The elderly person, old age and ageing,

in the light of the COVID-19 pandemic

I- INTRODUCTION

The global health crisis caused by the SARS-CoV-2 coronavirus since late 2019 has forced most countries to face an unprecedented public health crisis. The pandemic has caused a very high number of people infected and patients with COVID-19 disease. A significant percentage of people have been identified with severe symptoms associated with high mortality, particularly in people with one or more comorbidities, as well as in those with advanced senescence. These elements have had a significant health, social and economic impact.

The CNBA, aware of the seriousness of this impact on the lives of older people, has taken on the responsibility of understanding its causes and implications. Thus, it decided to undertake not only an analysis of the repercussions of the pandemic and the living conditions that accompanied it, but also to propose more broadly an ethical reflection on the place that older people occupy within our society and its future.

At the same time, the response of countries to take measures to deal with the pandemic may have contributed to the violation of the individual rights and freedoms of their own citizens, in the name of the common good. It is therefore worth remembering that the fundamental principle of the **primacy of the person** is based on respect for their dignity and uniqueness (non-stigmatisation, non- discrimination), as well as on the protection of their fundamental freedoms (autonomy, right to know or not to know, etc.). The limitation of autonomy and individual freedoms calls into question the field of bioethics and human rights. While the measures adopted in the event of a pandemic are exercised within the framework of the principle of solidarity and for the protection of the common good, they must nevertheless limit their individual effects in a **proportionate** manner that guarantees a balance between the autonomy of the person and solidarity towards others.

The effects of COVID-19 in Andorra were very significant during the first wave, particularly affecting the most vulnerable and oldest people. In Andorra, as in other Western countries, thanks to social progress and advances in the field of health, old age evolves within the framework of an increasingly preserved autonomy that allows older people to lead an active social life, with the corollary of an increase in life expectancy.

This demographic factor coexists with a decrease in the birth rate. In recent years, Andorra's demographic data show a growing rate of ageing and over-ageing. The ageing of the population and the impact that the pandemic has had on older people in Andorra have led the CNBA to address the situation in a critical and constructive manner, from an ethical point of view.

In many countries, older people, as a group affected by the deadly effects of the disease and at the same time in the name of their necessary protection, have seen their rights limited during the pandemic. Although access to healthcare cannot be governed by certain selection criteria such as age, sex, social origin or disabilities**, the pretext of"advanced age"** could undermine equitable access to healthcare. This same argument may have led to premature hospital discharges as well as medical and social prioritisation. Although measures have been taken to contain the situation, the utilitarian approach and the associated ethical conflicts have caused much debate in society. Measures have been taken for the benefit of older people, but without first knowing their opinion and obtaining their possible consent. Beneficence continued and was often expanded, but at the same time to the detriment of their autonomy. When the isolation of institutionalized older people proved too strict, their right to freedom and privacy was affected. Both pandemic control methods and social restrictions likely affected older people in their socio-familial dimension, particularly those in institutions, but also those living alone at home. The pandemic caused fear, stress, loneliness and social isolation. These elements, in turn, generated cognitive and motor deficiencies**, a formidable challenge to resilience**, especially for the most vulnerable and fragile. Older people with cognitive impairment may have had difficulty understanding information about COVID-19 because their caregivers were unable to devote enough time to them and information campaigns aimed at the general population were often inadequate for them.

The consequences of the pandemic on family support for **people at the end of their lives** has led, in many cases, to the latter having to face death without the presence of their family. Likewise, families deprived of the right of access to their relatives at the end of life have seen how the pandemic separated them from their loved ones. Accompanying a loved one at the time of their death and honouring the body of the deceased through the rituals specific to

each family are acts rooted in our culture that help alleviate the suffering associated with the farewell process. Not being able to live through this stage can make grieving more difficult.

Civil society and public authorities must consider **the living conditions of older people in the event of a disaster situation** (pandemic, heat wave, earthquake, etc.). The pandemic reveals or reminds us that the sudden onset of an aggravation of fraitly linked to ageing, illness or dependency leads to a loss of autonomy and individual freedoms that endangers human dignity, a useful fact for anticipating health and social action plans.

In light of the pandemic and its impact on older people, it is necessary to consider the scale of values that must underpin the social foundations of tomorrow's democracy. History has taught us that human beings often pay with human lives for the (r)evolutions that have built their society. The high price of the pandemic leads us to reflect on this evolution.

II- OPINION

1 CONCEPTS AND DEFINITIONS

1-1 Some reminders about the SARS-CoV-2 coronavirus and the COVID-19 (disease)

For two decades, it has been the third beta-coronavirus to be transmitted from person to person after SARS-CoV in China and MERS-CoV in the Middle East. The common characteristic that justifies its virulence is that it replicates in the lower respiratory tract, causing pneumonia and, in the most severe cases, respiratory distress syndrome (RDS).

SARS-CoV-2 is highly contagious and is transmitted by inhalation of respiratory aerosols as well as by direct rather than indirect human contact (contaminated surfaces and objects). The virus is spiked with spicules whose S protein (spike) at its ends binds very strongly to the ACE2 cellular receptor to penetrate the host cell and integrate the viral RNA into the cellular genome. Knowledge of the greater contagiousness and pathogenicity of this virus compared to its predecessors, the rapid identification of its RNA and its mutagenic potential, have made it possible to accelerate research worldwide to obtain vaccines and therapies adapted to the 4 progressive phases of the disease. Covid-19 disease: 1: infectious – 2: pulmonary – 3: hyperinflammatory – 4: vascular and thrombotic. From phase 2 onwards, immune mechanisms interfere between the immunopathology of SARS-Cov-2 and immunosenescence **(appendix 1)**.

1-2 Some scientific bases and definitions concerning older people

The demographic growth of people over 65 years of age is unprecedented, while their level of health has not kept pace with their average life expectancy. This explains the prevalence of chronic pathologies and the emergence of epidemics and the interest in a public health policy.

Vulnerability, unlike disability which is the consequence of a previous pathology, results from a risk incurred by a person who finds themselves in a certain situation (health and/or social).

Ageing is expressed by a gradual, stage-by-stage slowdown of functional psychomotor capacities. It is never global or homogeneous. It is based on a genetic basis subject to epigenetic variations whose phenotypic translation can be late and in the form of multimorbidity and disability.

Frailty is a clinical syndrome that must be distinguished between age-related and comorbidity-related syndromes. This is the case of sarcopenia due to excessive reduction in muscle mass and strength, causing walking disorders, falls, hospitalisations, loss of autonomy in the elderly and consequent deaths. In 2016, France recorded more than 10,000 deaths related to falls in people over 65 years of age, while that same year, 3,477 people lost their lives in road accidents.[1] An unresolved question is whether age-related frailty is the result of subclinical multimorbidity or of the ageing process related solely to age. This question is fundamental for demographic reasons. Its answer will only be possible by correlating the phenotypes of "ageing frailty" with biomarkers linked to non-chronological but biological age. The expected biomarkers of senescence must be precise, reliable and non-invasive.

The aim of **geroscience** is to identify the mechanisms of biological aging that influence comorbidity in order to identify molecular and cellular targets for curative and preventive therapeutic applications.The onset or delay of diseases depends on several homeostatic mechanisms, whose deficit leads over time to an accumulation of unrepaired damage. It seems that the interaction between damage and repair may explain why some people age more rapidly than others.

The areas involved and likely to be explored by geroscience are listed in **Appendix 2.**

1-3 Research on ageing and its prevention

With its first results, geroscience gives hope for "technological leaps" that will allow a better understanding of the molecular nature of senescence, the establishment of a reference measure, the development of new drugs such as senolytics and the application of preventive measures throughout life.

With this preventive aim, the WHO has developed the "WHO ICOPE" programme (Integrated Care for Older People)[2], the result of which is the INSPIRE ICOPE CARE PROGRAM, which

[1] Report of the Cour des Comptes, « La prévention de la perte d'autonomie des personnes âgées », November 2021, www.ccomptes.fr

[2] Vellas B., «How to Implement Integrated Care for Older Persons—ICOPE—Massively in Clinical Practice for a Healthy Longevity». J Aging Res & Lifestyle 2023; 12:18-19, http://dx.doi.org/10.14283/jarlife.2023.

makes it possible to screen and clinically monitor the ageing of 200,000 elderly people in the Occitanie region, as well as in Andorra and Catalonia, over a period of 5 years. By monitoring the intrinsic capacity (physical and mental) of an independent elderly person over 60 years of age, 6 parameters are studied using 2 digital medicine tools with a conversational robot connected to a database. The tests are carried out every 4 to 6 months. In the event of identified deterioration, an algorithmic alert organizes the rapid intervention of a professional (medical, medico-social, social). This remarkable example of ageing prevention will be accessible to a younger segment of the working population in the medium term. This mobile phone application is inexpensive and allows, to a certain extent, to prolong the comfort of life of an elderly person living at home, an economic investment beneficial to society. This is a technological step in the prevention of ageing while awaiting a more precise, reliable and accessible marker of ageing.

1-4 Vulnerability of the elderly and COVID-19 disease

The vulnerability of the elderly varies according to their level of frailty, their immune status, their possible comorbidities but also their living, social and economic conditions. The clinical presentation of COVID-19 in the elderly is often atypical: with few symptoms, misleading due to polymedication, poorly expressed by the suffering of isolation and/or the lack of geroculture[3] in a non-specialized hospital environment.

The preference given to biological (physiological) age over chronological age avoids, in the context of pandemic management, engaging in discriminatory limitations, particularly when chronological age becomes the legal age. This underlines the importance of the general practitioner and local caregivers in the health but also socioeconomic management of the crisis. For different reasons, they have the knowledge of:

- family history, genetic background, autoimmune, etc.

- personal history (medical-surgical, infectious, particularly viral, vaccination, comorbidities, disability, invalidity)

- living conditions (housing, residential establishment, social-family environment)

[3] Culture related to ageing and older people.

- economic conditions (precariousness, resources).

The impact of senescence on the immune system (in Appendix 1) justifies that the vulnerability of older people should be considered as a separate entity. Its **case-by-case assessment** is essential in the management of the influenza virus and even more so of COVID-19, whether it involves antiviral, immune or vaccine therapies.

Recent advances in knowledge contribute to the early treatment of the onset of viral infections and to the prevention of hyperinflammation that can cause a cytokine storm affecting numerous organs, sometimes in a fulminant and fatal manner.

If there is no doubt that the person must be included in the vaccination priorities, there is also no doubt that he or she cannot be subject to experimentation without free and informed consent. Indeed, the lack of knowledge of the data concerning the efficacy of new vaccines, but also concerning their safety, may differ from clinical use given the frailty linked to age and the multimorbidity associated with it. In addition, the indication and choice of vaccine cannot be left to the patient and depend, case by case, at first, only on local medicine and, in case of doubt, on the responsibility of the specialists concerned.

2 IMPACT OF THE COVID-19 PANDEMIC IN ANDORRA

2-1 METHODOLOGY

The CNBA working group based its work on a **literature review** of scientific publications and official government reports on the pandemic and ageing, unfortunately not yet on both at the same time. The working group carried out, in the strictly Andorran framework, **hearings** with professionals concerned and **a survey** of older people and caregivers.

The hearings

They took place from 14 September to 14 November 2022. All audited persons (in 12 hearings) previously gave their written consent to a recording of the hearing which was subsequently synthesized by the working group. The audited persons testify about how they lived this experience according to the place of their practice during the pandemic: care centers and

homes, organisations and associations, municipalities and the Ministry of Social Affairs. The same hearing plan in **Appendix 3** is led by the same member of the working group who conducted the previous ones in order to optimize the integrity of the topics addressed and their reproducibility in each hearing: the impact of the pandemic after the first wave and confinement, as well as during the following waves (from 2020 to 2022), both in residential institutions, and in people's homes, in relation to the elderly, caregivers and assistants, as well as families.[4]

Surveys

The CNBA was particularly interested in the surveys carried out by the CRES which was the subject of a hearing (A9). The working group itself initiated a retrospective survey among older people and caregivers on the impact of the COVID-19 pandemic. The results are difficult to interpret for several reasons. Uninterpretable quantitatively, due to the low number of people over 65 and even more so over 80 years of age surveyed, these data do not reflect the real age range within the general population. The qualitative results can be used **provided there is adequate face-to-face support** from the investigator. On the one hand, by completing a written survey; on the other, it is a question of time and communication, which must be adapted cas-by-case, with the necessary gerontological basis applied by the support person. Too often, the telephone survey turns out to be inadequate and, consequently, selective among the population. Similarly, the form distributed in a waiting room, a mailbox or a room in a nursing home can be discouraging and reinforce the feeling of social isolation often, of unexpressed rejection. **Appendix 4**[5] mentions, through some examples, the difficulties encountered and avenues for avenues to be explored in order to improve the intergenerational bond, here as in other professional fields that are in frequent contact with older people. However, the relevance of these initial data feeds ethical reflection.

[4] The reference to a hearing in the text is marked with the letter A followed by a number corresponding to the auditee(s) as mentioned in Appendix 3..

[5] "Scientific research (social, health, media) that uses inappropriate means for older people is of little use and a source of interpretative errors."

2-2 RESULTS

2-2-1 Existing structures and the Andorran model of transversality of health and social skills

What emerges from all the different hearings is the adaptability of existing structures to deal with the pandemic. This will involve, for example, the creation of a **geriatric network** based on the transformation of a social-health facility (El Cedre) into a geriatric hospital facility capable of accommodating patients with COVID-19 and avoiding unnecessary transfers to the hospital, thus alleviating some of the emergencies and hospitalisations.[6] The infected patients received at El Cedre came either from nursing homes[7] or from their homes through the concerned general practitioners (A1, A2).

The transversality goes much further. It extends from health to social matters, from municipalities to the concerned ministries (health, social affairs and others), through interlocutors and administrative services that know each other well[8]. This facilitates the ability to respond even to unforeseen situations in the planning of risk management for the population, for example the creation of a **crisis committee for elderly people who are sick at home** based on their COVID test and the Dependency Assessment Commission (A11). In the medium term, the transversal model can promote the transfer of tasks between health and social actors, as well as the emergence of new professions in this field. Their experience can therefore help to enlighten policymakers on the reality of social and health needs related to ageing and the resulting loss of autonomy.

2-2-2 From fear of the pandemic to the pandemic of fear

During the first wave and its period of confinement, all the hearings agreed on the expression of **the singular fear of contamination by the virus**. This phenomenon, feared mainly by the

[6] The admission of an elderly person to a regular emergency service and, through it, to certain hospitalisation services is often complex, of a multiple nature (polypathological, social), and inadequate to the temporary demands of their care without the intervention of geriatric skills.
[7] Clara Rabassa, Salita and Sant Vicenç d'Enclar.
[8] An enviable situation for countries whose demographic scale exposes them to the complexity of local authorities and, through them, their power of intervention.

most vulnerable, including the elderly, has spread to caregivers, professional and family carers, as well as to the families of each of the parties concerned. This fear has also been amplified by **the impact of the confinement measures** on the elderly and their closest environment. A part of whom are excluded, unequally and often disproportionately, depending on where they live, sometimes, but this has not failed to leave serious consequences. **The resonance of the media and social networks**, more in demand than ever due to confinement, has greatly contributed to this formidable amplification of collective fear. Many elderly people still persist in the fear of leaving their living space (A8). The experience of confinement for nursing and auxiliary staff, whose abilities and dedication have never failed, is not without consequences, especially for younger people seeking professional reorientation (A3-A4-A5-A11). We once again observe **the challenges of resilience for each of the parties involved:** the elderly person according to their level of vulnerability, the healthcare professional and social worker involved in caring for them, and finally, the family and loved ones.

During the pandemic in Andorra, as everywhere, it is necessary to distinguish between the first wave and its consequences before and after the lockdown (1st half of 2020) and the following period of successive waves from the 2nd half of 2020 to the 2nd half of 2022.

The first period[9], considered very deadly in Europe, has not been the subject of any official public health publication, distinguishing, according to age groups, deaths resulting from the COVID-19 disease and deaths from other causes associated with the presence of the virus[10]. Most of the deaths occurred in the intensive care and resuscitation unit of the hospital. The date of **13 March 2020** (start of lockdown) modified or eliminated certain health and social services dedicated to the elderly, including: the activity of Red Cross volunteers participating in the "Sempre acompanyar" (A7)[11] programme, the interruption of the "Com a casa" programme implemented in the municipality of Canillo one month before the pandemic (A10),

[9] Postponed to early March 2020 in Andorra compared to France (14 January 2020) and Spain (31 January 2020).

[10] Specific mortality figures, presented during certain hearings, are pending confirmation and cannot be published in this report.

[11] "Overnight, some people found themselves alone, without family, as in the case of the English community, without being able to go out or speak face to face with anyone…" (A10)

the closure of all day centers including that of Sant Vicenç d'Enclar (A4), the interruption of the usual first aid and health prevention activity of Primary Care to reorient itself secondarily towards other activities such as vaccination and screening (A6). This was decided based on the requirements of respecting confinement and the **reorganisation of the health and social services that remain active**. Outside the hospital and its usual SAAS network, we can mention, without limitation, the geriatric care network, medical transport for dialysis patients and other transports at government request, as well as telephone assistance for elderly people at home. Among the many telephone interlocutors, we can mention here the permanent employees of the Red Cross (A7) and the municipal personal services (A10) to respond, with perfect knowledge to the persons concerned, to the basic needs of elderly people living far away (food, medicines, hygiene, etc.) and a medical alert mission to inform the ministerial social services (A11) in charge of on-site care assistance, financial aid and monitoring at national level.

During the period of confinement, the Ministerial Commission for the Evaluation of Dependency offered the possibility of staying in a **hotel residence**[12] to people staying in centers and residences for the elderly according to criteria of good health and low dependency. This provision seems to have been misinterpreted by some families (A11). The distancing restrictions, less than those of the centers themselves, explain the viral contamination of some displaced residents. Depending on the case, hospitalisation or on-site care by staff assigned to the center of origin was required. The stay in a hotel residence was interrupted after 6 to 8 weeks due to a lack of volunteers and nursing staff (A11).

The restrictions imposed on healthcare staff during confinement, the implementation of which by certain establishments may have exceeded government directives, led to an inequality in restrictions from one center to another for caregivers called outside (A6) in the context of the fear of contamination, mentioned above. Certain measures concerning **family access** were maintained long after confinement[13] (A2). Nursing home care has been significantly mobilised in all places of residence to promote links with families and loved ones (telephone, videoconferencing). Some initiatives have organised family visits in end-of-life situations during confinement with the use of appropriated equipment (clothing) and

[12] The Hotel Fénix for El Cedre and the Hotel Centric for Salita, the centres of Clara Rabassa and Sant Vicenç d'Enclar did not choose this hotel residence option for their residents.

[13] Such as testing and distancing, sometimes for more than a year.

measures. From excessive prohibitions to permissiveness, these transgressive situations in the name of the primacy of the person can be understood as beneficial and supportive in a period conducive to disbelief. However, it reflects that **the pandemic has decidedly allowed caregivers (Care) to have a different and more appropriate vision of the elderly person** (A2-A3-A4-A5-A6-A7-A9).

Following the confinement, the pandemic evolved over the next 4 semesters. It was marked by the **vaccination** of the population, with priority initially given as a precaution to the most vulnerable, including the elderly according to chronological age criteria and to the most exposed professionals who help to cover basic needs.

The Cedre has been converted into a geriatric hospital (A2). Primary care is reorganising its previous activities but also new ones linked to the pandemic based on its missions dependent on SAAS (medical) or the ministry (vaccination and screening tests) (A6). The Red Cross has benefited from a significant contribution of volunteers dedicated to IT logistics for vaccination centres (Argentine seasonal workers unable to return home) as well as for screening centres, all set up with the government. The resumption of activities of the “sempre acompanyar” programme includes contamination prevention protocols for volunteers (mandatory use of mask and hydro-alcoholic gel). The resumption of home visits, which were enthusiastically welcomed in 60% of cases, made it possible to convince some of those who wanted to prolong their isolation for fear of being contaminated by explaining the protective measures using barrier gestures. (A7)

2-2-3 The impact of isolation on the elderly during and after confinement

The perception of the elderly and, by an unfortunate combination, that of ageing, contributes to modifying the representation that our society has of old age to the point of isolating them socially and sometimes even excluding them from the desired living space. Proof of this is the progressive disappearance of family and/or intergenerational homes, as well as the change of place of residence (from home to residence) imposed too often: **an isolation whose limitations the pandemic has reinforced, contrary to what was the basis of its social integration**.

Failure to detect a sensory or cognitive deficit, or inadequate housing for a person with reduced mobility, are elements that favour this disintegration. Even more so for the most fragile and vulnerable.

The testimonies are unanimous: the pandemic has had the effect of accentuating the isolation of older people living at home, alone or as a couple. (A6 - A7 - A10 - A11).

- **Isolation based on where one lives**

The isolation of mountain dwellings, sometimes unsuited to the real capacities of the people affected, geographically far from their families, keeps their inhabitants far from shops and basic services: food, medicines and parapharmacy, home health care, daily hygiene, heating, electricity and other repairs, transport, information and communication. The period of confinement reinforced isolation by excluding face-to-face visits from family, loved ones, regular Red Cross volunteers and concerned social workers. Telephone assistance from municipalities (A10), the Ministry (A11) and their respective social workers, the Red Cross (A7), primary care (A6), was undeniably supportive, although abundance and diversity could sometimes reinforce the feeling of isolation, fear and abandonment of oneself in the face of multiple interlocutors, unknown and redundant in their approach. The pandemic context has echoed the medical-social priority of adapting housing and its maintenance to the elderly person's real capacities of autonomy.

Isolation in a residence is of a different nature, especially in the many cases resulting from exclusion from the desired place of living (home, family). The onset of the pandemic and the limitations of confinement are therefore experienced as a double punishment, isolating them by a sudden break in the emotional bond with their family and their closest caregivers and loving carers (A2-A3-A4). During the pandemic, any trip outside their usual residence (hospitalization, hotel residence) can only reinforce, for some, a feeling of abandonment and, sometimes, of submission to limitations that are misunderstood and/or experienced as unfair, sometimes inhuman.

- **Economic isolation**

The CNBA was able to collect testimonies confirming the financial difficulties, exacerbated in times of "socio-health" crisis[14], due to the downward trend in retirement pensions and the inadequacy of additional solidarity and occasional aid. The same applies to the insufficient remuneration of social workers working at home, as well as the employment of family carers paid below the minimum wage threshold, a valuable help to compensate for the shortage of professional help at home. (A11- A10).[15]

- **Cultural isolation**

The role of municipalities is particularly important for cultural activity and educational initiatives for older people. Remarkable initiatives carried out such as, for example, "com a casa" (A10), "sempre acompanyar" (A7), prevention of ageing (A1- A2) actions against digital exclusion and that of others technologies that have become essential in everyday life (A10) deserve to be consolidated and extended in order to avoid inequality between people living in the different parishes of the Principality.

The pandemic may also have accentuated differences in social and cultural integration according to individual capacities for autonomy, the impact of which linked to ageing is more often reflected in their slowdown than in their sudden loss, generally of another (pathogenic) origin. Thus, **the professional world in contact with the elderly**, whether care or not, may be led, for example, to equate a slowdown in understanding with a lack of understanding. The prevention of ageing is an essential step forward in understanding the slowdown in one's own capacities (A2), as is the need for successive reassessments, particularly psychological, in cases of chronic pathology (A3-A4). The time constraints imposed on professionals *de facto* lead to **social exclusion** if they do not adapt to physiological ageing, when it slows down certain sensory, cognitive and/or motor functions. It goes without saying that the experience of such

[14] The health crisis but also the social crisis of the COVID-19 pandemic.

[15] The economic force to prevent ageing and dependency comes from this support at home (see chapter 3 of this report).

exclusion is reinforced in the case of excessive familiarity and, even more so, certain violent behaviours towards the vulnerable elderly person. Caregivers and carers seek additional training related to gerontology to improve their daily practice in caring for the elderly and, at the same time, benefit from adequate psychological support. The testimonies are unanimous: the pandemic has changed the social vision of the management of the psychological problems of the elderly and their environment. (A2-A3-A4-A6-A9-A10-A11).

Extreme conditions of confinement bring us back to the isolation of the **sick and disabled elderly person at the end of life**. They raise the need to provide quality support without moving them away from the familiar world, either at home, if it meets dignified living conditions, or in a residential establishment, usually definitive, even if it is unwanted.

2-2-4 The question of prioritization

This question was systematically asked at each of the hearings. Indeed, in most European countries, a problem of equal access to certain care has arisen based on criteria such as age, gender, social context and even certain disabilities. This was also denounced by the European Society of Geriatric Medicine on 23 March 2020. This was the case of the too late implementation of follow-up care, surgical or medical interventions in terms of nutrition and hydration, and social and psychological support.

We know that certain situations can evolve very quickly for vulnerable elderly people. The question is whether Andorra has finally been affected by this problem like its neighbouring countries (Spain, France). In other words, due to a lack of knowledge of the vulnerability of older people (outside of geriatric services) or due to specific situations of health and/or social prioritization, have some older people found themselves disproportionately excluded from access to a certain number of care[16] ?

The response was also unanimous[17]: there is no inequality in the access of older people in Andorra to hospitalization and intensive care, the places for which have been multiplied by three (from 10 to 30), sometimes limited but sufficient (A10).

[16] « Cure » and « Care »

[17] A1-A2-A3-A4-A5-A6-A7-A8 -A9-A10-A11

The pandemic has highlighted **the complexity of having to prioritize between face-to-face and distance learning**. We will discuss this here through two examples, one related to health and the other social. The first refers to general practitioners overwhelmed with calls on weekends in the middle of a pandemic. They are faced to the possibility of travelling to patients they know or to patients from another group who fail in their emergency calls: a question of availability but also of the ability to respond to the greatest number of requests for assistance and care. If distance learning cannot replace face-to-face teaching in certain clinical situations, the priority of face-to-face teaching may be based on other criteria resulting for example from a poor understanding of the information collected by telephone and its consequences. Another example also came from the critical situation of a shortage of social workers to cover all affected households. The complicated choice fell first on dependent people, with no home help, either family or professional, and regardless of their state of health. (A11).

Inequality of access to health and social care is a reality in disaster situations and justifies the prior organisation of health and social planning in the light of the lessons learned from the past.

The global extension of remote working, resulting from the pandemic, is a matter of ethical reflection on the contribution of new technologies, not without guaranteeing the rights to care and social protection of privacy, whatever the age, in particular for the most vulnerable and fragile among us. This issue justifies once again the need to reintegrate older people into the social body by opposing all forms of discrimination and stigmatisation, preserving the values of dignity, integrity, participation, independence and, more broadly, through adequate legal protection, as we will consider it later.

2-2-5 The resilience of older people in situations of pandemic catastrophe[18]

The COVID-19 pandemic illustrates, through its medical, social and economic consequences, **the dimension of the catastrophe** [19] with its fearsome **psycho-traumatisms** suffered

[18] This text and its figure repeat the one written in March 2022 by a member of the working group: https://www.fertilevision.fr/index.php/citoyens-concernes/item/162-resilience-personnel-agees-pandemie, incorporating the Andorran testimonies collected during the hearings dedicated to this report.

[19] Etymologically: from the Greek Kata (downward caesura) strophê (inversion), transfer to decay.

especially by the most vulnerable among us, first of all the elderly and their possible comorbidities.

Unlike the suffering that was part of their human condition throughout their life, the pandemic has caused **brutal psychological agony** for a large number of them. The way out obtained through **resilience** was often compromised by a post-traumatic shock that fasted too long, for various reasons.

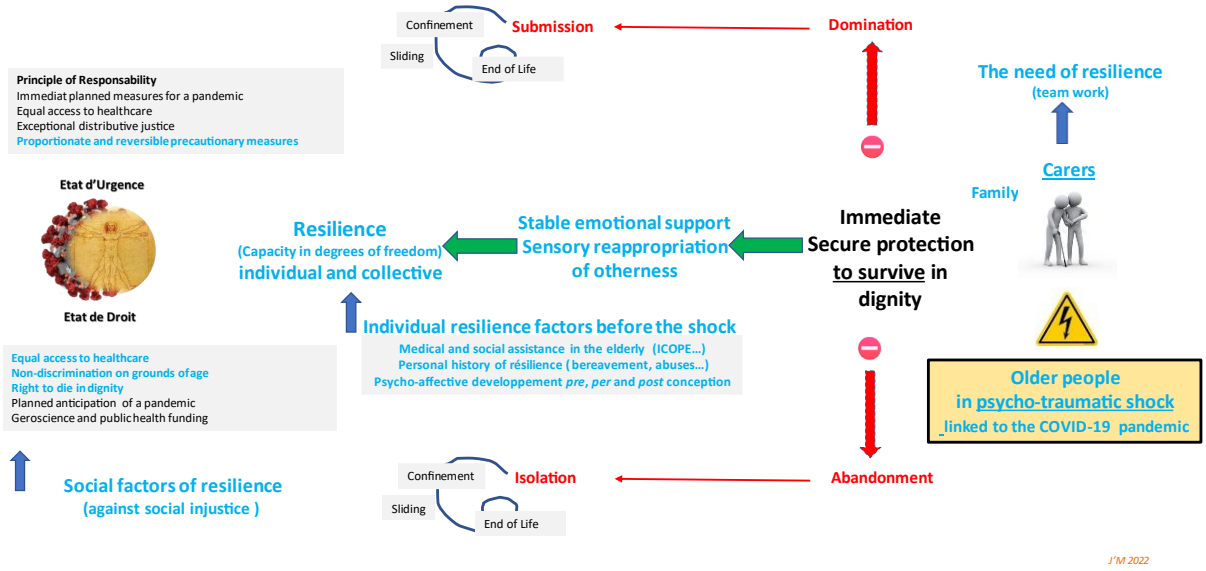
However, ageing is not as such an obstacle to resilience that is possible at every age of life. In fact, it is a defence mechanism that allows us to recover by reliving another way of life, depending on the meaning given to the trauma in question. Their success certainly depends on the skills acquired during the life before the trauma, but also on the ability to recover thanks to the **immediate emotional support** of the environment, wherever the elderly person is, in a residential institution or at home. Here too, the weight of words counts: displacement and not placement in a nursing home, support and not retention at home, in the name of the absolute refusal to reify the human person whatever their age.

Moving into accommodation is experienced as a heartbreaking experience or, on the contrary, as a security of living conditions. Similarly, home help provides security in a family environment, but sometimes its relentlessness towards a person who is too alone, often poorly treated (lack of protection of the person and their property) contravenes respect for their dignity. Resilience capacities are first and foremost individual but also collective (family, social carers, caregivers).

The breakdown of the social bond, a source of isolation from otherness, reinforced during periods of confinement by the ban on visits, by the deprivation of internal links in the accommodation, manifests itself **in moral distress.** It induces, in the absence of immediate support, a **syndrome of sliding towards the end of life** with physical deterioration, malnutrition, cognitive disorders, which can lead to death rather than COVID-19. Current neuroimaging shows that a brain without otherness atrophies. This establishes the interest of a **sensory** niche according to Boris Cyrulnik's concept of "psycho-ecology".[20] The rapidity of

[20] In » Des âmes et des saisons: Psycho-écologie », Boris Cyrulnik, Paris, Odile Jacob 2021

the intervention time ensuring stable emotional support and the progressive sensory reappropriation of otherness will condition the recovery of a more acceptable human life. For example, a deficit in the memory of words can make language and communication difficult (Alzheimer's or equivalent): not taking them into account using other means of sensory communication other than speech (gestures, images, music), aggravates the slide and the confinement of the person and their family, in an increasingly less bearable spiral. Thus the importance of the trauma will depend on the meaning that the person makes of it with their sensory capacities.



Resilience factors for the eldery during psycho-affective trauma in the light of the COVID -19 pandemic

Depending on the cognitive level of the elderly person, assessing their **need for attachment** for essential emotional stability can be complex, often hampered by an inadequate perception of their physiological age. The hearings also referred to the impact of the pandemic on the perception of the age of the elderly. Fear of the pandemic has more frequently led some caregivers and family members to want to overprotect the person. This overprotection, comfortable for many, could reduce their autonomy through the perception of an age greater than that of reality (A2-A7-A5). On the other hand, the perception of age linked to that of good care and good autonomy was that of a lower age, likely to be later experienced as an emotional abandonment by the family (A3-10).

All those audited consider that **overprotection** to be the most frequent influence of the pandemic, on the perception of older age of the elderly. This assessment of real (physiological) age remains essential to avoid the risk of an **excess of attachment** that is “too” unfavourable to one’s autonomy and can lead to submission to confinement, or of an **excess of “less”**, experienced as abandonment to that same confinement. These two inhuman risks seriously amplify the psycho-affective trauma of the elderly person, whose abandonment through a regressive defence will hinder their resilience. Such a violation of the principle of non-maleficence undermines the dignity of one’s being and can lead us or even precipitate us into the spiral of sliding towards the end of life.

Furthermore, **in terms of the end of life,** some people consider it appropriate to mention the deliberate and conscious choice to end their life in dignity, previously expressed in the case of psychological agony or psycho-traumatic syndrome.

It constitutes a sufficient force of obligation for society to validate end-of-life support, respectful of the right to die with dignity. For others, depending on their beliefs, resilience offers the possibility of realizing the primary meaning of being alive, the intimate relationship of being uniquely alive in the pursuit of a sustained relationship with death and its afterlife. In both cases, freedom of conscience respectful of human dignity is legitimately part of the first principle of primacy of the person to which our culture is fundamentally linked (A2).

In a disaster situation, resilience concerns not only the individual and the community around them, but also society as a whole. It is up to the **political decision-maker** to anticipate disaster situations through a **social contract** in the interest of the person. In the event of an extreme emergency, the means implemented as a precautionary measure must be proportionate, transitory and reversible. The responsibility of the state of emergency and the rule of law is at stake in the protection of older people, but also of future generations. **The reversibility of a provision** is sometimes wrongly considered, in the eyes of public opinion, as the setback of a “right to progress” behind the mask of the public good. On the contrary, it is **a degree of freedom essential for the resilience** of caregivers and those receiving care, as well as for the development of research whose only objective value is **scientific truth**, which the latest pandemic has not failed to remind us of those who preceded it.

How can we not think in March 2022 that the resilience of the person, the community and society contributes to the essential reconstruction of a new way of life after a natural disaster such as a pandemic of this magnitude, an earthquake, a heat wave whose consequences are beyond a duty of memory for the political decision-maker, but also a civic duty of transmission to future generations.

3 ARGUMENTATIVE DISCUSSION

3-1 THE AUTONOMY AND VULNERABILITY OF THE ELDERLY PERSON

3-1-1 The relativity of the autonomy of the elderly person

Autonomy is part of a life story, in everyday life and in its environment. It is existential for the person, rarely absolute and even more rarely absent.

The increasingly evident distortion between chronological age and self-determination, that is, the person's ability to decide for themselves and by themselves, induces a form of social denial of the autonomy of the elderly person.

Autonomy, like dependency, cannot, in any case, fall under a binary concept considering that a person is or is not autonomous, is or is not dependent. This is simply related to the many functions on which they depend: sensory, motor and cognitive.

For example, it would not be ethically acceptable that the pretext of dependency could harm the exercise of intellectual autonomy.

Likewise, being autonomous does not mean being able to decide without the help and support of a trusted third party, even if this third party contributes *de facto* to a certain relativity of this autonomy. The relationship of trust with a third party can beneficially exert an emotional or competent influence on the decision, but it should not replace that which ultimately legitimately belongs to the person concerned. In this respect, excessive precaution through

the security choices of a third party caregiver or family member (under the pretext of non-maleficence and beneficence) can unethically oppose the exercise of autonomy, an obvious fact that brings us here the first lessons of the COVID-19 pandemic.

Another example is that elderly patients in cases of extreme scarcity of health resources , must be treated under the same conditions as the rest of the population, i.e. according to clinical criteria on a case-by-case basis. Accepting such discrimination would undervalue certain human lives due to the moment of their life, which contradicts the foundations of our rule of law and its Constitution.

Loss of autonomy is an individual issue related to vulnerability previously defined as a result of the uncertainty of a potential morbid risk, unlike dependency or disability which are usually sequelae of an illness. For example, a fall with fracture makes the elderly person vulnerable to the risk of long-lasting functional incapacity and the dependency that could result from it. Previously, taking long-acting antidepressants can expose the person to the risk of orthostatic hypotension[21] and falls, all of which are vulnerability factors with potential risk of medical complications, sometimes disability and great dependency.

The first sensory deficits affect first sight, then hearing and cognition; they contribute to isolation and social exclusion. Their support by society is a priority in order to exercise autonomy in understanding information, communicating and then freely deciding for oneself. There are also oral and dental problems, sources of malnutrition, then undernutrition and osteosarcopenia[22], to take the example of falls with fractures.

The overall motor deficit is often assessed in terms of the number of falls: in France, every year, 2 million falls among people aged 65 or over are responsible for 10,000 deaths, the leading cause of accidental mortality, and more than 130,000 hospitalisations, justifying a

[21]Sudden drop in blood pressure when standing up or getting up.
[22] Kirk B., Al Saedi A., Duque G., « Osteosarcopenia: A case of geroscience», 2019, Aging Medecine, 2:147- 156, https://doi.org/10.1002/agm2.12080

three-year plan (2022 – 2023 – 2024) to prevent falls among the elderly.[23] Many trans-European initiatives are working to prevent the incidence of falls among the elderly.[24]

The appearance of cognitive disorders also refers to the notion of **relative autonomy** and the duty to respect psychological autonomy: any loss of autonomy can be a source of psychological disorders, depressive responses and at any age of life. In the extreme case of the impossibility of a person being able to exercise their relative autonomy (never absent) in the case of very advanced brain degeneration: their emotional reactivity, the meaning of which escapes us, justifies that the choice of decision made in their place respects what objectively would have been theirs.

The loss of autonomy of the elderly is also an economic and social issue.

- Numerous demographic and economic studies carried out both in our neighbouring countries and internationally[25] demonstrate this. Among the first reports published after the pandemic, the « Cour des Comptes » estimates annual avoidable health expenditure at 1.5 billion euros for one year of increase in disability-free life expectancy, over the period 2021-2031[26]. It estimates that for France in 2020, despite a decline linked to the COVID-19 pandemic of almost six months compared to 2019, life expectancy is 85.32 years for women and 79.5 years for men. It considers that at 65 years of age, women still have 23.7 years of life left and men 19.6 years. This report does not fail to specify that, beyond this financial impact, this annual increase in disability-free life expectancy represents « a significant improvement in the quality of life and autonomy of older people ».

[23] Plan antichute des personnes âgées | solidarites.gouv.fr | Ministère du Travail, de la Santé et des Solidarités update on 16/01/2024

[24] This was the case for the HAPPIER programme in terms of physical and mental health for Belgium, Spain, France and Ireland, 2015, HAPPIER-IPP-janvier2015.pdf (gymsana.be)

[25] European Commission, Directorate-General for Communications Networks, Content and Technology, Worthington, H., Simmonds, P., Farla, K. et al., The silver economy – Final report, Publications Office, 2018, https://www.data.europa.eu/doi/10.2759/685036

[26] Cour des Comptes, « La Prévention de la perte d'autonomie des personnes âgées: Construire une priorité partagée », Paris, november 2021, https://www.ccomptes.fr

- In our health systems, the "slowing down of functions (sensory, motor, cognitive, etc.) of the elderly is in direct opposition to the demands and constraints of efficiency, productivity and profitability imposed on medical and non-medical professionals[27]".

These two elements illustrate the double economic and social challenge of preventing the loss of autonomy of the elderly, in which the "family carer" is given an important role, worthy of recognition, protection and the right to respite[28].

Thus, the fact that residential establishments are increasingly dedicated to high dependency already represents the alternative of taking charge of the loss of autonomy at home. This cannot be done without housing adapted to the person and without the support of professional caregivers as well as family members or loved ones. A real social choice for policy-makers in organizing the living conditions of the older people whose **unwanted loneliness** becomes, for public health systems, one of the greatest threats to health and life expectancy.

3-1-2 Discrimination and its link to loss of autonomy

Our daily lives intersect with **discrimination based on age** or ageism. There are many examples, including:

- Digital exclusion in everyday household applications and in communication (health, shops, banks).

- The distortion between the time imposed on the caregiver and the time necessary for the free expression of elderly people subjected to care at home or in an institution, to a consultation, to the reception of an emergency service inadequate to the medical and social complexity, to act quickly and appropriately.

[27] Comité Consultatif National d'Ethique pour les Sciences de la vie et de la Santé, Opinion No. 128 Ethical Issues of Ageing What is the meaning of the concentration of older people among themselves, in so-called residential establishments? What levers for an inclusive society for older people? Paris, February 2018, https://www.ccne-ethique.fr/sites/default/les/2021-02/ccne_avis_128.pdf

[28] See the ethical-legal aspects presented in chapter 3-3.

- Loss of financial autonomy following a reduction in retirement pension despite its indexation to the cost of living, misappropriation of income regardless of where one lives[29]…

Beyond a health and social assistance system that is inadequate to the demographic and economic reality, the vision of the elderly is distorted by the fear of ageing, by the fantasy of "eternal youth", but also by the lack of understanding of the reality of the ageing process. This contributes to modifying the representation that our society has of old age to the point of hiding it from the general public, making it invisible and mute and, consequently, even excluding it. It symbolizes what is opposed, in democracy, to the values that justify a society being inclusive (diversity, equity and solidarity), the very essence of the Welfare State.
While our societies are giving themselves the means to fight against discrimination in terms of sex, gender, race and religion, it is curious to observe that the same does not happen with segregation according to chronologically advanced age or ageism, as some of the measures adopted around the world during the COVID-19 pandemic did not stop reminding us.

Discrimination is a chronic stressor whose psychological impact can be expressed through pathology. The continuous activation of the hypothalamic-pituitary-adrenal axis induces a cascade of metabolic disorders that impair the physical and mental health of people subjected to discrimination. Recent meta-analytic studies reveal that the experience of daily discrimination is associated with anxiety, depression, psychological distress and even mental illness.

Similarly, several studies have suggested a link between discrimination, premature ageing and reduced life expectancy.

A recent pioneering study has shown that exposure to stress and racial discrimination throughout life causes epigenetic alterations, demonstrating that discrimination can lead to accelerated ageing.[30]

[29] Mc Kenna B.G., Mekawi Y., Katrinli S. et al, «When anger remains unspoken: anger and accelerated epigenetic aging among stress-exposed black Americans», Psychosom. Med. 2021; 83: 949-958, https://doi.org/10.1097/PSY.0000000000001007
[30] Fiselier A., Narendran A., Raiche J. et al, «From discrimination and disease to aging and disease an epigenetic connection», The Lancet Regional Health - Americas, Volume 12, 2022, 100282.

A certain number of cardiovascular and autoimmune diseases have been correlated with advancing age due to important epigenetic factors. Certain clinical forms of COVID-19 appear to be aggravated by stress and underlying discriminatory psycho-traumas. COVID-19 may also facilitate the already accelerated ageing among people who are victims of discrimination.

Future studies are essential to clarify the effects of discrimination not only on diseases but also on ageing in order to determine the preventive measures that may be required in terms of health and, if necessary, in relation to the law.

Knowing that in a century a third of the population will reach 90 years of age (and no longer 65) according to the European Commission and that, according to the OECD, the population aged 80 or over should double between 2019 and 2050 in OECD countries including France and Spain, ageism becomes a major obstacle to maintaining an egalitarian, inclusive and democratic society: **the great social challenge of the first half of the 21st century**.

3-1-3 Patient autonomy and consent at the end of life

End of life is a generic term that encompasses very different situations (medical and legal). This is the case of diseases considered to be in a terminal phase whose duration is or is not reasonably determinable in the short term of life expectancy.

We recall here, as with COVID-19, that as long as recovery from an illness is not objectively excluded, it should not be considered a terminal illness, even if it is particularly serious for the most vulnerable people due to a polypathological context or advanced ageing (rather than age).

It is not the purpose of this work to develop the ethical aspects of the end of life. We will only mention here the question relating to the autonomy and consent of the patient, at the end of life.

The interest of advance directives of whishes [31] is essential to the extent that their revocability, accepted by all, is not overlooked. The formulation and collection of these instructions is based on an exchange about life and death, promoting the expression of the elderly person's autonomy, in a life project but also at the end of life, particularly in terms of place of living and mode of support. They require written consent following the most enlightening information possible, according to the recommendations of the CNBA[32] for the drafting of the document of advance wishes document.

Assessing the person's autonomy regarding the end of their life[33] means verifying his or her capacities to understand, appreciate, reason, express and maintain a previous choice or his or her wishes. It would be appropriate for a written document from the doctor to attest to the validity of the directives. However, another moment is that of the situation of a particularly serious illness or one with a short term lethal prognosis: the advance directives become a support for dialogue with the caregiver to ensure that they respond to the patient's wishes when confronted with the concrete reality of this moment of finitude.

Respect for the dignity of the person and the autonomy of his or her will are the basis of the common approach by carers, assistants and family members. On its own and in very exceptional circumstances, an important reason of public health may contravene the will of the person, in a coercive manner. This was the case, for example, with certain confinement measures during the SARS-Cov2 pandemic, isolating elderly people living in institution from their loved ones at the time of their death and sometimes immediately afterwards, in defiance of their wishes expressed in advance. It is a matter of underlining once again that the precaution of the State of emergency in a situation of uncertainty must remain proportionate, temporary and reversible as quickly as possible so as not to undermine the freedom and autonomy that constitute the dignity of the person, whatever their state of health, their social and psychological vulnerability, as well as their age.

[31] Semantics closer to reality than advance directives.

[32] Comitè Nacional de Bioètica d'Andorra, Consideracions per a l'elaboraciò d'un document de voluntats anticipades, Consideracions_Doc_Voluntats_Anticipades.pdf (salut.ad)

[33] Comité Consultatif National d'Ethique pour les sciences de la vie et de la santé, Avis 121 : Fin de vie, autonomie de la personne, volonté de mourir, Paris 2013, http://www.ccne-ethique.fr./avis_121_0.pdf

3-2 PREVENTION OF AGEING: ITS INTERGENERATIONAL DIMENSION, ITS SOCIO-ECONOMIC SCOPE AND ITS ETHICAL VALUES

3-2-1 Physiological ageing, its corrective factors and its limits

It is generally acknowledged that the boundaries between physiological ageing and pathological ageing are difficult to distinguish as they interact with each other. However, it is important to remember that the mechanism of physiological ageing begins very early, when growth stops for some and more likely as soon as repair and regeneration mechanisms such as programmed cell death (or apoptosis) are initiated, replaced and renewed continuously over successive cell generations. So there is no shortage of corrective factors for physiological ageing, until a dysfunction of one of them limits repair, with or without detectable repercussions.

The repair of cells, tissues and organs and their life cycle concerns all generations: it is transgenerational.

The mobilization of geroscience[34] is essential to prevent physiological ageing and probably, through it, the avoidable occurrence of a large number of pathologies, sources of handicap and dependency. This is a first argument in favor of the intergenerational dimension of ageing and its prevention

3-2-2 Ageing has a little-known socio-economic value

The economic approach to ageing beyond retirement age can only be based on a real, physiological, rather than chronological age. The “lesser evil” recourse to chronological age is that of age brackets, which can be adjusted periodically. From retirement age to nearly 80 years old, the vast majority of seniors are active and in good health. The following decade is

[34] See Appendix 1

often affected by the occurrence of a chronic pathology or disability, of varying severity. The last age bracket group, beyond 90 years, extends to the end of life, whose limit today set by the scientific community is at around of 120 years old.

A report[35] initiated by the European Commission defines the Senior Economy or Silver Economy as the sum of all economic activities that meet the needs of people aged 50 or over. It covers a range of economic activities linked to the production, consumption and trade of goods and services of interest to older people, both public and private, with their direct and indirect effects. In 2015, the Silver Economy generated more than €4.2 billion in GDP and supported more than 78 million jobs across the EU economy. The forecast for 2025 is €6.4 billion and 88 million jobs, or respectively 32% of GDP and 38% of EU jobs.

These perspectives should be able to address the economic challenges linked today to a decline in the working population and its vital consequences for our social protection systems. They will depend on measures taken in favour of connected health and integrated care, the adapted development of home automation, smart transport and other services that are likely to be adopted by the elderly, tourism for the elderly and education open to all ages. This is a second argument in favour of the intergenerational dimension of ageing and its prevention

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3-2-3 Preventing ageing is multi-faceted and requires a multidisciplinary approach.

Preventing ageing is fundamentally health-related and social. It consists of detecting and correcting, as necessary, the first sensory deficits: firstly, vision, then hearing and cognitive deficits. They concern adults, often in full professional activity, even before they reach retirement age. Their effects become more pronounced and intertwined over time.

Lack of care penalises the inclusive possibilities of active seniors in the world of work and, more generally, of people who are too needy to remedy this during the second half of their life, with the discriminatory effects mentioned above and contrary to the right to prevention of ageing and the rights of old age, developed later (chapters 3-3).

[35] European Commission/Technopolis Group/Oxford Economics, « the Silver Economy », 2018. Available at: https://op.europa.eu/doi:10.2759/795588

The controlled contribution of artificial intelligence already makes it possible to prevent ageing on a case-by-case and on large-scale basis[36], as demonstrated by the ICOPE (WHO) application on mobile phones[37], now accessible to people over 60 years of age and soon to be extended to older age groups. The aim is to maintain the intrinsic capacities of the elderly person for as long as possible by means of complete and regular monitoring and by intervening in a personalized way through a digital platform dedicated to participatory medicine.

Indeed, such a public health platform integrates each person concerned with their own self-assessments, caregivers and assistants under the coordination of the treating physician, as well as new integrated care technologies. Among the intrinsic capacities it targets: vision, hearing, memory, appetite, mobility, psychological health and resilience.

At the same time, large-scale data processing and its health, social and economic repercussions undoubtedly pave the way for **improving the quality of life** as we age, in our social body. For example, two years after its launch, on 11 February 2023, the French region of Occitanie registered 30,239 participants in the ICOPE programme (average age 74.7 years, of whom 62% were women) and 7,500 healthcare professionals who downloaded the corresponding digital tools. This WHO ICOPE programme is also being successfully developed in Andorra[38] and Catalonia.

The social environment impacts the prevention of ageing at several levels, including:

- **Living spaces**: housing, work, temporary accommodation, individual and collective transport, access to shops, banks, social and administrative services by reducing the digital divide and facilitating easy access to new technological aids for health and housing.
- **Leisure and culture** give meaning to maintaining cognitive and physical capacities, in particular for the “third age”, whose galloping demographics from retirement age to

[36] Vellas B., How to Implemente Integrated Care for Older Persons -ICOPE- Massively in Clinical Practice for Healthy Longevity. , 2023, J Aging Res & Lifestyle 2023 ;12 :18-19, http://dx.doi.org/10.14283/jarlife.2023.4
[37] See 3-1 of this notice.
[38] According to the testimony of all the people interviewed (Appendix 3) in the context of chapter 2 of this opinion.

almost 80 years, are particularly in demand for leisure activities, tourism abroad, without forgetting also those from abroad who choose to reside in our country.

- **The local environment**: family, loved ones whose stable emotional support is essential to the effectiveness of resilience in terms of rebuilding a life project and then the end of life[39]. It is sometimes marred by situations of unwanted abandonment or abuse in the case of severe cognitive deficits, an attack on the dignity of the elderly person, poorly or not protected with regard to ethics and the law.

It is easy to understand that **at all ages of life, education is the foundation of life expectancy**. It begins at a very early age in the immediate family and/or those close to it, and is nourished by the intergenerational bond and the inclusive force of the social body. A recent study from Milan[40] shows that education and age interact in the appearance of frailty following an exponential relationship, which suggests the importance of the social dimension of education with respect to frailty. Preventive interventions through their multidisciplinarity could be particularly effective at advanced age.

Instruction is the corollary of education up to the most advanced ages, where free access to knowledge and new technologies is an essential "master key" to social integration. Education and Instruction compromise the ethics of responsibility of the political decision-maker to promote a new paradigm of ageing: that of a **new economy of inclusion**, dedicated no longer to the performance of the average level of life expectancy[41] but to its most homogeneous distribution. possible within the population. This is evidenced by the close correlation between equal access to education and life expectancy. From then on, our economy of the common goodwill be able to achieve the promotion of homogeneity of life expectancy in old age.

[39] See Chapter 2-2-5 on the resilience of the elderly during a pandemic.
[40] Bellelli F., Consorti E., Hettiarachchige T.M.K. et al. « Relationship among Age, Education and Frailty in Older Persons ». J Frailty Aging 12, 326–328 (2023). https://doi.org/10.14283/jfa.2023.39
[41] Closing the gaps according to social strata.

3-2-4 The consequences of a culture that prevents ageing

In 2020, national demographic studies show that life expectancy at birth is roughly the same in France as in Spain, around 85 years for women and over 79 years for men.[42] The impact of the pandemic (OECD 2021) has reduced life expectancy by 6 months in France, by 18 months in Spain (United Kingdom: 12 months – United States: 19 months); however, this remains a marginal reduction outside the dynamics of population ageing over the past three or four decades. WHO demographic projections show the same trend worldwide: the population over 80 years of age is expected to double between 2019 and 2050 in Europe, triple in China and quintuple in South Korea.

In our countries, where the birth rate is low and continues to decline[43], preventing ageing can only lead to an increasing proportion of active older people and contribute to rectangularising the age pyramid.

These effects on quality of life and life expectancy have economic, social, actuarial and financial repercussions, of which health, social participation and economic security are the three keywords for a **healthy life expectancy**, pushing back as far as possible the high dependency.

It is now up to our decision-makers to **reinvent an intergenerational** economic and social **model**

- **An economy** that fosters research and innovation for healthy ageing, employment, productivity, social recognition of the seniors' activities , as well as the lasting and equitable financial viability of people retirement benefits by monetary and budgetary policies adapted to the demographic reality of our populations

- **Social services** to prevent and combat loneliness and isolation, whose pathogenic power affects all age groups, in particular the oldest: an absolute intergenerational priority for the loneliest and poorest.

[42] Life expectancy at birth is 85.74 years for women and 80.36 years for men in Spain (INE 2022); 85.2 years for women and 79.3 for men in France (INSEE 2022). Life expectancy at age 65 (OECD 2021) is 23.5 years for women and 19.2 years for men in Spain; in France, 23.3 years for women and 19.2 years for men

[43] The balance between births and deaths is negative, the imbalance worsens every year with the social, family and health repercussions of "forced" loneliness.

Equal access to ageing prevention is likely to legitimately extend into adulthood well before early retirement. It promotes generational decompartmentalisation and through it, a better understanding of ageing and old age. It is an ethical response against unacceptable age-based discrimination and all its consequences on respect of the person and on the future of generations to come.

3-3 FROM THE EXERCISE OF THE RIGHTS OF THE ELDERLY TO THE DEVELOPMENT OF SOCIAL LAW FOR THE NEW FORMS OF SOLIDARITY AND THE GUARANTEE OF RIGHTS AND FREEDOMS IN ALL STAGES OF AGEING

The dissolution of chronological age in favor of real (physiological) age in terms of health as defined by the WHO, leads us to reconsider, in our so-called developed countries, the meaning of senescence, the social status of old age and the institutionalization of retirement. It arises from an ethical-legal reflection for the possible transition from ethics to law.

3-3-1 The exercise of the rights of the elderly

The debate raises a first question about the obstacle to the exercise of the rights enjoyed by the elderly in our democracies: rights common to all citizens, rights specific to certain stages of life.

The retirement stage in the life cycle is subject to prerequisites and conditions.

Those of Andorran law are listed in **Appendix 5**.

The demographic reasons for longevity and health force us to **rethink the conditions of financial viability of our social insurance models**: health insurance, and dependency insurance, old-age insurance which is above all the insurance of payment of a retirement pension.

The lifelong retirement pension is subject to conditions of age and duration of social security contributions from which the amount of the retirement pension can be calculated based on the acquisition of points obtained during the « active » life.

However, the method of calculating the value of the point is periodically reassessed and generally results in a lower value of the retirement pension.

This observation is not without repercussions on purchasing power and the deterioration of living conditions over time, subject to the vegetative growth of an increasingly less productive economy. The compensatory social assistance system (A12) of the welfare state only covers situations of particular poverty. To a certain extent, Andorra does not escape this observation made by its neighbouring countries (**Appendix 5**).

The use of technological aids (humanoid robotics) **to combat the effects of loneliness**, in addition to carers, but perhaps also for the payment of pensions instead of many defective jobs, will require guarantees and protection from appropriate, internationally harmonised regulations.

The European Social Charter and Andorra: it entered into force in the Principality on 1 January 2005, and Andorra has therefore adhered, along with the majority of the member states of the Council of Europe, to the principles of the Charter. Since its entry into force, legislative amendments have been made in order to transpose the Charter into internal regulations.

Andorra has acceded to **the Convention on Human Rights and Biomedicine (Oviedo Convention)** and its ratification entered into force in the Principality on 1 October 2023.

3-3-2 The evolution of social protection for the elderly towards new forms of solidarity

The elderly, a term sometimes used as a discriminatory term by gerontophobes, are today exposed to **a feeling of indignity because of their own ageing**, their possible threefold loss of autonomy, freedoms and resources, which may undermine the fundamental rights and freedoms recognised to every person.

Their *de facto* isolation (maleficence), regardless of where they live, cannot be an acquired right in a society that is insufficiently inclusive due to the lack of intergenerational solidarity.

It is worth emphasising the importance of an ethics of language to express the semantic truth distorted by certain verbal habits. Awareness of the pejorative dimension of some of them should contribute to modifying them and thus changing what is imprecise, false, discriminatory and sometimes even perverse. Common language, which has become consciously respectful of the elderly, will prefer, for example: home support to

"maintenance", "transfer" to "a residence rather than to an accommodation facility", in certain cases support is preferable to "care"… This is, in fact, the necessary ethical evolution of mentalities regarding the vision of the elderly person and their ageing. It must be taken into account when drafting legislative and regulatory texts related to old age and ageing.

Home care professions must benefit from training, support and promotion with financial compensation in terms of salary, taking into account the difficulty of care required by the frailty of people and the risk of professional suffering, insufficiently understood by the community[44]. Personal services defend the local economy, the increase of their salaries and the creation of their jobs. They represent an essential growth factor for our countries in times of economic recession.

Support staff in residences for the elderly are limited in number, insufficiently trained to provide moral support to residents, insufficiently valued and often insufficiently paid despite the situations they face: loneliness, isolation, vulnerability of others, depressive reaction to the institutionalization of the elderly where people essentially remain in the same situation of old age and dependency until the end of their lives. Their working conditions expose them to the occupational and risk of cumulative psycho-traumas, given the number of residents they care for.

Advances in labor legislation are essential to enable a loved one to help and support a sick or disabled person:

- Specific family solidarity leave, for example to support a loved one at the end of life,
- Remuneration elements of a savings account for suspending work for family solidarity purposes: daily allowance paid by Health insurance,
- Transformation of the leave, with prior employer's agreement, into a period of part-time activity, including two days'rest not taken, for the benefit of relatives suffering loss of autonomy or incapacity.

[44] Thus, the European Court of Human Rights has recognised the right of the elderly person to benefit from the services most beneficial to their autonomy, whatever the cost (McDonald v. UK case, 20 May 2014).

These measures should benefit not only employees but also unemployed people**: the principle of national solidarity** encourages the legal emergence of “nonprofessional" work because it is socially useful and a source of savings for social finances.

In France, the law of 8 August 2016 creates the personal activity account (CPA), which promotes socially useful activities whose essential question is that of financing: by national solidarity? by the employer? by a flat-rate contribution from the individuals themselves? Thus, the CCNE, in its opinion 128, mentions the periods dedicated by family carers and volunteers to supporting dependent people - the use of new forms of volunteering to support frailted and vulnerable people - the relaxation of the rules in force in institutions for the elderly.

The new rules of social law should make it possible to respond to the challenges of ageing and the duty to respect the rights of people made vulnerable by the alteration of their decision-making faculties. The protection of vulnerable adults in a spirit of transversality aims to cover the vulnerability of the elderly as much as that of people with disabilities.

3-3-3 Rights and freedoms guaranteed at all stages of ageing

Ageing, as we have already seen, starts very early. It refers us to the meaning of existence in general, whereas the elderly person refers to the existence in particular of each one of us, as our living memory, within our family and our loved ones.

Knowledge of ageing allows us to change the way we look at old age and consider the elderly person as a full-fledged citizen, **holder of effective rights**, **capable of exercising them** directly and, if necessary, with the help of professionals, family members and carers, or indirectly through legal representatives.

The constitutional right to old age, ageing and its prevention

We all know that every human being is unique and that this uniqueness increases with age and life experiences. Ignoring this to the point that the abuse of language and negative stereotypes about old age only qualify people in terms of their age amounts to discrimination based on age or “ageism”. However, unlike other discriminations (sex, race, religion, etc**.), our societies lack legal instruments of protection against ageism** and to abolish any possible

discrimination on the grounds of age. Sometimes they are insufficient or are not developed and applied to the extent necessary to abolish any discrimination on the grounds of age.

Regarding article 6 of the Andorran Constitution[45], since age is a persona condition, there is constitutional protection against discrimination on the grounds of age and an obligation for public authorities to guarantee it. However, this constitutional obligation does not seem to have been elaborated in the legislative framework.

In 2014, the **French Criminal Code** introduced, in its article 318[46], the offence of discrimination by incorporating the qualification of personal conditions in the formulation of the elements to be taken into consideration in determining discrimination. The change in law in 2015 refers to a medical verification of the person's condition. However, today in Andorra, perhaps due to its small demographic size, this article of the Criminal Code has not been applied in its aspect of age discrimination, since no judicial proceedings have been initiated in this regard.

Since 2023, the Criminal Code has also been amended to protect people with disabilities from abandonment by those responsible for their care.[47] In addition to these protective measures, the same text provides for the aggravating circumstance of being a victim of special vulnerability due to age or disability[48], a circumstance that has already been applied to guarantee special protection for the elderly.

[45] Article 6 of the Constitution of the Principality of Andorra:
1. All persons are equal before the law. No one may be discriminated against on the grounds of birth, race, sex, origin, religion, opinion or any other personal or social condition.
2. The public authorities must create the conditions for the equality and freedom of persons to be real and effective.

[46] Law 9/2005, of February 21, 2005, qualified as a criminal code. Article 338. Discrimination
The Criminal Code, amended in 2015, provides for an exception: discrimination in matters of life insurance, disability, handicap or incapacity for work. In this case, discrimination must necessarily be based on medically established considerations relating to the person's state of health. Therefore, in these cases, discrimination based solely on the person's age is not permitted, since a proven and not presumed deterioration in the state of health is necessary (Law 40/2014, of 11 September, qualification of modification of Law 9/2005, of 21 February, qualification of the Criminal Code).

[47] Article 167 of the Andorran Penal Code states:
1. The abandonment of a minor or a disabled person by the person responsible for their care is punishable by imprisonment for up to two years.
2. If the act is committed by the holders of the functions of guardian, the penalty will be imprisonment for three months to three years.
3. If the circumstances of the abandonment endanger the life or health of the minor or disabled person, the penalty is two to five years in prison.

[48] Art. 30, paragraf 5 of the Andorran Penal Code «Ser la víctima especialment vulnerable tenint en compte l'edat, la condició física o psíquica, la discapacitat o una altra circumstància semblant».

Does the "intergenerational" transversality of constitutional rights not justify the development of a law on old age and ageing with specific legal instruments to respect older people in terms of pensions, health, housing, culture and leisure, social solidarity but also health prevention, discrimination, exclusion and education of the professionals concerned, including those in teaching, research and service provision?

Reducing inequalities in education and health:

If education is considered to be a universal right, it should not allow citizens a different life expectancy depending on where they live and their possibilities of accessing quality education[49] and participatory social inclusion, particularly leisure and cultural activities.

The same applies to equal access to appropriate care requirements and assistance needs, of which the COVID-19 pandemic may have revealed situations of deprivation of intensive care, systematized on the basis of age or any other circumstance other than commonly accepted clinical criteria. This highlights once again that age is not in itself a disease, even for the most vulnerable. This inequality of access could only aggravate marginalization and forced isolation with no regard for the protection of the human rights of the elderly.

In light of the COVID-19 pandemic, the ethical-legal reflection also focuses on the principle of proportionality applied to the governance of a fair balance between the state of emergency and the rule of law, following the example of the measures adopted regarding confinement based on chronological age, health and social vigilance measures, and the quality of information provided to the general public.

On this last point, the WHO has described as an **infodemic** the pandemic of misinformation (intentionally false) spread by certain media and social networks with little concern for the serious consequences that aggravate people's vulnerability in terms of mental health, but also undermining the integrity of research, healthcare and the environment. Legal provisions must

[49] It will also be a question of countering depopulation and desertification, especially in certain rural areas, by granting tax incentives to families and companies that establish themselves there, by developing connectivity (fibre optics) and through it suitable useful and innovative technologies, even if this affects countries with a larger population than Andorra. These provisions can only unblock isolated people without social ties. This problem appeared in numerous hearings in the case of Andorra, in relation to local services.

be established as scientific and technological knowledge in this field evolves, in order to prevent such misleading behavior.

Reducing health inequalities and improving the lives of older people, their families and communities is the objective of the United Nations Declaration on the Decade of Healthy Ageing (2021-2030), which gave rise to the WHO Global Strategy and Action Plan on Ageing.

3-4 ETHICAL CHALLENGES IN FAVOUR OF PUBLIC DEBATE AND GOVERNANCE IN SUPPORT OF AGEING AND ITS INTEGRATION IN OUR WESTERN SOCIETIES

Public dialogue and debate are an essential contribution of participatory democracy that legitimately feeds into the decision of national representation and its governance. They refer to an ethics of language whose semantic truth comes from knowledge of science in the broad sense of the term. Access to knowledge, aware of one's own uncertainties, is an essential prerequisite for public debate.

3-4-1 Crisis communication in a pandemic situation

An additional international analysis to that developed in chapter 2 on the impact of the pandemic in Andorra (2-2-2) highlights the **morbid spiral of disinformation** during the first months of the virus's spread.

The ethics of language[50] should designate disinformation as false or misleading information, intentional and potentially harmful to others. The disorders of the infodemic (called by the WHO as the rapid dissemination of misleading health information, especially through social

[50] She distinguishes between misinformation which is false or misleading but not intentional – disinformation which is intentional and harmful – and malinformation which is true, making public what is private and intentionally harmful.

networks) have contributed to amplifying the pandemic of fear, especially for the most vulnerable, affected by the disease and/or isolation[51], including the most advanced in age.

Inappropriate communication maintains fear and doubt, initially it is responsible for behaviors that in turn amplify the spread of the virus. These behaviours are generated by the loss of confidence in science, unduly qualified in the mass media and social networks.

The spiral of fear fueled by disinformation accentuates vulnerability and particularly harms the mental health not only of older people but also of their carers and caregivers.

Secondly, it is clear that the spiral also undermines the integrity of:

- Research, such as excessive scientific publications that weaken the control systems established through accelerated review procedures, which can also affect the upstream ethical and scientific validation of early-stage research protocols.
- The environment with a negative impact on care, education and prevention programmes (sexually transmitted diseases, including HIV) due to a (sometimes disproportionate) reallocation of resources towards activities specific to the virus and to COVID -19, not to mention the vicious circle between the risk of the pandemic and the loss of biodiversity due to the increased proximity between humans and wildlife, diverting it, in certain countries, towards food, cosmetic and various therapies.

Health literacy[52] is an effective way to combat disinformation and infodemic. This ability to find health information is a major public health issue. Providing an adequate level of true health knowledge, accessible at every real age of life, allows people for better understanding, better adherence to recommendations, greater autonomy in their search for and analysis of information, and participation in the dissemination of scientific truth.

Furthermore, it is worth remembering that the first link in the chain of knowledge is **uncertainty**, the foundation of research. Health literacy depends on the expertise of field

[51] At the root of specific governance arrangements such as in the UK, loneliness, social isolation and COVID-19 | Local Government Association.

[52] In January 2023, the Council of Europe's CDBIO published a guide to health literacy, in English and French: https://www.coe.int/fr/web/bioethics/guide-to-health-literacy

workers, as well as public health workers, and their communication skills in gerontology for advanced ages of life.

The ethical challenges of governing a united, equitable and fair society **in a pandemic situation** are those of:

- Health and social planning, knowing that, unlike certain natural disasters, the gradual development of pandemics gives the government a reasonable period of time to create an administrative body for coordination and intervention.[53]
- Transparent information on the actual evolution of knowledge and its state of uncertainty
- The justification of proportionate and reversible precautionary measures for unproven risks and preventive measures as soon as possible for a proven risk.
- Equitable access to health, care, work, resource allocation, technologies, education and information.
- Respect for individual freedoms and the dignity of the person until their point of finitude, their autonomy in decision-making, their protection against discrimination and their social participation.

3-4-2 Intergenerational communication: the challenges and societal challenges of governance relating to ageing and old age

If the environment induces different ways of being a child, a young adult and an elderly person, categorical stigmatisation based on age and discriminatory risks are no longer in place in a supportive, equitable and inclusive society for many reasons.

Intergenerational communication is essential to address the challenges of the inevitable transformation of our society linked to ageing.

Among these challenges, the **demographic challenge** is threefold:

[53] CIB UNESCO, 6 september 2023: Draft report of the International Bioethics Committee (IBC) on the COVID-19 pandemic: lessons learned and recommendations for future directions - UNESCO Digital Library

- Longevity: as the working population increases[54], the prevention of ageing must allow for a case-by-case reassessment of working age and delay severe dependency as far as possible.[55]
- The constant decline in the birth rate and the need to rebalance the deficit of births in relation to deaths justify a reorganisation of work according to age in order to allow couples of childbearing age to conceive and educate their children without prejudice to the pursuit of their professional careers, particularly for women
- The desertification of rural areas and certain urban areas where older people are particularly isolated, invites repopulation through high-speed connectivity, access to new technologies (including telemedicine) and financial incentives for installation companies, businesses and service providers. It raises the question of migratory movements and the importance of integrated immigration as a demographic and economic adjustment variable.

The digital and technological challenge

It is about bridging the digital divide between generations, particularly in the context of information gathering (on goods and services) and communication that generates social interaction, that older people have suffered most from the distancing measures designed to prevent the spread of the SARS-CoV-2 virus.

Learning adapted to the capacities[56] of each person, even at an advanced age[57] requires intergenerational communication to meet the needs of remote communication with health professionals, service providers and administrations, as well as in the two worlds of work and

[54] In 2018, the OECD already estimated that in 2050, 77 people for every 100 of current working age would retire, compared to 30.6% in 2015 (https://www.oecd.org/economy/surveys/Spain-2018-OCDE-economic-survey/vision-general.pdf) and L. Gratton and A. L. Scott that half of European children had a life expectancy of 109 years (Gratton, L., SCOTT A., La vida de 100 años: « Vivir y trabajar en la era de la longevidad », Lettera, Bilbao, 2018).

[55] More than illness and even more than age, it is dependency that represents a high cost for society, according to the report of the National Observatoire National de la Fin de Vie, "la fin de vie des personnes âgées", Paris, la documentation française 2014, Observatoire national fin de vie 2013 Fin de vie des personnes agees | vie-publique.fr

[56] Variables based on personality, health status, level of compliance or resistance to change.

[57] Including the adaptability of the proposed system.

leisure. Digital technology is an amplifier of autonomy in decision-making and quality of life, but also a tool for multiplying new forms of solidarity.

Often linked to ICT[58], there are many new technologies for habitability: home automation (monitoring of activities and domestic devices), robotization to combat unwanted loneliness, digitalization of care: telemedicine, assisted imaging, health data monitoring (measuring vital functions but also detecting falls, discomfort and sleep disorders).

Humanoid robotization is on the way, it will probably improve quality of life, partially provide certain support aids and prevent, to a some extent, the loss of autonomy. However, this invasive perspective on the labour market still requires the harmonisation of practices and their regulation at an international level, given the unprecedented acceleration of innovation and development of such robots.

Certainly, robotisation, by supporting the ageing of workers well before their retirement, would allow the expansion and adaptation of their health, work and leisure capacities over time and, therefore, their autonomy within the social and family body. It will still be necessary to ensure that these machines integrate the principles and values in the decision-making process of their artificial intelligence, capable of replacing the no longer physical but cognitive capacities of humans, so as to respect the dignity, non-discrimination, equality and justice of users and guarantee them legal responsibility for their humanoid decision.

Finally, the digital and technological challenge has a cost that requires a regulatory framework for the legal protection of older people against possible breaches of trust by certain providers who show little concern for the frailty and vulnerability of their interlocutors.

The educational challenge is that of an intergenerational culture.

The challenge of education is, above all, to make people understand that ageing is an opportunity linked to life. Awareness of its increasingly slow evolution requires eliminating the distorting vision of the collective imagination about elderly who represent almost half of the consumer population of goods and services and, consequently, rethinking what justifies

[58] Information and communication technologies.

the welfare state and human rights for the well-being of the greatest human survival ever achieved.

From the earliest age, the parental and school education should converge to teach :

- solidarity with the most vulnerable people of all ages,
- that ageing is intrinsic to life and its finitude, that "ageing well" is conditioned by three factors: economic security, health, social and family participation
- altruism because everyone's well-being depends on intergenerational mutual support.

At a later stage, educational guidance should promote the value of personal assistance professions, their social scope and the attractiveness of rapidly evolving career paths.

Each age of life has its place in our society with its individual rights and freedoms, its direct or indirect capacity to exercise them and its duties of respect and intergenerational solidarity. The ethics of language invites us, in this educational framework, to reflect on all forms of discrimination and exclusion based on age and generation.

At any age, the acquisition of training (literacy) and information aimed at citizen participation in public debate is the foundation of ethical reflection and of the eventual transition from ethics to law. For example, given the evolution of old age, society must be able to legally guarantee the protection and security of elderly people who are particularly vulnerable for physical or cognitive reasons, even more so when they do not have the necessary means to survive with dignity.

The role of the media, while respecting freedom of expression, is to contribute to developing a positive awareness of ageing, of the real age of the person and of his or her old age. Obviously, this cannot be limited to the performance of a great age whatever the state of health of the person concerned, but can be interested, for example, in the reality of the social determinants of healthy life expectancy or that of extreme dependency and loneliness[59], which is silenced in the general public as an existential denial. Intergenerational culture should be able to benefit from media coverage of the true place of old age and ageing in an inclusive and supportive society.

[59] Loneliness alone increases the risk of premature mortality by 25 to 30% according to meta-analyses carried out in Europe and the United States.

If, to quote Nelson Mandela, education is the most powerful weapon to change the world, the level of education remains today the great source of social inequalities and, through it, of a significant decrease in life expectancy. The homogeneity of life expectancy in old age, unlike the average life expectancy of a population, is still too little analysed. However, it reflects equal access to what is often considered a universal right: education, a real challenge of ageing for future generations.

The development of intergenerational dynamics can be a response to the isolation and exclusion of older people, regardless of where they live (CCNE Opinion 128). Interactive experiences based on differences in age, health status, in the world of work or leisure can, in fact, induce solidarity in favour of the social integration of each other, thanks to the active and reciprocal contribution of the generations concerned.

Beyond the experiences mentioned above, it also allows the elderly person to exercise their rights directly with the possible help of a trusted person or third parties (guardianship, curatorship, judicial guardianship) who should be able to be required to have gerontological competence.

Intergenerational dynamics enhances the value of older people in relation to younger people, restores meaning to life, reduces loss of self-esteem and depression, and increases resilience for a new life or an end-of-life project.

Intergenerational dynamics depend on the gerontological competence of the elderly person's interlocutors, in addition to the time and availability of spirit requirements for authentic and reciprocal communication.[60]

It also requires information, training and support for social and health actors, for whom the notions of performance and financial profitability are, from an ethical point of view, socially acceptable means.[61] They justify promoting relational care and improving it through the interdisciplinary nature of prior reflection on complex decisionmaking[62]; the gain in objectivity will not fail to generate savings through less suffering in the work of caregivers, also to the

[60] This excludes a proportion of older people from remote surveys and, in particular, from telephone surveys (demographic and opinion) without possible non-discriminatory correction.
[61] For individual health improvement.
[62] Multiple pathologies, unwanted social isolation, situations of abuse and mistreatment that affect physical and mental integrity.

benefit of patients and their loved ones. In this context, home support professions deserve to be valued as much as those in specialized establishments for a financial attractiveness in line with the difficulty of care and the risks to which they are personally exposed. The same applies to promoting family help at home with dignity. This is the responsibility of the State, directly but also indirectly in new forms of citizen solidarity such as associative or corporate sponsorship.

The link between the present situation and personal history, which is strengthened with age by the memory of old events, is a favourable condition for actively listening to the words of vulnerable and more or less dependent elderly people. It establishes the participatory exchange essential for quality of life, respect for older people and their social reintegration. It therefore concerns the entire family and professional environment and the gerontological knowledge necessary to optimise the intergenerational communication with which it interacts.

3-4-3 Democracy and ageing

By placing ethics at the centre of the relationship between knowledge and power, Western democracies have developed a participatory citizen dimension to contribute to the reflection of national representation in its decision-making power as well as in its executive governance.

Information precedes public debate[63]. It is expressed through different ethical bodies at local, national, continental and international levels. Some are likely to produce binding texts[64]; others, the most numerous, are consultative and as such independent of political power and the courts in place.

Public debate, by integrating public participation, for the public and by the public, justifies the commitment of those who make political decisions to listen to them regarding the legislative

[63] A high-level Seminar on public debate was organised by the Council of Europe's Steering Commiittee on Bioethic in June 2019, followed in November 2019 by the publication of a guide for public debate on human rights and biomedicine https://www.coe.int/fr:web/bioethics/public-debate

[64]Oviedo Convention of the Council of Europe for countries that have ratified it.

and governance choices raised by technological but also societal advances, as illustrated in this report.

The CNBA report follows other reports outside our borders on the COVID-19 pandemic or on old age and ageing.

It is one of the first to draw on the lessons learned from the pandemic on the elderly to update an ethical reflection on the future place of ageing and old age in our Western societies: a contribution to the public debates that will follow.

It raises a number of questions about democratic governance, including the following four:

- Can the legal age still be based on the only chronological age limit for retirement, for representing the nation and, more broadly, for exercising freedoms and human rights?
- How to fight against unwanted loneliness, one of the greatest threats to public health[65] and how to raise society's awareness about attacks on the physical and mental integrity of vulnerable older people, in the same way as they are done against other groups such as minors and women, and even among women, in the face of the silence of the oldest, first carers of their spouse and then doomed to loneliness and social exclusion?
- How can we reorganize a public policy of transgenerational prevention of ageing and social protection of the most vulnerable and disadvantaged?
- How can we re-establish an intergenerational culture in our democracies, such as the place of the elderly in other cultures from Africa to the Far East?

[65] In terms of morbidity and mortality, far beyond other prevalent risks such as obesity, in the American Psychological Association, "So Lonely I Could Die," August 2017.
https://www.apa.org/news/press/releases/2017/08/lunerable-death

4- CONCLUSION AND RECOMMENDATIONS

The evolution of our society after the Age of Enlightenment and then industrialization (19th century) adapted in the 20th century to that of new technologies. The social advances that accompanied those of science led after the two world wars to an unprecedented human longevity despite the equally unprecedented danger to our planet. In line with our history, the great challenge of the 21st century will be both human ageing and the preservation of genetic diversity and its environment.

The COVID-19 pandemic is already teaching us that in the face of uncertainty, prior health and social planning is essential, as well as health literacy at all ages to combat disinformation from certain media, a source of fear, doubt and viral spread.

The primacy of the person is the common basis of the recommendations of this opinion.

The most immediate are considered to be :

- **Health**: no prioritisation is justified beyond strictly medical criteria to ensure equal access to care, regardless of age.
- **Social**: fighting against unwanted loneliness and poverty is an essential requirement in terms of social, economic, educational and cultural benefits, regardless of where one lives, by promoting, as far as possible, support at home across generations until the end of one's own life cycle.
- **Legal**: the exercise of the rights of the elderly person, like any other, must guarantee: protection from any situation of particular vulnerability, from any form of stigmatisation and discrimination such as that based on age, equal access to justice and to its « gerocompetence », the evolution of social rights with updated legal instruments for the protection of ageing, particularly in terms of retirement, health, housing, social inclusion and participation.

Preventing ageing is the cornerstone of an intergenerational society (and no longer just a multigenerational one), recommended as necessary and desirable by the CNBA.

By maintaining the capacities of each person from adulthood and for all affected generations up to the highly dependent generation, the prevention of ageing legitimises real age in relation to chronological age, allows the development of essential economic resources (Silver Economy), to reorganise the world of work and leisure, social protection and intergenerational solidarity.

Citizen participation in geroculture and public debate on *the elderly person, old age and ageing* contributes in solidarity to the democratic reflection of national representation and its governance, as evidenced in this report.

Reinventing **an intergenerational culture** within our Western democracies, inclusive, united and equitable, is the great challenge of the next three decades of our century.

III- APPENDICES

APPENDIX 1

The impact of senescence on the immune system

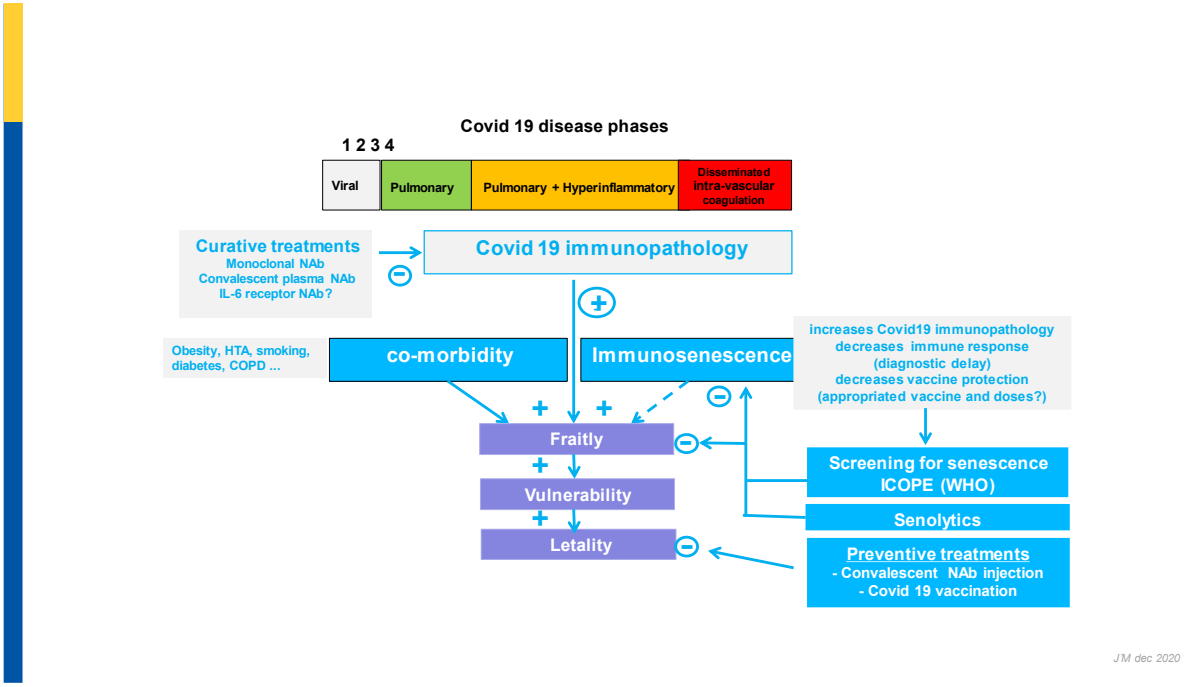
It is useful to remember that **cellular senescence** facilitates the programming of tissue development and healing while limiting tumorigenesis.

It is the pathological accumulation of senescent cells that induces age-related morbidity. They are a therapeutic target for **senolytics** promoting apoptosis (programmed cell death) or for **therapies inhibiting the secretory phenotype** (SASP: senescent-associated secreted phenotype). The cellular senescence induced by a virus such as SARS-CoV2 is becoming better understood, suggesting that senolytic targeting of cells infected by the virus could be a new therapeutic option for COVID-19.[66]

This table[67] illustrates the **dual impact of COVID-19 and senescence on the immune system and the current state of knowledge about possible therapeutic options.**

[66] Lee S., Yu Y., Trimpert J. et al, Virus-induced senescence is driver and therapeutic target in COVID-19, Nature. 2021 Nov;599(7884):283-289, https://doi.org/10.1038/s41586-021-03995

[67] Montagut J., la vaccination anti COVID-19 : :contribution éthico-scientifique, La vaccination anti COVID-19 : contribution éthico-scientifique (FR/EN) (fertilevision.fr)



Immunopathology of COVID-19 and Immunosenescence

The vulnerability of the elderly varies according to their level of frailty, their immune status and any co-morbidities they may have, as well as their living conditions, social environment (housing, nursing homes) and economic situation (precariousness, resources). The clinical presentation of COVID-19 in the elderly is often atypical: with few symptoms, misleading because of polymedication, poor communication because of isolation and, in the event of a prolonged stay in a COVID-19 care service, a lack of geriatric culture with the risk of limited access to care, inadequate nutrition and a delay in motor and muscular recovery after the acute phase.

The impact of senescence on the immune system (respiratory and other vital organs) justifies the vulnerability of the elderly person considered as a separate entity, assessed on a case-by-case basis in the management of COVID-19. Numerous studies have suggested that senescent cells can also bypass innate and adaptive immune responses. Senescent cells develop a senescence-associated secretory phenotype (SASP) by which pro-inflammatory cytokines and chemokines are secreted. As shown in this figure, immunosenescence can exacerbate the immunopathology of COVID-19.

.

Such changes in immune competence with a higher inflammatory prevalence may explain an increased tendency to the cytokine storm, a source of pulmonary fibrosis and respiratory distress as well as disseminated vascular hypercoagulation (Huang 2020) and by it, a singularly high lethality rate of COVID-19 (Salje 2020). Similarly, a strong immune stimulant can overwhelm the immune system in the most vulnerable patients affected by multi-morbidity, for example during the cytokine storm of the acute respiratory distress syndrome of COVID-19 in adults. More often than not, immunosenescence reduces the immune response and its clinical symptomatology, as well as vaccine protection, as studies have already shown in the case of influenza.

Appendix 2

Biological ageing markers that could be explored by geroscience

- **genome instability,** with the accumulation of somatic DNA mutations (B lymphocytes, neurons, etc.) whose loss of repair mechanism efficiency promotes biological ageing. The reliability of their quantification is currently being studied.
- **telomere shortening,** the measurement of which today has little clinical relevance
- **Epigenetic clocks**, which deviate from chronological clocks: DNA methylation, histone modification and non-coding RNA, form the basis of developmental theories in which epigenetic mechanisms refine the genetic programme very early on, from the prenatal period, so that it can adapt to environmental challenges. Transcriptional modulation under the influence of epigenetic changes adapts the phenotype and, if ineffective, can lead to an ageing phenotype.
- **mitochondrial function,** which is involved in regulating cell metabolism, in particular apoptosis (programmed cell death): this is a powerful biomarker of biological ageing, whose measurement is not yet applicable in clinic
- **Cellular senescence** is triggered by the mechanisms described above in response to stress. It develops a secretory phenotype (SASP) which, amplified by the accumulation of senescent cells, leads to tissue degeneration and dysfunction, for example in specific age-related degenerative diseases. The means of quantifying it are the source of active research as well as for « senolytic » treatments or senotherapy. Numerous studies suggest that senescent cells, although immunogenic, can bypass innate immune responses and (not without consequences for vaccines). Nevertheless, in vivo treatment with a strong immune stimulant can probably overwhelm the immune system of an elderly person, as in the case of the cytokine storm observed in patients developing a severe form of COVID-19 with acute respiratory distress syndrome, the main cause of mortality among severely affected persons. This element should be taken into account in the indication for certain anti-COVID-19 RNA vaccines.

- **Autophagy** is an essential function of proteostasis, and the deficiency of which contributes to immunosenescence. Although it is currently the subject of complex analysis, it appears to be modulated by therapeutic agents.
- **depletion of stem cells**
- **detection of nutritional dysregulation,** through the perception of intracellular and/or extracellular nutrient signals, through signals induced by insulin IGF1, mTOR or AMPK. For example, a high-fat diet stimulates cell senescence.

Appendix 3

Outline of the key points common to all the hearings

The course of the pandemic in Andorra

1er quarter and half-year 2020

- Before confinement
- During confinement

Continuation of waves during confinement

- In 2020
- In 2021

Existing structures

- Involved during confinement
- After confinement

Impact of the pandemic on residential institutions for

- the elderly
- caregivers
- families

Impact of the pandemic in living areas for

- the elderly in their own homes
- caregivers and carers
- the volunteers
- families

the question of prioritization

- sanitary
- social

impact of pandemic on resilience

- the elderly
- nursing staff
- families

the consequences of pandemic and its initial lessons

- after-effects
- communication with the elderly

- perception of age
- prevention of ageing
- the social integration of older people and their resources

Auditee codes : preceded by A (audited) in the text of the report and its appendices, according to the order of the hearings.

Eva Heras (1)

Centres et Résidences :

El Cedre : Maria Anglada (2)

Salita : Marta Saiz / Patricia Morais (3)

San Viçens : Cristina Burillo /Sophie Lelievre (4)

Clara Rabassa : Erika Mengual (5)

Primary care centers : Sarah Pie (6)

Organisations and associations :

Red Cross : Carine Leclerc (7)

Federation of Associations of the elderly : Felix Zapatero (8)

CRES : Joan Micó - Aura Trifu (9)

Municipalities :

Canillo : Miquel Casal (10)

Ministry of Social Affairs

Montse Gil (11)

Social worker

Thaïs Segura (12)

Appendix 4

Scientific surveys (social, health, media), which involve inadequate means for the elderly, are not very usable and a source of interpretative errors

Through regular surveys, **the CRES Andorran Observatory** measures changes in the perceptions of the Andorran population, particularly on topical issues. The CNBA looked at the surveys carried out in 2020 and 2021 (July and November 2020 – April and October 2021), the observatory period linked to the pandemic. The people questioned by telephone were chosen at random (around 750) from Andorran numbers and according to 4 age groups: 18-29; 30-44; 45-64; 65 and over.

This remarkable work and its follow-up for the population as a whole covers, among other things, confinement, the impact of the pandemic and its individual, family and societal consequences, the impact on personal life and habits, mood and mental health, and the economic situation. The data collected was very useful to the CNBA working group and could serve as a guide, but it should be stressed that the return of people over 65[68] is, however, difficult to interpret in the last age bracket for the following reasons: the small number of respondents (120), whose distribution in relation to the demographics of Andorra could have led to a subdivision of this bracket into 2 or 3, the selective bias linked to the use of the telephone and calls made exclusively at home, and the risk of misinterpreting certain data.

For example:

- the fear of contamination among ≥65 years old in November 2020 rises from 11% to 25% in October 2021, even though vaccination probably protects the majority of them individually and the survey also shows that they have been less affected by Covid 19 than all other age groups.

[68] Only people living at home were interviewed; those living in residences were not subject to the CRES surveys.

- The assessment of the psychological impact of the pandemic, based on anxiety and depression tests, showed that people aged ≥65 years were the least affected, which raises the question of telephone selection bias, the small number of people involved and, above all, an approach similar to that used for other age groups, in terms of presentation time, comprehension and response.

Although this is a small sample, trends can be observed and, very humbly, conclusions can be drawn, although they are outside the competence of the CNBA working group.

It was with great interest that the working group was able to exchange views with Joan Micó, Director of CRES and his collaborator Aura Trifu, during a particularly instructive hearing based on concrete examples, and to agree together on **the awareness, reinforced by the pandemic, of integrating a change in the social vision of ageing and in the viewpoint given to the necessary knowledge of the person of advanced age**, particularly in its psychological and socio-economic aspects.

To quote Joan Micó, "we need to work on the approach to elderly in order to **objectively collect the authentic reality of the data with interviewers trained in dialogue with older people.**"

The CNBA working group proposed **a survey**, using a written form, on the experience of the pandemic by people aged ≥ 65 years, divided into 4 age groups: 60-69 years; 70- 79 years; 80-89 years; > 90 years. We present here the results for a homogeneous group in the waiting room of a geriatric consultation (El Cedre). In addition to the results based on a sample too small to draw any conclusions, it enabled us to assess the characteristics required for this type of work: clear and appropriate wording of the questionnaire, face-to-face support if needed, a choice of answers and the possibility of free text, etc.

It concerns 28 patients who answered a questionnaire about their feelings of confinement according to age group, sex and place of residence during this period.

The responses are relevant, and the small number of people involved means that we can take a qualitative approach to the results, with the following trends enriching ethical reflection, in a way that complements large population surveys, because it focuses on the person as an individual and in a geriatric context.

Two items offer quantitative scoring. The lack of response increases with age (70% after 80 vs. 30% before 80). This could be explained by a lack of support or prior explanation for more complicated learning after the age of 80.

1- Perceived change in health :

1-1 Nutritional disorders were uncommon: 6 weight losses, including one anorexic out of 27 (22%), and 3 weight gains in women.

1-2 Walking difficulties and accidental falls increase from the age of 70 onwards over the other 3 age groups: for walking difficulties 5 men including 3 at home including one aged ≥ 90 years - 3 women, in a centre including one aged ≥ 90 years, for accidental falls 2 men including one with walking difficulties, at home and aged ≥ 90 years – 4 women including one with walking difficulties, in a centre and aged ≥ 90 years.

1-3 The most frequent cognitive disorders were memory and temporo-spatial disorientation: for memory (11/27: 41%), 80% of whom were under 80, 7 men vs. 4 women, with a balanced distribution according to place of life - for temporo-spatial disorientation (12/27: 44%), 67% of whom were under 80, 6 men vs. 6 women and 5/6 of both men and women living in the centre. For the other behavioural disorders, **mood changes** were balanced between men and women, and between the different age groups, and mainly concerned residents (13/14). **Agitation** was rarely mentioned (5/27: 18%). **Insomnia** was also rarely ticked (6/27: 22%) (which seems to decrease after the age of 80 and to affect more men than women, but the number of respondents was too small).

2- Perception of feelings :

Psychological disorders were most frequently found among residents: sadness (16/27: 59%) (12/16 in centre: 75%), **anxiety** (14/27: 52%) (10/14 in centre: 71%), **feelings of abandonment** (12/27: 44%) (10/12 in centre: 83%), **fear** (10/27: 37%) (8/10 in centre: 80%).

Emotional lability (9/27: 33%), aggressiveness (10/27: 37%), anhedonia and abulia (5/27: 18%) (ticked off by the same people, associating them with all the other psychological disorders except fear (2 times/5)) do not allow us to draw any proposals for reflection except in **certain associations** such as

- 10 women vs 2 men associate sadness with anxiety
- 7 women vs 2 men associate sadness with feelings of abandonment and fear
- Aggressiveness is associated with feelings of abandonment (7/10), emotional lability (6/10), sadness (5/10) and fear (4/10), with a balanced distribution between men and women, except for fear, which was felt twice as often by women than men in the survey.

3- Perception of what helped most during confinement

3-1 The naturally more numerous face-to-face visits in residential homes were marked by a lack of response, 5 times out of 18. Homebound elderly people suffered most from isolation and inadequate support, with conversation limited mainly to telephone calls from family.

3-2 The most reassuring presence :

In residence: carers (10/18: 55%) - relatives (5/18: 28%) - family (3/18: 17%)

At home: 2/6 no response - family (3/4: 75%) - carers (2/4: 50%)

At home family: family (2/3) and one no response

3-3 The most beneficial activity during confinement

Regardless of age group, **cognitive activities** (reading and other activities) were chosen by 75% of men and 86% of women (difference not significant given the small number of cases). The second activity was being **accompanied by** family or a loved one and/or health-carer, as the confinement of the volunteers excluded face-to-face contact. **Motor activities** accounted for 39% of all responses (11/28: 39%). Unsurprisingly, the distribution varied significantly depending on the place of living.

During periods of confinement, this underlines the importance of face-to-face support from healthcare staff, maintaining cognitive activity and taking into account the decline in

appreciation of the benefits of motor activity with age, particularly after the age of 80 and in residence (compared with the home).

3-4 Assessing the presence of an animal in the home

It may come as a surprise. In residential homes, people did not see the benefit, perhaps because of a lack of experience (17/18 did not answer the question, compared with 2/9 living at home or with a family). Only one respondent living with a family expressed a benefit, and the few others (7) saw no difference between having or not having a pet.

To conclude,

It is not up to the CNBA to carry out such investigations. It has neither the means nor the competence to do so. Looking at what has happened in most Western countries, he points out that the emergence of the pandemic has meant that medical and social energies have taken precedence over public health in the field of gerontology.

To a certain extent, this situation justifies the CNBA's approach.

Annexe 5

Conditions and prerequisites for retirement in Andorra (June 2023)

A retirement benefit can be requested from the age of 65 under the Old Age Insurance. Exceptionally, from the age of 61. In this case, we could consider that there is no age limit.

The economic benefit for retirement may consist of:

• Either an old-age pension through a life annuity (the usual solution for a life annuity)

• Or retirement capital (exceptional).

In both cases, it is not granted automatically, since an express request must be made to the **Caixa Andorrana de Seguretat Social** (CASS). This parapublic entity has the essential mission of ensuring the administrative, technical and financial management of the Andorran social security system, under the control of the government. (Law 17/2008, of October 3, on Social Security).

1-Lifetime retirement pension

1-1 Requirements to obtain it

• Be at least 65 years old and have contributed for at least 15 years (until 2015 it was only 12 years)

• Be over 61 years old and have 40 years of contributions.

In addition, there is an international agreement between Andorra, France, Spain and Portugal that takes into account in this calculation the period of contributions in any of these three countries. The payment of the benefit is distributed over time in each country.

1-2 The contribution and distribution system

Contributions are paid monthly to the CASS both for employees and for those who are self-employed.

Employees contribute 22% of their total salary base, of which 6.5% is paid by the employee and 15.5% by the employer. The distribution of this 22% is divided into 12% for the retirement branch, i.e. retirement pensions, and 10% for the general branch of health and disability benefits (temporary or permanent).

Self-employed persons or independent workers (independent professionals or businessmen) pay contributions according to the level of pension and turnover based on a percentage of 25%, 50%, 62.5%, 75%, 100%, 125% and 137.5% of the average global monthly salary of the previous year published by the government (for example for the year 2022: €2,284.67 for monthly payments).[69]

1-3 Calculation of the pension amount

This is done through a complex calculation system (according to article 200 of Law17/2008, of October 3, on social security[70]).

Basically, the system works by **acquiring points** that are obtained by paying monthly contributions. The greater the number of points, the higher the amount of the retirement pension.

The value of the points is set annually by the CASS

This calculation system has been modified on several occasions in recent years, but the result has always been reflected in a retirement pension of a generally lower value. There is no maximum limit for the amount of the pension, but recently, for high pensions, progressive correction factors have been introduced that go downwards.

The result is that pensions are now more equal and generally lower than before.

[69] Decree 37/2023, of January 20, 2023. Butlletí Oficial del Principat d'Andorra (BOPA), número 11 any 2023 www.bopa.ad
[70] www.portaljuridicandorra.ad

2- Retirement capital for old age (according to articles 195 and 197 of Law 17/2008, of October 3, on Social Security.)

It consists of reimbursing the insured for the contributions made for retirement, at the amount updated with the **CPI** (consumer price index) during the two years prior to the application.

Prerequisites:

• Be 65 years old and have contributed for between 5 and 15 years

• Be entitled to receive a retirement pension equal to or less than the official minimum wage (currently, for the year 2024 it is set at €1,376.27 per month).[71]

3- Early retirement pension (before age 65)

It is possible to opt for early retirement but it is incompatible with working or carrying on a profession or business.

Prerequisites:

• Be over 61 years old.

• Have paid contributions for a minimum of 40 years.

• Not be registered with the CASS as an employed or self-employed worker.

Calculation of the pension:

• It is applied with a correction coefficient of 7% for each year or part of an application made until the age of 65.

• The amount obtained is maintained for life. (According to article 202 of Law 17/2008, of October 3, on Social Security).

[71] Decree 577/2023, of December 20, 2023, fixació del salari mínim interprofessional per a l'any 2024. BOPA núm. 156, 2023 www.bopa.ad

4- Delayed retirement pension (after age 65)

This consists of continuing to pay contributions to the general branch **and** the retirement branch until effective retirement. That is, continuing to work or carry out a professional or business activity from age 65.

There is no maximum age limit.

At the time of effective retirement, the person can assert his or her right to retirement according to the contribution points he or she has at that time. (according to Article 204 of Social Security Act 17/2008, of October 3, 2008)

5-The compatibility of receiving a retirement pension with a work activity

Once the insured person reaches the age of 65, he or she may continue working as an employee or as a self-employed person

- unless they are in receipt of an early retirement pension
- unless they are entitled to a disability pension. In the event of disability, the pension is automatically converted into a retirement pension (of a lower amount). (according to Article 205 of Social Security Act 17/2008 of October 3, 2008)

6-Reference to labor legislation.

Legislative changes in retirement have led to changes in labor regulations.[72]

• The employment contract automatically expires when the worker reaches retirement age that allows him to apply for retirement (65 years), unless the pension does not reach the economic threshold of social cohesion (set by the State based on the assets and income of all the members of the family nucleus).

• The worker and the employer may agree on a new employment contract that does not imply the continuity of the previous contract (previous seniority does not count, with the special

[72] Articles 29 and 83 of Law 31/2018, of December 6, 2018, on labour relations.

mention that severance pay is not taken into account for redundancy compensation purposes ; the salary does not necessarily have to be the same).

• The new contract may be accompanied by different conditions (for example: part-time or reduced working day).

• The new contract may be with another company.

• The new contract must necessarily be for a period of 1 year, extendable with the agreement of both parties (in practice it eliminates severance pay without cause).

• Contributions are only paid for the general branch (10% of the total salary), not for the retirement branch.

7 - Social assistance (July 2023 - A12)

As retirement pensions are not currently very high, there is a system of social assistance in cases of need, as determined by the relevant social services.

Andorran residents can receive socio-economic assistance and/or support when they retire and in the event of illness or vulnerability.

7-1 Long-term care insurance

It comes under the social and health services of the Department of Social Affairs, in accordance with Law 6/2014 of April 24, 2014. This law defines the conditions for benefits for the elderly, after assessment of their dependency and/or disability by multidisciplinary committees such as COVAS (social and health assessment) and CONAVA (disability assessment)[73]

Residents in Andorra have health cover based on the co-payment between the CASS (Caixa Andorrana de Seguretat Social) and the insured person. The level of cover varies according to the nature of the treatment[74]. It may be necessary to take out additional insurance. For certain particularly costly illnesses and/or those with insufficient financial resources, health cover is 100% (third-party payment).

[73] whose composition does not a priori include a family representative

[74] around 90% in hospital, 75% in outpatient care, 65% in rehabilitation

In the case of family reunification, the Immigration Service requires the person being reunited, who is usually over 65, to have private insurance to cover costs in the event of illness or because of their state of health. In such cases, they cannot benefit from CASS cover.

7-2 State aid for the elderly or their family/close carers

According to Law 6/2014, of 24 April, three situations objectify the government's economic performance:

- Solidarity pensions, in the event of a lower level determined by the government in terms of assets and personal and/or immediate family resources
- family allowances for dependent children (related to certain elderly people)
- occasional financial aid

Occasional financial assistance is temporary personal or family assistance, sometimes definitive with annual or periodic renewals, to meet basic needs and prevent marginalization, avoid exclusion and promote autonomy. In this case, neither the person nor the family nor other social protection benefits have sufficient economic resources to deal with the situation for which the application is made.

The law provides for other types of services for families, such as the use of RESPIRO spaces, day centres and areas dedicated to the elderly, where they can share care time with other people and dedicated professionals, while retaining their usual place to live, in their own home or that of their loved ones, and also in a residence.
Other benefits are provided by law, free or co-paid depending on the socio-familial and economic situation of the beneficiary or obliged family members to do so. They are assessed by the social and health services. They concern primary care - the SAD home care service provided by the State, which offers support of a high human quality, but whose demand exceeds the availability of time and people - TAD (Télé Atenciò Domiciliàra) home care provided by the Andorran Red Cross, which can detect, prevent and act in emergency situations - the Day Centre offering daytime support to the elderly and their families (Cura i

atenciò), for which the possibility of extending the hours of coverage and offering this service at weekends is being studied.

7-3 the ethical issues involved in social and family support for the elderly

The ethical considerations that emerged from the various hearings (A6-A7-A10-A11-A12) concerned families or close relations who are prepared to contribute to the "Cure & Care" of the elderly person in their usual place of life, provided that they do not lose their fundamental rights and their professional status, through financial and/or tax measures to compensate for the loss of all or part of their professional activity. They legitimize the representation of families in decision-making bodies.

In this respect, the necessary allocation of resources is all the more important in the context of societal remodelling for demographic, economic, social and cultural reasons[75]. A real challenge for humanity at the dawn of the third decade of the 21st century.

[75] developed in this report

Appendix 6

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Appendix 7

Abbreviations

CASS : Caixa Andorrana de Seguretat Social

CNBA : Comitè nacional de bioètica d'Andorra,

CCNE : Comité national d'éthique pour les sciences de la vie et la santé

CDBIO : Comité Directeur pour la Bioéthique dans les domaines de la Biomédecine et la santé du Conseil de l'Europe

IBC : International Bioethics Committee - UNESCO

CoE : Council of Europe

CONAVA : Comissió d'Avaluació de la Discapacitat (Andorra)

COVAS : Comissió d'Avaluació Sociosanitària (Andorra)

CRES : Centre de Recerca Sociològica de l'Institut d'Estudis Andorrans

DVA : Directives volontaires anticipées

ICOPE : Integrated Care for Older Persons

INE : Instituto nacional de estadistica (Espagne)

INSEE : Institut national de la statistique et des études économiques (France)

LGA : Local government association (Royaume-Uni)

OECD : Organisation for Economic Co-operation and Development

SAAS : Servei andorrà d'atenció sanitària

SASP : senescent-associated secreted phenotype

UNESCO : United Nations Educational, Scientific and Cultural Organization

UE : Union européenne

WHO : Word Health Organization

Appendix 8

Composition of the working group

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Unanimously approved at the meeting of the Comitè Nacional de Bioètica d'Andorra, in extraordinary session on April 8, 2024

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