. The World Health Organisation's contributions to the ethics of geriatric care

Geriatric care includes both health and social care and should address the social determinants of health (WHO, 2019:3). Healthcare for the geriatric

community should comprise of physical, mental, and sexual health (WHO, 2017b:16). The required care should be grounded in the context of the geriatric community as a vulnerable community. This vulnerability is because of health challenges, social injustice, environmental burdens, and the application of emerging technologies in the biomedical sciences.

Holtzer (2015:20,49,62) correctly scopes elderly care as more than merely the washing and hygiene care of elderly people. Chronic illness, disturbed family relationships and psycho-social challenges contribute to the level of care required by ageing people. It is for this reason that the WHO (2019) has developed the integrated care for older people (ICOPE) approach. The ICOPE approach acknowledges the integration of both health and social care for the ageing population. The background to this approach is that next to interventions at clinical level, effort and resources should be invested at the service and system levels.

Another ethical challenge is the role of the geriatric person in view of the destruction of the family unit. Alongside the growing ageing population is an associated problem, namely the growing number of orphans in Third World countries due to HIV/Aids, (civil) war, poverty, and hunger (WHO, 2017c). The challenge here is how to care for children in a society where there are no parents, but only grandparents. This puts an additional strain on the geriatric community and their well-being. Geriatric people take on the role of parents again – this time for a second generation. Concurrently is it evident that caring for children can be compromised if the geriatric person is sick and is in no position to take care of someone else. Such a situation cannot contribute towards the well-being of geriatric people and their communities.

From the WHO's comments, the following ethics guidelines for geriatric care in public health can be identified:

(a) An ethical approach to geriatric care should secure the basic ethical principles of autonomy, do good, cause no harm, justice, dignity, care for all, respect, professional workplace behaviour and integrity of decision and application.

(b) Policies, strategies, and actions should be in place to secure the quality of health, the eradication of disease and the prevention of any harmful action such as home-based violence and abuse of geriatric people.

(c) Geriatric people should be part of basic public health interventions such as ensuring favourable living conditions and specific interventions such as mainstreaming them into community life.

(d) Government has the dual responsibility to secure economic support and to provide physical and social infrastructure for the geriatric community.

(e) A multi-focused approach beyond healthcare provision should be followed in public health support for the geriatric community.

The discussion so far identified public health ethical guidelines for the geriatric community based on the WHO's view of this matter. Given the significance of Christian medical and bioethics, is the following question what value can such an ethic add to geriatric care? The next paragraph will attend to this question.

6. Will a Christian medical ethics perspective make us any wiser?

In the discussion on ethics guidelines for geriatric communities in public health, the relevant question is whether Christian medical or bioethics can add more insights. The reference to Christian medical or bioethics is because very little discussion exists technically on a Christian public health ethic (see Lategan and Van Zyl, 2018). The primary reason is that public health is presented by the government as agency for public health. By nature, democracy cannot have separate policy instruments or pathways for different faith or religious groups. However, Christian medical or bioethics can provide an important contribution towards the discussion on ethics guidelines for geriatric care in a public health framework based on relevant perspectives available from medical and bioethics.

This observation is confirmed by Saunders (2015:117-120) who alludes to the huge and constructive Christian contribution to medical ethics. (The assumption is that the same arguments can be aligned to bioethics.) For Christian medical ethics is the *intrinsic value* of and *respect* for human life a core belief. Doctors and healthcare staff are accountable to God on how life is viewed and treated. The contribution from Christianity to medical ethics is not only essential but also identifies ethical matters and provides perspectives that can influence decisions. Although Christians are not the only ones promoting the intrinsic value of human life, "Christians have been the most consistent advocates of this viewpoint, defenders of the vulnerable, and good medical ethics continues to benefit from that voice" (Saunders, 2015:120). He further comments on Christian theism as a lens through which life's experiences can be interpreted. His observation is that Christian medical ethics should be based on 'doing' and less on the doctrines of God's

self-revelation (Saunders, 2015: 118). In a universal sense doctrine will not change the content of the global accepted United Nations' Declaration of Human Rights or the Helsinki Declaration that describes the ethics of medical research. *It is at the implementation level that the impact of Christian ethics should be seen*. God's love (*agape*) demands should be accepted, and the meaning thereof should be worked out. The practice is to see the divine image in a fellow person (Saunders, 2015:119). From Saunders' discussion the guiding comments for this study are (a) that a Christian medical ethics should provide motivation why some actions cannot be supported and (b) Christian viewpoints may not change existing policies and practices, but the application thereof depends on the Christian values associated with healthcare. In essence, Saunders promote the influence of a Christian medical ethics on the *implementation* of ethics guidelines and decisions.

This interpretation is supported by amongst others Körtner and Habgood who are from different countries and commenting from different time spans.

Körtner (2011**)** makes an important comment relevant for this study. Based on his view, the modern idea of human dignity does not depend on theological grounding. However, theology should assist Christians *firstly* to find access to this discussion and *secondly* how theology itself and churches can contribute towards this discussion. In response to Körtner's comment, the discussion should include the *sanctity of life* versus *quality of life*. What should be noted from this debate is the joining of two oppositive views on the meaning of life. Sanctity of life is very much a religious and moral matter whilst quality of life depends on functional categories (see for a discussion Gilmore, 1984). Of relevance for this study, is to uphold the view that life is precious as it is God-given, people are created in the image of God and that life cannot be reduced to qualitative categories of functional abilities.

In his support of a Christian medial ethic, Habgood (1985:12-13) comments that care for the well-being of patients and concern about the technologies used to support patients, relate to death and suffering as two prominent challenges in medical ethics. Linked to these challenges are the decisions taken on the well-being of patients. Religion and faith-based orientation are important knowledge resources for decision making. Relevant examples are how death is viewed and to what extend can suffering be regarded as ethical? He argues that for example dignity may not be helpful when decisions about the allocations of resources in a geriatric hospital must be made but when this matter is ignored, "the decision could have been easier, and different and worse." The perspective that is hold on God, will also influence actions and decisions as the fundamental perspective is that in Christian medical ethics

no one can play "god" in making decisions about life. Within the doctrine on creation, the focus is primarily on creation, but creativity is very often ignored. Applied to this study, the abilities which geriatric people have, are also important when programmes are developed for them or when assisted dying is discussed. Theology can play in immense important role to remind that there is a Power superseding the power vested in human decisions and medical devices. He comments that "The real resources of theology lie not in some intellectual scheme, but in the awareness of a power greater than our power, a care for individuals greater than our own care, and a forgiveness greater than our own capacity for failure and error, which makes it possible for us to live with ourselves without complacency and without despair" (Habgood,1985:13).

McCarthy (2017:2-3) identifies six core Christian beliefs relevant to medical ethics. These beliefs are:

- **God the life-giver**: Life is a gift of love to creation. Apart from people sharing in this gift, they are also unique in the sense that they are created in God's image. Because of people being created in the image of God, people could claim dignity. Because of God's image, we can relate to God and other people. This relation should reflect God's own being.
- **God as Trinity**: The understanding of what it means to be a person should come from an understanding of God. People stands in relation to the unity of the Trinity. Relationship is therefore reflective of being a person.
- **God Incarnate**: Christian believers must follow the example of Jesus to demonstrate selfless love, care, and responsibility for humans.
- **God the Redeemer**: The redemption of Christ should be reflected in our relationship with one another.
- **God and justice**: Behaviour towards the vulnerable is viewed by Jesus as our treatment of Him.
- **God and community**: Based on the Trinitarian understanding of God, relationship lies at the basis of what it implies to be a person. Relationship calls for people to be bounded in community.

From these core Christian beliefs, she identifies four leading principles relevant to medical ethics. The principles follow a priority order notable as *affirming life, caring for the vulnerable, building community* and *respecting the individual* that emerge from the core Christian beliefs outlined above. These principles complement one another, and one leads to the other (McCarthy, 2017:3-4).

The challenges remain, however, how to apply these principles to practice. McCarthy (2017:5) offers useful advice. There is the *normative, non-normative* and the *anti-normative* approach. Normative means the principle is implemented, non-normative refers to that it was not possible to implement the principle fully, however the action is still acceptable as the situation does not allow another option; but the principle was not contradicted. Anti-normative implies that the principle was refuted.

These commentaries imply that a Christian approach to geriatric care should not be neglected. Although this view is supported, the reality may turn out different. As illustration can the allocation of ventilators during COVID-19 be taken as example. The opinions offered by Adam and Clough (2020) are useful. They discuss the challenge with triage ethics approving either the "first-come, first-served" or the "save the most lives" approach during the pandemic. Their point is that triage ethics will always embody discrimination towards people as preference should be given to one person or group above the other. If the challenge of not having enough ventilators is considered, the best way out of this dilemma is to recommend 'saving the most lives' above the 'first-come, first served' approach. Regardless how the matter is viewed, no approach is the desirable approach as only one group may benefit from the medical intervention. Conceptually may preference be given to working people as they are contributing to the economy, or they may still have family responsibilities such as raising children. Should the geriatric community not benefit from the limited availability of ventilators, then in such circumstances the best choice in support of the least harm should be followed. The importance is, however, that better solutions should be sought. Burggraeve (2021:37f) is opting for a *growth ethic* that will take us from where we are to a more desirable solution.

Based on the discussion in this section of the study, the following pointers are promoted to be part of public health ethics guidelines for geriatric care:

(a) the value of life and dignity,
(b) respect for life regardless the age or state and the protection thereof,
(c) a habitat for care based on humanity and fostering relationship, and
(d) equal treatment regardless race, creed, or culture,

These pointers should also acknowledge that

(a) the ideal principle may not be realised due to context, especially resources, and
(b) the commitment of ongoing engagement to move from where a person and or group is to where it should be.

From the perspectives gained from Christian medical ethics, the public health ethics guidelines for geriatric care based on WHO reports can now be confirmed.

7. Public health ethics guidelines for geriatric care

The various discussions in this study following from the WHO's documents and guidelines, have prepared the basis for the identification of ethics guidelines for geriatric care in a public health framework. These discussions culminated in the following:

(a) respecting the geriatric community, especially their vulnerability and fragility,
(b) protecting their lives from abuse and neglect, and upholding dignity,
(c) securing a safe environment to live in, and
(d) providing quality access to healthcare and provision.

These guidelines can be mirrored against Beauchamp and Childress' (2013) four guiding principles for bioethics, notable as *autonomy, beneficence, non-maleficence,* and *justice*. These principles, however, are generally regarded in healthcare as the backbone for ethics in health- and medical-related activities. From a public health ethics perspective, these principles can be refined for geriatric care to include:

- Do no harm to vulnerable persons or groups.
- Protect the dignity of a person and groups.
- Care and respect for all people regardless stage of life, medical condition, background or religious or sexual orientation.
- Promote professional workplace behaviour.
- Evaluate the integrity of decision and application.

The application of these guidelines can be evaluated against four leading questions associated with ethics. These questions are:

(a) Are we doing things right?
(b) Are we doing the right thing?
(c) How can the common good be promoted?
(d) What benefit is there?

The advocacy of these guidelines can be promoted based on the role that workplace behaviour can play in the implementation of these guidelines.

8. The contribution of workplace behaviour towards geriatric care

Geriatric people often have multiple pathologies and are surrounded by a complex social environment. Holtzer (2015:24) concludes that caring for the elderly community is a highly skilled, professional, and responsible job. This demands a more comprehensive view of geriatric care.

Homan (2000) frames public health within a professional ethic. Her motivations are based on the role that public health must play when dealing with the ethical challenges caused by social determinants. Homan's view is that the service provided should be professional, therefore the focus on professional ethics. Her other focus is that the ethics of a profession should be labelled as social responsibility.

Professional ethics and social responsibility are interrelated aspects when dealing with ethical challenges. The appropriateness of such an approach is based on the constitutional guarantee of healthcare which implies services, their accessibility, and quality. If public health's focus is on the promotion of health and the prevention of disease and injury amongst population groups and communities, then such services should be in place and what is in place should be well managed and delivered.

Homan (2000:58) assigns "see, judge, and act" to the public health profession to guarantee the public's health. The three acknowledged functions of public health are assessment, policy development and assurance. When this is absent, public health as profession fails and communities' health is endangered. Such failure speaks to the heart of ethics not to do any harm (non-maleficence) and to have the welfare of a community as core interest (beneficence). Homan's view on the ethics of a profession reflects on the practitioner him- or herself, the added value to a profession and the service to a community. Through this focus responsibility is maximised, which expresses commitment to social responsibility and justice.

This perspective argues in favour of changed public and professional behaviour when ethics guidelines for geriatric care are presented. A supplementary view is presented by Verbruggen (2013), Gostin (2003), Carter, Kerridge, Sainsbury and Letts (2012), and Krebs (2008).

Verbruggen (2013:161-165) says that professional ethics emerges from the professional engagement between people in a concrete situation. An operating knowledge of the core activity is required to secure professional ethical behaviour.

Gostin (2003:180) argues that the role of professional ethics in public health is to promote professionalism and to give effect to the public's trust that public health workers will act in support of common welfare.

A commentary from Carter, *et al.* (2012:102) is important: public health is about the community and not the individual. The challenge is, however, how the individual's rights have been assessed against those of the group. The art is therefore to make a collective decision for the group.

The same observation is offered by Krebs (2008:579) that there needs to be a balance between the individual's freedom and liberty and the government's responsibility to protect citizen's rights.

The argument presented is that a professional ethic depends on (a) working knowledge of an activity; (b) promoting the common good; (c) recognising the individual's needs without ignoring the commitment to the community; (d) being an agent for the government's responsibility towards the citizenry; and (e) delivering on the reasonable attainment of a community or populations' needs.

This approach should secure good care for the geriatric community and contribute to healthy ageing. It should be evident that good care refers not so much to following protocols only, but to relationships and more and better communication with the elderly (Vanlaere and Gastmans, 2010:132-133). In such a relationship, dignity will be realised and supported (Vanlaere and Gastmans, 2010:169). It is for this reason that Vanlaere and Gastmans (2010:169) advocate fewer rules and more dialogue. Holtzer (2015:21) shares a similar view. Good care is much more than technical activities and precise procedures and protocols.

9. Summary

This study focuses on the geriatric community as a vulnerable group. This group's vulnerability is due to health, social and economic challenges (National Institute on Aging and the WHO, 2011, WHO, 2015, 2016, 2017a, 2017b and 2017c).

Although it is accepted that social factors contribute just as much to a healthy society as good physical health does, the social determinants impacting on the health of the geriatric community are not well delineated, discussed or addressed. The supposition is that the downside of social determinants is more observed than recorded and discussed in literature. The concern with this conclusion is that the WHO's accepted approach to healthy ageing may

not be comprehensively considered and actively promoted in public health.

From the discussions in this study are five principles evident that can be used as ethics guidelines for geriatric care:

(a) Ageing populations and elderly or geriatric communities are evident across the world. The WHO predicts that elderly population growth will result in almost double the number from the current number of elderly people by 2050. This will present health, social, economic, environmental, and political challenges. Promoting the values of health and social care associated with vulnerable groups are essential. Prevention directed at geriatric communities cannot be neglected.

(b) In developing countries, the growth in the percentage of ageing people will be greater due to improved healthcare which impacts positively on life expectation. Developing countries will experience more challenges to address the needs of the growing elderly population as economic development may not be adequate to deal effectively with these challenges. Timeous planning and the provision of resources are essential. The ethical call is relevant to *developed* healthcare systems to assist *developing* healthcare systems not to be unprepared in supporting geriatric communities. This principle is known as *moral cosmopolitanism* or *justice* (see Horn, 2015).

(c) The cost of healthcare is singled out as a worrying factor due to budget constraints in a declining economy and the rising cost of healthcare in general, resulting from technological developments and the need to address communicable and non-communicable diseases. The potential impact of the COVID-19 pandemic on world economies is assumed and must still be calculated in *n+1* based on *n-1* economic growth. Basic care can never be waived.

(d) Within the body of knowledge on the geriatric community and its ethical challenges, the ethical contributions are mostly related to medical ethics (for example, doctor-patient relationship), bioethics (end of life challenges) and healthcare ethics (treatment of geriatric people). A comprehensive public health focus on the ethical dilemmas of the geriatric community is not sufficiently attended to. The principle is to actively promote prevention of sickness and disease.

(e) The central role of social determinants in healthcare cannot be ignored. Evidence is clear that social factors contribute just as much to a healthy society as good physical health does. Geriatric communities,

as vulnerability communities, are often on the downside of social determinants which result in compromised well-being and consequently health.

A Christian medical ethics approach confirmed the prominence of a Christian ethics view in the application of guidelines for geriatric care.

Declaration

Parts of this study are based on a completed PhD study in Community Health at the University of the Free State (Lategan, 2021).

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