

**Future of ageing**

**Call for evidence**

June 2021

# Introduction

Life expectancy at birth continues to [increase](https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/bulletins/nationallifetablesunitedkingdom/2017to2019) in the UK. However this masks substantial [differences](https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/lifeexpectancyforlocalareasoftheuk/between2001to2003and2017to2019#:~:text=In%20England%20in%202017%20to,%2C%20Blackpool%20(74.4%20years).) in life expectancy in different parts of the country, with a gap of 10.5 years for men between areas in England with the highest and lowest life expectancies, and 7.7 years for women. Moreover, [healthy life expectancy](https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/healthstatelifeexpectanciesuk/latest) has levelled off for men and decreased for women, meaning that there is a growing period of disability and ill health at the end of life.This has significant implications both for the wellbeing of individuals in later life, and for wider society.

There is [increasing interest](https://publications.parliament.uk/pa/ld5801/ldselect/ldsctech/183/18302.htm) in the role that biomedical research and technological innovation can play in helping people live well in old age, and in helping society respond appropriately to the age shift in the population. Such research and innovation is very wide-ranging, including developments in:

* **geroscience research**, aiming to intervene in the ageing process by identifying and treating the underlying causes of biological ageing, including through a better understanding of genetic factors;
* **assistive and communications technologies** to help people to stay connected and independent for longer; and/or to provide reassurance and support for families and other carers; and
* **innovative medical technologies**, including the use of AI, to support earlier diagnosis and treatment of diseases that commonly occur in older age.

Developments in these various fields offer scope for important future benefits, both for individuals and for wider society, and are currently being promoted in the UK through the [Ageing Society Grand Challenge](https://www.gov.uk/government/publications/industrial-strategy-the-grand-challenges/missions). However, they also raise significant ethical questions. These need to be considered as early as possible, to minimise the risk that unexamined assumptions and approaches to ageing are ‘baked in’ from very early in the process of research and development. The Nuffield Council on Bioethics has established an expert [working group](https://www.nuffieldbioethics.org/publications/the-future-of-ageing/the-working-group) to explore these issues.

Particular issues of concern include:

* **how the challenges and opportunities of ageing are conceptualised** – attitudes to ageing and stereotypes about ageing have a powerful influence both on the targets of research and innovation, and on the way any innovations are likely to be designed and implemented;
* **how the aims of research and innovation in this field should be prioritised** – who developments are aimed at, who is most likely to benefit, and who has been involved in making those decisions?
* **ethical aspects of the design and conduct of studies**, including considerations of benefits and harms, inclusion and exclusion criteria for participation, and the role of diverse older people in co-design and co-production; and
* **how concern for equity can be taken into account** throughout the research process, including with respect to access to the benefits of research and innovation.

Research and innovation do not take place in a vacuum. All these research-specific questions arise in the context of wider social policy – for example in terms of:

* the many other factors (such as housing, income, local infrastructure, and social support) that influence prospects for a fulfilling old age;
* the many inequalities throughout the life course that significantly affect both life expectancy and quality of life in old age; and
* questions of intergenerational solidarity and fairness.

The possible impacts of research and innovation also generate further societal-wide questions relating to where responsibility lies for enabling people to live well in older age – between individuals themselves, their families, professionals, wider society, and the state.

The following sections look at each of these themes in turn, with equity questions arising as a cross-cutting theme throughout. Please feel free to respond to as many or as few questions as you wish, or simply to comment in the ‘[any other comments](#_Any_other_comments)’ section. While the inquiry’s focus is primarily on the situation in the UK, comparative evidence or commentary from other countries is warmly welcomed.

## Submitting your response

Please use the respondent’s form provided [here](https://www.nuffieldbioethics.org/assets/pdfs/Respondent-form-ageing-call-for-evidence.docx) to respond to this call for evidence. Once completed, please email your response to Kate Harvey.

***Please note****: This call for evidence is designed mainly for academics and policymakers with a particular interest in ageing, although we welcome responses from anyone who would like to contribute. Please also see* [*our website*](https://www.nuffieldbioethics.org/publications/the-future-of-ageing) *for details of other opportunities to contribute to this inquiry, including for older people and their families, and for those working directly with older people in health and social care.*

# How we think about ageing

## Conceptions of ageing

The way in which we (including researchers, policymakers of all kinds, the media, and the general public) think and talk about ageing plays an important role in [shaping the research agenda](https://link.springer.com/chapter/10.1007/978-981-13-3693-5_4). Beliefs and attitudes about ageing help define the questions to which research and innovation seek to offer solutions. Current debates (discussed further in our [background paper](https://www.nuffieldbioethics.org/assets/pdfs/Ageing-background-paper-final.pdf)) include:

* the balance between seeing biological and chronological ageing primarily in terms of deficits and loss, or in terms of opportunities and prospects for ongoing social contribution (e.g., as in the ‘[capabilities’](https://criticalgerontology.com/capabilities-approach-healthy-ageing/) approach to ageing);
* the extent to which biological ageing is understood to be [malleable](https://www.un.org/en/development/desa/population/events/pdf/expert/29/session6/EGM_26Feb2019_S6_AndrewScott.pdf) – recognising the scope for a person’s current health trajectory to change, whether through existing well-understood social and public health measures, or through biomedical innovation; and
* the influence of [ageism](https://www.nature.com/articles/s43587-021-00036-4), and what can be/is being done to challenge ageist attitudes.

The experience over the last year of the COVID-19 pandemic has shone a spotlight on how [assumptions about older people directly affect policy](https://link.springer.com/article/10.1007/s12062-020-09320-4) – for example in terms of their assumed vulnerability and inability to make personal choices about risk, or in terms of age-related thresholds for access to certain forms of care. It has also highlighted how the interests of different parts of the population (for example older people vs school children) can at times be in tension – an issue to which we return in [section 6](#_Implications_for_who) of this call for evidence.

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| **Question 1****Please comment on how attitudes to ageing influence research and innovation – and how more positive attitudes to ageing could be promoted within the research and innovation context.** |

*Issues you might wish to touch on in your response include (but are not limited to):*

* whether there is a common view of what ‘old age’ is, or what the key features of ‘old age’ are, in your field or area of work – and how this influences your work;
* the connections / distinctions between ageing, disease, and disability – and how these affect approaches to research and innovation;
* whether there are common barriers or limitations in your field due to ageism;
* specific examples of effective approaches to combating ageism – whether in research / innovation, or more broadly in policy and service provision;
* how negative stereotypes of ageing and old age in research and technological innovation (for example those that focus solely on deficits) can be challenged.

## Ageing as a special case?

Ageing is often seen as separate, even ‘deviant’, from a healthy norm – in policy, in research, and even in ethics. This is exemplified by the way that services and design for older people are often treated as a special case rather than as part of the mainstream. This may arise because of neglect (with mainstream policy focused on the needs of healthy, able, adult populations), or it may be with the intention of providing more specialised services (for example in the specialty of geriatrics / elderly care). In the case of products specifically targeting older populations, one criticism has been that they are too often “[big, beige and boring](https://www.technologyreview.com/2019/08/21/75537/old-age-is-made-upand-this-concept-is-hurting-everyone/)” – and that as a result older people are put off using products and devices that could in fact be helpful in their daily lives.

There is increasing emphasis by leading organisations concerned with ageing such as the [Centre for Ageing Better](https://www.ageing-better.org.uk/blogs/retailers-need-rethink-inclusive-products-better-meet-needs-over-50s) on the importance of seeking inclusive approaches to wider social policy: designing the needs of older people ‘into’ generic design and policy, rather than thinking about older people’s needs as an afterthought.

One example of treating ageing as a special case is found in the current proposal for a special UN Convention on the rights of older people. The [aim](https://www.helpage.org/what-we-do/un-convention/) of those putting forward this proposal is to ensure that the rights of older people are not overlooked – especially when they are relatively invisible to wider society. They hope that it would trigger legal and social changes that would lead to better access to services, and prevent the needs and preferences of older people being ignored. The proposed use of a separate convention has, however, also [generated concerns](https://baronessgreengross.wordpress.com/2020/10/02/do-we-need-specific-human-rights-for-older-people/), including whether it is ethical to consider the rights of older people separately from those of other adults.

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| **Question 2****Please comment on the advantages and disadvantages of taking a more inclusive approach (e.g., in design, in healthcare, in wider social policy) so that the needs of older people are ‘designed in’ to mainstream approaches, rather than considered separately**.  |

*Issues you might wish to touch on in your response include* *(but are not limited to):*

* examples of existing good practice where social policy (e.g., in housing, transport, employment, healthcare, or digital infrastructure to enable connectedness) has taken an inclusive approach to older people’s needs – and any advantages / disadvantages;
* how this approach could be encouraged in other areas / made routine – or why you feel this would be a problematic approach;
* the implications for biomedical research and/or technological innovation;
* the advantages and disadvantages of developing distinct human rights for older people.

# The aims of research and innovation in this field – and how they are prioritised

## Processes for setting priorities

Research funding comes from many different sources – public funders such as research councils and governments; charities and foundations; and the commercial sector. Each of these funders will have different remits and drivers (including in some cases commercial considerations) that affect the areas of research and innovation that they choose to fund. For example the remit of many charitable medical research funders is limited to one or more specific diseases.

However, there are a number of ethical challenges in making decisions about what to prioritise that are common to all funders. These include, for example, questions of *who* is involved in setting priorities (whose voice is seen to have value); and the values and assumptions that underpin those priorities, whether explicitly or implicitly.

One example of a national-level organisation taking an explicitly inclusive approach to identifying priority areas for research and innovation in ageing is [AgeWell Canada](https://gh.bmj.com/content/bmjgh/6/2/e004462.full.pdf). In 2018, AgeWell Canada published eight [challenge areas](https://agewell-nce.ca/wp-content/uploads/2018/05/Booklet_8_Challenges_English_2019oct2_digital.pdf) for the future of technology and ageing research in Canada, based on an extensive public consultation process across over 1,000 stakeholders – including input from many older Canadians and carers, as well as its own network of members and partner organisations. As a publicly-funded body, AgeWell also seeks to influence the focus of private sector innovation – for example through supporting start-ups working in these priority areas of research.

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| **Question 3****What priority-setting processes in ageing research / innovation are you familiar with? How do you think they should change, if it all?** |

*Issues you might wish to touch on in your response include* *(but are not limited to):*

* who should be involved in setting priorities for research/innovation in this field;
* what might be the advantages / disadvantages of greater involvement by older people and/or by broader intergenerational public input;
* who, in your experience, is unheard in decisions about priorities;
* what you regard as good practice in designing procedures for priority setting – for example what criteria such procedures should meet;
* whether issues of equity should be built into prioritisation decisions – and if so, how;
* examples of what you regard as existing good practice in this field, including any examples of initiatives that have supported a wide diversity of involvement.

## Overarching research aims

In the UK, the ‘Ageing Society Grand Challenge’ (one of four themes in the Government’s 2017 [*Industrial strategy*](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/730048/industrial-strategy-white-paper-web-ready-a4-version.pdf)) aimed to “harness the power of innovation to help meet the needs of an ageing society” with a “[mission](https://www.gov.uk/government/publications/industrial-strategy-the-grand-challenges/missions) [to] ensure that people can enjoy at least five extra healthy, independent years of life by 2035, while narrowing the gap between the experience of the richest and poorest.” It is suggested that “success in this mission will help people remain independent for longer, continue to participate through work and within their communities, and stay connected to others to counter the epidemic of loneliness”. These indicators of success overlap to a degree with the eight ‘challenge areas’ identified by AgeWell Canada in 2018: supportive homes and communities; health care and health service delivery; autonomy and independence; cognitive health and dementia; mobility and transportation; healthy lifestyles and wellness; staying connected; and financial wellness and employment.

The House of Lords Science and Technology Committee 2021 report, [*Ageing: science, technology and healthy living*](https://publications.parliament.uk/pa/ld5801/ldselect/ldsctech/183/18302.htm), supports the mission of the Ageing Society Grand Challenge but expresses some doubt as to whether it will be achievable on the basis of current approaches. The Committee cites concerns expressed by researchers about the adequacy of the funding available to basic ageing research, compared with that dedicated to technology and data-driven approaches. It further highlights the wider challenges for the funding of basic ageing research in the UK, given that so much biomedical research funding is disease-specific. This picture was contrasted with the situation in the US, with funding for ageing research more readily available both through public means (through the National Institute of Aging) and through much better access to private capital to support translation.

The important role of private finance in supporting the translation of breakthroughs in basic research in geroscience to clinical trials also highlights how priorities in research are likely to be influenced by commercial considerations. Some leading [funders](https://www.calicolabs.com/) of geroscience research place a strong emphasis on the scope of research to increase lifespan as well as healthspan. This contrasts with approaches that focus on improving the life expectancy of the most disadvantaged (‘levelling up’ within existing understanding of human life-span), and/or on improving healthspan across a population.

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| **Question 4****Which ageing challenges should medical and technological developments prioritise – and why?** |

*Issues you might wish to touch on in your response include (but are not limited to):*

* whether the aims and outcomes set out in the UK’s Healthy Ageing Challenge are the right ones to target (and why/why not?);
* whether there are other aspects of ‘ageing well’ that are not covered by these aims / outcomes, where you believe biomedical science or technological innovation has an important part to play (and why?)
* to what extent considerable life extension is possible or desirable (and why / why not?)
* what relative priority should be given to different ways of tackling these challenges – for example through developments in assistive technologies vs investments in basic and translational science?

# Design and conduct of research studies related to ageing

## Benefits and harms

A key ethical question in any field of research is that of the relationship between likely benefits and possible harms. Research and innovation in the field of ageing covers a very broad spectrum of approaches, each raising different considerations with respect to benefit and harm.

* **Geroscience research** seeks to intervene in common hallmarks of ageing in ways that, in the long-term, could delay the onset of, or even prevent, a number of conditions associated with ageing. Significant success in this field could make an important contribution to healthy life expectancy for future generations, particularly given the current impact on older people of receiving multiple treatments for multiple conditions, and the associated risks of [polypharmacy](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4295469/#:~:text=Polypharmacy%20is%20an%20area%20of,the%20number%20of%20drugs%20used.). Concerns have been expressed, however, over the risk of hype – not least in the language of finding a ‘[cure for ageing](https://www.sens.org/webmd-feature-is-there-a-cure-for-aging/)’. Given the challenges of translating research findings in animals to humans, it will be important to be realistic about likely timescales for such interventions. More immediate benefits may be more likely to arise through the translation of our increased understanding of the hallmarks of ageing into novel treatments for single conditions such as [age-related macular degeneration and diabetic retinopathy](https://unitybiotechnology.com/pipeline/).
* Many developments in **communication and assistive technologies** are self-evidently beneficial, providing convenience and increased safety for older people who can choose how and when to make use of them. However, risks in their use might include devices being [marketed / used inappropriately](https://www.youtube.com/watch?v=jem0uhgksbg&t=2s), so that the person loses capacities that could have been regained rather than compensated for; depersonalisation and loss of the human touch and engagement implicit in the notion of ‘caring’; or technologies used to control rather than empower and support older people.
* **Developments in diagnostics**, arising, for example, from data-driven research including the use of AI techniques, or the identification of new biomarkers,offer prospect of earlier identification either of some of the common diseases of ageing, or of risk factors for these conditions. Success in this area would offer scope for important benefits in cases where effective preventative measures or treatments were available. Risks include diagnosis without access to a subsequent action plan or effective treatment; over-medicalisation of middle and later life; and increasing rates of polypharmacy.

A common challenge across all three broad fields described above is that of [equity](https://www.ageing-better.org.uk/sites/default/files/2017-12/Inequalities%20insight%20report.pdf), and the need to ensure that those who are already disadvantaged with respect to their health have equal access to any such benefits.

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| **Question 5****Please comment on the likely benefits, and possible harms, of developments in the area of ageing research with which you are familiar.** |

*Issues you might wish to touch on in your response include (but need not be limited to):*

* the kind of timeframe (1, 5, 10, 20, 30 years?) in which you envisage benefits becoming available;
* what form those benefits might take, at whom they are targeted (e.g., older people now, future cohorts of older people, professionals, family carers?) – and how widely accessible they are likely to be to diverse users / patients;
* any harms that you think might be associated with these developments – and how these might be mitigated;
* what action might need to be taken to help ensure that developments in your field contribute to reducing existing inequalities, rather than potentially adding to them;
* any implications for sustainability, whether of the environment or of existing systems.

**Codesign and coproduction of research**

There is an [increasing recognition](https://www.nihr.ac.uk/about-us/our-contribution-to-research/how-we-involve-patients-carers-and-the-public.htm) of the value of future users of research and innovation being involved not only in prioritising research aims but also in the design and conduct of studies. In the context of ageing research, this potentially involves partnerships both with older people, and with younger generations, who may be the ones most affected by developments in earlier diagnosis or earlier intervention in the diseases associated with ageing.

Examples of existing partnerships between researchers and older people in the UK include:

* the [Age Innovation Hub](https://ageinnovationhub.crowdicity.com/hubbub/communitypage/104570) at University College London which invites older people to submit ideas “around “everyday annoyances or pains technology could help with”; and then help co-create solutions;
* [The 1000 Elders](https://www.birmingham.ac.uk/research/inflammation-ageing/research/1000-elders/elders.aspx) group at the University of Birmingham which brings together researchers and older people to work on healthy ageing –from identifying research priorities, to piloting aspects of a study, commenting on participant literature, and participating as healthy controls;
* an initiative at the [University of Stirling](https://www.stir.ac.uk/news/2021/march-2021-news/stirling-researchers-to-transform-housing-design-for-dementia/) in which older people are collaborating with builders, architects, and housing providers with the aim of identifying designs that could support healthy cognitive ageing;
* The National Innovation Centre for Ageing in Newcastle who engaged with volunteers from age 11 up to brainstorm approaches to a ‘[four generational kitchen](https://www.voice-global.org/public/opportunities/archived/the-4-generational-4g-kitchen/)’ that would support multi-generational living.

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| **Question 6****Please comment on the role of older people, and of intergenerational public input, in helping shape research and innovation directed towards the needs of current and future older populations.** |

*Issues you might wish to touch on in your response include (but need not be limited to):*

* providing examples of ways that older people, and/or members of the public of all ages, have been involved in the design and conduct of studies, and how this has affected the study and findings;
* identifying the challenges of taking this kind of approach, and how these might be overcome (or why, in your view, this kind of participative approach to research is not appropriate in your particular field);
* consideration of how the voices of those who tend to be underrepresented or marginalised can be heard, and their needs and experiences incorporated in research design and conduct.

## Recruitment criteria

Older people are [widely excluded](https://acsjournals.onlinelibrary.wiley.com/doi/full/10.3322/caac.21638) from participating in trials of medicines or other interventions that could potentially be of benefit to them. This may mean that older people are subsequently unable to benefit from interventions that are shown to work in younger people. Alternatively, where interventions are licensed for everyone on the basis of studies only in younger people, older people and those living with other conditions may be exposed to unknown risks, because of the lack of knowledge as to how the new intervention might affect their other conditions, or interact with other medications.

Such exclusion criteria in research may be direct, through specific age restrictions; or indirect, for example through exclusion of anyone living with other long-standing conditions. They may be based on specific safety concerns, or arise incidentally: for example through non-medical recruitment requirements that older people are less likely to meet, or through ‘gatekeeper’ influence whereby older people are not approached in the first place.

Setting meaningful and inclusive recruitment criteria represents a specific challenge in geroscience research: as studies move from animal models to humans, should they target those who already have age-related conditions, or should they be working with younger generations with the aim of intervening early? (See also [Regulatory challenges](#_Regulatory_challenges) below.)

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| **Question 7****How can older people be better represented in clinical trials that are of potential relevance to them?** |

*Issues you might wish to touch on in your response include (but need not be limited to):*

providing examples of barriers in your field, and how these might be overcome;

the implications of under-representation of older people in trials – and of equality of representation *within* the older population;

any particular issues relating to appropriate recruitment criteria for geroscience research;

the advantages and disadvantages of introducing regulatory incentives to promote the routine involvement of older people in studies relevant to their health (for example on the lines of existing requirements in the UK and EU to develop ‘paediatric investigation plans’ for research that could potentially benefit children).

## Regulatory challenges

A number of regulatory challenges arise in connection with specific areas of ageing research and innovation. While some of these challenges are primarily technical in nature (for example the use of [proxy endpoints](https://www.voice-global.org/public/opportunities/archived/the-4-generational-4g-kitchen/) for research where benefits are likely to accrue a long way in the future), the way that regulatory questions are tackled often has ethical implications.

### Geroscience research

The timescales involved in research into biological ageing are much longer than in most fields of science. This raises challenging regulatory questions: relating first to the identification of meaningful endpoints for studies (what constitutes ‘success’ in the short or mid-term); and second to how research findings might translate into licensable products. Current regulatory systems are designed around single conditions, with medications licensed for named ‘indications’. A novel intervention that targeted a single ageing pathway involved in multiple conditions would at present need to seek licensing authorisation for each of these conditions separately.

One proposed solution to this challenge is that of [classifying ‘ageing’ itself as a disease](https://www.thelancet.com/journals/landia/article/PIIS2213-8587%2818%2930214-6/fulltext), so that interventions could be measured for their capacity to influence one or more of the hallmarks of ageing. Another [innovative approach](https://www.karger.com/Article/FullText/502257) has been put forward in the Targeting Aging with Metformin ([TAME](https://www.afar.org/tame-trial)) study which aims to measure whether metformin can delay the onset of any one of a number of age-related conditions including stroke, heart failure, dementia and cancer – thus aiming to use a composite, rather than single disease, endpoint.

### Technological innovation

A particular challenge in the technological field is the very unclear dividing line between technologies and devices developed for lifestyle (or ‘wellness’) purposes, and those designed specifically for medical purposes. In practice, it seems likely that these purposes will increasingly be blurred, as we use lifestyle devices to monitor our own health, and health and care providers make greater use of generalist digital services. However, at present, distinctly different regulatory regimes apply to the authorisation and marketing of devices, depending on how they are [classified](https://www.wareable.com/health-and-wellbeing/wearable-tech-and-regulation-5678).

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| **Question 8****Please comment on the ethical aspects of the regulatory challenges raised by the field of ageing research with which you are familiar.**  |

*Issues you might like to touch on in your response include (but need not be limited to):*

* whether, for regulatory purposes, ‘ageing’ should be classified as a disease – and any ethical implications of this;
* any alternative approaches to the regulatory challenges of interventions based on geroscience – and any associated ethical implications;
* how assistive and connective technologies that may be used to support older people should be regulated, and the ethical implications of preferred approaches.

# Understanding research and innovation in the wider policy context

The contribution that technological innovation and biomedical research can make to living well in old age also needs to be considered in the context of the many other factors that influence health and well-being across the life-course, including:

* [many broader aspects of social policy](https://www.ageing-better.org.uk/summary-state-ageing-2020) (including housing, employment and integrated communities), and associated inequalities and experience of discrimination;
* differential uptake of the [public health interventions already known to be effective](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/786248/a_menu_of_interventions_for_productive_healthy_ageing.pdf) related to factors such as exercise, diet, alcohol intake, and smoking;
* variable levels [of knowledge and skills](https://www.nature.com/articles/s43587-020-00004-4#Tab1) relating to service provision for older people, including, for example, awareness of the needs of people with dementia among the general health and care workforce, and the casualisation of the social care workforce.

The importance of these many social factors for healthy ageing across the lifecourse raises the question of how funding for research and innovation in this field should most effectively be targeted (see also [section 3](#_The_aims_of)). The innovation agency NESTA provides one recent example of research funding being linked specifically to wider public health considerations: its [goal](https://www.nesta.org.uk/healthy-life/) to halve the UK prevalence of obesity by 2030 is being tackled through a focus on food environments and loneliness.

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| **Question 9****What role should biomedical and technological approaches play versus greater emphasis on, and funding of, other policy approaches that might have a similar effect on ‘levelling up’ the healthspans of the most disadvantaged to the least?**  |

*Issues you might like to touch on in your response include (but need not be limited to):*

* the role of targeted public health initiatives aiming to promote better health throughout the life-course – and any evidence/evaluation of how spending in this area would translate, for example, into meeting the aims of the Healthy Ageing Challenge;
* the role of research in supporting better translation of existing public health knowledge into social policy;
* examples of the changes required in wider service provision to support people to live better in old age, and the feasibility and cost-effectiveness of prioritising these kinds of wider social interventions;
* how ‘[natural experiments](https://health-policy-systems.biomedcentral.com/articles/10.1186/s12961-020-00564-2)’ in social and public health measures relevant to ageing might be evaluated in ways that might influence ageing policy;
* how questions of equity are/might be factored into these policy decisions
* the role of clear, cross-organisational leadership in promoting healthy ageing.

# Implications for who bears responsibility for healthy ageing

## Individual, family and state responsibilities for healthy ageing

Increasing awareness of the malleability of ageing – whether through existing public health and health promotion measures, or through innovations in geroscience – raises important questions about responsibility for our future health. If we can increasingly influence the way we age, either through our own health-related behaviours or through willingness to take new medications, do we have a duty to do so? And how might any such individual responsibility to ‘age responsibly’ affect the responsibilities of others (the state, our families, health and care professionals, the insurance sector) to support us financially and care for us when required? Such arguments about the nature of personal responsibility need to be considered in the wider picture of the social determinants of health and the many factors that affect or limit our opportunities for choosing to [live healthy lives](https://www.nuffieldbioethics.org/assets/pdfs/Public-health-ethical-issues.pdf).

## Impact on personal freedoms

The way that responsibilities are exercised by others may also have a significant impact on individual freedoms. Decisions by the Government, by regulatory authorities, by individual care homeowners, and by insurers, during the COVID-19 pandemic have had a very direct impact on care home residents’ abilities to make their own choices – for example preventing them from deciding for themselves how to balance their risk from infection with the importance of remaining in direct contact with family and friends.

## Intergenerational solidarity and fairness

The idea that the age shift in the population should be viewed necessarily as a ‘burden’ on younger people has been strongly challenged, with emphasis on the ‘[longevity dividend’](https://ilcuk.org.uk/maximising-the-longevity-dividend/) that could be achieved by better inclusion of older people both in the workforce and as consumers (see also [section 2](#_How_we_think) on attitudes to ageing). Moreover, there is [good evidence](https://pubmed.ncbi.nlm.nih.gov/31887609/) that preventative approaches that support healthy ageing offer scope for significant reductions in both health and social care costs.

Nevertheless, many of the factors identified as affecting our ability to live well in old age – from adequate housing and accessible transport to the challenge of sustainable funding of the social care sector – have significant financial implications both for now and into the future. Even with the contribution of successful developments in biomedical research and technological innovation, there is clearly a financial cost to transforming society to one that is accessible to, and supportive of, people as they age. The need for this kind of investment is sometimes put in terms of conflict between older and younger generations – particularly when younger people appear to be particularly badly affected by public funding cuts. However, it could also be seen in terms of sustainability of approach for all generations, nearly all of whom will themselves reach later life.

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| **Question 10****Please comment on the responsibilities of the various stakeholders (older people themselves, their families, professionals, wider society, the state) with respect to a healthier old age – including with respect to intergenerational solidarity and fairness.** |

*Issues you might like to touch on in your response include (but need not be limited to):*

* the responsibilities of the state to act to support healthier and inclusive ageing;
* the extent to which we are to be held responsible for the way we grow old;
* the implications of this for wider social policy - e.g.
	+ in terms of where the responsibility lies for funding/ providing / regulating care required in connection with the mental or physical consequences of ageing?
	+ in terms of protecting personal autonomy and choice;
* the implications of current approaches to ageing policy for future generations.

# Any other comments

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| **Please raise any other issues that you consider relevant to our terms of reference, including any comments you might wish to make on the fictional future research scenarios on our webpage.**  |