A PUBLIC HEALTH ETHICS FRAMEWORK FOR THE GERIATRIC COMMUNITY: A SOUTH AFRICAN PERSPECTIVE

BY

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SUBMITTED IN FULFILMENT OF THE REQUIREMENTS IN RESPECT OF THE DOCTORAL DEGREE IN COMMUNITY HEALTH IN THE DEPARTMENT OF COMMUNITY HEALTH, FACULTY OF HEALTH SCIENCES, UNIVERSITY OF THE FREE STATE

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DEDICATION

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to Hanlie

If the cello has no string it will fail to sing,
if a man has no love he will fail to live through the day - Parrish Toppano, Royal Falcon.

VOTE OF THANKS

Vivat Academia,
Vivat Professores,
Vivat membrum quodlibet,
Vivant membra quaelibet,
Semper sint in flore!
(Gaudeamus igitur)

In 2017 I completed a project on doctoral studies published as "*Get ready, Get set, Go! Preparing for your doctoral studies and doctoral education*" (Lategan, L.O.K, [Editor]. 2017. Bloemfontein: SUN MeDIA). Ever since then, I have wondered how "user-friendly" these guidelines actually are to potential and current doctoral students.

My participation from 2017 to 2019 as a member of the Doctoral Degrees Reference Group drafting the Qualification Standard for doctoral degrees for the Council on Higher Education added to my curiosity on the attributes that should be gained during a doctoral study.

When I was granted sabbatical leave during 2017, I wanted to do more than simply travel and write a paper. Prof. Gert van Zyl planted the seed in regard to this study. Since then he and Prof. Willem Kruger have acted as dedicated supervisors. Their professional and scholarly support were invaluable in bringing this study to conclusion. My heartfelt appreciation for offering me the opportunity to be your student! Much appreciated.

I began this study on 1 July 2017, and it is around the same time in 2021 that I can present the summative results.

As no man is an island, so no study is completed in isolation.

Prof. Antoni Szubarga did the data analysis and discussed the information deriving from the data analysis. Ms Nanette Lötter performed the language editing. Ms Elmarié Robberts assisted with the lay-out of the thesis. Your "frontline" support is indispensable.

Without the voluntary participation of the identified geriatric institutions the data sampling would not have been possible. This, too, is proof of the importance of learning from practitioners the art of one's discipline.

I am indebted to my *alma mater* for taking me on as a student, and to my employer, the Central University of Technology, for supporting this study financially.

I have learned much from colleagues and students – you are invaluable as "teachers!" I am forever grateful to my promotors in Philosophy (Profs Kobus Smit & Danie Strauss) and Theology (Profs Pieter Potgieter & Johan Janse van Rensburg) whose advice to "build an argument" has remained with me. I am also appreciative of my mentor Prof. Roger Burggraeve who taught me to think beyond my own paradigm.

This study was conducted during a time of personal loss with the passing on of my mother, Marie, who introduced me to "geriatric care". The COVID-19 pandemic made me realise the vulnerability of the geriatric community. I believe we should always treat our elderly, whether young elderly or old elderly, with respect and dignity. Through this study I would like to ameliorate their vulnerability at least in the way public health is offered to them.

During the course of this study I recalled fond memories of my parents, Colin and Marie Lategan, and my parents-in-law, Jurie and Christie Nel, from whom I also learned about growing old with dignity.

In my personal life there is an inner circle. I am humbled by the meaning you are adding to my life.

Then to my tutor, Hanlie, who cares beyond each day: my sincere gratitude and appreciation!

Soli Deo Gloria!

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ABBREVIATIONS

COVID-19	2019 novel Coronavirus
EU	European Union
GDP	Gross Domestic Product
GHSs	General Household Surveys
HSREC	Health Sciences Research Ethics Committee
PCA	Principal Component Analysis
RSA	Republic of South Africa
SDG	Sustainable Development Goals
SPSS	Statistical Package for the Social Sciences
WHO	World Health Organization

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ABSTRACT

At the end of her tenure (2007–2017) as Director-General for the World Health Organization (WHO), Margaret Chan (2017) published a report on the developments in public health during this period. She emphasised the growing role that social determinants can play to improve public health. The new thinking is that social determinants, and not physical challenges only, contribute to health.

The downside of her comment is that social factors can also negatively influence quality of health and well-being of communities. Such a negative impact will increase the vulnerability of a community.

Ethical challenges are often associated with vulnerability. This is particularly evident in the geriatric community.

A growing ageing and consequently an elderly or geriatric community will place more demands on the already challenged social and health services. This, in turn, will put more strain on the geriatric community. Statistics from the WHO's *World Report on Ageing and Health* (2015) suggests that the world population older than 60 years will nearly double by 2050. This is a global phenomenon. The 2020 South African Mid-year Population Estimates Report approximates the people older than 60 years to be 9.1% of the population. This Report states that the population 60 years and above increased by 1.9 million people from 2002 to 2020. This growth represents an increase of 1.1% for the period 2002 to 2003, and 3.0% for the period 2019 to 2020.

A review of literature relevant to the geriatric community obtained from databases such as Science Direct, Proquest, Taylor and Francis, Sabinet African Journal Collection and relevant National Department of Health policies, strategies and plans, suggest the apparent absence of a public health ethics framework for the geriatric community.

The perspectives originating from the literature led to the research question for this study: *What are the important ethical aspects to consider for a public health ethics framework for the geriatric community in the South African context?*

This study was based on a literature review as part of a qualitative method and the Q-methodology, which is qualitative in its information collection and data sampling but

quantitative in terms of the method of analysis. Six geriatric institutions, two each from the Free State, Northern Cape and Northwest Provinces, participated in the data collection for the study. A questionnaire (Q-sort table) was completed, comprising 50 statements (Q-set) which were ranked (Q-sorting) by the twenty-two participants (P-set) from the six participating institutions. The collection of data derived from the ranking of statements was representative of three indexes:

(a) an Index of Social Determinants (Questions 1 – 20);
(b) an Index of Public Health Ethics (Questions 21 – 35); and
(c) an Index of a Public Health Ethics Framework (Questions 36 – 50).

The data collected from the ranking of statements was analysed using the Statistical Package for Social Sciences software. Information was produced based on the interpretation of the data against the literature review presented in Chapter 1. The research results are discussed in Chapters 2 – 4.

From **Chapter 2** it is evident that the lack of sufficient healthcare provision and the quality of healthcare provision are social determinants impacting negatively on the geriatric community's health. These social determinants contribute to the ethical challenges experienced by the geriatric community.

Chapter 3 addresses the question of what public health ethics implies for the geriatric community. Working with the geriatric community, the ethical principles of (a) respecting their vulnerability and fragility, (b) protecting their lives from abuse and neglect, and upholding dignity, (c) securing a safe environment to live in, and (d) providing quality access to healthcare and provision, were identified as the ethical basis of public health for the geriatric community. The chapter concludes that *public health ethics is the application of ethical principles through a professional ethic resulting in care and relationship building.*

In **Chapter 4** eight building blocks are identified that were used in the development of a framework for public health ethics. These building blocks are:

- Promote the core value of public health;
- Identify the principles for public health ethics;
- Recognise ethical challenges for agent and recipient of service;
- Advance ethics leadership;

- Introduce ethics education;
- Promote social justice;
- Develop ethical expertise; and
- Practise care ethics.

In **Chapter 5** an integrated public health ethics framework for the geriatric community is presented. The perspectives presented in the literature review (cf. Chapter 1), the perspectives developed on social determinants having an impact on the geriatric community (cf. Chapters 1 & 2), and the ranking of statements (cf. Chapters 2 – 4) contributed to the development of a public health ethics framework. Based on the ranking of statements, building blocks were identified that contributed to the public health ethics framework for the geriatric community (cf. Chapter 5). These building blocks contributed to a public health ethics framework, and were grounded in normative and applied ethics and linked to virtue ethics, deontology and consequentialism. Four questions associated with ethics were posed to explain the application of the framework. These questions also assisted with the alignment of the building blocks to the basic purpose of public health, namely the organised strategies, interventions, and services to improve the health and well-being of the community or population. The questions are:

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

Keywords: Ageing; Ethics; Care ethics; Professional ethics; Geriatric community; Public health; Public health ethics; Social determinants

"Ethics is an intellectual activity; it is the result of careful consideration."

Anton van Niekerk (2020, translated)

PREFACE:
ACCOUNTABILITY AS ETHICS SCHOLAR

As a scholar of ethics, my understanding and research in the field of ethics were very much influenced by former studies in philosophy and theology.

As philosophy scholar my orientation was informed by Herman Dooyeweerd's Cosmonomic Philosophy, based on the 15 modalities of existence. Ethics is one of these modalities. In Dooyeweerd's philosophy, the core basis of ethics is defined as *moral love* (Dooyeweerd, 1984 & Smit, 1985).

Through Reformed Theology, "moral love" was better understood as doing to others what is right. "Doing" refers to activity*,* and "right" is the opposite of wrong. In the ethics lexicon this means that no harm shall be done to others. The influence of Joachim Douma and Willem Velema was evident. Responsibility became a central feature in my ethical thinking (Douma, 1983 & Velema, 1976).

A study in business ethics extended my understanding of ethics to include responsible decisions, as articulated by Joseph Badaracco (1998). He emphasises the difficult choices, based on personal values and commitments that the individual has to make.

Thanks to Roger Burggraeve, a Levinas scholar of note, I was introduced to care ethics, which focuses on ethics in everyday situations and growth ethics, accenting the ethical growth to the ideal situation (Burggraeve, 1997). *Ethics should take you from where you are to where you ought to be*.

It was especially the focus on "decisions" that broadened my view that ethics is not only a set of principles, but also a consideration of how to *identify* and how to *apply* the identified principle. What is more: the application of principles should be evaluated. The emerging question is therefore whether the best principle has been identified for the situation. This approach to ethics resonates with the well-known questions in business management and leadership, amongst others: *Are we doing things right?* and *Are we doing the right thing*? With this orientation the alignment of the three branches of ethics, namely virtue ethics, deontology and consequentialism, were adopted into my own ethical practice.

These studies and observations contributed to an enriched understanding of ethics as the

identification of ethical principles for a situation or activity to address or prevent an ethical dilemma.

From this orientation to ethics, it was evident that ethics is based on ethical principles which are universally accepted, and require action to identify (an) appropriate principle(s) for a situation or activity. Identification, as action, is influenced by life orientation (worldview) and a belief system. The purpose of ethics is to address or prevent an ethical dilemma. Ethics adds value creation by changing the prospects of an ethical dilemma.

My initial interest was on the compromise in ethics as the choice between the lesser of two evils in a borderline situation (Lategan, 1992 & 1995). The fields of application were medical ethics, bioethics, and pastoral ethics.

Since 2011, the focus of my research in medical ethics and bioethics has been extended to healthcare ethics. The primary reason was to look more attentively at ethical challenges within health systems, practices and approaches to health. The shift was further guided by observing that ethics, in general, is often limited to identify broad-based principles for a situation without addressing the possible impact that the application may have on a situation.

This resulted in a more comprehensive, multi-focused view of ethics as outlined below.

First, applications of principles can result in new ethical challenges (issues) which can, in return, lead to ethical dilemmas (choice between conflicting ethical requirements). As an example: the value of life is always regarded as an ethical principle. Hence, active euthanasia or euthanasia on request was declined. Assisted ending of life opened the debate on quality of life, own decision making and autonomy of personal decisions. Principles must be doable and implementable.

Second, especially from a religious perspective, ethics is often regarded as a final judgment. "Thou shall not kill" is used commonly to deny the right to active euthanasia. The claim is that life should always be protected. Palliative care, however, supposes no activity to prolong life but rather to comfort the person. Palliative care can be regarded as an extension of the obligation to protect life although it has a different objective.

Third, the application of ethical principles should address the ethical dilemma but at the

same time offer opportunities of *growth*. Decisions are taken to address ethical dilemmas, hence there are situations of imperfection. The question is what is learnt from this situation and how can someone be supported to gain ethical intelligence to address ethical dilemmas in future? Ethical decisions do not always have "happy endings".

Fourth*,* ethics should deal with *vulnerability* to contribute to *social justice.* The concept of vulnerability is often reserved for application to groups such as women and children, older people, handicapped persons and refugees. Vulnerability is also due to weak healthcare systems, lack of finances, lack of communication and lack of access to (and affordability of) healthcare. A changing society, value and belief system and life and world orientation can further contribute to vulnerability.

Fifth*,* care ethics offered the opportunity to develop relations, roles and responsibilities when dealing with ethical matters. An important pointer is *engagement* with people and the situation. In healthcare, engagement understood as shared lived experiences, is often absent. Care ethics will assist in avoiding power relationships and domination. The challenge is to meet *respectfully* the care receiver in his/her context.

Six*,* challenges to ethics cannot be limited to the care receiver only but should also be extended to the caregiver. This perspective was enriched by Glouberman and Mintzberg's (2001) four quadrant views on the world of health, namely *cure* (doctor), *care* (nurses, therapists, general healthcare workers), *control* (managers) and *community* (support networks, pharmaceutical developers, technologists, and more) as they all contribute to offering a professional and quality service. This insight assisted in advocating the important role of medical humanities and coaching within healthcare. To this insight, professional ethics and integrity can also be linked.

Seven, ethics must be managed. This claim is based on the application of ethical protocols and decision making to improve the integrity of the situation. The question is what will be the outcome of the decision taken? Notably influenced by my profession as research manager, there is a necessity to ask what the value is of applying ethical principles. *What difference will it make*?

This wider look at ethics assisted me to identify more central themes relevant for ethical discourse.

While I am aware of the comprehensive meaning and influence of Beauchamp and Childress's (2013) basis for bioethics, *autonomy, beneficence, non-maleficence* and *justice*, also known as the "Georgetown mantra", more ethical principles should be added to healthcare workers' vocabulary when dealing with ethical challenges outside medical ethics and bioethics. Although implied by the above principles, specific focus should also be on:

- Do no harm;
- Dignity of person and relevance of situation;
- Care for all;
- Respect;
- Professional workplace behaviour; and
- Integrity of decision and application.

Since early childhood I have gradually become aware of the many challenges of the geriatric community. Without really understanding it then, an intuitive interpretation was that doing right to the elderly requires more than merely providing somewhere to stay or food and drink. It was only at a later stage in my life, with the realisation that generations come and go (Lategan, 2017), that I became aware of how powerless the geriatric person is. This sparked the idea of this study.

This study should be viewed in the context of the broad-based understanding of *ethics as identifying principles to prevent or address an ethical dilemma.*

The ethical foundations of this study will be further debated against the background of my multi-focused understanding of ethics in healthcare. The Georgetown mantra and extended principles will be the basis to depart from.

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Health research without a link to daily practice remains fruitless.

H.M.J. Schrojenstein (2016:215)

INTRODUCTION:
A PUBLIC HEALTH ETHICS FRAMEWORK FOR THE GERIATRIC COMMUNITY: A SOUTH AFRICAN PERSPECTIVE

1. INTRODUCTION

At the end of her tenure (2007–2017) as Director-General of the World Health Organization (WHO), Margaret Chan published a report on the developments in public health during this period. She emphasised the growing role that social determinants can play to improve public health (Chan, 2017:8,38-39,129). *The new thinking is that social determinants, and not physical challenges only, contribute to health.*

In this study, social determinants for health are described, as a result of Chan's influence, as those social factors that impact on health, either positive or negative. Typical examples are education, habitat, environment, sanitation, safety and security of food and water resources, access to and affordability of quality medical care, essential medicines and vaccines for all, communication and information and social interaction and behaviour.

Health is understood in terms of WHO's seminal definition thereof, "as a state of complete physical, mental and social well-being and not merely the absence of the disease or infirmity (WHO, 1946). This is echoed by the United Nations' Sustainable Development Goal (SDG) 3, namely "To ensure healthy lives and promote well-being for all at all ages" (SDG, 2015: Goal 3).

The reference to social determinants leads to a first observation, namely the vulnerability of communities resulting from social factors that are not contributing to health improvement and well-being of communities.

Vulnerability is a growing challenge especially amongst geriatric people who are represented in a rising ageing and consequently elderly or geriatric community. Statistics from WHO (2015:43) suggest that the world population older than 60 years will nearly double by 2050. This population is in general referred to as *geriatric*. Vulnerability amongst the geriatric community is due to ongoing social factors impacting negatively on this community's health, of which healthcare provision in general and challenges with the quality of healthcare provision are important contributing factors.

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

The Coronavirus disease (COVID-19), caused by the severe acute respiratory syndrome Coronavirus-2 (SARS-CoV-2), cannot be ignored in the discussion on vulnerability as the current pandemic, caused by the SARS-CoV-2 virus, is contributing to increased economic and healthcare vulnerability. With the breakout of the pandemic it was projected that 50% of people dying from COVID-19 would be older than 80 years (WHO, 2020a; 2020b). The morbidity points primarily towards elderly people. This pandemic again draws attention to an unresolved question: that of saving lives in the context of limited healthcare resources. This question is not new as health economists have raised the question before: on whom should the available budget be spent? Must it be spent on people who *can* contribute to the economy, or people who *have* contributed to the economy (Annemans, 2016; Williams & Evans, 2012)?

A fair claim is therefore that vulnerability will remain part of the geriatric community. This assertion is substantiated by literature-informed arguments reflecting on (i) changing global healthcare practices and (ii) the South African public healthcare system that is evidently not ready to deal with the growing ageing and geriatric communities. The arguments are presented in sections 2 and 3.

From this claim follows the question of whether, even though ethical principles are enshrined in public health practice, medical ethics, bioethics and supportive ethical protocols, there is a public health ethics framework for the geriatric community in South Africa that is readily available to inform and guide the healthcare strategies, interventions, plans and practices in support of this community.

Based on the above claim and question, the baseline argument in this study is that such a framework is not available. More important than the reasons *why* such a framework is not available, is the question of *what* should form part of this framework?

A lead may be taken from the WHO's (2017a:14) report on developing a framework for healthy ageing, commenting that an ethical framework should have both a definition and

guidelines when one moral threshold is selected over another. Content is therefore important in a framework.

To answer the question, what should be part of such a framework, a first hint is to unpack the vulnerability of the geriatric community within the changing face of healthcare provision and practice.

The next section will look closely at the contribution of changing healthcare provisions and practices to the geriatric community's vulnerability.

2. THE CHANGING FACE OF HEALTHCARE PROVISION AND PRACTICE

One of the reasons why the WHO (2015:28,30) promotes the concept of healthy ageing, is to raise awareness of the healthcare challenges experienced by elderly people, on account of inequalities and social determinants, but also in relation to the ongoing improvement of health equity.

The promotion of healthy ageing depends largely on healthcare provision and practice. Published research on healthcare provision and practice confirms the importance of ethics in the wake of the changing face of healthcare provision and practice. Three references assist in comprehending the ethical challenges sparked by changing healthcare provision and practice. No community can escape changes in healthcare provision and practice. The assumption is that these changes are experienced more severely in vulnerable communities, and this includes the geriatric community. The following three commentaries support this assumption:

- Creplet (2013:103-106) refers to the powerful effect of knowledge and technology on medicine, doctors, and patients as the "third revolution in healthcare." One can expect, therefore, that new ethical challenges will follow the rapid development of medical knowledge and technology application. In addition, the role of commercialisation of healthcare cannot be ignored. His views confirm not only the imbedded role of ethics in healthcare but also how healthcare is influenced by this "revolution". The core of the third revolution is to reconcile technology with a value system.

- Balboni and Balboni (2018:3) comment on the change in healthcare by using the analogy from *hospitality* to *hostility* and state that this should in fact be the other way

around. Their overview suggests first an intimate relation between doctor and patient with the doctor being at the bedside of the patient. The first change is notable through the role of the nurse becoming more a substitute for the doctor's care. The doctor is now portrayed as the scientist. The hostility of the doctor-patient relationship is informed by the distance between doctor and patient and the role that the economy plays in healthcare. The following telling comment represents this change from hospitality to hostility: "While the powers of science and technology have so obviously brought enormous human benefits, these developments have also undercut the significance of person-centred care in medicine" (Balboni & Balboni, 2018:18). Their comments create awareness of the unintended consequences of science and technology on healthcare.

- Vanlaere, Burggraeve and Lategan (2019:1-4) and Lategan, Burggraeve and Vanlaere (2015:17-22) argue that care receivers are not the only ones to experience ethical challenges: those who cure and care also experience these. The position is promoted that curing and caring for people demand much more than medical and healthcare knowledge only. Although the caring relationship with the patient is vital, it is equally important to understand that the application of this caring relationship is very often challenged due to the nature of human relationships, the caring environment and the medical condition itself, for example, in the case of a patient who is nearing the end of life. These perspectives confirm that healthcare providers and healthcare recipients are all in need of equal ethical treatment and that imbalances should be understood and addressed.

These developments have resulted in a changing healthcare relationship that goes wider than the *doctor-patient relationship*. A positive outcome is the acknowledgement of the care receivers' autonomy, and at the same time their vulnerability. This is well illustrated by the concept of "participatory medicine". This concept serves as an encouragement for people to have an interest in their own care. The good intention is not implementable, however, when there is a surrogate decision maker, as is the case with people who have been diagnosed with dementia. Bolt, Van der Steen, Schols, Zwakhalen and Meijers (2019:432-442) report that taking decisions on behalf of geriatric people can cause friction with healthcare workers, especially when the expectation of the care does not link up with the practice of the care. For elderly people this new relationship can be problematic, as identified by the WHO's studies on palliative care (2018) and mental health (2012). These studies identify the growing reality of more elderly people who require palliative care and

who have been diagnosed with mental health challenges. The consequence is the potential inability of elderly people to care for themselves.

Given the vulnerability of people, and for purposes of this study on the geriatric community, the obvious next question is the readiness to respond to the influence of social determinants on the geriatric community.

3. READINESS TO DEAL WITH GERIATRIC COMMUNITIES

According to the 2017 statistics in South Africa, 8.1% of the population is older than 60 years (Republic of South Africa [RSA], 2017:3). The 2020 Mid-year Population Estimates Report indicates that the number of people older than 60 years is 9.1% of the population (RSA, 2020:5). This Report states that the population of those 60 years and above increased by 1.9 m people from 2002 – 2020. This growth represents an increase of 1.1% for the period 2002 to 2003, and 3.0% for the period 2019 to 2020 (RSA, 2020:10,12).

Statistics South Africa (RSA, 2017:3) comments that the growing number of elderly people will increase social, health and financial demands. Specific reference is made to (a) social assistance programmes, (b) easy access to cash transfers to food programmes, and (c) access to healthcare. The Sustainable Development Goals (SDG) Country Report in 2019 estimated that 71.9% of elderly people received an old-age pension by 2015. This pension is one of the social grants of the Bill of Rights in the Constitution, highlighting the socio-economic rights of South African people (RSA, 2019:26). The high percentage of old-age pension awards is an indication of the geriatric community's vulnerability. Furthermore, the 2019 novel coronavirus (COVID-19) pandemic confirmed the fragility of the elderly. Hence a call was made to protect the elderly in more than just their health (RSA, 2020).

The burning question is whether the country is ready to deal with these demands. Apparently not, as some commentaries question the readiness to care for geriatric communities. In 2013 Kalula (2013:1) expressed his concern that South Africa is not ready "to meet the challenges of providing adequate and appropriate healthcare to the older population in future." Sigasana (2017) shares the same worry in asking if the elderly in South Africa is invisible, meaning not noticed. Zikali (2018) cites Potonick (2018), who comments that South Africa has one of the fastest ageing populations of all countries in Africa. He raises a question on the care of elderly people with mental problems. Goodrick (2013:4-6) views the problems resulting from a growing ageing population from a policy

perspective. His study identifies accommodation and high child and elderly demands on government as factors that should be reckoned with. What is more, is that a growing elderly society impacts on economic organisation and political dominance and can cause social instability. To the list of potential challenges it can be added that it takes time to deliver on the desired results that are expected from policy implementation.

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

This remark is contextualised by Mhaka-Mutepfa, Hunter, Mpofu and Cumming (2016:51), who argue that due to the HIV/Aids pandemic, grandparents in sub-Saharan Africa have increasingly taken on the role of carer for grandchildren. A case study in Zimbabwe, based on lived experience, has shown that the additional role of carer assigned to grandparents has an impact on their health and well-being. Since there are not enough personal and social resources available to support the social environment, this means that geriatric people live in highly stressful environments without sufficient resources or protective factors to support them (Mhaka-Mutepfa *et al.*, 2016:52,53,57,59,61).

Apart from the fact that (South) Africa is apparently not ready to deal with a growing ageing population and related matters, there is another challenge that must be reckoned with, even though at another conceptual level: although there may be an assumption that sufficient ethical guidelines are in place to deal with the geriatric community in public health, this is evidently not the case. The important role of (public health) ethics in dealing with the challenges caused by an ageing and elderly society is discussed in the next section.

4. THE NEED FOR AN ETHICS FRAMEWORK FOR THE GERIATRIC COMMUNITY

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

more inclusive approaches that optimize the functional ability of every person."

The WHO Report on Developing an Ethics Framework for Healthy Ageing shares a similar comment: "Frameworks for public health ethics are more closely related to healthy ageing, but they are still not specific enough to the problems of old age, because the ageing population introduces the issues of intergenerational fairness and resource allocation, which must also be addressed" (WHO, 2017a:11).

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

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

Although there is agreement that ethics play an important role in caring for (geriatric) people, there is not concrete evidence of a public health ethics framework in South Africa to deal with the geriatric community. This study aims to develop a public health ethics framework for the geriatric community from a South African perspective.

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

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

- The evident absence of refined ethical guidelines in geriatric care following the framework for healthy ageing.

The reflections from reviewing relevant WHO Reports on ageing assist in summarising the need for a public health ethics framework for the geriatric community. The next section presents the case.

5. PROFILING A PUBLIC HEALTH ETHICS FRAMEWORK FOR THE GERIATRIC COMMUNITY

The discussion has so far presented two important observations, namely:

(a) the influence of social determinants on health and well-being; and
(b) the influence of the changing nature of healthcare on the vulnerability of the geriatric community.

This study has the geriatric community as focus. While the undeniable need exists to address geriatric healthcare in the context of public healthcare, it is evident that this cannot be done without adding ethical principles and guidelines when dealing with geriatric healthcare.

This study will therefore concern itself with a public health ethics framework for the geriatric community.

These observations lead to the **aim** of this study, which is to develop a public health ethics framework for the geriatric community, from a South African perspective.

The various parts of the study will contribute towards the development of the framework. The framework will be presented in Chapter 5.

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Aging is an existential step for which we can prepare, on the assumption that human life in its longevity, interweaves those who are older and those younger, on the crucial issue of human existence.

L. Nunes (2015)

CHAPTER 1

LITERATURE REVIEW AND RESEARCH DESIGN: GROWING OLD – THE NEED FOR A PUBLIC HEALTH ETHICS FRAMEWORK FOR THE GERIATRIC COMMUNITY

In this chapter, arguments in support of a public health ethics framework for the geriatric community are presented. Supportive arguments are presented by means of a literature review. Three major themes are considered, namely:

(a) What is public health?
(b) What is ethics?
(c) What are the ethical challenges of the geriatric community?

Semantic claims for public health and ethics are presented.

The literature review confirms that the primary focus of public health is on the promotion of health, and the prevention of disease and injury. In public health the focus is on a community or population, and not on an individual. This study has phrased this focus as organised strategies, interventions, and services to promote health and well-being.

The interpretation of ethics confirms the usefulness of a principle-based ethics framework together with an applied ethics approach when public health ethics is identified.

From this review and the semantic claims on public health and ethics, the problem statement, research problem, aim and objectives for the study have been identified.

The research question for this study is: *What are the important ethical aspects to consider for a public health ethics framework for the geriatric community in the South African context?*

The methodology to address the research question and to deliver on the aims and objectives of the study is based on a mixed methods approach which includes both qualitative and quantitative research strategies.

The summative argument presented in this chapter is that both the qualitative and

quantitative research results have contributed towards the development of a public health ethics framework for the geriatric community.

1.1 BACKGROUND AND APPROACH TO DISCUSSION

The motivation for a public health ethics framework for the South African geriatric community is presented in the Introduction to this study (cf. pages 2-10).

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

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

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

This chapter has two parts. In **Part A**, the supportive arguments for a public health ethics framework for the geriatric community are grounded. In **Part B**, a mixed methods approach is discussed to assist with the development of the framework.

Part A (pages 20 - 48) engages with mainstream debates on geriatric people, geriatric care, population development, public health and healthcare ethics, primarily over the last decade. The researcher also reflects on his own contribution to these debates over the last decade as presented in the Preface of the study (cf. page xvi-xx).

The body of literature was demarcated primarily from 2010 to 2020. The reason for this was that during this period there was a growing awareness of ageing population groups and consequently of the need for policy development. However, policies take some time to be developed, implemented, monitored, and evaluated. Hence, the full impact of policy development in support of the geriatric community may not be known yet. A further complication in relation to not having a detailed overview of the impact of the mentioned policy development, is the COVID-19 pandemic, which has added new challenges to the fragility of vulnerable population groups, notably in terms of their physical and mental health.

The study also interacts with an own body of knowledge which has been produced relevant to the topic. The focus of this collection of publications has been around understanding what geriatric care and its ethical challenges are in the context of medical ethics, bioethics and healthcare ethics, and what their interrelatedness is within public health and public health ethics (Lategan, 2017a; 2017b; 2018; 2019; 2020). From this research, two results can be shared that are relevant for this study:

(a) Ethical statements confirming the value and respect for life, attention to vulnerability, and identified supportive mechanisms to secure an enabling ethical environment for the geriatric community.

(b) A development away from a theory-based medical ethic (as part of virtue ethics) to a care ethic in healthcare (as part of applied ethics) as a relationship between healthcare provider and healthcare receiver emerging from healthcare related principles.

From own research on the above topics, two baseline ethical perspectives were formulated that influence geriatric care.

(a) *Declining life is characterised by physical weakness, fear, uncertainty, and a loss of meaning.* This perspective informs the need to care for geriatric people and to add continuous meaning to their lives. From an ethical point of view, there is a dual obligation: for geriatric persons to act ethically towards other people if and where possible, and for the community to always behave ethically towards elderly people.

(b) *Life is vulnerable and temporary*. Part of the vulnerability of life is old age, declining life expectations and the reality that life will come to an end. In view of the scope of

this study, it is important to identify ethical guidelines on how to treat the geriatric community respectfully, regardless of old age and the approaching end of life.

A South African contribution has been added to the development of a public health ethics framework for the geriatric community. The contribution from South Africa could benefit the national health system but could also contribute to the global awareness of the ethical guidelines for ageing and elderly populations within Sub-Saharan Africa.

A literature review has been used as a qualitative research technique in support of this outcome. This review takes as its starting point Trafford and Leshem's (2012:68-74) idea of a literature review. According to these authors, the researcher uses own lexicon and paradigms to present a body of knowledge that can be recognised by respective users. The analysis of and reflection on available literature deepen the knowledge base. Tilley (2016:58) confirms that documents contributing towards historical and or contextual knowledge, can be referred to as "useful data".

This study has been mindful of Mouton's (2001:78) differentiation between a scholarly review and a literature review. The scholarly review refers to how other researchers have interpreted and dealt with a research problem within a body of knowledge. The literature review, on the other hand, is influenced by personal orientations and perspectives (formed by scientific traditions, evidence-based research and world and life view).

A multi-disciplinary approach was followed in this study. Multi-disciplinary refers to the interaction between two or more distinct disciplines to formulate a new perspective (Kokt, Lategan & Orkin, 2012:141). The reason for choosing such an approach is that public health ethics straddles the broad disciplinary bases of healthcare, public health, and ethics.

The study had no intention of presenting a scoping review of the need for such a framework, but rather to identify how such a framework could contribute to geriatric care in the context of public health. This chapter contains, however, an element of a scoping review as defined by Pham, Rajić, Greig, Sargeant, Papadopoulos and McEwan (2014:351), namely the mapping of existing literature around a theme or topic. The approach suggested by Sucharew and Macaluso (2019:416-417) was followed. These authors suggest that a scoping review provides an overview of the available research evidence without producing a summative answer to the research question or evaluating the quality of the evidence. The value of the scoping review is the broad-based perspective provided.

As inclusion criteria for the literature review, the relevant research published in article publication databases such as Science Direct, Proquest, Taylor and Francis, Sabinet African Journal Collection was accepted, including journal articles, conference proceedings, books and chapters in books, legislation, policies and public communications on the topic. The exclusion criterion was that literature will not be older than ten years, except for seminal publications, legislation, and policies, or material used to illustrate the time space of the debate around a specific topic.

Part B (pages 49 - 57) of the chapter presents the Q-methodology as a mixed method approach to the research aim of the study.

PART A

1.2 DEFINING THE GERIATRIC COMMUNITY

Old age, ageing people and elderly people are well known concepts and are often used interchangeably. These concepts refer to a specific section of the population.

In this study, the term "geriatric" is used when referring to old people. The word "geriatric" derives from the Greek word γέρων = *geron*, meaning old man (Newman, 1971:37). The interpretation is that it is a person of age.

Geriatric care originates from the Greek γέρων ("old man") and ιατρός = *iatros* meaning healer (Newman, 1971:85). Geriatric care means *caring for the elderly*. This concept presupposes special care for a specific group of people.

The scientific study of ageing is known as *gerontology.* While gerontology concerns itself with old age, geriatrics, which is a branch of gerontology, looks at the medical care aspect of ageing (Mitchell, 2013:482).

Although there are differences in the way that old people are categorised, the chronological age of 65 years is normally considered as index for being a person of age. Mitchell (2013:481) refers to the "older adult" to accommodate a variety of life spans.

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

The WHO uses 60 years as indicator of older population growth and therefore as criterion to identify the age category for older people. The same approach has been taken in other reports on ageing (WHO, 2017b; WHO, 2019). Normally three groups of old age people are defined: the young-old (60-74 years); the old-old (75-84 years) and the very-old (85 years and older).

As this study is on older persons, 60 years was taken as cohort age for this group of people. For the purpose of this study, the population index of 60 years was therefore determined

as reference to older people. As this study is directed at all groups of older people, the generic terms used for people older than 60 years of age are "geriatric people" (plural) and "geriatric person" (singular). "Geriatric community" (singular) is used to refer to a group of older people. For this study, age intervals were not considered in order to classify different groups of old age people as the study's focus was on the development of an ethics framework for elderly people and not on an ethics framework for different groups of elderly people.

"Ageing" as a reference term is used to indicate growth in a population group and elderly community due to the population growth. "Elderly people" (plural) and "elderly person" (singular) are used where they are specific to a reference.

"Elderly" may be used a synonym for "geriatric", depending on the sentence construction and the synonym use to avoid repetitions of the same concept in a sentence.

The age cohort for "geriatric" and "elderly" are similar unless a specific reference may have a different interpretation.

1.3 DEFINING PUBLIC HEALTH

1.3.1 An overview of the concept "public health"

There exists a broad range of definitions and descriptions of what public health is. In a study of various definitions and descriptions relevant to public health, at least five pointers were observed (cf. Lategan & Van Zyl, 2018):

(a) Public health focuses on communities and not on the individual.
(b) Public health deals with organised strategies, programmes, and interventions to improve quality of health, combat disease and limit injury.
(c) Public health calls on multi agents, primarily from government, to accomplish quality of health and well-being and to formulate supportive polices and strategies.
(d) Public health's scope goes beyond physical health to secure quality of health and well-being.
(e) Public health always has an ethical basis as it deals largely with vulnerable communities.

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

Holtz (2013:13) aligns her definition to the 1948 Universal Declaration of Human Rights, where a standard of living adequate for health and family is promoted. This includes medical care and the right to security in the event of sickness, disability, or lack of livelihood. Public health should be extended beyond healthcare to include preconditions for good health such as water, sanitation and nutrition. Her view that adequate healthcare ought to promote social stability and economic growth, should be noted. Adequate criteria include (a) equitable access to healthcare for prevention and treatment, (b) affordability, and (c) sustainability (Holtz, 2013:13).

According to Berridge (2016:2), time and context influence the way in which public health is defined. She considers some examples of how public health has developed over time. Regardless of the public health need at the time, common characteristics of public health are (a) the focus on the health of a population; (b) the longevity of individual members; (c) the freedom from disease; (d) *prevention* of illness rather than the *provision* of health and well-being; and (e) both healthy and sick people are the focus of attention.

This approach is also followed by Johns Hopkins Bloomberg School of Public Health (2017). This school follows a pragmatic approach in defining public health. Where the clinicians treat diseases and injuries of one patient at a time, public health researchers, practitioners and educators work with communities and populations. Public health will identify causes of disease and disability and will implement largescale solutions. A relevant example is that instead of treating a gunshot wound (clinical intervention), public health will identify the causes of gun violence and develop appropriate interventions to deal with this matter.

More perspectives on what should be considered as the task of public health are provided by Childress, Faden, Gaare, Gostin, Kahn, Bonnie, Kass, Mastroianni, Moreno and Nieburg (2012:361). For them, understanding the causes of disease and disability in a population,

and how to improve on the reasons contributing to the progress in dealing with disease and disability, are important features of public health. Multiple agencies in delivering on public health services are required. These agencies include government, relevant professionals and members of the community, and should assist with the development, implementation, and assessment of interventions. The cooperation is extended to the community, as cooperative behaviour and relationships with a view to creating mutual values and trust are required (Childress *et al.,* 2012:362). The collection of activities ranging from immunisation, anti-smoke campaigns, seat-belt legislation, motorcycle and bicycle helmets and swimming pool fences to occupational and community health, for example, make it difficult to map the terrain of public health.

A more social view on public health is followed by Kass (2001:1776), who defines public health as a social approach to protecting and promoting health. Through social rather than individual actions, the well-being of communities is sought. A similar approach is taken by Holland (2012:359), who refers to public health as the protection and promotion of a population's health. Public health therefore has a population or community perspective.

Kahn (2015:1-3) advocates a broad-based understanding of public health. The Ebola disease is used to exemplify the case. Dealing with a disease such as Ebola requires not only public health as strategy but also food (security & nutrition), wildlife management and environmental affairs in support of public health strategies. Food security and human development are big challenges within the public health domain. For food security the emphasis is often on export regulations and not on local use or produce. Furthermore, migration and urbanisation often challenge the sustainability of public health. It is for this reason that Kahn is in favour of a holistic approach.

A representative overview of what public health should focus on is presented by Ten Have, Ter Meulen and Van Leeuwen (2013:349-350), who identify three characteristics of public health, namely that (a) it focuses on health and quality of life of the entire population; (b) it includes lifestyle, living conditions, environmental conditions and socio-economic determinants for health and care; and (c) it concentrates on the group and not the individual. Care should be linked to these characteristics to provide an effective service.

Based on different approaches to public health, Horn (2015:26) comments that there is general agreement that public health deals with the health of communities and is delivered by government or organisations rather than by individuals. What is often contested is the

scope of public health. Her analysis of some definitions of public health concludes with the useful comment that public health is "some form of organised or collective effort undertaken to promote the health of a community or population, particularly by preventing disease" (Horn, 2015:27). Horn (2015:27) further outlines the fact that a broad-based egalitarian approach blurs the boundaries between individual healthcare and service-provision measures such as housing. She confirms government's obligation to provide key services, and establishes the rules for public health. Horn argues in favour of a moral basis for public health in line with the growing voice in favour of social justice. She identifies two moral impulses driving public health, namely (a) improving health and (b) focusing on the needs of the most disadvantaged (Horn, 2015:28-29).

From these definitions some pointers for geriatric care in public health can be identified:

(a) Policies, strategies and actions should be in place to secure the quality of health, the eradication of disease and the prevention of any harmful action such as home-based violence and abuse of geriatric people.
(b) Geriatric people should be part of basic public health interventions such as ensuring favourable living conditions and specific interventions such as mainstreaming them into community life.
(c) Government has the dual responsibility to secure economic support and to provide physical and social infrastructure for the geriatric community.
(d) A multi-focused approach beyond healthcare provision should be followed in public health support for the geriatric community.
(e) An ethical approach should secure the basic ethical principles of autonomy, beneficence, non-maleficence, justice, do no harm, dignity of person and relevance of situation, care for all, respect, professional workplace behaviour and integrity of decision and application.

The different mappings of public health and their applications contributed to scope public health within the outline of this study.

1.3.2 The scope of public health

Of particular relevance for this study are the *services* offered by public health (as identified by Childress *et al.*), the *broad-based approach* to the activities and reach of public health (as argued by Kahn) and the *ethical basis* of public health (as presented by Horn).

These observations contributed two more perspectives to public health.

First, public health's focus cannot be limited to the activities of government only but should be extended to its agencies such as geriatric institutions, whether public or private. Although government should be the initiator of public health activities by virtue of its mandate, such activities need to be relevant for communities, especially in the South African healthcare system, which is marked by inequalities and inefficiencies.

Second, the focus of public health is correctly placed on healthcare as a service informed by policies, strategies, interventions and plans aimed at health promotion, disease prevention and injury limitation in the group or the community. The collective outcome of these activities is health promotion and well-being relevant to human existence and functionality.

With this as background, it can be accepted that health promotion and well-being are part of the public health value chain, which is based on access to healthcare, a quality habitat (consisting of social, environmental, work and living spaces conducive to good health), leisure as self-care, and effective service delivery. This approach also gives effect to healthcare as social justice which is a constitutional right.

Although public health is directed towards a community (as a group) or the population (as a whole), this does not mean that the individual is not gaining any benefit from the support to the community or that the individual has no responsibility towards the community. The benefit for all lies in equality of access to medical facilities (hence health as justice), safety of product and interventions (hence promotion of health) and the creation of a healthy society (hence an empowering environment). The defined focus in public health is therefore on collaboration and participation between individuals as part of a community or population. The individual needs to be responsive through a changing lifestyle resulting from the public health strategies and as a spontaneous reaction sparked by responsible citizenship.

Public health is always directed towards promoting humanity. Service delivery and a moral basis can therefore not be removed from promoting strategies and taking preventive actions.

Based on the semantic claims presented in this section and the reflections on these claims, a summative view is that ***public health*** refers to *organised strategies, interventions and*

services to promote the quality of health and well-being of a community or population based on a public health value chain.

This understanding of public health was used in defining public health ethics and developing a public health ethics framework for the geriatric community.

To do so, the ethical challenges emanating from an ageing society should be thoroughly understood.

1.4 AGEING – A GROWING (HEALTH) CHALLENGE WITH ETHICAL CONSEQUENCES

The statement is not new: A growing ageing and consequently elderly population is not without its health challenges and ethical consequences.

A growing ageing population will have a big impact on the provision of healthcare (National Institute on Aging and the WHO, 2011:22). The impact goes beyond the mere administration of resources such as human resources, financial resources, infrastructure, equipment, and medicine needed to deliver healthcare. An ageing population will also impact on family life, work, and elderly people's place in the community (National Institute on Aging and the WHO, 2011:20-22; WHO, 2020a). The World Report on Ageing and Health (WHO, 2015) emphasises the impact a growing ageing community will have on health and health systems and confirms the workforce and budget consequences of such a population growth. The consequences for a growing ageing society are influenced by the way ageing is perceived, the implementation of available policies steering the needs of an ageing population, and the effectiveness of service delivery to an ageing population (cf. WHO, 2020a).

The growing elderly community is a reality (cf. section 1.2). Although not targeted as a reaction to the WHO's predictions on a growing elderly society, metaphors are used such as "time bomb", "age quake" and "glacier" to describe the rapid growth of the ageing population. These metaphors are not without significance when looking at the expected increase of elderly people in overall population growth (Mitchell, 2013:497).

An ageing population should not be viewed as negative at all. Several reports, such as the Global Health and Aging Report (National Institute on Aging and the WHO, 2011) and the

Report on Ageing and Health (WHO, 2015), identify the ongoing increase in life expectation as the reason for a continuous population growth resulting in higher numbers of elderly people. The increase in life expectation is generally due to the improvement in health and living conditions, increased access to healthcare services, improved healthcare delivery, better policies and (relatively) supportive budgets (National Institute on Aging & the WHO 2011:2; WHO, 2015:10).

To address the outcomes of an ageing population, the World Report on Aging and Health focuses on "healthy" ageing. Healthy ageing is defined as "the process of developing and maintaining functional ability that enables well-being in older age" (WHO, 2015:28). The focus on healthy ageing is through raising awareness of inequalities, importance of social determinants and the continuous improvement of health equity.

Two concepts, (a) functional ability and (b) environments, are important for the development of a public health ethics framework for the geriatric community.

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

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

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

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

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

The following discussions inform the comment as to why these realities can permeate ethical dilemmas:

1.4.1 Mental health diseases

The WHO reports on a growing awareness of mental health and palliative care.

Within an ageing population, a daunting reality is that the numbers of people with dementia, especially Alzheimer's disease, will continue to grow alongside the ageing population (National Institute on Aging and the WHO, 2011:3; WHO, 2012:2,3). Dealing with dementia calls on, among other things, palliative care and end of life care (WHO, 2018:5). The ethical challenges of palliative care and end of life care originate from the respect for life and the dignity of the person (WHO, 2012:53; Lategan, 2020:73).

The problem with dementia is that it raises ethical questions around the appropriateness of palliative care, surrogate decision making, dignity of the elderly and whether long-term care facilities are ready to deal with mental disorders (Lategan, 2020:78-79).

Within the context of public health, the question is raised of what preventative strategies are in place to support the geriatric community challenged by mental health. From a public health perspective, matters such as keeping geriatric people *in* a community as *part* of a community are an ethical requirement. The motive behind this is not to isolate any person with a mental disorder from social engagement. To do this successfully, however, adequate support is needed to secure the optimal functional ability of geriatric people.

1.4.2 Cost of healthcare

The expected shift in the mortality rate because of chronic non-communicable diseases will become very costly for healthcare (National Institute on Aging and the WHO, 2011:15; WHO, 2013:82; WHO, 2015:127-47). The morbidity points primarily towards elderly people.

The underlying ethical challenge is that of saving lives in the context of limited or decreasing healthcare resources. This by no means implies that there are *no* resources available. The debate originates from the discussion amongst the health economists who raised the question: *on whom should the available budget be spent?* and *to whom should the resources be available?*

The opposing views represent a typical either/or opinion. Either: the budget should be spent on, and the resources available should be there for, those people who *can* contribute to the economy; or: those people who *have* contributed to the economy should benefit from the budget and resources. The opinions may be extended to include choices related to vulnerable, self-care, private or public patients. Whatever the outcome, the answer will lead to ethical dilemmas (Annemans, 2016:145,146,154). The view from the WHO (2015:10) is that calculating the cost of elderly care is based on stereotypes such as that life can be categorised into fixed stages or that cost-containment is the starting point in policy making. The problem arises when age and economic contribution become opposing ideologies. A perspective from Sandal (2012:108) is important. He identifies two challenges, namely (a) equality and (b) the potential decline or waiving of behaviour or norms. Equality implies the question of whether everyone can make equal decisions. Sandal calls this the "honest principle". The potential decline or waiving of behaviour or norms is known as the "corruption principle". It is for this reason that there is no conclusive answer.

The reality of the market principle above all is captured in Geybels and Van Stichel's (2018:164) comment that the current economic sphere has reduced human beings to *homo economicus,* meaning the "economic person"*.* This is normally interpreted as people having self-interest for own gain. The downside is that a person's value is expressed through his/her contribution to the economy only. Business ethics flags the concern of whether life should be reduced to economics only. Clearly, the answer is "no." Direction can be taken from Verstraeten and Liedekerke (2010:13-17). According to them, if business ethics encompasses the values directing responsible ways of doing business, responsible behaviour in business, society and ecology, then there is no way in which a person's worth can be reduced to a monetary value only. Such an approach is not supportive of responsible behaviour in business.

To this debate, another perspective can be added: Fried (2016:S167-S177) argues from the perspective of "demographic dividends". She argues that when people live longer, there are savings on the cost of health. The "third" demographic dividends result from the social

benefits which originate from generative social capital of older adults. The argument presented is that geriatric people's care cannot be viewed from an increased cost angle only as, if well managed, there should be positive financial benefits too.

1.4.3 COVID-19

Challenges for the geriatric community have increased due the COVID-19 pandemic. Reports from the WHO (2020b; 2020c) point primarily towards the morbidity of elderly people. The underlying challenge is that of saving lives in the context of limited healthcare resources. This challenge has deepened in the context of healthcare as a basic human right, but with economic consequences. Public and scientific commentaries on healthcare during the COVID-19 pandemic are repeatedly focusing on *economic* and *healthcare* vulnerability. The interchange between economics and healthcare is presented as a catch twenty-two situation. Without a strong economy, good healthcare cannot be secured. A strong economy depends on healthy workers. Although economy and healthcare are interdependent, this co-dependency should not be presented as a dichotomy. Healthy workers in a medical context mean much more than merely absence of illness. Broadbent, Walker, Ikidou, Sullivan and Glassman (2020) are right to point out the false dichotomy between the one and the other. They correctly comment that "lockdowns kill people through disruption of health services and deprivation of livelihoods." They argue further that there is no equality in cost or benefit. The challenge is if life and economic contribution become opposing ideologies.

It is therefore not surprising that there is a growing need for a public health ethics framework for the geriatric community.

This need should be separated from a general medical ethics perspective that focuses on topics such as palliative care, protection of dignity, protection of declining life, healthcare and treatment, assisted life ending approaches and support, and euthanasia (Van den Broek, 2012; WHO, 2012; Lategan, 2020).

Given the inequality in a society, it cannot be ignored that different systems (private and basic healthcare), access (language, distance, money, comprehension) and improvement (diet, living conditions, and mental health) have an influence on the quality of health and well-being of a person.

The need for a public health ethics framework for the geriatric community was further profiled by the scope of geriatric care.

1.5 THE SCOPE OF GERIATRIC CARE

Geriatric care includes both health and social care and should address the social determinants of health (WHO, 2019:3). Healthcare for the geriatric community should include physical, mental and sexual health (WHO, 2017b:16). The required care should be grounded in the context of the geriatric community as a vulnerable community. This vulnerability is because of health challenges, social injustice, environmental burdens, and the application of emerging technologies in the biomedical sciences. Limited access to health and social services enhance vulnerability (Lategan, 2017a:120,124,135) and social determinants that do not contribute to healthy ageing (Lategan & Van Zyl, 2018:147,150,152,153,155,157,158,167). Vulnerability calls for medical and social intervention as geriatric people may no longer be able to take care of their own health or to continue broader interaction with society and communities. The most difficult aspect of the vulnerability is the loss of competency and identity (Lategan, 2017b:21).

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

In dealing with geriatric care, the (ethical) question is often asked as to how much of the focus should be on curing the aged person. Is this doable, keeping budget constraints in mind, and realistic, in view of life expectancy? The ensuing question is whether the focus should not be more on what old people value, namely mobility, self-care, being able to pursue usual activities (whatever they may be) and being free from pain, discomfort, anxiety and depression.

Williams and Evans (2012:439) comment that the focus should be moved from the notion of ‘cure’ as the criterion of benefit. Instead measures of effectiveness should be adopted that turn on the impact of treatment on people’s quality of life.

The positive role of palliative care, as observed by Weru (2017), can be aligned with the above perspective. Palliative care should not be reserved for dying patients only but should also deal with the effects of incurable diseases. The respective points are that cure should be understood in the context of care and that care should be a major focus of health provision to the geriatric community.

The scope of geriatric care should be understood in the context of healthcare. Nuyens, De Ridder and Annemans (2013) refer to the importance of the broader context of policy, budget management, efficiency, access and benefit, inequality, health and illness, age, investment in healthcare, mental health, cultural difference, religious experience, growing technology, role of medical insurance, assisted death, training (skills mix), information and innovation when the context of healthcare is discussed.

Although they write from a European perspective, their comments are very useful in identifying ethical challenges associated with developments in geriatric care and the need to understand the complex context of healthcare provision. Their comments are particularly applicable in extending the scope of ethical challenges beyond the already documented perspectives by adding a broad-based understanding of ethical challenges associated with the geriatric community and their care.

This next two sections attend to the broad-based challenges experienced by the geriatric community followed by the ethical challenges experienced by the geriatric community.

1.6 BROAD-BASED CHALLENGES EXPERIENCED BY THE GERIATRIC COMMUNITY

Literature-based studies on geriatric care conclude that lived experiences and life-orientation contribute to geriatric persons' health, well-being and acceptance of ageing. These studies not only confirm the impact of social determinants on the geriatric community's health but also identify broad-based ethical challenges in geriatric care. The studies by Holtzer (2015), Mitchell (2013), Ten Have *et al*. (2013), Nunes (2015), Vanlaere and Gastmans (2010; 2011), Vens (2013) and Lategan (2020; 2017a; 2017b) present five noteworthy perspectives, as outlined below.

First, the geriatric person is *vulnerable* because of declining health, absence of self-worth, loss of independence, challenges to personal safety and security, declining finances due to

inflation, uncertainty in the economy, passive income and cost of elderly care and the reality of death and dying. On top of these challenges are issues such as elderly abuse, elderly neglect and loss of autonomy and individualism. The situation becomes more complex when geriatric people are not able to participate in decision making (because of dementia), have insufficient access to medical facilities (for example, due to the absence of basic healthcare, mobility, language or location), take on a new family role (becoming a "parent" to a grandchild), or have to provide for a family (due to a social grant). This becomes even more problematic when geriatric people who, because of their dependence on healthcare, are not in a position to participate effectively in society. The problem is intensified amongst geriatric persons as they are part of a *vulnerable community*. Vulnerable communities are identified as having some or all of the following characteristics: limited economic development; inadequate protection of human rights and discrimination on the basis of the health status; inadequate community and cultural experience; limited availability of healthcare and treatment options and limited ability of individuals in the community to provide informed consent. Vulnerability therefore includes human experiences such as ethical decision making, physical suffering, psychological disorders, economic challenges, and cultural orientation. These matters are imbedded in the ethical issues associated with geriatric care.

Second, is the *certainty* of death and dying. Although it is expected of healthcare workers to care, they cannot record or represent the reality of what happens after death or take away the anxiety caused by the imminent end of life. In different stages of old age, different needs exist. The early geriatric person may want to do more, while the person in his/her last phase of life may have limited or no expectations. Making end of life decisions are stressful, especially when there are mental health challenges.

Third, *reflecting on the past* is not always comforting. Geriatric people can often be depressed because of missed opportunities, the knowledge that the past life cannot be undone, lack of recognition, and a sense of lost and broken relationships.

Fourth, could there be *a culture shock* experience. A replacement culture exists due to consumerism. If something is not good enough, has no further use or is broken, it is replaced by something new. The same attitude is experienced by the geriatric community. If they are no longer fit for society, they should be replaced by a new generation. This creates a feeling that they are no longer wanted. At the same time, the health economy may be a challenge to their income. Will they have enough money to pay for rising living

and medical costs? The geriatric community may also feel insecure because of a postmodern, post-religious or post-truth culture. They were used to certain fixed ideas and rules (modernism), and now everyone's opinion is valid (post-modernism). Where society was based on religious orientation, such orientation either no longer exists or only exists in a very limited way. Truth has taken on a new interpretation which very often clashes with former belief or value systems. These conditions are very often difficult to accept.

Fifth, is there an emotional struggle about the *purpose of life*, loss of respect and status, how to add meaning to life and how to accept this stage of life. The harsh reality is that this is not just another phase of life: this is the last phase of life. The emotional distress caused by this knowledge can easily upset the well-being of the elderly person. Linked to this, elderly people are very often lonely people. Elderly people are lonely because of isolation either through lack of mobility, limited contact with other people, bad health or simply due to limitation of environment.

From these comments, it is evident that geriatric people are challenged by physical, emotional, personal, religious, and environmental issues, as confirmed by Nunes (2015:233-234).

The next section considers ethical challenges experienced by the geriatric community.

1.7 ETHICAL CHALLENGES EXPERIENCED BY THE GERIATRIC COMMUNITY

In this section, seven ethical challenges experienced by the geriatric community are discussed. The seven challenges are not presented as a complete list of ethical challenges but rather as a representative list of ethical challenges.

1.7.1 Classifying people based on age only

A first ethical challenge is the classification of people above a certain age as elderly – and hence all "elderly people" are then treated in the same way. This is in accordance to the WHO's 60 years as guideline.

Vens (2013:31-41) correctly argues that there cannot be generalisation, that elderly people are at different stages of their lives as part of their life cycles, and by default will have different health challenges. A proper solution would be to contextualise ageing in an

anthropological context. The value of this approach is that ageing will be understood in the context of life cycle and the required care aligned with the need associated for that life cycle. Another advantage of this approach is that elderly people should also review and understand their changing life conditions against the broader context of a life cycle. What should further emanate from a life cycle approach is that as people are ageing, they are moving into new life cycles where physical, social and health vulnerability are increasing. A major challenge, however, is the potential resistance of the geriatric community to accept that they no longer have the abilities that they used to have. This does not mean that the elderly person's life is valued based on his/her abilities, but merely that there are special challenges associated with ageing that may not be the case in other life cycles. To deny one's state of health and ability is just as unethical as treating all elderly people as if they no longer have any rights over their own lives.

1.7.2 Excluding either medical or social interventions

A second ethical challenge is when geriatric persons are excluded from one or more interventions, for example medical or social interventions.

Medical intervention is necessary when geriatric people are no longer able to take care of their health on their own. Social intervention is required to manage their declining interaction with society. These interventions can easily create the impression that the elderly constitute a "problem" group (Vens, 2013:32). The ethical challenge that emerges, is the behaviour and/or the perception that geriatric persons need to be treated differently from other people. This relativism of capability and dignity leads to confrontation between the elderly and other people. The elderly very often experience that their lives have been taken over by other people or that other people are now deciding what is good for them and what is not. This leads to a feeling of disempowerment and loss of autonomy. As if this is not enough, the geriatric community often encounters disempowerment and loss of autonomy in the way that people treat them, communicate with them, and involve them in decisions pertaining their own lives. The common layman's reasoning may be that elderly people are now comparable to children – they are no longer able to make any decisions on their own. Although this reality may be applicable to geriatric people with dementia, one should not generalise or apply this to all elderly people.

A complex problem that may arise is, for example, the question of the dignity of geriatric people who have limited, if any, quality of life. The question is, how should such people be

treated? This dilemma is further deepened by the contemporary challenge of assistance related to the ending of life.

1.7.3 Communication challenges

A third ethical challenge is that within the context of disempowerment and loss of autonomy, communication challenges arise.

Communication is supposed to involve one person (read the elderly) in a broader context (read the community). But communication often excludes geriatric persons from the discourse, leading to a degrading of personhood. A well-known example is where elderly people are very often addressed by doctors, nurses, therapists, and caregivers in an overly familiar manner, as if all people are to be treated the same. Their "past" is ignored.

This example is further problematised in different cultures where elderly people may interpret such communication as disrespectful and ignorant, in view of who they used to be (Phalime, 2014:62-90).

1.7.4 End of life care

A fourth ethical challenge is the question of whether life should be prolonged at all costs, whether there is meaning to a declining life, and how the value of life should be determined. End of life should not be confused with assisted life ending approaches and support or euthanasia. End of life is generally understood as caring for people who are dying, immaterial of age or medical condition. The scope of end of life care includes matters such as supportive doctor-patient relationships, surrogate decision making, patient's preferences, communication, treatment plan and end of life goals (Medical Dictionary, 2018).

End of life care is gaining attention as there is worldwide evidence of a growing elderly community which opens new ethical challenges in healthcare around the value and meaning of life. The opinion is that if one has the right to live, one also has the right to die (De Wachter, 2013:2020.)

End of life care efforts become more complicated for elderly people when their existence is not necessarily challenged through illness but rather through vulnerability. Vulnerability in end of life care refers to the health and personal risks someone experiences due to disease,

treatment and/or context. Vulnerability is not limited to elderly people only, but it is accepted that the last phase of their lives and/or the nearing end of life add to a different experience and expectation of life.

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

1.7.5 Sustainability of geriatric care

A fifth ethical challenge is that elderly treatment at all costs cannot be sustainable.

In healthcare the approach is always to do everything that is possible to do. Due to budget limitations, this may not be feasible, and *cost* and *age* should be weighed against the cost of treatment. This calls not only for the correct modelling of cost, but also for dealing with the abovementioned ethical dilemma.

Williams and Evans (2017:439-446) consider respectively the cases for and against in this ethical dilemma to highlight its complexity. Where a treatment offers only modest benefits, a person may have to live a long time to make treatment worthwhile – that is, to make the benefit to the person larger than the sacrifices of rival candidates who failed to get treated. Theoretically, depending on the circumstances, a national health programme for the entire population may be so important and expensive that it may require cutbacks on treatment of elderly people because of, for example, life expectation. This may be regarded as discrimination against the geriatric community. This potential dilemma can be addressed by considering the following guidelines: age matters in two ways: people's capacity to benefit from treatment, and a benefit already received. In prioritising benefit, younger people are often favoured above elderly people (Williams in Williams & Evans, 2017:440).

Evans (in Williams & Evans, 2012:442-443) argues that one needs to understand the individual risk and situation before a decision can be taken. Age, however, is no reason to deprive people of healthcare. The potential value younger people may have above elderly people is no reason to pass a decision in favour of one group only (Evans in Williams & Evans, 2012:443). The fact that older people are widely seen as being of lesser social worth than younger people, is the result of prejudice and should also be disregarded. Age should

not become the reason not to support a specific group or to decide that they are not worth spending money on (Evans in Williams & Evans, 2012:446).

Ten Have *et al.* (2013:144-149,155), refer to the challenge of age as a criterion to determine the roll-out of healthcare (selection criterion). Very often the challenge is the choice between long term care and affordability. For these authors, evidence must be offered to justify a decision. Before a final decision can be taken, the ethical values of these evidences should be evaluated.

1.7.6 Conflict between opposing possibilities

A sixth ethical challenge is the conflict between what needs to be done and what can be done.

Holtzer (2015:71) refers to Lieven Annemans who identified three values in healthcare, namely *quality, solidarity* and *sustainability.* These values can conflict with each other. If the objective is to strive towards the highest quality, it may not always be affordable. This challenges the sustainability of care. If patients need to pay themselves, it may be interpreted as a loss of solidarity with the community. If cost efficiency is the solution, how must it be implemented? As ethical guideline, three actions count: prevention (keep people healthy), cure (make sick people healthy again) and care (assist those in need). This guideline should address the expectation of the geriatric community concerning good care. The conflict is created through managing the healthcare; it is not caused by the patient. To put the health of a person at risk because of management and policy implementation, is ethically unacceptable.

At the same time, the potential conflict includes not only the geriatric community but also the healthcare worker. This confirms the ethical vulnerability of the healthcare worker who has to care in spite of the potential conflict that may exist (Vanlaere, Burggraeve & Lategan, 2019:7-22; Phalime, 2014:91-108).

1.7.7 Family roles and responsibilities

A seventh ethical challenge is the role of the geriatric person in view of the destruction of the family unit.

Alongside the growing ageing population is an associated problem, namely the growing number of orphans in Third World countries due to HIV/Aids, (civil) war, poverty, and

hunger (WHO, 2017c). The challenge here is how to care for children in a society where there are no parents, but only grandparents. This puts an additional strain on the elderly people and their well-being. Elderly people take on the role of parents again – this time for a second generation. At the same time is it evident that caring for children can be compromised if the elderly person is sick and is in no position to take care of someone else. Such a situation cannot contribute towards the well-being of geriatric people and their communities.

Following from these identified ethical challenges, the follow-up question concerns how to deal with the ethical challenges experienced by the geriatric community.

The next section returns to this question by first attending to what ethics is, exactly.

1.8 CONCEPTUAL INTERPRETATIONS OF ETHICS

The development of a public heath ethics framework requires an understanding of what ethics is. In the ensuing sections, different conceptual interpretations of what ethics actually is, will be discussed. These conceptual interpretations will lay the foundation for the planned framework.

1.8.1 The meaning of ethics

The word "ethics" derives from the Greek word ήθος = "ethos" meaning habit or morals (Newman, 1971:80). This concept refers to a set of beliefs or ideas on what the accepted behaviour is towards other people, society, structures, and nature. The Latin word for ethics is *moris* and refers to customs, norm or behaviours that are acceptable to society (Smuts, Bruwer & Van Stekelenburg 1992:54).

The general interpretation of ethics is that it deals with those factors, either external (for example the influence of a community or population) or internal (one's own attitude or belief system) that guide a person, community or agency to act in a particular manner. This interpretation further suggests that to guide a person, community, or agency to act in a specific way, there must be an identified basis to do so. This basis is generally accepted to be principles or norms accepted by a society.

A representative view of what ethics is, is that ethics deals with the identification of principles or norms and the application of these to a situation (Ten Have *et al.*, 2013:8-11). Their response goes further than to equate ethics to principles or values only. These principles or values imply action as represented by the identification and application of the principles or values. This study will primarily refer to principles as the basis for ethics, and values as the application of principles to a situation.

With this as point of departure for the discussion on the meaning of ethics, the understanding of what ethics is, is further informed by Carter, Kerridge, Sainsbury and Letts (2012:101), amongst others, who comment that ethics can be grouped into *meta-ethics* (dealing with foundational ethical questions), *normative ethics* (providing principles) and *applied ethics* (application to situation). The "traditional" way of scoping what ethics is, or in the case of this study, what public health ethics is, follows a principle-based approach.

Alongside these groupings of ethics there are three schools of thought, namely *virtue ethics*, *consequential ethics,* and *duty ethics* (deontology). Virtue ethics is person-based and looks at the moral character of a person. Consequentialism judges a situation by the consequences or outcomes of a situation. Deontology is based on the actions (duties) within a situation (Mautner, 1997:180-181,593). The approach taken in this study is a combination of these schools, namely principle identification (virtue ethics), decisions (consequentialism) and action and behaviour (deontology).

This study took two approaches to explain what ethics is and how it will be used in developing the planned public health ethics framework. In identifying what public health ethics is, the normative approach was taken. In integrating public health ethics in the planned framework, an applied approach was taken.

When the normative or principle approach is taken, a baseline definition for ethics is (a) the identification of principles for a situation or activity, (b) the decisions emanating from these principles, and (c) the performed behaviour to prevent ethical dilemmas.

A working definition in this study for ethics is: *Ethics are principles, principle-informed decisions, and behaviour to prevent ethical dilemmas.*

Building on this explanation of ethics and on the definition for public health (section 1.3), *public health ethics can be defined as the ethical principles, decisions, and behaviour to*

improve a community or population's health and well-being.

The understanding of what (public health) ethics is, is further extended by an applied ethics approach. Applied ethics contributes to the identification and application of ethical principles to a given situation or activity. This approach adds to an understanding of the context of application. Applied ethics' advantage is that it is more a process than a final product for ethical consideration (Beauchamp, 2005:11).

With this observation in mind, it can be stated that public health ethics is more applied ethics as it addresses specific matters within healthcare. As applied ethics, it is also a social ethic as it concerns itself with communities or populations. The applied ethics approach will link the ethical principles for a community or population's health and well-being to the healthcare needs of a community or population.

A working definition in this study for public health ethics as applied ethics is: *Public health ethics is the application of ethical principles through decisions and professional behaviour to improve the community's health and well-being.*

In developing a public health ethic, and subsequent framework for the geriatric community, it is presented as an applied social ethic with healthcare and professional relevance. With this approach, public health ethics is constructed within care ethics and professional ethics.

Care ethics is essentially applied ethics based on relationship building between people through the application of ethical principles within their engagement. Professional ethics refers to the ethical behaviour required by the workplace.

Sections 1.8.2 and 1.8.3 will focus on care ethics and professional ethics respectively.

1.8.2 Care ethics[1]

The concept of care ethics originates from Carol Gilligan's book, "In a different voice" (1982). Gilligan's care ethics is a different "voice" to Kohlberg's fixed approach to women's development and ethical behaviour. The different voice is the role that communication,

[1] The overview of care ethics is based on a conceptual analysis of care ethics (Lategan, 2018) and its application to the geriatric community (Lategan, 2019) and end of life (Lategan, 2020).

responsiveness and relationships play in dealing with ethical dilemmas. Hence, principles are important, but can never solve ethical dilemmas alone. Gilligan's argument is that answers should be contextual and not categorical.

Geybels and Van Stichel (2018:128-131) go further by linking care ethics with *involvement ethics*. This perspective is in response to Gilligan's care ethics which has a more private or individual approach as opposed to Kohlberg's view on moral development, where justice is the highest ethical value. This represents a more public approach. Geybels and Van Stichel comment that Kohlberg and Gilligan each promote a particular approach: justice and care respectively. Geybel and Van Stichel differ on the separation of private and public life. They argue that care is as much a public affair as it is a private affair. According to them, *involvement ethics* will bridge this divide.

The meaning of care ethics for public health ethics is identified by Grypdonck, Vanlaere and Timmerman's (2018:9) hands-on definition, namely that care ethics deals with the ethics of everyday care. Within care, the "other" is essential. By focusing on the other, the situation will be avoided that the own agenda is pushed. This necessitates the importance of relationship building between caregiver and care-receiver (Vanlaere & Burggraeve, 2017:44-52). Understanding relationship building is further supported by Grypdonck, Vanlaere and Timmerman's (2018:15) comment that all involved in the network of caregiving and care-receiving should be part of this relationship. They further assist with understanding this concept by commenting that care ethics is more than the mere application of theory and principles to ethical dilemmas in everyday life. It is essentially about restoring relationships and dealing with situations in a pragmatic manner. Experience is important when dealing with ethical dilemmas in practice.

Tjong Tjin Tai (2014:196-197) confirms the scope of care ethics as the reality of ethical challenges in practice and how these are addressed in practice. An important objective of care ethics is the protection and development of relations between people and the action within relations. The main aim is to address a moral dilemma in practice.

Three perspectives are valuable for public health:

(a) Vulnerability gives rise to care;
(b) The way in which society operates, contributes to people's vulnerability; and
(c) The vulnerable should not be marginalised but mainstreamed back into society.

From the outline of the discussion above, it can be said that care ethics is about care, relations, commitment to the other, and responsiveness.

The meaning of care ethics for public health ethics is:

(a) care expressed through relationship development between agent and community or population;

(b) awareness of potentially more ethical challenges than those that exist on a theoretical level; and

(c) constructive involvement with and response to vulnerable communities.

The value of a care ethic is that it addresses ethical challenges as they emerge.

1.8.3 Professional ethics

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

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

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

This perspective argues in favour of changed public and professional behaviour when a public health ethics framework for geriatric people is presented. A supplementary view is presented by Verbruggen (2013), Gostin (2003), Carter *et al.* (2012), and Krebs (2008).

Verbruggen (2013:161-165) says that professional ethics emerges from the professional engagement between people in a concrete situation. An operating knowledge of the core activity is required to secure professional ethical behaviour (cf. Chapter 4; section 4.5).

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

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

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

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

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

1.9 THE DEVELOPMENT OF A PUBLIC HEALTH ETHICS FRAMEWORK

The various discussions in this chapter have prepared the basis for the development of a public health ethics framework for the geriatric community.

From the literature review five specific observations have been made:

(a) Ageing populations and elderly or geriatric communities are evident across the world. The World Health Organization predicts that elderly population growth will result in almost double the number from the current number of elderly people by 2050. This will present health, social, environmental, and political challenges.

(b) In developing countries the growth in the percentage of ageing people will be greater due to improved healthcare which impacts positively on life expectation. Developing countries will experience more challenges to address the needs of the growing elderly population as economic development may not be adequate to deal effectively with these challenges.

(c) The cost of healthcare is singled out as a worrying factor due to budget constraints in a declining economy and the rising cost of healthcare in general, resulting from technological developments and the need to address communicable and non-communicable diseases. The potential impact of the COVID-19 pandemic on world economies is assumed and must still be calculated in n+1 based on n-1 economic growth.

(d) There is a comprehensive body of literature, policies and plans available on geriatric care but this body originates mostly from developed countries. In South Africa there is a limited body of knowledge available on the geriatric community and its ethical challenges.

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

Four additional observations were identified that are relevant to this study:

(a) The need for a public health ethic is more a global discussion than a South African discussion.
(b) The central role of social determinants in healthcare, namely that social factors contribute just as much to a healthy society as good physical health does.
(c) South African social determinants causing ethical challenges for the geriatric community still need to be confirmed.
(d) The discussion on an ageing and subsequently an elderly population, together with the important role of ethics within public health, presents a case for *why* a public health ethics framework for the geriatric community is warranted.

The remark is especially appropriate in the context of the impact of social determinants on the geriatric community. A first emerging question is: *Which social determinants are giving rise to ethical challenges in public health for the geriatric community?*

A second emerging question is: What are the important ethical aspects to consider for a public health ethics framework for the geriatric community in the South African context?
Based on an understanding of what social determinants pose ethical challenges to the geriatric community and what the important ethical aspects are that must be considered in public health directed at the geriatric community, a public health ethics framework for the geriatric community was developed. Chapters 2 and 3 used the qualitative concepts developed in this chapter to contribute to the identification and development of building blocks for a public health ethics framework for the geriatric community. The building blocks are presented in Chapter 4 and the framework in Chapter 5.

1.10 PROBLEM STATEMENT

In identifying the problem statement for the study, advice was taken from a comment by Thomas, Sage, Dillenberg and Guillory (2002:1057), who claim that ensuring and protecting the health of the public (in this case the geriatric community) is inherently a moral obligation. This obligation was originally implicitly assumed but is now explicitly stated. There is a growing demand to be more specific on ethical matters due to technological developments which give rise to new ethical challenges. New challenges in healthcare and the abuse of power necessitate clear ethical statements. For the mentioned authors, public health principles include principles that concern individuals, institutions, and groups.

From the literature study it is evident that there is a growing elderly community. The importance of ethics in geriatric care was highlighted, as well as the implications thereof for public health. As a result of the literature review it has become obvious that a public health ethics framework for the geriatric community is absent. This comment in no way means that there are no guidelines available. The argument is rather that the principles of medical ethics and bioethics cannot simply be duplicated in a public health ethic as the scope is different. Notably, the focus in public health is on the group rather than the individual and on prevention instead of cure. A public health ethics framework is required to address all the ethical aspects of geriatric care responsibly and effectively. In compiling such a framework, the influence of social determinants on the geriatric community cannot be ignored. The social determinants suggest the identified ethical challenges that may be experienced by the geriatric community. Of special interest to this study was the lack of resources to support quality health and well-being services.

In view of the literature study's confirmation of the absence and therefore the need for a public health ethics framework for the geriatric community, the **problem statement** for this study is that there is no public health ethics framework for the geriatric community.

1.11 AIM OF THE STUDY

The **aim** of this study was to develop a public health ethics framework for the geriatric community.

The anticipated framework was drafted based on the results of the qualitative and quantitative research.

The aim of the study can be supplemented by the ***statement of purpose,*** namely that a public health ethics framework needs to be developed for the geriatric community.

1.12 RESEARCH QUESTION

A first question that emanated from the literature review was: *What is public health ethics for the geriatric community in the South African context?*

This question can be labelled as an exploratory research question (Jansen, 2008:11). The exploratory research question is supported by an explanatory question (Jansen, 2008:10-

11): *What is the added value of public health ethics for the geriatric community despite the existence of medical, bioethical, and healthcare ethics, protocols and statements?*

Following from these answers, the **research question** for this study was: *What are the important ethical aspects to consider for a public health ethics framework for the geriatric community in the South African context?*

1.13 RESEARCH OBJECTIVES

From the research question, three **research objectives** were identified:

- To identify the South African social determinants that present ethical challenges for the geriatric community.
- To define public health ethics for the South African geriatric community.
- To develop a public health ethics framework for the South African geriatric community.

To achieve these research objectives, a mixed method approach represented by qualitative and quantitative methods was used.

PART B

1.14 RESEARCH METHOD AND METHODOLOGY

This study was based on a literature review as part of a qualitative method and the Q-methodology which is qualitative in its information collection and data sampling but quantitative in terms of the method of analysis.

1.14.1 Characteristics of qualitative research

The research method for this study was grounded within the broader domain of a qualitative study, characterised by validity, practicality and effectiveness (Maree & Van der Westhuizen 2008:38). Fischer (2019:61) comments that existing material (such as literature or previous surveys) can assist with the development of the concourse, that is the documented full extent of opinions and viewpoints on a topic.

According to Silverman (2006:282-291), this method is very much descriptive (non-experimental). Silverman (2006:43) remarks that qualitative research finds its strength in the ability to study phenomena which are not available. Following Hammersley (1992), he continues by stating that the value of qualitative research is flexible and reflects on what people are doing. Qualitative research studies reflect on *process* and *outcomes* and *meaning* and *causes.* The application value is the meaning it brings to practitioners and administrators. Qualitative research is therefore applicable to real life situations (Silverman 2006:349-351). It is seen as a valid description of a phenomenon or activity and it can be applied to practice.

1.14.2 Scope of the qualitative approach

Two techniques within the qualitative methodology were used:

- the literature review to analyse and assess the debate on ethics in public health, and
- the Q-methodology (as part of a qualitative method) to identify
    i. which social determinants present ethical challenges in public health, and
    ii. what should be part of a public health ethics framework addressing these challenges.

1.14.3 Outline of Q-methodology

The Q-methodology originates from and was developed by William Stephenson (1902-1989). He focused on the subjective or first-person viewpoints of his participants. This approach is different from the R-methodology, where the focus is on objectivity in human behaviour (Brown & Good, 2012:1).

Newman and Ramlo (2015:2-3) observe that using the Q-methodology creates many opportunities for analysis. They reference the term "qualiquantology", as the philosophical underpinnings within the Q-methodology are a mixture of qualitative and quantitative ideas. For this reason, this methodology is "inherently mixed" and can be grouped in the broader context of mixed methods. Mixed methods provide the opportunity to systematically integrate both qualitative and quantitative results which will provide a more complete utilisation of the collected data (Wisdom & Creswell, 2013:3).

Brown (2011:2) claims that the Q-methodology provides a "framework for a science of subjectivity". Within this framework the procedures of data collection (Q-methodology) and analysis (factor analysis) can be used.

According to Alderson, Roy, Bryant, Ahmed and House (2018:737), the Q-methodology is particularly useful in understanding stakeholders' or participants' viewpoints. (This is known as inter-rater comparisons.) This method assists in the understanding of how a matter is viewed and what impact these views may have during implementation. This is part of a qualitative approach to the study.

Mason (2018) associates the Q-methodology with two main stages: (a) developing the statements and sorting them; and (b) analysing and interpreting of the ranked statements. Du Plessis (2005:10,142-172) unpacks the Q-methodology in five stages which correlate with the above two stages. These stages are collecting of information from the discourse, sampling, sorting of statements, factor analysis and interpretation. As the overall focus of the stages correlates, Mason's more streamlined approach was used.

The Q-methodology outlines both consensus and deviation (Alderson *et al.*, 2018:739-740). This is based on ranking predefined statements relevant to the research question of the study. These statements address the research question that was derived from the literature review. Participants ranked these statements. The rankings are part of the participants'

subjective view on a topic. Through the sampling of different viewpoints, possible barriers and levers in implementation, the envisaged framework can be anticipated. This is confirmed by Newman and Ramlo (2015:7), who comment that in the Q-methodology the interest is not in objectivity but subjectivity of viewpoints. They make an interesting comment by saying that the ranking of statements may not be based on a scientific epistemology but rather on a personal (own view) or public epistemology (how other's epistemology is viewed) (Newman & Ramlo, 2015:9).

The advantage of this method is that it narrows many viewpoints down to a few, which can be regarded as a shared way of thinking. An additional advantage is that it can include from a small group (even one participant) to a large group. Shabila, Al-Tawil, Al-Hadithi and Sondorp (2014:2) state that the Q-methodology is not designed for hypothesis testing, therefore it is not subjected to sample size estimation. Again, a larger group of participants should not change the outcome of the research as the focus of the Q-methodology is rooted in shared viewpoints and not generality of viewpoints.

Fischer (2019:49) assigns a positive outcome to this methodology. She says that an objective or scientific understanding is given to subjective opinions.

The Q-methodology was used to contribute towards drafting the planned framework. This technique identified (a) which social determinants can create ethical challenges in public health, and (b) what a public health ethics framework should cover to address these challenges.

1.14.4 Application of Q-methodology

1.14.4.1 *Information sampling and data collection*

The primary purpose of information sampling is to explore complex human issues, contribute to trustworthiness and constitute transferability of results. The overarching aim of qualitative sampling is to understand the complexity of an activity (Marshall, 1996:524). In this study the purpose of sampling the information and collecting the data was to support the development of a public health ethics framework for the geriatric community. The focus was not on the *generalisation* of results but rather on the *implementation* thereof.

The information sampling was based on the ranking of statements. From the ranking of statements was the data generated.

From the literature review, a first account of 70 statements were identified. These statements were relevant to the purpose of the study. Associated statements were grouped together and edited, resulting in a final list of 50 statements. This number correlates with the views of Fischer (2019:61) and Watts and Stenner (2005:75), who recommend a questionnaire of between 40 and 80 statements, as such a number provides a wide range of topics that can be ranked.

The 50 statements could be grouped into three sets of statements. These set of statements were relevant firstly to indicate which social determinants create ethical challenges in public health, secondly to identify what meaning can be linked to public health ethics, and thirdly to indicate what contributes to a public health ethics framework for the geriatric community (cf. sections 1.15.1-1.15.3).

The target audience or respondents represented by the identified population group ranked the statements based on the questionnaire provided to them. The terminology used within the Q-methodology is the **P-set** for the respondents. The questionnaire is referred to as **Q-sort table** and the statements as **Q-set**. The ranking of statements is known as **Q-sorting** (Shabila *et al.,* 2014:2).

The ranking of statements contributed to data collection. The purpose of data collection was to elicit subjective viewpoints and to identify shared patterns amongst individuals (Shabila *et al.,* 2014:2).

The ranking of statements was based on presenting the statements by means of a five-point Likert-scale questionnaire where the ranking took place based on 1 representing "least important" to 5 representing "cannot do without this". The ranking of statements fits the two extremes of the Likert-scale namely either "agree" or "disagree" with a moderate or neutral point of indecisive. Using the Likert scale represents a quantitative approach within the Q-methodology.

The different job profiles and therefore work responsibilities in the P-set as well as diversity in location based on geographic area (province & city or rural) secured the multiplicity in participation.

Within the Q-set analysis, factor analysis was used to reduce the responses into fewer dimensions. This assisted with identifying the sorting statements by the P-set who responded essentially in the same way (Shabila *et al.,* 2014:3).

1.14.4.2 *Population identification and approach to information collection*

The target population excluded geriatric people and focused on those who provide services to the geriatric community within the domain of public health. The identified audience included doctors, healthcare practitioners/workers (nurses, therapists, caretakers) and healthcare policy makers, managers, and administrators. The reason for the exclusion criterion is that the framework is a public health ethics framework that can be used as a guideline for ethical engagement with the geriatric community. The study was performed under ethical approval code UFS-HSD2019/0471/250 and UFS-HSD2019/0471/250.0001 (cf. Appendix 3).

Six geriatric institutions, two each in the Free State, Northern Cape, and North-West provinces, were identified. These provinces have the smallest populations compared to the other six provinces and represent 29.14% of the total population older than 60 years (RSA, 2020). Economically, these provinces fall outside the mainstream Gross Domestic Product (GDP) for provinces in South Africa (RSA, 2018).

The geriatric institutions were identified based on convenience and purposeful sampling. The convenience sampling was based on Marshall's (1996:524) grouping of the most accessible environment in the catchment area. Purposeful sampling was also used to identify and select geriatric institutions that are in marginalised provinces and often under-serviced regions. These institutions may not often be part of data collection activities on a particular topic due to their locality (Palinkas, Horwitz, Green, Wisdom, Duan & Hoagwood, 2015:535).

As the data was collected from more than one geriatric institution located in three provinces in South Africa, the impact of demographics and their intersectionality can be assessed as well (Fischer 2019:75). Demographic variables can either be categorical (age, gender, marital status) or continuous (age, years of education, family size). Although not the purpose of the ranking, this can also point out what commonalities or differences exist between the participants. This approach was not pursued as the focus of the study was on the development of a framework that can be used across geriatric facilities.

The data was sampled through completing questionnaires by twenty-two participants who agreed to participate in the ranking of the statements. This took place during July 2020 to August 2020. Due to COVID-19 regulations from March to September 2020, it was not

permissible for the researcher to visit the institutions. The collection of data took place during the time of national lockdown restrictions Level 3 (from June 2020 to 16 August 2020) and Level 2 from 17 August 2020 to 20 September 2020. The lockdown restrictions fell under the national state of disaster announced by President Cyril Ramaphosa on 15 March 2020. Elderly people were restricted from moving out of their homes or geriatric institutions. This restriction was caused by the global view that older people were at a higher risk of being infected due to physiological changes because of ageing and underlying health conditions (WHO, 2020a).

Because of these regulations, the researcher called the manager at each of these institutions telephonically and requested permission to engage with staff at the institution. Based on the provision of possible names, the researcher engaged them individually with at least a written request for their participation and consent (cf. Appendix 2). The questionnaires were sent via courier services separately in sealed envelopes addressed to each of the participants. The questionnaires were completed and returned in sealed envelopes via a courier service, as arranged by the researcher. Hence there was no cost for the participants. The completion of the questionnaires was independent and voluntary. The independence of completing the questionnaire was verified through the data coding scheme (cf. Appendix 5).

The analysis of the data was performed from October to December 2020. The Statistical Package for the Social Sciences (SPSS) statistical support software was used to analyse the data. The interpretation of the data and the development of information were done from December 2020 to May 2021.

1.15 APPLICATION: DESIGN OF QUESTIONNAIRE

A questionnaire was designed to sample data via the Q-methodology. The questionnaire can be viewed in Appendix 1. The following explanation was provided to each category in the questionnaire:

1.15.1 Statements around social determinants

The World Health Organization (WHO, 2015; 2017a; 2017b; 2017c; 2018) is clear on the fact that health is influenced by more factors than physical illness only. Typical factors influencing health are living conditions, food and water, social interaction, and availability of healthcare. These influences on health are referred to as social determinants.

This section focused on (a) the social determinants influencing the health of the geriatric community and (b) what social determinants will cause ethical challenges for the geriatric community.

Statements 1-8 dealt with a general view on public health and social determinants, 9-14 on social determinants influencing geriatric people's health, and 15-20 on the consequences of social determinants on geriatric people's health.

From the ranking of the statements the following was achieved:

(a) confirmation of what social determinants are;
(b) the social determinants that influence the health of the geriatric community; and
(c) the possible ethical challenges that emerge from these social determinants.

1.15.2 Statements around public health ethics

This section concentrated on what public health ethics is. "Ethics" is normally understood as the choice between what is right and what is wrong. In the context of public health ethics, ethics refers to choosing what is best to promote the health of a community or population. The absence of ethical behaviour towards the geriatric community or the delivery of healthcare to this community also influences the health of geriatric people. Public health ethics for the geriatric community does not deal only with geriatric people but also with those who care for geriatric people, or the systems that support the geriatric community.

This section laid the foundation for determining exactly what (a) ethics, (b) public health ethics and (c) public health ethics imply for the geriatric community.

1.15.3 Statements around a public health ethics framework

This section focused on the design of a public health ethics framework for the geriatric community. The aim of the framework is to apply ethics to the promotion of the geriatric community health and living conditions. The framework will be presented in the context of a care ethic for the geriatric community. The value-adding perspective of this framework is that it will break through the typical framing of ethics as theory or decision-making only.

This section identified building blocks for a public health ethics framework that can be used to assess behaviour, decision making or implementation of programmes in respect of the geriatric community.

1.15.4 Analysis of data collection

The SPSS statistical support software was used to analyse the ranking of statements captured by means of the Likert scale. The analysis assisted with determining which social determinants create ethical challenges in public health and what should be part of a public health ethics framework.

According to Fischer (2019:72), the data analysis can be performed by means of a non-Q *by variable* analysis (feedback per participant) and *by person* analysis (feedback per statement). The latter was more applicable to the scope of this study as the group's thinking on matters relevant to public health ethics was important in conceptualising the planned framework.

The analysis of the data collection is shared in Chapters 2-4. The information deriving from the data interpretations contributed to the public health ethics framework presented in Chapter 5.

1.15.5 Sharing of results

The ranking of statements contributed to identifying building blocks for the public health ethics framework. From these building blocks a public health ethics framework was compiled.

A summative webinar was convened for the participants in ranking these statements. The Zoom digital platform was preferred due to the COVID-19 restrictions still in place in June 2021, as well as the growing concern of a third wave of infections during the same period and already experienced at that stage in the Northern Cape and Free State provinces. The purpose of the webinar was to inform participants on the outcomes of the research. This discussion is known as the post-Q discussions.

An extended ethical clearance was applied for in respect of this webinar, as the ethical clearance from the Health Sciences Research Ethics Committee (HSREC) at the University of the Free State was only valid for one year.

A decision was made to focus during the webinar on the participants in the study only as the main objective was to give feedback and not to obtain consensus on the outcome of the framework or parts thereof. From the six participating institutions in the Q-sorting, 33% of institutions and 9% of the participants (P-set) attended the webinar. The Zoom recording function was used to capture the discussions. The invitation to participate in the webinar identified the agreement to participate in the webinar. When accessing the Zoom portal, attendees were also alerted to the fact that permission was given for recording. As the researcher was the host on the Zoom platform, the recording could be captured and after recording keeping could be deleted.

The results collected through the Q-set and the identified building blocks for the public health ethics framework and the framework itself were reported on. The discussion allowed for an extension of the Q-set in the Q-sort by permitting additional qualitative inputs such as open-ended comments (Fischer, 2019:62).

As no comments were provided that deviated from or challenged the framework presented, this webinar served as an agreement with what the aim and purpose of the framework were and provided reasonable support for the intention to present such a framework to the public health policy makers.

1.15.6 Summary of the literature review and Q-methodology approach

The research method and methodology used in this study can be summarised as follows:

- Literature review as scholarly review;
- Concourse of statements from a scholarly review;
- Prioritisation of statements;
- Data collection;
- Q-data analysis;
- Information sampling; and
- Post Q discussions.

1.16 ARCHITECTURE OF STUDY

This study is presented within the article option for the *Philosophia Doctor* qualification in the Department of Community Health at the Faculty of Health Sciences at the University of the Free State. This is in accordance with Regulation A 104 (b):

> *"In accordance with the stipulations of a faculty board, as contained in the Faculty Rules, a Doctoral Degree may be presented in the form of one (1) of the following options:*
>
> > *(ii) three (3) academic interrelated, publishable manuscripts/published articles and papers and, in certain fields, creative work such as artefacts, compositions, public performances and public exhibitions, in partial fulfilment of the research requirements (three hundred and sixty (360) credits)"* (University of the Free State, 2021: 12).

For this study three article themes were identified that are aligned with the research question identified for this study. These themes are:

(a) What social determinants will cause ethical challenges?
(b) What are the important ethical aspects to consider for a public health ethics framework for the geriatric community in the South African context?
(c) A public health ethics framework for the geriatric community in South Africa.

These articles are presented in this study according to the broad-based guidelines of public health journals. For peer review, the specific format of a journal is followed.

A summative overview of the study is:

- Preface
- Introduction to study
- Chapter 1
- Chapters 2-4 (Article format)
- Chapter 5
- Conclusion

This study is supported by appendixes reflective of:

- **Appendix 1**: Questionnaire
- **Appendix 2**: Letters to participate
- **Appendix 3**: Ethics Clearance, 2020 and 2021

- **Appendix 4**: Protocol
- **Appendix 5**: Frequency tables

Figure 1.1 provides a visual presentation of the lay-out of the study to develop a public health ethics framework for the geriatric community.

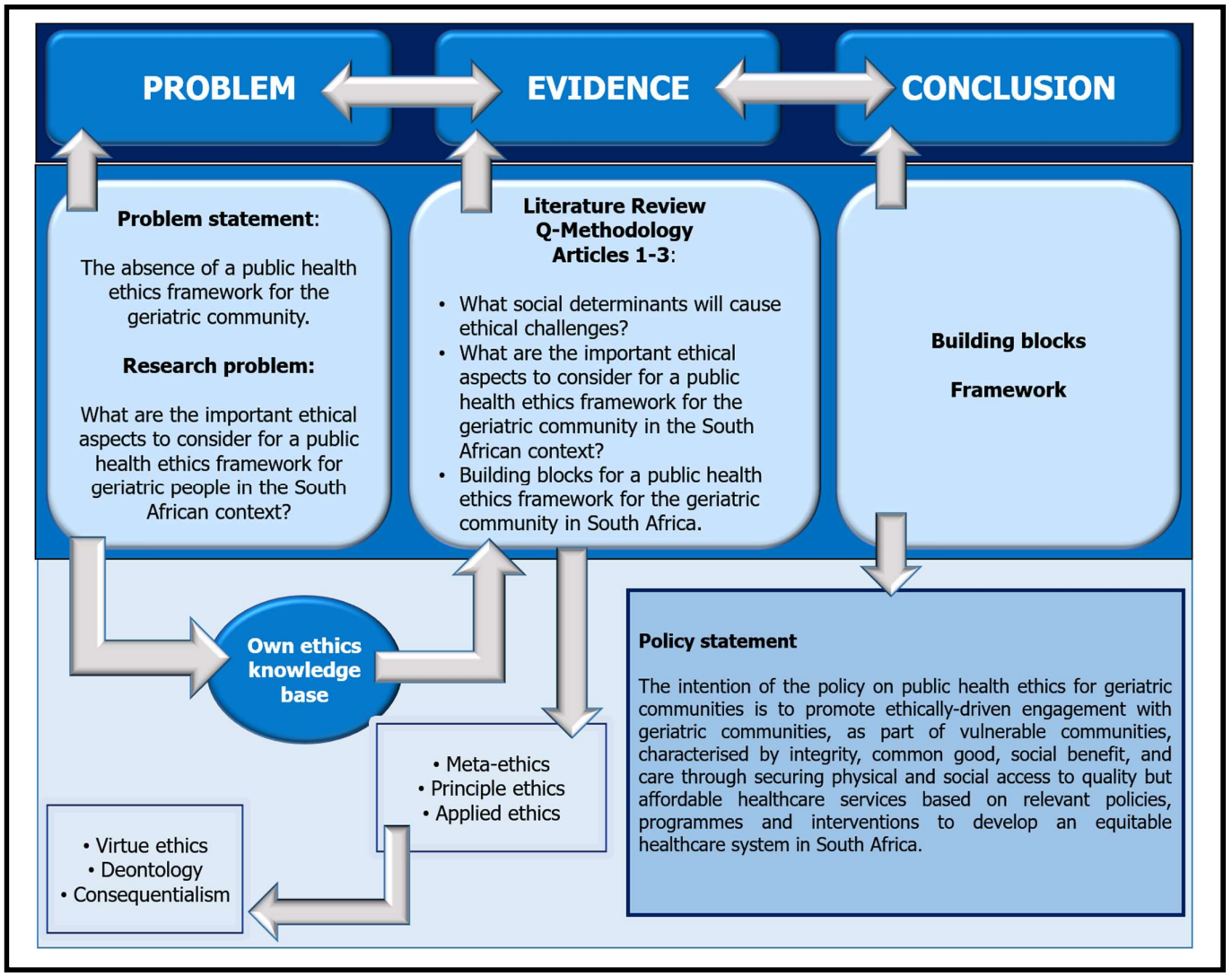

Figure 1.1: Layout of study to develop a public health ethics framework for the geriatric community

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Those docs, they always ask how you live so long. I tell 'em: If I'd known I was gonna live this long, I'd have taken better care of myself.

Eubie Blake, musician

CHAPTER 2

WHAT SOCIAL DETERMINANTS WILL CAUSE ETHICAL CHALLENGES IN GERIATRIC CARE?

This chapter first confirms which social determinants impact on geriatric care. Following on this identification, the focus is on which of these social determinants give rise to ethical challenges.

The Q-methodology was used to collect the data. Participants from six geriatric institutions ranked the statements captured in a questionnaire.

The data was analysed using the Statistical Package for Social Sciences software. The information produced was interpreted against the literature review presented in Chapter 1. From the data collection and analysis, it was evident that the lack of sufficient healthcare provision and the quality of healthcare provision are social determinants impacting negatively on the geriatric community's health. These social determinants contribute to the ethical challenges experienced by the geriatric community.

2.1 ABSTRACT

- **Background:** Social determinants are defined as those non-medical factors that influence health. Their influence is especially evident in vulnerable communities such as the geriatric community. From World Health Organization's reports, it is generally accepted that the number of geriatric people will double by 2050. The growth in the number of geriatric people in South Africa is in line with global expectations and the influence of social determinants is recognised. What is not confirmed yet is which social determinants will cause ethical challenges in geriatric healthcare in South Africa.
- **Objectives:** This study first identified which social determinants influence geriatric care. The study then ascertained which of these social determinants give rise to ethical challenges in geriatric care.
- **Methods:** The Q-methodology was used to rank 20 statements grouped into three indexes, focusing respectively on a general view on public health and social determinants, social determinants influencing geriatric people's health, and the consequences of social determinants on geriatric people's health. The ranking was based on presenting the statements by means of a five-point Likert-scale. Twenty-two

participants from six geriatric institutions in three provinces participated in the ranking of statements. The institutions were identified based on convenience and purposeful sampling. Principal component analysis (PCA) was used to summarise the information content and factor analysis to reduce the statements into fewer dimensions.

- **Results and discussion:** The ranking of statements confirmed the generally accepted view in research that social determinants impact on the health of geriatric people. The responses to the statements were an additional confirmation that quality of healthcare services and access to healthcare services influence geriatric care. The challenge with healthcare services and their quality not only impacts on health but raises ethical challenges. Matters such as corruption, limited resources and the current COVID-19 pandemic contribute to the influence of social determinants and the expected but failed ethical behaviour towards the geriatric community.
- **Conclusion:** One of the causes of vulnerability in the geriatric community is that there are ongoing social factors that impact negatively on health, of which healthcare provision and the quality of healthcare provision are important contributing factors. These factors contribute towards ethical challenges in healthcare for the geriatric community.

2.2 INTRODUCTION

Chan (2017), Berridge (2016), Braveman and Gottlieb (2014), Braveman, Egerter and Williams (2011), Wilkinson and Marmot (2003) confirm the influence of social determinants on health. Social determinants in health are well formulated by Braveman *et al.* (2011:383), as "non-medical factors influencing health." The World Health Organization (WHO) confirms in various reports (WHO, 2015; 2017; 2018) that health is influenced by more factors than physical illness only. Aspects such as living conditions, food and water, social interface, and availability of healthcare influence general health. Wilkinson and Marmot (2003:10) confirm that health follows the social gradient.

In the discussion on social determinants the question is no longer *if* social factors influence health, either positively or negatively, but rather *which* social determinants have a bigger impact on the health of people. The distinction of Braveman *et al*. (2011:383), between upstream and downstream social determinants strengthens this observation. Upstream social determinants have a greater impact on health than downstream factors.

Following from this observation, the focus is now on how social factors operate and how interventions can activate health-promoting pathways and interrupt health-damaging ones. This approach links up with the WHO's focus on ageing through promoting the concept of "healthy ageing". Healthy ageing is defined as "the process of developing and maintaining functional ability that enables well-being in older age" (WHO, 2015:28).

One of the negative consequences of social determinants is their impact on vulnerable communities. One such community is the geriatric community. Statistics from WHO (2015) suggest that the world population older than 60 years will nearly double by 2050. According to the South African Mid-year Population Estimates Report 2020 (Republic of South Africa [RSA], 2020a), 9.1% of the population is older than 60 years. This group represents 5.43 million people out of an estimated population of 59.62 million people. Geriatric people are in general vulnerable because of their condition (for example, they may have less physical mobility), but also at risk due to the specific causes they are exposed to (for example access to healthcare) (Caresentric, 2017).

A neglected aspect of social determinants that influence geriatric care is the absence of identifying which social determinants are open to ethical challenges, consequently leading to ethical dilemmas.

2.3 OBJECTIVE

This study first identified which social determinants influence geriatric care. The study then ascertained which of these social determinants give rise to ethical challenges in geriatric healthcare.

2.4 METHOD

A qualitative approach was used in the study and the Q-methodology was selected for data collection. The Q-methodology focuses on the subjective viewpoints of participants. According to Alderson, Roy, Bryant, Ahmed and House (2018:737), the Q-methodology is particularly useful in understanding stakeholders' or participants' viewpoints, also known as inter-rater comparisons. This method assists in understanding how a matter is viewed and what impact these views may have during implementation. Mason (2018) associates the Q-methodology with two main stages: (a) developing the statements and sorting them, and (b) analysing and interpreting the ranked statements. Du Plessis (2005:10,142-172)

unpacks the Q-methodology in five stages, which correlate with the above two stages. These stages are collecting of information from the discourse, sampling, sorting of statements, factor analysis and interpretation. As the overall focus of stages correlates, Mason's more streamlined approach was used.

The Q-methodology outlines both consensus and deviation (Alderson *et al.*, 2018:739-740) and is based on ranking predefined statements (Q-sorting) relevant to the research question of a study. The statements (Q-set) derived from the literature review and are ranked by the participants (P-set).

The advantage of this method is that it narrows many viewpoints down to a few, which can be regarded as a shared way of thinking. An additional advantage is that it can include any groups from small (even with only one participant) to large.

The ranking was based on presenting the statements by means of a five-point Likert-scale questionnaire (Q-sort table) where the ranking took place according to "*least important*" (1) to "*cannot do without this*" (5). The ranking of statements can fit the two extremes of the Likert-scale, namely either agree or disagree, with the moderate or neutral point being indecisive. The Likert-scale represents a quantitative approach within the Q-methodology.

For the objective of this study, twenty statements were identified from the literature review that were grouped into three indexes. Statements 1-8 presented a general view on public health and social determinants, Statements 9-14 focused on social determinants influencing geriatric people's health, and Statements 15-20 looked at the consequences of social determinants on geriatric people's health. From the ranking of these statements the following was achieved: (a) confirmation of which social determinants influence the geriatric community, and (b) confirmation of the possible ethical challenges that emerge from these social determinants.

Six geriatric institutions, two each in the Free State, Northern Cape, and North-West provinces, were identified. These provinces have the smallest populations compared to the other six provinces and represent 29.14% of the population older than 60 years (RSA, 2020b). Economically these provinces fall outside the mainstream Gross Domestic Product (GDP) for provinces in South Africa (RSA, 2018). The geriatric institutions and the participants were identified based on Marshall's (1996:522-525) grouping of convenience sampling (most accessible environment). Purposeful sampling was also used to identify and

select geriatric institutions that are in marginalised provinces and often under-serviced regions and that may not always be part of data collection on a particular topic due to their locality (Palinkas, Horwitz, Green, Wisdom, Duan & Hoagwood, 2015:535). The data was sampled from July to August 2020 and analysed from October to December 2020. The COVID-19 pandemic did not influence the collection of data as the questionnaires were delivered and collected via pre-arranged courier services.

Twenty-two participants from the six geriatric institutions participated in the ranking of the statements. The target population excluded geriatric people and focused on those who work with geriatric people in the domain of public health, namely doctors, registered nurses, nurses, healthcare workers, managers and administrators. Geriatric people were excluded from the study as the focus was on the gathering of in-depth information on public health ethics as perceived by the identified target population, the healthcare providers and managers.

Ethics approval was obtained from the HSREC (UFS-HSD2019/0471/250) and approval to conduct the study was obtained from the managers of the various institutions. Informed consent was obtained from all participants before the start of the data collection.

Cronbach's alpha was calculated to assess the reliability of the statistics. From Table 2.1, it is noted that Cronbach's alpha is 0.744. This confirmed the internal consistency of the scale and a uni-dimensionality in the sample of test items.

Table 2.1: Reliability of statistics

Cronbach's alpha	Cronbach's alpha based on standardised items	No. of items
.744	.831	20

Principal component analysis (PCA) was used to summarise the information content. Based on the collected data, the rotated component matrix (Table 2.2) identified six factors from the outcome of the survey. Variables were assigned to the factors. The rotated component matrix sorted the variables by the factor they belonged to and by co-variance with the factor.

PCA was used for the extraction method. For the rotation method, Varimax with Kaiser normalisation was used.

Table 2.2: Rotated component matrix

Statements	Component					
	1	2	3	4	5	6
Poor management of healthcare influences health.	.953					
Geriatric people's health is influenced by living conditions such as accommodation/housing, food, nutrition, electricity, water, sanitation and the general environment.	.868					
Geriatric people's health is influenced by access to healthcare, whether financial, area (location of healthcare facility), language or mobility.	.852				-.389	
Health is influenced by more than physical challenges or illness only.	.837					
Poor service delivery influences healthcare.	.828			.378		
Lack of finances influences access to and quality of healthcare.	.816					
Social factors such as low income, little and substandard education, limited employment options, high levels of unemployment and poor living and working conditions influence the health of all people.	.730			.464		
Geriatric people's health is influenced by social factors such as the role in the family (for example caring for grant children), isolation from peers and/or children.	.699		-.404			
Geriatric people's health is influenced by public health preparedness to prevent disease and create good living conditions.	.583					-.557
Government only has a financial responsibility to promote the health of geriatric people.		.884				
The healthcare of geriatric people is poorly managed.		-.792				
Geriatric people's interest is more important than the communities' interest.		.776				-.328
Geriatric people have the responsibility to care for themselves.			.903			
Geriatric people need to be educated on how to care for themselves.			.854			
Geriatric people have different needs from other population age groups.	.356	.352	.461	.391	-.420	
Differences in the availability of healthcare support systems is the biggest challenge of geriatric people.		.304	.375	-.720		
Lifestyle influences health.	.444	.334		.706		
Public health is about prevention and not treatment.		-.374	.335	.547	.364	
There are enough healthcare support systems available to support geriatric people.					.905	
Public health is about collaboration between government, healthcare facilities and communities.	.322					.845

The first factor confirmed the influence of social determinants on the geriatric community's health. This confirmation is in line with the general acceptable interpretation of social

determinants, namely all non-medical factors influencing health. Within this dimension, personal circumstances (for example social conditions) and system problems (for example access to healthcare) are confirmed as contributing to the social determinants influencing health.

A second factor concentrated on the management of resources and expectations of geriatric communities' healthcare. Resources are a recurring theme in dealing with healthcare. Age preference when healthcare is implemented, challenges the reality regarding to whom limited resources should be allocated.

A third factor was the responsibility to manage own healthcare. The reference to responsibility is imbedded in ethics as a core of personal behaviour.

A fourth factor related to having appropriate public health support systems in place and the impact they have on the individual's behaviour. This dimension is particularly relevant when support is planned. As public health is an organised government or delegated agent intervention to prevent poor health, an ethical challenge arises when this responsibility is neglected.

A fifth factor suggested a multi-systems approach to geriatric healthcare whilst the sixth factor requires a multi-partner approach to geriatric care.

2.5 RESULTS AND DISCUSSIONS

The respondents (Q-set) in the target group were represented by 72.7% female and 27.3% male respondents respectively. The identification of participants was not based on gender representation but job responsibility within the geriatric institution. The gender representation suggests that more females than males work in the identified geriatric institutions.

The highest percentage of respondents was in the age group 46 – 60 years (36.4%). They were followed by a group 70 years and older (27.3%). The majority of respondents had either post-school education (18.2%) or higher education (54.5%) qualifications, resulting in 61.1% of the total respondents with professional registration. Just more than half of the respondents, namely 51.1%, work as doctors, (registered) nurses or healthcare workers. Medical doctors and registered nurses represented 40.9% of the total participants.

Managers and administrative staff represented 22.7% each of the total respondents. Of all the respondents, 36.4% had between 0 and 5 years' work experience, with 18.2% each having between 21 and 30 years, and 30 years and more, of work experience.

The frequency information confirmed two cohorts: one with medical or healthcare experience (49.9% of respondents), and the other with management or administrative experience (45.4% of respondents). The information confirmed a high percentage of post-school training (72.7% of respondents), with 36.4 % respondents having cumulatively 21 years and more of work experience.

These cohort profiles were used to analyse the feedback of respondents on (a) statements around social determinants (cf. Table 2.3), social determinants influencing geriatric people's health (cf. Table 2.4), and the consequences of social determinants on geriatric people's health (cf. Table 2.5).

Table 2.3: Statements around social determinants

Statements	Strongly disagree		Disagree		Neutral		Agree		Strongly agree	
	Count	%	Count	%	Count	%	Count	%	Count	%
S1: Public health is about prevention and not treatment.	3	14.3%	4	19.0%	0	0.0%	13	61.9%	1	4.8%
S2: Public health is about collaboration between government, healthcare facilities and communities.	0	0.0%	0	0.0%	1	4.5%	15	68.2%	6	27.3%
S3: Health is influenced by more than physical challenges or illness only.	0	0.0%	0	0.0%	0	0.0%	11	52.4%	10	47.6%
S4: Social factors such as low income, little and substandard education, limited employment options, high levels of unemployment and poor living and working conditions influence the health of all people.	0	0.0%	0	0.0%	0	0.0%	8	36.4%	14	63.6%
S5: Lifestyle influences health.	0	0.0%	1	4.5%	0	0.0%	11	50.0%	10	45.5%
S6: Poor service delivery influences healthcare.	0	0.0%	0	0.0%	0	0.0%	8	36.4%	14	63.6%
S7: The poor management of healthcare influences health.	0	0.0%	0	0.0%	0	0.0%	8	38.1%	13	61.9%
S8: Lack of finances influences access to and quality of healthcare.	0	0.0%	1	4.5%	0	0.0%	9	40.9%	12	54.5%

All respondents agreed or strongly agreed with Statement 3 that health is influenced by more than physical challenges or illness only. This is aligned with the accepted understanding of the influence of social determinants on the health of people. Both the medical cohort and the management cohort were in agreement with this statement. The significance thereof is that this observation is accepted beyond the healthcare practitioners and workers' cohort and should positively influence the management of healthcare provision for the geriatric community.

The respondents were also 100% in agreement that social factors such as low income, little and substandard education, limited employment options, high levels of unemployment and poor living and working conditions influence the health of all people. This is in line with the general understanding of social gradients influencing health (Wilkinson & Marmot, 2003). What is even more telling is that 63.6% strongly agreed with Statement 3. Healthcare, the management thereof and finances are all contributing factors confirming the influence of social determinants. This was confirmed by 100% of the respondents who agreed or strongly agreed with Statements 6 and 7, and 95.5% who agreed or strongly agreed with Statement 8. These responses are in line with Statistics South Africa's Mid-year Population Estimates Report for 2020 (RSA, 2020a). The report identifies the apparent vulnerabilities in the age group 60 years and older caused by the need for social assistance programmes, easy access to cash transfers, food programmes and healthcare. The situation is not improving due to the COVID-19 pandemic (RSA, 2020b). Older people are at a higher risk of being infected by the Coronavirus because of physiological changes and underlying health conditions associated with ageing.

In addition, in ranking the statements, participants were equally represented from urban and rural geriatric institutions. The representation was a confirmation that social determinants in principle are not limited to a particular environment although the socio-economic status of an environment influences the impact of social determinants on people. Statements 4 and 5 are very much person- and context-influenced, whilst Statements 6 to 8 relate to the quality and availability of healthcare. The significance of Statement 4 is influenced by heavy dependency on social or elderly grants in South Africa, social environment and social circumstances of being parent to grandchildren due to cultural and health reasons (Moore, 2020; Goodrick, 2013; Mhaka-Mutepfa, Hunter, Mpofu & Cumming, 2016). Responses to Statements 6 to 8 also confirmed the significance of service delivery, quality, and the availability thereof. Within the context of geriatric healthcare service delivery, quality and availability of the service are essential. The COVID-

19 pandemic and associated lockdown arrangements by the government of South Africa have not eased the burden, as a result of a declined economy and reduced access to healthcare. An overarching concern is that the National Health Department's Strategic Plan for South Africa, 2020 – 2025 is not specific in its strategies or goals when addressing the social and structural determinants impacting on the health of elderly people (RSA, 2020c). Although the mentioned Plan aims to improve on the delivery and quality of healthcare, the absence of a specific action itself constitutes an ethical dilemma, as effective care for elderly people is challenged.

Table 2.4: Statements around social determinants influencing geriatric people's health

Statements	Strongly disagree		Disagree		Neutral		Agree		Strongly agree	
	Count	%	Count	%	Count	%	Count	%	Count	%
S9: Geriatric people's health is influenced by access to healthcare, whether financial, area (location of healthcare facility), language or mobility.	0	0.0%	0	0.0%	0	0.0%	11	50.0%	11	50.0%
S10: Geriatric people's health is influenced by living conditions such as accommodation/housing, food, nutrition, electricity, water, sanitation and the general environment.	0	0.0%	0	0.0%	0	0.0%	9	40.9%	13	59.1%
S11: Geriatric people's health is influenced by social factors such as the role in the family (for example caring for grant children), isolation from peers and/or children.	0	0.0%	0	0.0%	1	4.5%	14	63.6%	7	31.8%*
S12: Geriatric people's health is influenced by public health preparedness to prevent disease and create good living conditions.	0	0.0%	0	0.0%	1	4.5%	17	77.3%	4	18.2%
S13: Geriatric people have the responsibility to care for themselves.	2	9.1%	8	36.4%	5	22.7%	5	22.7%	2	9.1%
S14: Geriatric people need to be educated on how to care for themselves.	1	4.8%	4	19.0%	4	19.0%	10	47.6%	2	9.5%*

Note: The percentages in the table above are rounded up to first decimal place.*

Table 2.4 reflects on social determinants influencing geriatric people's health. Statements 9 to 11 ranked access to healthcare, the influence of living conditions and social factors. The responses to these three statements suggest that the existence of these conditions is outside the behaviour control of geriatric people. Statement 12 refers to organised activities to secure healthy living for geriatric people. The agreement or strong agreement is 100% for Statements 9 and 10, while the influence of family, peers or isolation had a 95.5% ranking of agreement or strong agreement. The influence of access to healthcare, living conditions and social factors confirm the vulnerability of geriatric people as confirmed by the literature. The vulnerability is further highlighted by factors such as language. Without proper communication the needs of geriatric people cannot be expressed or comprehended. The significance of these three categories of social and structural determinants on geriatric people becomes more complex when challenged by socio-economic factors and the provision of basic healthcare. The National Department of Health's Strategic Plan of South Africa, 2020 – 2025 (RSA, 2020c) has as a goal the completion of the reform of health systems (Goal 6) within South Africa. The Plan confirms the challenges in the health systems and the quality of healthcare. The South African Lancet National Commission's Report (2018:2) on healthcare in South Africa identifies effectiveness in guaranteeing the delivery of quality health service to all citizens as one of the characteristics of a quality health system. The key diagnostic findings in the Report confirm that challenges with data quality remain "a significant barrier to the assessment of health system" (The South African Lancet National Commission's Report, 2018:3).

Statements 13 and 14 presented a mixed response to whether geriatric people have the responsibility to care for themselves and whether they should be educated on how to care for themselves. Almost half of the respondents, 45.5%, either strongly disagreed or disagreed with the statement that geriatric people have the responsibility to care for themselves. Although still significant, 31.8% of respondents were in agreement that elderly people have the responsibility to care for themselves. While not stated explicitly, the general assumption is that the health condition of the geriatric person plays a leading role in this statement. Geriatric people with mental health challenges or in palliative care will normally be excluded from this group. The 22.7% of respondents who were neutral most probably considered the state of health of the geriatric person. The high percentage of respondents who disagreed that geriatric people should care for themselves strengthens the perception that geriatric people cannot make their own decisions. It may be that the isolation of the geriatric community during the COVID-19 pandemic contributed towards this view. Through a factor analysis of .876, the relevance of this statement for the influence of social

determinants is confirmed. Statement 14 had an opposite ranking to Statement 13. More than half (57.1%) of the respondents agreed with the statement that geriatric people need to be educated to care for themselves while 23.8% either disagreed or strongly disagreed. Nineteen percent (19%) of the respondents were neutral on this matter. No qualitative reasons were provided for the strong agreement on the importance of educating geriatric people to care for themselves. Based on the concept of healthy ageing, this statement, when read together with the previous statement, presented the observation that through education on self-care, the opinion may change that geriatric people should care for themselves. The need for education is emphasised by Kececi and Balduck (2012), with their suggestion that healthy ageing promotion strategies must be anchored in health education. Health education will assist people to make decisions about their health (Mallmann, Neto, Sousa & Vasconcelos, 2015).

An estimated 4.3 million people out of an estimated 5.3 million people in South Africa received an old age pension from government in 2020 (RSA, 2020b). This group represents 81.13% of the old age population. The high number of elderly people dependant on government's financial support confirms the deprived socio-economic conditions of elderly people in South Africa. This observation further directs public health towards the focus of dealing with the geriatric community based on functional ability as part of healthy ageing. These comments also direct towards the meaningful role that public health should play in the geriatric community's healthcare. This was further confirmed by the high number of respondents who were in agreement with Statement 1, namely that public health is about prevention and not treatment. This observation was further strengthened through the 95.5% agreement ranking of Statement 2, that healthcare should be a partnership between government, healthcare facilities and communities.

Table 2.5: Statements on consequences of social determinants on geriatric people's health

Statement	Strongly disagree		Disagree		Neutral		Agree		Strongly agree	
	Count	%	Count	%	Count	%	Count	%	Count	%
S15: Government has only a financial responsibility to promote the health of geriatric people.	9	42.9%*	11	52.4%	0	0.0%	0	0.0%	1	4.8%*
S16: Geriatric people have different needs from other population age groups.	0	0.0%	2	9.1%	2	9.1%	11	50.0%	7	31.8%
S17: Geriatric people's interest is more important that the communities' interest.	3	13.6%	8	36.4%	8	36.4%	2	9.1%	1	4.5%
S18: Differences in the availability of healthcare support systems is geriatric people's biggest challenge.	1	4.8%	1	4.8%	4	19.0%	10	47.6%	5	23.8%
S19: There are enough healthcare support systems available to support geriatric people.	7	31.8%	14	63.6%	0	0.0%	0	0.0%	1	4.5%*
S20: The healthcare of geriatric people is poorly managed.	0	0.0%	2	9.1%	3	13.6%	14	63.6%*	3	13.6%

Note: The percentages in the table above are rounded up to first decimal place.*

The insufficient availability and poor quality of healthcare services for geriatric people were confirmed through Statements 19 and 20. An overwhelming 94.5% disagreed or strongly disagreed that there are enough healthcare support systems available to support geriatric people. This observation is in line with public commentaries that not enough is done to support the geriatric community (Kalula, 2013; Sigasana, 2017; Zikali, 2018). This observation was further confirmed through the 72.2% ranking that healthcare is poorly managed. An additional interpretation of Statement 20 was that the absence of sufficient healthcare support systems is further challenged by the poor management of the services. The link to these statements was confirmed through an Inter-Item Correlation Matrix. Similar correlations existed with Statements 12 and 15. With the assistance of Pearson's correlation coefficient, the association between variables of interest be measured. Statements 12, 15, 19 and 20 emphasised the magnitude of public health in general and service delivery for geriatric healthcare in particular. The ranking of these statements served as a confirmation of the importance of good service delivery. The 9.1% disagreement to this statement can possibly relate to the experience within the own geriatric institution and not geriatric healthcare as a system in general.

It is evident that the government's responsibility goes beyond finance. The high percentage of respondents who agreed (52.4%) or strongly agreed (42.9%) with Statement 15 were aligned with the general acceptance of such a view. The significance of this response is based on respondents who were representative of the (a) medical, healthcare practitioners and workers and (b) management and administration cohorts. This ranking aligned with general principles in both healthcare ethics and business ethics, namely to always act in the best interest of a person. Weber (2001) articulates the complexity of this responsibility well through the observation that compliance, cost, quality of care, patient and healthcare worker should be considered in decisions in healthcare provision.

It is noteworthy that 4.7% of the respondents strongly agreed that government has a financial responsibility only. This opinion can be linked to the agreement in Statement 2 that there is a joint responsibility to care for the elderly. This response, although very small, can also be aligned with the view that sufficient finance will contribute to the required care. Such an observation is in line with the leading role that finance plays in healthcare although it is at odds with an ethical view that financial means only are not enough to care for the geriatric community. The interpretation of these results should be read together with Statement 16, where 81.8% of respondents agreed or strongly agreed that the geriatric community have different needs from other population age groups. This statement

confirmed the specific needs for this population group. Statement 17 was in line with a general healthcare ethics perspective, namely that no population age group should have preference over another group. Half (50%) of the respondents disagreed or strongly disagreed that the geriatric community's interest is more important than that of the populations' interest. It is striking that 13.6% of the respondents fell in the age group between 30-45 years. The remaining respondents (86.4%) were all older than 45 years, which served as a confirmation that different age groups may have different needs, but the one group cannot have preference over the other. What is more dominant with the geriatric community are challenges associated with end of life as such challenges confirm the imperfection of life (Holtzer, 2015:125).

2.6 CONCLUSION

The scope of this study was first to identify which social determinants influence geriatric care and second to identify which of these social determinants give rise to ethical challenges in geriatric healthcare.

From the results above, it was evident that the availability of healthcare, access to healthcare and the quality of healthcare are important factors influencing the health of geriatric people. These activities can be grouped together as healthcare services. The results further confirmed that living conditions and social factors play an equally important role in the health of the geriatric community. The responses confirmed that social determinants' role in public health is equally important in both urban and rural contexts. This is in line with the general confirmation in literature that socio-economic factors influence the reception of healthcare. It is further noteworthy that regardless of the geographic location, the role of the social determinants on health is not viewed differently. Availability of and access to service and the quality thereof is undeniably a constitutional right. According to the South African Constitution, healthcare is an economic right (RSA, 1996). Although enshrined in the Constitution, healthcare services and their level of quality are deeply challenged. The challenges grow as there are huge divides between provinces, and in provinces between urban and rural communities. The absence of services or the quality of services are confronted by high levels of government corruption, the collapse of services and the COVID-19 pandemic. The challenges to vaccinate the geriatric community illustrate the lack of performance of the healthcare system (RSA, 2021).

The healthcare and management cohort who responded to these statements served as an

additional confirmation that service and lifestyle are important determinants for the healthcare of the geriatric community. Service evokes social responsibility and individual lifestyle responsibility. This perspective supports changed public and professional behaviour when a public health ethics framework for geriatric people is presented.

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Et tu, Brute?

William Shakespeare, Julius Caesar

Our only purpose in life is growth. There are no accidents.

Elisabeth Kübler-Ross

CHAPTER 3

WHAT IS PUBLIC HEALTH ETHICS FOR THE GERIATRIC COMMUNITY?

This chapter addresses the question of what public health ethics is for the geriatric community. The argument is presented that the core of what public health is, should be the basis to identify public health ethics.

The Q-methodology was used to collect the information from participants from six geriatric institutions, based on the ranking of statements captured in a questionnaire. The data was analysed using the Statistical Package for Social Sciences software. The data collected was interpreted against the literature review presented in Chapter 1.

The ranking of statements suggests that the need is less to understand what ethics is and more to know *how* to apply the principles of ethics to the working environment.

The position was taken that public health ethics can be viewed from applied, professional and social ethics points of view. It was further observed that ethical behaviour is not only observable from person-to-person, but also through systems, processes, and practices.

This study defines public health ethics as the application of healthcare principles through a professional ethic resulting in care and relationship building.

The leading public health ethics principles for the geriatric community are the promotion of health, respect for life, upholding of dignity, protection of vulnerability, quality of living and environment, and access to services.

3.1 ABSTRACT

Background: A growing ageing community will put additional demands on the public health system. In return, this will contribute to ethical consequences for the healthcare sector. A public health ethics framework can contribute towards addressing the ethical challenges faced by the geriatric community.

Aim: This study intends to contribute to a public health ethics framework for the geriatric community from a South African perspective.

Setting: Twenty-two participants from six geriatric institutions, two each in the three provinces, participated in the research.
Method: The Q-methodology was selected for this study. Fifteen statements were ranked by means of a five-point Likert-scale questionnaire. The statements were grouped into three areas, namely what is ethics, what is public health ethics, and what is public health ethics for the geriatric community.
Results: Ethical behaviour is observable not only from person-to-person but also though systems, processes, and practices. The need is to understand *how* to apply ethics principles to the working environment. The position is taken that a public health ethic can be viewed from applied, professional and social ethics.
Conclusion: Public health ethics is the application of healthcare principles through a professional ethic resulting in care and relationship building. The core of what public health is, should be the basis to identify a public health ethic where the focus is on the community and improvement of the quality of health and well-being of the community.
Contribution: No evidence of a public health ethics framework for the geriatric community could be identified in South Africa.

3.2 INTRODUCTION

Convincing evidence for a growing ageing population and hence elderly society has been presented by the World Health Organization (WHO). The consequences are well presented by the WHO's references to the demands an ageing population and society will place on healthcare provision (WHO, 2015; 2017). It is generally assumed that these consequences will not be without ethical challenges and therefore require ethical guidelines, as commented by Chan (2017).

The growing impact of social determinants on health requires ethical considerations when public health services are identified and implemented. The geriatric community can benefit from a public health ethics framework due to their health, social and financial vulnerability.

Chan's comment raised the question if there is (at least) a guiding definition and therefore scope of what public health ethics for the geriatric community is. Although it will be unfair to claim that there is no sufficient definition or scope of activities, within a South African context such reference is absent as confirmed by publication indexes such as Science Direct, Proquest, Taylor and Francis and Sabinet African Journal Collection Sabinet. On the official website of the National Department of Health no such policies could be identified either.

The aim of this study is to contribute to the development of a public health ethics framework for the geriatric community.

In dealing with this intention, this study's departing point was Beauchamp and Childress's (2013, first published 1979) emphasis on the respect for *beneficence, non-maleficence, autonomy,* and *justice* as principles for bioethics. These principles, however, are generally regarded in healthcare as the backbone for ethics in health- and medical-related activities. In a seminal discussion initiated by Gillon (1994), the above principles were extended by adding "scope" to them. This recommendation has since then commonly been known as the "four principles plus scope" approach. Gillon argued that regardless of personal belief, orientation and affiliation, any person can commit to these principles. After the English philosopher W.D. Ross, he referred to the four principles as *prima facie* principles, meaning that they are binding unless in conflict with another moral principle. "Scope" raised the concern of *if* and *how* these principles are applied and what their subsequent consequences could be. The need to add "scope" to these principles can further be informed by Ten Have, Ter Meulen and Van Leeuwen (2013:8-11), who argue that ethics deals with either external factors (for example the influence of a group or a community) or internal factors (one's own attitude or belief system), guiding a person or agency to act in a particular manner. The summative interpretation is that ethics is based on principles. An additional assignment is that ethics reflects on factors influencing the interpretation and application of these principles. This understanding is aligned with the Greek word *ήθος* from which the word ethics is derived. "Ethos" refers to a set of beliefs or ideas on what the accepted behaviour is towards other people and society.

This general understanding of what ethics is, invites a general understanding of public health too. Berridge's discussion of public health influenced the approach taken in this chapter to phrase a working definition and scope for public health. Although public health exists beyond a single definition, Berridge (2016:2,69) argues that public health refers to a profession and a body of knowledge. In its narrowest sense, public health refers to the health of a population, the longevity of individual members and the freedom from disease. Public health also has prevention of illness rather than the provision of health and well-being as an anticipatory character. This approach can be aligned to Baylis, Kenny and Sherwin (2008), who argue for an ethics framework serving public health needs to prevent illness, build physically and socially healthy communities and eliminate health inequities.

As a working definition for this study, *public health* refers to *the organised strategies,*

interventions, and services to promote the quality of health and well-being of a community or population. (Cf. Lategan & Van Zyl, 2018 for a detailed discussion on defining public health.)

This definition also identifies the expectations associated with public health, notably the quality of service and healthcare provision.

Given the above discussion on public health and ethics, *public health ethics* can be defined as the ethical principles, decisions, and behaviour to improve a community or population's health and well-being.

From this definition the identified scope of public health ethics is (a) the identification and application (b) of ethical healthcare principles (c) to secure quality of healthcare provision and services for a targeted population (d) to result in the improvement of health and well-being. This understanding of public health resonates with three "thought schools" in ethics, namely principle identification (virtue ethics), action and behaviour (deontology) and the outcome of the applied principles (consequentialism).

The public health focus on the population suggests two differences between public health ethics, and medical ethics and bioethics. Where medical ethics and bioethics focus on the individual (for example the doctor–patient relationship or death and dying), the focus in public health ethics is on the population or a community. The focus is therefore not on individual needs but rather on the community's needs. The focus is also on prevention and not therapeutic or clinical intervention.

Three approaches were taken in profiling what public health ethics is for the geriatric community.

These were:

(a) *applied ethics* as it addresses the application of principles in service delivery and provision;
(b) *professional ethics* as it calls on the behaviour towards vulnerable groups; and
(c) *social ethics* as it concerns itself with groups. These approaches were used in the discussion of the research results presented in the Result Section (cf. 3.4) and Discussion Section (cf. 3.5).

The approach taken was informed by comments offered by Baylis *et al.* that the four *prima facie* principles identified for bioethics cannot simply be applied to public health. The bioethical principles deal with the conflict between individuals in a clinical situation. Public health ethics instead "must begin with a recognition of the values at the core of public health, not a modification of values used to guide other kinds of health care interactions" (Baylis *et al.,* 2008:4).

In this study the focus was on the geriatric community. The intended outcome was to identify what constitutes public health ethics for the geriatric community.

3.3 METHOD

A qualitative approach was used in the study and the Q-methodology was selected for data collection. The Q-methodology focuses on the subjective viewpoints of participants. According to Alderson, Roy, Bryant, Ahmed and House (2018:737), the Q-methodology is particularly useful in understanding stakeholders' or participants' viewpoints, also known as inter-rater comparisons. This method assists in understanding how a matter is viewed and what impact these views may have during implementation. Mason (2018) associates the Q-methodology with two main stages: (a) developing the statements and sorting them, and (b) analysing and interpreting the ranked statements. Du Plessis (2005:10,142-172) unpacks the Q-methodology in five stages, which correlate with the above two stages. These stages are collecting of information from the discourse, sampling, sorting of statements, factor analysis and interpretation. As the overall focus of stages correlates, Mason's more streamlined approach was used.

The Q-methodology outlines both consensus and deviation (Alderson *et al*., 2018:739-740), which are based on ranking predefined statements (Q-sorting) relevant to the research question of a study. The statements (Q-set) derived from the literature review and are ranked by the participants (P-set).

The *advantage* of this method is that it narrows many viewpoints down to a few which can be regarded as shared way of thinking. An additional advantage is that it can include from a small group (even one participant) to a large group.

The ranking was based on presenting the statements by means of a five-point Likert-scale questionnaire (Q-sort table) where the ranking took place according to the "*least important"*

(represented by 1) to "*cannot do without this*" (represented by 5). The ranking of statements can fit the two extremes of the Likert-scale, namely agree or disagree, with a moderate or neutral point of being indecisive. The Likert-scale represents a quantitative approach within the Q-methodology.

For this study fifteen (15) statements were identified from the literature review that were grouped into three indexes, namely what is ethics, what is public health ethics and what is public health ethics for geriatric people.

Six geriatric institutions, two each in the Free State, Northern Cape and North-West provinces, were identified. These provinces have the smallest populations compared to the other six provinces and represent 29.14% of the population older than 60 years (Republic of South Africa [RSA], 2020a, 2020b). Economically these provinces fall outside the mainstream Gross Domestic Product (GDP) for provinces in South Africa (RSA, 2018). The geriatric institutions and the participants were identified based on Marshall's (1996:524) grouping of convenience sampling (most accessible environment). Purposeful sampling was also used to identify and select geriatric institutions that are in marginalised provinces and often under-serviced regions and that may not always be part of data collection on a particular topic due to their locality (Palinkas, Horwitz, Green, Wisdom, Duan & Hoagwood, 2015:535). The data was sampled from July to August 2020 and analysed from October to December 2020. The COVID-19 pandemic did not influence the collection of data as the questionnaires were delivered and collected via pre-arranged courier services.

Twenty-two participants from the six geriatric institutions participated in the ranking of the statements. The target population excluded geriatric people and focused on those who work with geriatric people in the domain of public health, namely doctors, registered nurses, nurses, healthcare workers, managers, and administrators. Geriatric people were excluded from the study as the focus was on the gathering of in-depth information on public health ethics as perceived by the identified target population, the healthcare providers and managers.

Ethics approval was obtained from the HSREC (UFS-HSD2019/0471/250) and approval to conduct the study was obtained from the managers of the various institutions. Informed consent was obtained from all participants before the start of the data collection.

The statements discussed in this study formed part of a larger questionnaire on designing

a public health ethics framework for geriatric people. From the biographical information analysed, just more than half of the respondents, namely 51.1%, worked as doctors, (registered) nurses or healthcare workers. Medical doctors and registered nurses represented 40.9% of the total participants. Managers and administrative staff represented 22.7% each of the total respondents. The frequency information confirmed two groups, one with medical or healthcare experience (49.9% of respondents) and one with management or administrative experience (45.4% of respondents). The information confirmed a high percentage of post-school training (72.7% of respondents), with 36.4 % respondents having cumulatively 21 years and more of work experience.

Cronbach's alpha was calculated to assess the reliability of the statistics. For this scale, Cronbach's alpha is **0.866**, which indicates a high level of internal consistency of the scale and a uni-dimensionality in the sample of test items.

Table 3.1: Reliability of statistics

Cronbach's alpha	Cronbach's alpha based on standardised items	N of items
.866	.905	15

Principal component analysis (PCA) was used to summarise the information content. Based on the collected data, the rotated component matrix (cf. Table 3.2) identified four factors from the outcome of the survey. Variables were assigned to the factors. The rotated component matrix sorted the variables by the factor they belonged to and by co-variance with the factor.

PCA was used for the extraction method. For the rotation method, Varimax with Kaiser normalisation was used.

Table 3.2: Rotated component matrix

Statement	Component			
	1	2	3	4
Ethics is about having the best interest of a person and/or situation at heart.	.906			
Public health ethics for geriatric people is about care and relationship-building between various stakeholders and geriatric people.	.873			
Ethics can be explained as the choice between what is good and what is bad.	.872	.302		
Ethics is not about the needs of the other only, but also the self.	.775	.326	.433	
Public health ethics for geriatric people is about what is best to promote the health of this population group.	.683		-.307	-.563
Ethics is knowing what you need to do right to prevent harm to the self, other people, systems and the immediate situation.	.301	.858		
Public health ethics for geriatric people deals with the fairness of how geriatric programmes are implemented.		.802		-.322
Public health ethics can play a role in the prevention of poor health.		.745		.407
Ethics is not only about people but also about systems, practices, processes and application.		.733		
Public health ethics for geriatric people should change behaviour towards elderly communities.	.329	.675		
Public health ethics for geriatric people should make healthcare practitioners more sensitive towards the vulnerability of geriatric people.	.578	.643		
Ethics is about dealing with the vulnerability of the self, other people, systems and the immediate situation.	.529	.642		
Ethics is influenced by one's liking or disliking of other people or systems.			.931	
Ethics is influenced by own understanding of what is good for the self, other people, systems or a situation.		.422	.648	
There are not enough ethical guidelines available to support healthy living conditions for geriatric people.				.889

The first factor confirms the generally accepted understanding of ethics, namely that there are relevant principles that need to be applied (virtue ethics) and that a choice should be made on the application of these principles (deontology). These principles should have a positive outcome for others and also the self (consequentialism). This factor identified that ethics is not only about identifying principles to address an ethical dilemma but also to prevent ethical dilemmas. The respect for beneficence, non-maleficence, autonomy, and justice implies that any action should be guided by this respect for people, institutions, and systems. In addition, the "four principles and scope" should evoke the assessment of how principles are applied and of what their intended and unintended consequences might be. This factor supported a move away from the perception that ethics is about the stark rationalistic approach to identifying principles for an ethical dilemma without considering the *preventative* nature of ethics, namely to respect people, institutions and systems based on universally accepted principles and the *corrective* character of ethics, namely to provide remedial guidelines when a matter goes off-course.

The second factor builds on the last observation. By doing so, ethics as principle-based behaviour and application promotes the health and well-being of communities which in return will have a positive effect on society. This factor elevates ethics away from the judgemental character associated with ethics, namely "*thou shalt not*." Ethics is also an enabler, promoting strategies such as the implementation of public health programmes and systems in support of the geriatric community. This factor supports the different approaches to public health ethics, namely applied, professional and social ethics.

The third factor confirms that the individual's own disposition towards ethics influences the ethical orientation to people, institutions, and systems. This observation also relates to the four principles and scope approach as presented by Gillon (1994).

The fourth factor is in line with the claim that there is no South African public health ethics definition and hence no framework for dealing with the geriatric community. The absence of a generally accepted definition does not mean that ethics is not practised in public health. Neither does the identification of principles mean that ethical misbehaviour will be prevented. This dimension contributes to the need to sensitise and educate public health officials and workers about the vulnerability of the geriatric community when performing their duties.

3.4 RESULTS

The 15 statements ranked in Table 3.3 contributed to the following results:

Table 3.3: Statements around public health ethics (Table to continue on next page)

	Strongly disagree		Disagree		Neutral		Agree		Strongly agree	
	Count	%	Count	%	Count	%	Count	%	Count	%
S1: Ethics can be explained as the choice between what is good and what is bad.	0	0.0%	0	0.0%	1	4.5%	15	68.2%	6	27.3%
S2: Ethics is about having the best interest of a person and/or situation at heart.	0	0.0%	0	0.0%	0	0.0%	13	65.0%	7	35.0%
S3: Ethics is not about the needs of the other only, but also the self.	0	0.0%	1	4.8%	2	9.5%	13	61.9%	5	23.8%
S4: Ethics is about dealing with the vulnerability of the self, other people, systems and the immediate situation.	0	0.0%	0	0.0%	1	4.8%	12	57.1%	8	38.1%
S5: Ethics is knowing what you need to do right to prevent harm to the self, other people, systems and the immediate situation.	0	0.0%	0	0.0%	1	4.5%	12	54.5%	9	40.9%*
S6: Ethics is influenced by own understanding of what is good for the self, other people, systems or a situation.	0	0.0%	1	4.5%	0	0.0%	14	63.6%	7	31.8%*
S7: Ethics is influenced by one's liking or disliking of other people or systems.	3	13.6%	3	13.6%	4	18.2%	9	40.9%*	3	13.6%

	Strongly disagree		Disagree		Neutral		Agree		Strongly agree	
	Count	%	Count	%	Count	%	Count	%	Count	%
S8: Ethics is not only about people but also about systems, practices, processes and application.	0	0.0%	0	0.0%	1	4.5%	14	63.6%	7	31.8%*
S9: Public health ethics for geriatric people is about what is best to promote the health of this population group.	1	4.5%	0	0.0%	1	4.5%	12	54.5%*	8	36.4%
S10: There are not enough ethical guidelines available to support healthy living conditions for geriatric people.	0	0.0%	1	4.5%	4	18.2%	13	59.1%*	4	18.2%
S11: Public health ethics can play a role in the prevention of poor health.	0	0.0%	0	0.0%	0	0.0%	14	63.6%	8	36.4%
S12: Public health ethics for geriatric people is about care and relationship-building between various stakeholders and geriatric people.	0	0.0%	0	0.0%	5	22.7%	11	50.0%	6	27.3%
S13: Public health ethics for geriatric people should make healthcare practitioners more sensitive towards the vulnerability of geriatric people.	0	0.0%	0	0.0%	1	4.5%	13	59.1%	8	36.4%
S14: Public health ethics for geriatric people deals with the fairness of how geriatric programmes are implemented.	0	0.0%	0	0.0%	2	9.1%	19	86.4%	1	4.5%
S15: Public health ethics for geriatric people should change behaviour towards elderly communities.	0	0.0%	0	0.0%	2	9.1%	16	72.7%	4	18.2%

Note: The percentages in the table above are rounded up to first decimal place.*

First, there is a high percentage of agreement with statements on what ethics is, and its meaningful contribution towards dealing with the geriatric community (Statements 1 to 5 & 8 to 15). These agreements confirmed the generally accepted interpretation of what ethics is, that the geriatric community's vulnerability should be a focus in public health ethics, and that ethics should address harm (whether caused through people, structures, systems or processes). That there is an accepted understanding of what ethics is, or in this case, what public health ethics is, may be a contributing factor to the little attention given to defining public health ethics in literature. This raised the question of whether the real matter is to understand with public health ethics is. Should the debate not have a different focus? When the doctors, healthcare practitioners, workers, managers and administrative officials consider the application of principles in their working environment, should they not have knowledge thereof? The need is therefore less that of defining what public health ethics is, and more that of understanding what the task of public health ethics is. Statement 10 contributed to this remark, with 77.3% of respondents who agreed or strongly agreed that there are not enough guidelines available to support healthy living conditions for the geriatric community. In return, the ranking of this statement linked with the need for a better understanding of deontology and consequentialism. At the same time, the question was raised as to whether a professional or an institutional code is merely perceived to be what one must do to stay out of trouble, rather than using the principles to direct decisions on what must be done in the workplace. Verbruggen (2013:161-162) comments that professional ethics is more than a personal morality. Professional ethics is a justifiable public intervention in people's lives, in this case their health. She further comments that professional ethics is not about the application of universal ethical principles but rather a professional engagement with people in a particular context based on these principles. Grypdonck, Vanlaere and Timmerman (2018) argue that the focus should not be on the own agenda but on what the essential need of the receiver is. The high ranking (agree or strongly agree) of Statements 13 to 15 suggests that there should be more sensitivity towards the vulnerability of the geriatric community (95.5%), fairness on implementation of programmes (90.9%) and a changed behaviour towards the geriatric community (90.9%).

Second, the individual's orientation towards the role of the self or personal likes or dislikes invited mixed responses. Statement 7 confirmed the agreement or strong agreement that a personal view influences ethics (54.3%). The same ranking represented 27.2% of respondents who disagreed or strongly disagreed with the statement. The significance of this observation confirmed the role of the individual in ethics, more so in a professional

context that is often challenged by work skills and experience, and cultural or ideological orientation. Several studies confirming that cultural or ideological orientations play no role, can be countered by an equal number of studies that will make the opposite case. Instead of pursuing this debate, however, another route is taken, supported by discourse ethics. In the context of discourse ethics, the focus is away from *power* to *reasonable*. Power represents ideology, while reasonable supposes a consensus on what is doable and achievable. Raymakers (2016) roughly drafts, after Habermas' Discussion Ethics, a discussion ethic free of domination during the discussion. Statement 11 contributes to the context of this discussion. The 77.3% agree or strongly agree ranking contributed to the awareness that care and relationship-building are important contributors to public health ethics. This can be confirmed by Baylis *et al.* (2008:6), who propose relational personhood and autonomy as core for public health and a public health ethic. Statements 4 to 11 further confirms the vulnerability of the geriatric community as ethical challenge, and the positive contribution public health ethics can make towards the health and well-being of the geriatric community. The overall conclusion is that although personal views on ethics cannot be ignored, the personal view can be directed to avoid domination in defining or applying ethics. In public health ethics the focus should be away from the individual to the community and that within the community, care and relationship-building should be core in identifying and applying principles relevant to public health ethics.

Third, the meaning that ethics should have for the individual is a personalistic view and confirms the value of all humans in ethics. This view should not be confused with the interpretation that a person is the supreme value for ethics. This confirmation is consistent with the *prima facie* principles identified in the introduction of this study. Statements 1 to 3 shared a 90% + agreement or strong agreement with the statement. According to Statement 2, there was 100% certainty that ethics is about what is best for the person or situation. The neutrality ranking of Statement 3 (9.5%) and the disagreement (4.8%) can be interpreted against the background of personalism, where the self is the absolute doctrine for ethics. The majority of rankings for this statement rejected personalism. The value of this ranking is the awareness that ethics is about the other *and* the self, hence not one party only. Statement 8 contributed to a broader view than people as the only focus in public health. The 95.5 % agree or strongly agree ranking of this statement motivates the perspective that within public health ethics systems, practices and processes cannot be ignored. The statements involved individual responsibility towards ethics. Notable is the high percentage agree or strongly agree expressed through the ranking of statements in favour of actions such as "choice", "interest at heart", "dealing", "prevent",

"understanding", and more.

Fourth, people together with systems, practices, processes and applications are part of the scope of public health ethics as ranked by Statement 8. The 95.4% agree or strongly agree ranking endorsed the understanding that ethical systems, practices, processes and applications are important for the health and well-being of the geriatric community. Although this interpretation can be taken as given, similar to what (public health) ethics is, the question arises as to whether public health ethics exists as awareness or whether it is practised as part of healthcare provision and policy. This question is justifiable, especially in the context of the locations of participating institutions. The participants work in economically and socially marginalised or under-serviced geographical areas. The official websites of the provincial health departments carry no communications on ethics in general, apart from a brief reference to the *Batho Pele (People First) Principles* that commit to quality of service and delivery. (The comment is based on the website information retrieved on 27 March 2021.) Although the *Batho Pele Principles* are not specifically mentioned in the National Department of Health's Strategic Plan, 2020 – 2025 (RSA, 2020c), this plan does identify the attention that should be given to systems, practices, and processes. The summative conclusion from this ranking is the agreement that in public health ethics, systems, practices, and processes cannot be ignored. The mere assumption that systems, practices, and processes are ethical, calls for managing this assumption through assessing compliance with professional codes. Crane and Matten (2004:151), advise that within these codes there should be general and specific statements. Building on their advice, a general statement is to respect elderly people and a specific statement is not to take a bribe in return for a service delivered.

Fifth, the rankings presented important interpretations. Only 20% of the statements have no neutral ranking (Statements 2, 6 & 11). These statements reflected on what ethics is, the individual's own understanding of ethics and the positive role ethics can play in preventing poor health. Only Statement 6 had a disagreement ranking of 4.5%. From these statements the conclusion may be drawn that there is a shared understanding of what ethics is and what its value is. These statements covered the nature of ethics, the influence of personal likes and dislikes in ethics, and personal engagement with other people. This confirmed the undisputable role that the individual's own orientation plays towards ethics. The neutrality ranking ranged from 4.5% to 22.7% (Statements 1, 5, 7, 8, 9 & 13). Of note is the 22.7% neutrality view in Statement 12 that public health ethics is about care and relationship building between various stakeholders and the geriatric community. This

observation is further informed by a 0% disagree or strongly disagree ranking of the same statement. Three interpretations are viable. Firstly, ethics is understood as deontology – the duties based on the choice between what is right or wrong. Secondly, if read with the 77.3% agree or strongly agree ranking, then the care and relationship building focus of ethics is further supported. Such an interpretation is more likely as there was a 0% disagree or strongly disagree ranking of the statement. The 94.4% ranking in Statement 8 can further contribute to this interpretation. This interpretation confirms a trend in the ranking of statements, that deontology is important in public health ethics. Another observation is that only three statements have a disagree ranking ranging between 4.5% and 4.8% (Statements 3, 6 & 10) which have limited influence on the interpretation of the ranking. Two of the statements (3 & 6) referred to the role of the individual in determining what ethics is. Statement 10 dealt with the availability of guidelines. The disagree ranking of 4.5% has no significant meaning on its own. Even if it is read with the neutrality ranking of 18.2% it does not influence the positive ranking of this statement. Statement 9 has a strong disagreement ranking of 4.5% which relates most probably to an understanding of what public health ethics is. Statement 7 is the only statement with rankings in all five categories. This underlined the role of the individual's liking or disliking of other people or systems.

Sixth, these rankings must be understood against the almost 50-50 representation from the (a) medical, healthcare practitioners and workers and (b) management and administration cohorts who responded to these statements. This serves in general as agreement on what ethics and public health ethics are, and what the identified role is for public health ethics. This interpreted agreement is further supported through the M-Estimators' educational level (cf. Table 3.4) and professional registration (reflected in Table 3.5). In Table 3.4, the Index of Public Health Ethics is constant with the respondents' highest educational level, namely post-school education.

Table 3.4: M-Estimators for education level

Index	Respondents' highest educational level	Huber's M-Estimator	Tukey's Biweight	Hampel's M-Estimator	Andrews' Wave
Index of Public Health Ethics	Grade 12	3.8960	3.7916	3.8194	3.7916
	Post-school education	4.2667	4.2667	4.2667	4.2667
	University education	4.1712	4.1728	4.1810	4.1723

Table 3.5 confirms that the Index of Public Health Ethics is constant with respondents' profession.

Table 3.5: M-Estimators for profession

Index	Respondents' profession	Huber's M-Estimator	Tukey's Biweight	Hampel's M-Estimator	Andrews' Wave
Index of Public Health Ethics	Medical doctor	3.8667	3.8667	3.8667	3.8667
	Manager	4.6665	4.7127	4.7111	4.7127
	Administrative Staff	4.2567	4.2490	4.2567	4.2490

3.5 DISCUSSION

The results presented above delineate the space of public health ethics as *applied ethics* but also create the link to *professional ethics*. The results further identified the need for a *care ethics* as social ethics.

Baylis *et al.* (2008), argue that the known principles for bioethics cannot simply be changed to fit public health ethics. What public health is, cannot be ignored and should be the point of departure. The core focus of public health is the community or population, and not the individual. This does not mean that the individual has no responsibility or that all responsibilities are delegated to the group. Virtue ethics applies to the moral character of individual and group. The reference of Baylis *et al*. (2008:10), to relational responsibility involves the individual and the group. The binding factors are a recognition of mutual vulnerability and interdependency. Gillon's four principles plus scope contribute to the awareness that both the individual and the group's orientation towards ethics influences the application of ethical principles. New discourses in deontology steer away from a stark rationalistic approach, making use of abstract principles for ethics practices to a more hermeneutical approach and focus on practices, stories, and codes. The revival of deontology emerged from a growing interest in applied ethics (such as professional ethics) (Raymakers, 2016:53). Care ethics contributes meaningfully to acknowledge power play in dealing with ethical challenges in practice and focuses on relationship building when dealing with these challenges (Tjong, Tjin Tai, 2014:196-197).

From these observations, the following can be confirmed.

- Public health is about the community or population, the attainment of health and

prevention of disease and improving quality of services in support of health and well-being of the group.

- Individual responsibility can never be removed from the community.
- Although bioethical principles such as respect for beneficence, non-maleficence, autonomy and justice were initially identified to deal with individual challenges around life and death, these principles have value for public health ethics as the principles subscribe to the basis of all ethics: *do no harm*.
- The ranking of statements confirms that although it is good to have a shared understanding of what ethics or public ethics is, the need is more for applying the ethical principals in pursing the objectives of public health.
- Professional ethics supported by a care ethics approach is beneficial for applying public health principles.

From these discussions, the following refined definition for public health ethics may be offered: *Public health ethics is the application of ethical principles through a professional ethic resulting in care and relationship building.*

Applied to the geriatric community, the community's vulnerability will guide the application of the principles. Professional ethics' and care ethics' specific contribution will be to avoid power domination and protect vulnerability.

3.6 CONCLUSION

In this study, fifteen statements were identified to outline what public health ethics is. From the ranking of the statements it was confirmed that promotion of health and well-being through quality of service and healthcare provision are the foci of public health. Health and well-being of geriatric people are challenged through vulnerability and harm caused by people, institutions, systems, practices, processes, and application. This is evident through the availability and the quality of service and healthcare provision.

The ranking of statements contributes to a less abstract understanding of public health ethics, namely principle identification. The statements created a broader interpretation of public health ethics, such as the requirement of professional behaviour and addressing the vulnerability of the geriatric community through care and relationship building. It is also apparent that public health ethics calls on various stakeholders to secure ethical behaviour when dealing with the geriatric community.

The application of public health ethics can best be delivered through professional ethics and care ethics.

Applied to the geriatric community, the application of principles, decisions, professional behaviour, and care will consider the specific healthcare needs of this community.

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

Margaret Chan

(2015. World Report on Ageing and Health. World Health Organization)

CHAPTER 4

BUILDING BLOCKS FOR A PUBLIC HEALTH ETHICS FRAMEWORK FOR THE GERIATRIC COMMUNITY

This chapter identifies building blocks that can be used in the development of a framework for public health ethics. Eight building blocks are identified.

The Q-methodology was used to collect the data. Participants from six geriatric institutions ranked the statements captured in a questionnaire. The data was analysed using the Statistical Package for Social Sciences software. The information produced was interpreted against the literature review presented in Chapter 1.

The building blocks were identified from the ranking of statements relevant to public health ethics. These building blocks are:

- Promote the core value of public health;
- Identify the principles for public health ethics;
- Recognise ethical challenges for agent and recipient of service;
- Advance ethics leadership;
- Introduce ethics education;
- Promote social justice;
- Develop ethical expertise; and
- Practise care ethics.

4.1 ABSTRACT

- **Background:** There is a growing South African elderly population with limited strategic planning or policy initiatives to address this group's vulnerability resulting in several public ethical issues that need to be considered. This paper has as aim the development of a public health ethics framework for the geriatric community. The purpose of the framework is to review ethical implications when working with the geriatric community.
- **Method:** The Q-methodology was selected for data collection. Fifteen statements were ranked by means of a five-point Likert-scale questionnaire. Twenty-two participants from six geriatric institutions participated in the ranking of the statements.
- **Results and Discussions:** The ranking of the statements confirmed the need for a

public health ethics framework. Such a framework should be application-based and practice-oriented. The framework can assist in addressing unfamiliarity with public health ethics in general and can extend the capacity for decision making. The ranking of these statements contributed to the scope of the planned framework, by considering the vulnerability of healthcare practitioners (as community of practitioners) and the geriatric community as a basis from which to promote justice in public health programmes.

- **Conclusion**: Based on the ranking of statements, eight building blocks for a public health ethics framework were identified. The building blocks are imbedded in professional ethics and care ethics. The proposed framework can give rise to social justice in public health and the ability to evaluate what the ethical implications are for public health policies, programmes and interventions aimed at the geriatric community.

4.2 WHY THE NEED FOR A PUBLIC HEALTH ETHICS FRAMEWORK FOR THE GERIATRIC COMMUNITY?

Kass' (2001:1777) seminal publication on a public health ethics framework is presented as an analytical tool to contemplate the ethical implications of proposed interventions, policy proposals, research initiatives and programmes in public health. Such a framework should enable public health workers to anticipate what the ethical implications and outcome of actions could be. This opens the possibility of alternative views on the ethical implications of public health interventions, or how ethical principles should be implemented. Any alternative should be an acceptable ethical option and not merely the satisfying of political considerations (Kass, 2001:1782).

Studies from Baylis, Kenny and Sherwin (2008), Spike (2018) and Marckmann, Schmidt, Sofaer and Strech (2015) also consider what informs a public health ethics framework. Although their approaches may differ, the common agreement for such a framework lies in ethical principles relevant to public health. All three studies recommend a *practice-oriented* framework. From the three sets of authors' comments, the interpretation is that a public health ethics framework needs to identify and apply ethical principles for healthcare that can promote health through healthcare services and interventions mindful of a targeted community's needs. The aim of the public health ethics framework is not only to be ethical in healthcare delivery but also to secure that communities' human rights are respected and advanced. The application of this framework is not only to promote ethical healthcare delivery but also to add to the understanding of how to be ethical in public health.

Baylis *et al.* (2008) place the emphasis on people and relationships in the context of public health's scope. They argue that the need exists to focus on relations among humans instead of individuals. Their framework is influenced by relational personhood (including relational autonomy and social justice) and relational solidarity (Baylis *et al.,* 2008:5). A public health ethics framework should make the role of public health visible (Baylis *et al.,* 2008:11).

Spike (2018:14-19) takes an approach of "mid-level" principles. This refers to widely accepted values. Following this approach, he identifies four values for public health ethics, which also have people and relationship as commonality. The principles are procedural justice (transparency of information sharing and sampling), the least restrictive alternative (upholding of human rights, least burden possible and protection of minority rights), the precautionary principle (maximum human safety), and the communitarian principle or social justice (social institutions and social connectives to individual well-being). The application of social justice is paramount in Spike's identification of "mid-level" principles.

Marckmann, Schmidt, Sofaer and Strech (2015:1-6) advance a practice-oriented public health ethics framework including both normative criteria based on an explicit ethical justification and a structured methodological approach for application. The purpose of a public health ethics framework is to provide a practical guide that can be used by public health workers. They opt for coherentism as a departure point. Coherentism implies that the focus is not from a single ethical principle but rather from ethical convictions and beliefs that are accepted in everyday life. A coherent framework is developed from specifying, testing, and revising the commonly accepted principles into a framework for action.

The approach followed by the above authors can be found in the American Public Leadership Society's *Ethical Practice of Public Health, Version 2.2* (2002). In this code the interdependence of people is presented as the basis for several ethical principles. As public health is directed at the health of communities, the interdependence of people is reflective of the basic aim of public health. At the same time, it is a recognition that individuals' health is tied to their life in a community. People and relationships are therefore emphasised. This code identifies key public health services and accompanying ethical principles with the focus on people and relationships, more sharply defined as professional relationships. Although not explicitly mentioned, it can be observed that power domination is always a reality towards, especially, vulnerable groups (Vanlaere, Burggraeve & Lategan, 2019:7-22).

This study focuses on the geriatric community as one such vulnerable group. This group's vulnerability is due to health, social and economic challenges (National Institute on Aging & the WHO, 2011; WHO, 2015, 2016, 2017). Such vulnerability could raise ethical dilemmas not only for the mentioned communities but also for healthcare providers. Therefore, the need for a South African public health ethics framework is based on the following arguments.

First, there is a growing South African elderly population, but very little strategic planning or policy initiatives exist to address this group's vulnerability, which is challenged by the impact of social determinants on their health. Service delivery and health provision are in general experiencing challenges as observed in the National Department of Health's Strategic Plan, 2020 – 2025 (Republic of South Arica [RSA], 2020a), and commented on by Kelly, Mrengqwa and Geffen (2019), Chenwi (2011), and Mathiso (2011). Despite the growing number of people in South Africa above 60 years of age (RSA, 2020b; 2020c), corresponding with international trends (WHO, 2015; 2017), this remains a neglected debate in South African public health. It appears to be a similar issue in sub-Saharan Africa, where there is improvement with policy formulation for healthy ageing but limited implementation of these polices, as confirmed in a scoping review by Saka, Oosthuizen and Manimbulu (2019).

Second, the geriatric population analysis in South Africa suggests economic needs and health marginalisation (Goodrick, 2013:98-99). Social isolation is reported in the literature (Mathiso, 2011:4-6). The question therefore emerges as to whether the geriatric community can stand their ground with ethical challenges either due to how public health activities are identified and implemented or in relation to the provision of basic healthcare needs.

Thirdly, healthcare practitioners and workers delivering public health programmes may evidently not be trained sufficiently or have enough experience to consider the ethical consequences of their actions and care (WHO, 2016; Kelly *et al.,* 2019; Naidoo, Waggie & Van Wyk, 2020).

In this paper, building blocks for a framework are presented to guide public health practitioners and workers offering care, management or administration, on how to pass ethical judgement on public health programmes and interventions aimed at the geriatric community. The building blocks that are presented are application-based. Such framework forms part of public health ethics as a field of application that coexists alongside public

health ethics as a field of study.

Professional ethics will be used as a basis to inform engagement with the geriatric community and *care ethics* as the ethical orientation in everyday care for the geriatric community.

4.3 METHOD

A qualitative approach was used in the study and the Q-methodology was selected for data collection. The Q-methodology focuses on the subjective viewpoints of participants. According to Alderson, Roy, Bryant, Ahmed and House (2018:737), the Q-methodology is particularly useful in understanding stakeholders' or participants' viewpoints, also known as inter-rater comparisons. This method assists in understanding how a matter is viewed and what impact these views may have during implementation. Mason (2018) associates the Q-methodology with two main stages: (a) developing the statements and sorting them, and (b) analysing and interpreting the ranked statements. Du Plessis (2005:10,142-172) unpacks the Q-methodology in five stages, which correlate with the above two stages. These stages are collecting of information from the discourse, sampling, sorting of statements, factor analysis and interpretation. As the overall focus of stages correlates, Mason's more streamlined approach was used.

The Q-methodology outlines both consensus and deviation (Alderson *et al.*, 2018:739-740), which is based on ranking predefined statements (Q-sorting) relevant to the research question of a study. The statements (Q-set) are derived from the literature review and are ranked by the participants (P-set).

The advantage of this method is that it narrows many viewpoints down to a few which can be regarded as a shared way of thinking. An additional advantage is that it can include a small group (even one participant) up to a large group.

The ranking was based on presenting the statements by means of a five-point Likert-scale questionnaire (Q-sort table) where the ranking took place with 1 representing "*least important"* to 5 representing "*cannot do without this"*. The ranking of statements can fit the two extremes of the Likert-scale, namely either agree or disagree, with a moderate or neutral point of being indecisive. The Likert-scale represents a quantitative approach within the Q-methodology.

For this study 15 statements were identified from the literature review to develop a public health ethics framework for the geriatric community.

Six geriatric institutions, two each in the Free State, Northern Cape and North-West provinces, were identified. These provinces have the smallest populations compared to the other six provinces and represent 29.14% of the population older than 60 years (RSA, 2020a). Economically these provinces fall outside the mainstream Gross Domestic Product (GDP) for provinces in South Africa (RSA, 2018). The geriatric institutions and the participants were identified based on Marshall's (1996:522-525) grouping of convenience sampling (most accessible environment). Purposeful sampling was also used to identify and select geriatric institutions that are in marginalised provinces and often under-serviced regions and that may not always be part of data collection on a particular topic due to their locality (Palinkas, Horwitz, Green, Wisdom, Duan & Hoagwood, 2015:535). The data was sampled from July to August 2020 and analysed from October to December 2020. The COVID-19 pandemic did not influence the collection of data as the questionnaires were delivered and collected via pre-arranged courier services.

Twenty-two participants from the six geriatric institutions participated in the ranking of the statements. The target population excluded geriatric people and focused on those who work with geriatric people in the domain of public health, namely doctors, registered nurses, nurses, healthcare workers, managers and administrators. Geriatric people were excluded from the study as the focus was on the gathering of in-depth information on public health ethics as perceived by the identified target population, the healthcare providers and managers.

From the biographical information analysed, just more than half of the respondents, namely 51.1%, worked as doctors, (registered) nurses or healthcare workers. Medical doctors and registered nurses represented 40.9% of the total participants. Managers and administrative staff represented 22.7% each of the total respondents. The frequency information confirmed two groups, one with medical or healthcare experience (49.9% of respondents) and one with management or administrative experience (45.4% of respondents). The information confirmed a high percentage of post-school training (72.7% of respondents), with 36.4% of respondents having cumulatively 21 years and more of work experience.

Ethics approval was obtained from the HSREC (UFS-HSD2019/0471/250) and approval to conduct the study was obtained from the managers of the various institutions. Informed

consent was obtained from all participants before the start of the data collection.

The statements discussed in this study formed part of a larger questionnaire on designing a public health ethics framework for the geriatric community.

Cronbach's alpha was calculated to assess the reliability of the statistics. For this scale, Cronbach's alpha is **0.912**, which indicates a high level of internal consistency of the scale and uni-dimensionality in the sample of test items.

Table 4.1: Reliability of statistics

Cronbach's alpha	Cronbach's alpha based on standardised items	N of items
.912	.924	15

Principal component analysis (PCA) was used to summarise the information content. Based on the collected data, the rotated component matrix (cf. Table 4.2) identified three factors from the outcome of the survey. Variables were assigned to the factors. The rotated component matrix sorted the variables by the factor they belonged to and by co-variance with the factor.

PCA was used for the extraction method. For the rotation method, Varimax with Kaiser normalisation was used.

Table 4.2: Rotated component matrix (Table to continue on next page)

Statement	Component		
	1	2	3
Public health ethics must promote human rights in geriatric care (medical justice).	.879		
Public health ethics must promote decision making capacity.	.832	.340	
Healthcare practitioners need ethical education.	.797		
Public health ethics must protect the vulnerability of geriatric people and healthcare practitioners.	.755	.397	
Leadership and management should promote ethical behaviour.	.682	.460	
Ethics should be integrated in the public health ethics value chain.	.656		.656
Ethical success depends on participation around a common goal.		.892	
Healthcare practitioners need a practical guide to assist them in ethical behaviour and decision making.		.869	
Ethical decision-making is to address the ethical dilemma at hand.		.862	
Ethics is about making a choice, implementation of the choice and evaluation of the outcome of the choice.	.305	.718	.531
Ethics decision making can have future consequences.	.311		.849
Public health policymakers do not know what the ethical needs of elderly people are.			.734

Statement	Component		
	1	2	3
Healthcare facilities/institutions and healthcare practitioners seldom talk about ethical challenges.	.504		-.681
Relationship building is important in ethics.	.426	.422	.676
Ethics is not about who is right or wrong but about what one can do to prevent or address a moral dilemma.	.432	.369	.533

The first factor confirmed that guidelines and leadership should be evident in the application of public health ethics. This factor further confirmed that public health ethics should be part of public health practice and that ethics education is required. It is also evident that public health ethics should contribute to medical justice. Vulnerability of practitioners and the geriatric community were confirmed.

The second factor endorsed the need for a framework to guide public health workers to make ethical decisions and evaluate the outcome of their decisions.

The third factor identified the need for a discussion on what public health ethical principles for the geriatric community are. These principles should address current moral dilemmas, prevent future dilemmas, and contribute to relationship building.

4.4 RESULTS

The 15 statements ranked in Table 4.3 contributed to the following results:

Table 4.3: Statements around a public health ethics framework (Table to continue on next page)

Statement	Strongly disagree		Disagree		Neutral		Agree		Strongly agree	
	Count	%	Count	%	Count	%	Count	%	Count	%
S1: Ethical decision making is to address the ethical dilemma at hand.	0	0.0%	0	0.0%	1	4.5%	15	68.2%	6	27.3%
S2: Ethics is about making a choice, implementation of the choice and evaluation of the outcome of the choice.	0	0.0%	0	0.0%	0	0.0%	15	68.2%	7	31.8%
S3: Ethics decision making can have future consequences.	0	0.0%	0	0.0%	0	0.0%	12	54.5%	10	45.5%
S4: Relationship building is important in ethics.	0	0.0%	0	0.0%	2	9.1%	12	54.5%	8	36.4%
S5: Healthcare practitioners need a practical guide to assist them in ethical behaviour and decision making.	0	0.0%	0	0.0%	0	0.0%	13	59.1%	9	40.9%
S6: Healthcare facilities/institutions and healthcare practitioners seldom talk about ethical challenges.	1	4.5%	1	4.5%	7	31.8% *	13	59.1%	0	0.0%
S7: Ethical success depends on participation around a common goal.	0	0.0%	0	0.0%	4	19.0%	11	52.4%	6	28.6%
S8: Ethics is not about who is right or wrong but about what one can do to prevent or address a moral dilemma.	0	0.0%	0	0.0%	1	4.5%	14	63.6%	7	31.8%*

Statement	Strongly disagree		Disagree		Neutral		Agree		Strongly agree	
	Count	%	Count	%	Count	%	Count	%	Count	%
S9: Public health policymakers do not know what the ethical needs of elderly people are.	0	0.0%	0	0.0%	6	27.3%	9	40.9%	7	31.8%
S10: Healthcare practitioners need ethical education.	0	0.0%	0	0.0%	3	13.6%	14	63.6%	5	22.7%*
S11: Leadership and management should promote ethical behaviour.	0	0.0%	0	0.0%	0	0.0%	12	57.1%	9	42.9%
S12: Public health ethics must promote human rights in geriatric care (medical justice).	0	0.0%	0	0.0%	2	9.1%	11	50.0%	9	40.9%
S13: Public health ethics must protect the vulnerability of geriatric people and healthcare practitioners.	0	0.0%	0	0.0%	1	4.5%	11	50.0%	10	45.5%
S14: Public health ethics must promote decision making capacity.	0	0.0%	0	0.0%	2	9.1%	12	54.5%	8	36.4%
S15: Ethics should be integrated in the public health ethics value chain.	0	0.0%	0	0.0%	0	0.0%	12	54.5%	10	45.5%

***Note*:** *The percentages in the table above are rounded up to first decimal place.*

The ranking of statements presented only one absolute strongly disagree ranking to the value of 4.5% (Statement 6). Only one strongly agree category was not ranked (Statement 6). The agree ranking for this statement was slightly below 60%. For 14 statements, the agree and strongly agree rankings are high in total, ranging from 70% to 100%. The ranking pattern can therefore be interpreted as in agreement with the need for a public health ethics framework for the geriatric community. This interpretation is further supported by no ranking of disagree or strongly disagree categories except for Statement 6. This added to the confirmation of the need for a public health ethics framework for the geriatric community.

The ranking of Statement 6 followed an interesting pattern if evaluated against the ranking of the other statements. This is the only statement that excluded the strongly agree ranking. The absence of a strongly agree ranking indicated that no respondent regarded this as a statement that they cannot do without. The rankings also illustrated the variance in opinion. The 31.8% neutrality statement can be interpreted in different ways. Firstly, the wording of the neutral as midpoint suggested that there is no specific view on this matter, either due to unfamiliarity with the topic, the topic is ambiguous or socially not desirable. Secondly, neutral should not be confused with undecided or do not know. Thirdly, the neutral scale is the easiest way to respond to a question (Chyung, Roberts, Swanson & Hankinson, 2017:17-18). Given the content of the statement, the reasonable interpretation is that the midpoint response is due to ignorance. This interpretation can be supported by the 9% disagree or strongly disagree and 59.1% agree rankings. The contribution of this Statement's ranking to the planned framework pointed towards the level of familiarity of healthcare workers with the ethical challenges of the geriatric community.

Within the ranking of the statements, 67% of them had at least one respondent using the neutral ranking for the statement. The Likert scale used for ranking these statements was an interval scale using equal intervals as opposed to an ordinal scale using rank-ordered levels. In view of the above explanation of the neutral ranking, the interpretation is that the respondents may not be familiar with the topic. The neutral rankings of Statements 6, 7 and 9 with 31.8%, 19% and 27.3% respectively, confirmed possible ignorance on the content of the statements. These statements, however, were focused on the familiarity of public health ethics and not on the desire not to have such a framework.

In Statement 5 there was a 100% agree or strongly agree ranking in support of a practical guide to assist healthcare practitioners in ethical behaviour and decision making. This was

further supported by the 100% agree or strongly agree ranking in Statement 15, that ethical principles cannot be selectively captured in this framework. The need for such a practical guide was further supported by the 90.1% ranking of Statement 14 that the framework should promote decision making capacity. The agree ranking of 59.1% of Statement 6 suggested that there may not be sufficient discussion of ethics in a particular geriatric institution, or that some healthcare workers may have been left out or were not aware of this discussion. A similar observation followed from Statement 9. The 72.7% agree or strongly agree ranking implied that the ethical needs of geriatric people may not be known to healthcare practitioners. Based on the coding scheme and data, this observation appears to be common across participating institutions. Either way, these statements underlined the need for such a guide. Based on the ranking in Statement 4, the 90.1% agree or strongly agree ranking implied that such a framework should contribute to more than merely what ethics is as a theory or description (Statements 1 & 2) or to make decisions (Statement 14). The framework should also contribute towards creating relationships (Statement 4) and preventing or addressing moral dilemmas (Statement 8). Statements 4 and 8 have an agree or strongly agree statement higher than 90%. The ranking of Statements 1 and 2 is in line with what is generally accepted as ethics or the scope of ethics. From these statements the conclusion is that there exists a need for a public health ethics framework.

Statement 13 captured the changed perspective from vulnerability of the healthcare receiver only, to also acknowledge the vulnerability of the healthcare provider. In the context of this study, there is a 95.5% acknowledgement that healthcare practitioners are vulnerable too, although presumably for different reasons. This acknowledgement is important in relationship building and advancement of ethical public values. Statement 12 ranked a 90.9% agree or strongly agree that human rights in healthcare should be promoted. This positive view on human rights promotion and the shared purpose of ethics confirms what the purpose and content of such a framework should be. Based on the coding scheme and data, the neutrality ranking was not representative of all participating institutions. The ranking of these statements contributed to the scope of the planned framework to consider the vulnerability of healthcare practitioners (as community of practitioners) and the geriatric community as basis to promote justice in public health programmes and interventions.

The scope of a public health ethics framework is further informed by Statements 2 and 3. Both statements have a 100% agree or strongly agree ranking that ethics is more than just knowing what the principles for public health ethics are. Statement 2 reflected on decision

making, decision implementing and evaluating the outcome of the decision. This statement consolidated that ethics has principles (theory basis of ethics) that must be applied to a situation (practice of ethics). Statement 8 contributed to the interpretation of this ranking. The 94.4% agree or strongly agree ranking of this statement suggested that knowing public health principles is not enough as the significance of ethics is to address or prevent ethical dilemmas in public health. Statement 3 contributed to an important matter in ethics, namely that ethical applications may *now* be the best for the situation in hand, but the application may lead (later) to another ethical challenge. With this comment, the universality of an ethical principle is confirmed but applications are unique to a situation and may not be applicable without revision for future similar situations. The meaning of these statements for the planned framework is that ethical principles can be identified but their applications for all possible scenarios cannot be identified.

Statement 9 highlighted an important requirement in public health ethics, namely to know the ethical needs of the geriatric community that public health workers are working with. The agree or strongly agree ranking of 72.7% suggested that this knowledge is absent. The 27.3% neutrality statement indicated that this is not a shared perspective. The ranking groups (agree or strongly agree and neutral) invited the question of whether ethical needs were not read as needs only. However, the value of this statement is that a framework is based on the general assumption that public health practitioners are familiar with the ethical needs of elderly people. This assumption is further aligned with Statement 6. Although there was a 59.1% agree ranking of this statement, the 9% disagree and strongly disagree represented a different opinion. Although the neutral ranking of 31% cannot be read together with the disagree or strongly agree rankings, it is evident that talks about ethical challenges are certainly neither absent nor active (For the neutral point reference: Maness, Sheela, Balusu & Pinjari, 2018:5).

Statement 11 had a joint 100% agree and strongly agree ranking that leadership and management should promote ethical behaviour. The responsibility goes further than managers only as Statement 10 indicated an 86.3% need for ethics education. The two statements supported the ethical responsibility of all working with the geriatric community, regardless of a person's responsibility. This interpretation can be read together with Statement 7 that ranked ethical success based on a common goal with a joint 81% agree or strongly agree.

4.5 DISCUSSION

The ranking of Statements (1, 2, 5, 11, 14 & 15) confirm the need for a public health ethics framework for the geriatric community that can be used in the workplace. The statements further suggest the purpose of such a framework, namely to create ethical knowledge, empower decision making on applying ethical principles to public health and to consider the consequences of applying ethical principles.

In drafting this framework, the approach suggested by Marckmann *et al*. (2015), and Spike (2018), is followed. Based on their recommendations, such a framework must be developed from what ethical principles are known, or from what are the most common ethical principles associated with public health for the geriatric community. The leading principle for all ethics is taken as "do no harm".[2]

Working with the geriatric community, the ethical principles of (a) respecting their vulnerability and fragility, (b) protecting their lives from abuse and neglect, and upholding dignity, (c) securing a safe environment to live in and (d) providing quality access to healthcare and provision, can be regarded as the ethical basis of public health for the geriatric community. These principles are confirmed in literature (Lategan, 2017a, 2017b; Vanlaere & Gastmans, 2010, 2011; Tadd, Vanlaere & Gastmans, 2010; Kasiram & Hölscher, 2015; Ludwick & Silva, 2003).

The 90% agree or strongly agree ranking of Statements 8, 12 and 13 substantiate a basis of understanding of public health ethics for the geriatric community. The ranking of the statements further suggests that although important, public health ethics is in scope different from medical ethics dealing with doctor-patient relationships and bioethics dealing with matters around life and death. The significance in outlining the conceptual difference between public health ethics, medical ethics and bioethics, accents the compelling need to know what the purpose of public health is, and what ethics foundation is required for this provision. A framework for public health ethics departs therefore from what public health is and what ethical principles should accompany public health. This represents a typical applied ethics approach to public health. Baylis *et al.* (2008), share a similar view in the development of a framework for public health ethics.

[2] The reference in Latin "*primum non nocere*" or better known as "do no harm" is associated with Hippocrates' treatise on Epidemics (Retsas, 2019).

The ethical principles outlined above are not limited to the physical and mental conditions of geriatric people only, but also include the environment in which they live and how services are presented to them. Lundgren and Etheredge (2020) use the COVID-19 pandemic to explain that public health interventions assisted the move away from the approved patient centred care towards public health ethics, as the focus was towards the collective and not towards individual patients. Public health ethics has at its core the welfare of the majority in society. The primary task of public health ethics is the allocation of resources in such a way that it maximises population health. Transparency is key to a public health ethics framework. It is for this reason that public health ethics is utilitarian in nature.

Based on these comments, the first building block for this framework is promoting the core value of public health.

The second building block is to identify the ethical principles for public health following from this core.

Applying this view to the planned framework, a next step would be to acknowledge that public health workers (as agents) and the geriatric community (as recipients of public health programmes) are vulnerable for their own reasons as identified by Statement 13. Where the vulnerability of the geriatric community is primarily linked to geriatric people's health, social and economic needs, less is known about the vulnerability of healthcare providers. Without ignoring their vulnerability for most probably the same reasons as above, workplace challenges can contribute to their vulnerability. Reports on corruption related to COVID-19 procurement, and the difficulty of rolling out the vaccine programme for the geriatric community, support the observations of workplace challenges (Heywood, 2020). The fact that the National Department of Health of South Africa (RSA, 2020a) does not have a strategic plan to address the needs of a growing geriatric community, confirms the under-preparedness for this development. The point in case is that the workplace can contribute to the ethical challenges experienced by healthcare practitioners.

The third building block for this framework is recognising ethical challenges for agent and recipient of service.

Statements 10 and 11 identified the need for education, leadership, and management. The expectation is that there should be an in-service training programme for healthcare practitioners. Ethical leadership is not unfamiliar with ethics. Ruger (2020:1) observes that

ethical leadership has honesty, transparency, impartiality, and integrity as trademarks. Of note is the comment that ethical leaders lead "from a sense of duty, not politics" (Ruger, 2020:3).

The fourth building block for this framework is to advance ethical leadership.

With regard to ethics training, a familiar approach is to start from an *inside-in* approach where the existing knowledge foundation of ethics is taken as basis for training. This seems to be more effective than to start from an *outside-in* approach where ethics is first explained. Such a procedure promotes tacit learning. It will also avoid a narrow understanding of ethics as theory only and will promote the application of the principles associated with ethics for the geriatric community (Schröder-Bäck, Duncan, Sherlaw, Brall & Czabanowska, 2014).

The fifth building block for this framework is to introduce ethics education.

Since the focus is on public health ethics, the South African Constitution's right of access to healthcare can be the focal point in education. Horn (2015) correctly links public health with social justice as more than just beneficence is required in public health. Although her proposal is in the context of global healthcare and moral cosmopolitanism, the tipping point is that the practice of an ethics-based public health system includes much more than merely goodness or kindness to people. Her advocacy can be expanded to medical justice as expression of social justice in healthcare. This concept of "medical justice" is most appropriate to public health ethics. Although this concept is more familiar in medical insurance claims and treatment of patients, the essence of medical justice is to protect receiver and provider of healthcare from bad practices and to ensure reliability in interpreting standards of care (Howard, 2003). Equity, access to resources and services, participation and rights are commonly regarded as the core values of social or medical justice in healthcare. Wallack (2019) remarks that public health challenges originate from injustice and inequality in society. For effective public health delivery, a narrative should be developed that communicates social justice values. The acceptance thereof will contribute to translating values in caring and formulating effective public policy. These remarks instil the importance of shared responsibility (Ruger, 2020:3). In this study, social justice will be used as an inclusive concept.

The sixth building block for this framework is promoting social justice in public health programmes, interventions, and delivery.

It is proposed that this framework be imbedded in (a) professional ethics and (b) care ethics.

Professional ethics is based on ethical principles for the workplace. It guides the behaviour between agent and recipient of service. Verbruggen (2013:161-165) comments that professional ethics emerges from the professional engagement between people in a concrete situation. Professional ethics can be captured in a professional code which is typically deontological in nature. Professional codes can be linked to a profession, an organisation or a sector. Verbruggen (2013:167-168) argues for an ethical professional expertise that is vested in a communicative ethics. This requires a dialogue amongst professionals on the ethical principles for their profession. An approach where work expertise is imbedded in ethical principles may be more conducive considering different levels of training, experience and responsibly in the workplace.

The seventh building block for this framework is developing ethical expertise.

Care ethics originates from a relationship to address responsibility, vulnerability and power challenges between the caregiver and care-receiver and all who are engaged in care. Grypdonck, Vanlaere and Timmerman (2018:9,10,11,24) comment that care ethics is practice orientated and deals with ethical challenges in daily care. Schotsmans (2012:21) adds to this by saying that care ethics is directed at the uniqueness and specificity of the situation and not at a common rule or value. Applied to public health and geriatric communities, care ethics is the *relationship* between public health agency and geriatric community, recognising their mutual vulnerability and potential power relationship within healthcare provision and carrying out the *responsibility* to improve healthcare services and provision.

The eighth building block for this framework is practising care ethics.

The suggested building blocks for a public health ethics framework is presented in Table 4.4.

Table 4.4: Building blocks for a public health ethics framework

Building block	Focus of building block	Benefit of building block
Promote the core value of public health.	Communities and not an individual only.	Community centred within promotion of health and prevention of disease.
Identify the principles for public health ethics.	Promotion of health, respect for life, dignity and vulnerability, quality of living and environment, and access to services.	Ethical awareness in public health for the geriatric community.
Recognise ethical challenges for agent and recipient of service.	Ethical challenges in the workplace and community.	Awareness of ethical challenges and vulnerability.
Advance ethics leadership.	The practice and promotion of ethics.	Ethical behaviour between healthcare provider and healthcare recipient.
Introduce ethics education.	Knowledge of/about ethics.	Preparedness to evaluate and deal with ethical challenges.
Promote social justice.	Equality of public health policies, programmes and interventions.	Equity and equality in public health.
Develop ethical expertise.	Practice-oriented understanding of ethics in public health.	Professional behaviour.
Practice care ethics.	Relationship building.	Avoid power domination towards vulnerable groups.

4.6 CONCLUSION

The 15 statements ranked in search of a public health ethics confirmed the undisputable need for a public health ethics framework. In addition, the need was expressed that it should be a user-friendly framework, steering away from a theoretical understanding of ethics to an application-based understanding of ethics. This framework can promote social justice in public health and the ability to evaluate what the ethical implications are for public health policies, programmes and interventions aimed at geriatric communities.

Eight building blocks were identified for the framework.

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If you are a doctor or surgeon, your expertise and knowledge come from a superior position. But when our role is to be providers of care, we should be there as equals.

Judy Cornish

(The Dementia Handbook: How to Provide Dementia Care at Home, 2017)

CHAPTER 5

DISCUSSION: A PUBLIC HEALTH ETHICS FRAMEWORK FOR THE GERIATRIC COMMUNITY: A SOUTH AFRICAN PERSPECTIVE

This chapter presents a public health ethics framework for the geriatric community.

The perspectives offered in the literature review (cf. Chapter 1), the views developed on social determinants impacting the geriatric community (cf. Chapters 1 & 2), and the ranking of statements (cf. Chapters 2 – 4), contributed to the identification of building blocks (cf. Chapter 4) that were used for the development of the framework (cf. Chapter 5).

The building blocks were grounded in normative ethics and applied ethics and linked to virtue ethics, deontology, and consequentialism.

Four leading questions associated with ethics were used to illustrate the application of the framework. The questions are:

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

5.1 BACKGROUND

The protocol for this study outlined the research question as: *What is public health ethics for geriatric people in the South African context?*

Relevant to this question was a refined research question: *What are the important ethical aspects to consider for a public health ethics framework for the geriatric community in the South African context?*

From the research question, three research objectives were identified:

- To identify the South African social determinants that create ethical challenges for the geriatric community.

- To define public health ethics for the geriatric community.
- To develop a public health ethics framework for the geriatric community.

To answer the research question and to deliver on the research objectives, this study has been based on a **literature review** as part of a qualitative method and the **Q-methodology** which is qualitative in its data sampling and information collection but quantitative in terms of the method of analysis. A questionnaire was designed to sample the information via the Q-methodology, based on the ranking of statements. The participants from the target audience ranked the statements based on the questionnaire provided to them. The terminology used within the Q-methodology is the P-set for the respondents. The questionnaire is referred to as the Q-sort table and the statements as the Q-set. The ranking of statements is known as Q-sorting (Shabila, Al-Tawil, Al-Hadithi & Sondorp, 2014:2).

The Q-sorting assisted in answering three questions that support the development of a public health ethics framework for the geriatric community. These questions are:

(a) What social determinants will cause ethical challenges? (cf. Chapter 2)
(b) What are the important ethical aspects to consider for a public health ethics framework for the geriatric community in the South African context? (cf. Chapter 3)
(c) What are the building blocks for a public health ethics framework for the geriatric community? (cf. Chapter 4)

The questionnaire was informed by a comprehensive literature study, as presented in Chapter 1. The literature reflected on ageing populations, growing geriatric communities, subsequent public healthcare approaches and provisions and ethical challenges associated with public healthcare for the geriatric community.

From the literature the following can be reported:

(a) The multi-phased health and well-being needs of the geriatric community range from physical, socio-economic and environmental, to socio-cultural and life expectancy. These needs can be referred to as being *ecological* in nature. The ecological metaphor refers to the encompassing needs of the geriatric community that can be grouped in five categories with personal as the core of these categories: resources (human, physical and financial), activities (integration in and contribution to community), social

networks (family life) and healthcare (to address fragility). Within a defined community such as the geriatric community, these needs are experienced collectively. These needs can raise ethical challenges. The focus of this study was on public health. Hence the discourse in this study has focused on geriatric healthcare within public health.

(b) The expected growth in ageing populations and hence the geriatric community will contribute to increasing healthcare needs. There is an expectation that developing countries will find it hard to address the healthcare needs of the growing elderly population as economic development may not be adequate to deal effectively with this need and its associated challenges. The burden increases as the impact of the COVID-19 pandemic on world economies becomes more evident. For South Africa, Chitiga-Mabugu, Henseler, Mabugu and Maisonnave (2021) present two scenarios based on distributional outcomes. Both scenarios show significant evidence of decline in economic growth and employment. These results will further challenge the negative effect that social determinants may have on the geriatric community.

(c) There is a comprehensive body of literature, policies and plans available on geriatric healthcare, but this body originates mostly from developed countries. In South Africa, as in other developing countries, there is only a limited body of knowledge available on geriatric healthcare. Consequently, only a small body of literature reporting on ethical challenges could be identified from knowledge databases such as Science Direct, Proquest, Taylor and Francis and Sabinet African Journal Collection. A conclusion is that the need for public health ethics is more a global discussion than a South African discussion. In South Africa, a comprehensive public health focus on geriatric care and the possible ethical challenges associated with the geriatric community are mainly absent.

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

(e) The geriatric community is vulnerable due, amongst other things, to declining health

and socio-economic challenges experienced by ageing communities. Vulnerability itself is subject to power domination. Philosophical analysis links power domination with vulnerability. The provision of healthcare is based on the power of the agent (government in the case of public health). The impact that weakening healthcare systems have on the geriatric community can be interpreted in the context of power domination. Ethical thought schools such as virtue ethics, deontology, and consequentialism should condemn all power relations caused by people and/or systems. To address power domination, professional ethics and care ethics were identified as ethical orientation when dealing with vulnerable communities.

In the Introduction to the study (cf. Introduction, section 5), two remarks were offered:

(a) the influence of social determinants on health and well-being; and

(b) the influence of the changing nature of healthcare on the vulnerability of the geriatric community.

Following on these remarks it was claimed that ethics in general and public health ethics in particular, can contribute towards:

(a) identifying what *ethical challenges* emerge from social determinants;

(b) assisting to prevent vulnerability in public healthcare aimed at the geriatric community;

(c) addressing and correcting those vulnerabilities in the geriatric community already in existence; and

(d) providing the ethical basis for policies, strategies, interventions, and services aimed at improving the quality of health and well-being of the geriatric community.

The claim above contributed to a central argument in this study, namely that ethics should not be viewed as adding value-based perspectives to public health only, but that it adds to making ethics applicable to real-life ethical situations.

The next section contributes towards a comprehensive perspective on public health ethics.

5.2 CONCEPTUAL ANALYSIS OF PUBLIC HEALTH ETHICS

The literature review in Chapter 1 and the ranking of statements regarding what public health ethics is, based on the Q-methodology in Chapter 3, contributed to two important observations.

(a) Carter, Kerridge, Sainsbury and Letts (2012:101) remark that ethics can be grouped into meta-ethics (dealing with foundational ethical questions), normative ethics (providing principles) and applied ethics (application to situation). The "traditional" way of scoping what ethics is, or in the case of this study, public health ethics, follows a principle-based approach. The scoping was extended to include an applied ethics approach, where the scope of ethics is informed by what ethical challenges are experienced within the field of ethical application and what must be done to address current ethical dilemmas and prevent future ethical dilemmas.

(b) Public health ethics consists of both an applied ethic and a professional ethic. Although medical and bioethics' guidelines can inform public health ethics, the unique space and core for public health ethics should be maintained as there is a distinctive difference between public health ethics and medical and bioethics. The difference is between the focus on health as opposed to the focus on life.

From the literature review, the opinion was presented that public health must first be understood before public health ethics can be formulated. This opinion is based on the argument that the core of what public health is, must be found in public health ethics (cf. Chapter 3, section 3.5).

This study confirms ***public health*** *as the organised strategies, interventions, and services to promote the quality of health and well-being of a community or population based on a public health value chain* (cf. Chapter 1, section 1.3).

The public health value chain is based on access to healthcare, a quality habitat (consisting of social, environmental, work and living spaces conducive to good health), leisure as self-care, effective service delivery and the improvement of health as social justice (cf. Chapter 1, section 1.3.2).

Although the importance of the quality habitat and leisure of self-care were not denied,

access to healthcare, effective service delivery and social justice attracted much more attention. The reasons may be threefold:

(a) Very little attention is paid to quality habitat and leisure as self-care for geriatric communities in literature and policies.

(b) Access to healthcare and service delivery remains a major challenge as has been reported due to COVID-19 regulations.

(c) The observation from literature, strategy and policy is that the value chain's meaning is not well accommodated in public health. What should be added, is that it is not so much the attention to the different links in the chain, but a missing coherent and integrated approach to geriatric care in public health.

Following the discussion on what public health is, the focus was then placed on public health ethics. Based on the normative or principle approach to ethics, public health ethics was defined as (a) the identifying principles for the promotion of a population's healthcare and well-being, (b) the decisions supporting the delivery of healthcare, and (c) the behaviour to improve quality of health and well-being of a population (cf. Chapter 1, section 1.8).

Based on the perspective that public health ethics is applied ethics, public health ethics was scoped as *the application of ethical principles through decisions and professional behaviour to improve the community's health and well-being.*

The literature review also pointed to existing ethical principles and guidelines aimed at the geriatric community's healthcare. Beauchamp and Childress's (2013) respect for *beneficence, non-maleficence, autonomy and justice* can indeed be regarded as the backbone for medical and bioethics and relevant to public health, but not sufficient for public health ethics, the reason being the scope of activities. Public health ethics' focus is primarily on the communities' health promotion and not on clinical interventions or decision making about the beginning and ending of life. As imbedded in virtue ethics, consequentialism and deontology, the choice between right and wrong and attention to current and future ethical dilemmas can never be ignored.

The rankings in Chapter 3 took the understanding of what public health ethics is a step further. In this chapter the focus was to identify what constitutes a public health ethic for

the geriatric community. The chapter concluded that the need exists to have a less abstract understanding of public health ethics which is based on principle identification only. The results confirmed a broader interpretation of public health ethics, such as addressing the vulnerability of geriatric communities through care and relationship building. It was also evident that public health ethics calls on various stakeholders to secure ethical behaviour when dealing with the geriatric community.

The ranking of the statements and interpretation of the ranking results delineated the space of public health ethics as *applied ethics* and within applied ethics it can be labelled as *professional ethics*. The results further identified the need for a *care ethics* as social ethics. Based on these comments, public health ethics for geriatric people may be defined as *the application of ethical principles through a professional ethic resulting in care and relationship building.*

The description of public health ethics assisted with identifying which social determinants give rise to ethical challenges for the geriatric community.

5.3 WHAT SOCIAL DETERMINANTS CAUSE ETHICAL CHALLENGES?

The orientation in Chapter 2 was first to identify which social determinants influence geriatric healthcare and second which of these social determinants give rise to ethical challenges in geriatric healthcare.

The results in Chapter 2 confirmed that the availability of healthcare, access to healthcare and the quality of healthcare are important factors influencing the healthcare of the geriatric community, as these factors impact on the vulnerability of geriatric communities. These activities were grouped together as healthcare services. The results further confirmed that living conditions and social factors play an equally important role in the health of the geriatric community. The responses confirmed that social determinants' role in public health are just as important in urban and rural contexts. This response is in line with the general confirmation in literature that socio-economic factors influence the delivery and reception of healthcare. Regardless of the sample size or profile of respondents to these questionnaires, the results from the questionnaire are not different from what is generally accepted in the literature, namely that the consequences of social determinants impact negatively on the geriatric community. It should also be noted that the influence of COVID-19 may have contributed to the excessive emphasis on healthcare access and availability.

Healthcare access and availability were already a challenge before the pandemic, as confirmed by the National Department of Health's Strategic Plan, 2020-2025 (RSA, 2020:10,15,21). A significant challenge is the absence of quality data on healthcare in South Africa, as reported in the South African Lancet National Commission's Report on healthcare in South Africa (2018:2).

The availability of and access to healthcare services and the quality thereof are undeniably a constitutional right, as healthcare itself is also an economic right confirmed by the South African Constitution (RSA, 1996). Compromised healthcare services for the geriatric community pose ethical challenges, as confirmed by the ranking interpretations presented in Chapter 2.

Chapter 2 further confirmed that healthcare services for geriatric communities require social responsibility. The geriatric community also have individual responsibility for their lifestyle. Hence, changed public and professional behaviour is required.

The literature review in Chapter 1 and the confirmation of the ethical challenges rising from the social determinants in Chapter 2 assisted with the development of a public health ethics framework for the geriatric community.

The next section presents the Q-methodology's contribution towards identifying building blocks for the framework.

5.4 BUILDING BLOCKS FOR A PUBLIC HEALTH ETHICS FRAMEWORK FOR THE GERIATRIC COMMUNITY

Following from the literature review in Chapter 1, a questionnaire was designed. The Q-methodology was identified as qualitative and quantitative method to sample and interpret data based on the ranking of statements. The questionnaire had 50 statements which presented three indexes namely:

(a) an Index of Social Determinants (Questions 1-20);
(b) an Index of Public Health Ethics (Questions 21-35); and
(c) an Index of a Public Health Ethics Framework (Questions 36-50).

The different indexes contributed towards the content of the building blocks used in the framework.

The content of the framework was further informed by four joint observations presented in Chapters 2-4.

The **first observation** was the reliability of the statistics. Cronbach's alpha was calculated to assess the reliability of the statistics. For the first scale, Cronbach's alpha was **.744** (cf. Table 2.1), the second scale was **0.866** (cf. Table 3.1) and the third scale **0.912** (cf. Table 4.1). These scales indicated a high level of internal consistency of the scales and uni-dimensionality in the sample of test items. Cronbach's alpha below 0.70 is not accepted as the internal consistency is regarded as low, while above 0.90 is regarded as duplication. The removal of some questions added too little to improve the alpha value of the third scale. The differences, however, can be assigned to the response to the different spread of answers over three indexes. The Cronbach's alpha value of the integrated indexes is 0.917 as presented in Table 5.1.

Table 5.1: Reliability of statistics

Cronbach's alpha	Cronbach's alpha based on standardised items	N of items
.917	.947	50

The removal of some questions will contribute very little to changing the alpha value. The statistic for this questionnaire can therefore be regarded as reliable.

The **second observation** was that the principal component analysis (PCA) was used to summarise the information content. Based on the collected data, the rotated component matrix identified six factors for the first index, four factors for the second and three for the third index. The rotated component matrix was used to determine what the factors represent. From these factors the influence of social determinants on geriatric communities' health was confirmed (cf. Chapter 2). Non-medical factors such as personal circumstances and systems problems can impact negatively on the geriatric community' health. The influence of social determinants on health requires interventions to address the negative influences of social determinants on a personal and systems level. This observation confirmed that the lack of, or insufficient healthcare provision can cause ethical challenges. At the same time care receivers' behaviour can also create ethical challenges. Healthcare provision for the geriatric community depends therefore on responsible implementation and responsible behaviour (cf. Chapter 4, section 4.5). This comment was further extended to argue that a public health ethic for the geriatric community is more than a set of principles only, as it depends on the ability to make ethical judgements, promote medical justice and

contribute towards well-being of communities (cf. Chapter 4, section 4.5).

The **third observation** was that the PCA was used to summarise the information content. Based on the collected data, the rotated component matrix (cf. Table 5.2) identified nine factors from the outcome of the survey. Variables were assigned to the factors. The rotated component matrix sorted the variables by the factor they belonged to and by co-variance with the factor.

Table 5.2: Rotated component matrix (Table to continue on next pages)

Statement	Component								
	1	2	3	4	5	6	7	8	9
Ethics can be explained as the choice between what is good and what is bad.	.953								
Ethical decision making is to address the ethical dilemma at hand.	.953								
Ethical success depends on participation around a common goal.	.906								
Ethics is not about the needs of the other only, but also the self.	.872						.389		
Public health ethics for geriatric people is about care and relationship-building between various stakeholders and geriatric people.	.812							.387	
Ethics is about having the best interest of a person and/or situation at heart.	.779	.425						.367	
Public health is about collaboration between government, healthcare facilities and communities.	.776						.452		.355
Healthcare practitioners need a practical guide to assist them in ethical behaviour and decision making.	.758				.348				
Ethics is about dealing with the vulnerability of the self, other people, systems and the immediate situation.	.722		.505					-.325	
Ethics is about making a choice, implementation of the choice and evaluation of the outcome of the choice.	.688	.380							.360
Public health ethics for geriatric people should make healthcare practitioners more sensitive towards the vulnerability of geriatric people.	.633	.350	.609						
Public health ethics must protect the vulnerability of geriatric people and healthcare practitioners.	.620		.537						
Public health ethics for geriatric people is about what is best to promote the health of this population group.	.606					-.459	-.396		.355
Public health ethics must promote human rights in geriatric care (medical justice).	.556		.403						.548
Ethics is not about who is right or wrong but about what one can do to prevent or address a moral dilemma.	.542			.533		.307			.336
Leadership and management should promote ethical behaviour.	.532	.391	.394		.385				

Statement	Component								
	1	2	3	4	5	6	7	8	9
Geriatric people's health is influenced by living conditions such as accommodation/housing, food, nutrition, electricity, water, sanitation and the general environment.		.946							
Poor service delivery influences healthcare.		.946							
Social factors such as low income, little and substandard education, limited employment options, high levels of unemployment and poor living and working conditions influence the health of all people.		.944							
Ethics decision making can have future consequences.		.814					.407		.324
Lifestyle influences health.		.745				-.446			
Ethics should be integrated in the public health ethics value chain.		.691				.357			.517
Healthcare facilities/institutions and healthcare practitioners seldom talk about ethical challenges.	.462	-.660					-.393		
Lack of finances influences access to and quality of healthcare.	.387	.647	.496						
The poor management of healthcare influences health.	.387	.647	.496						
Geriatric people's health is influenced by social factors such as the role in the family (for example caring for grant children), isolation from peers and/or children.	.318	.604			-.330		.362	-.364	
Health is influenced by more than physical challenges or illness only.	.540	.578	.396						
Ethics is influenced by own understanding of what is good for the self, other people, systems or a situation.	.522	.557					.422	-.395	
Public health ethics for geriatric people deals with the fairness of how geriatric programmes are implemented.			.858						
Public health ethics for geriatric people should change behaviour towards elderly communities.	.392		.777						
Ethics is to know what you need to do right to prevent harm to the self, other people, systems and the immediate situation.	.535	.301	.645			.306			
Geriatric people's health is influenced by public health preparedness to prevent disease and create good living conditions.	-.447	.450	.635				.336		

Statement	Component								
	1	2	3	4	5	6	7	8	9
Ethics is not only about people but also about systems, practices, processes and application.	.431		.538		-.474			-.422	
Government has only a financial responsibility to promote the health of geriatric people.				-.906					
Geriatric people's interest is more important that the communities' interest.				-.804	.358				
Public health ethics can play a role in the prevention of poor health.			.421	.741					
The healthcare of geriatric people is poorly managed.		-.349		.712			-.373		
Public health is about prevention and not treatment.			-.356	.550	.372		.472	.373	
Geriatric people have the responsibility to care for themselves.					.896				
Geriatric people need to be educated on how to care for themselves.					.864				
Public health policymakers do not know what the ethical needs of elderly people are.		.405			-.627				.511
Geriatric people have different needs from other population age groups.		.427		-.326	.509	-.376			
There are not enough ethical guidelines available to support healthy living conditions for geriatric people.						.854			
Differences in the availability of healthcare support systems is geriatric people's biggest challenge.				-.368	.349	.739			
Healthcare practitioners need ethical education.	.352					.733			.394
Ethics is influenced by one's liking or disliking of other people or systems.							.864		
There are enough healthcare support systems available to support geriatric people.								.968	
Geriatric people's health is influenced by access to healthcare, whether financial, area (location of healthcare facility), language or mobility.	.443	.513	.328					-.588	
Public health ethics must promote decision making capacity.	.567								.700
Relationship building is important in ethics.	.526	.308					.462		.546

The purpose of factor analysis was to identify interdependency between observed variables. The identified factors first outlined what ethics is, and based on this, what public health ethics is. The **first factor** highlighted that ethics is defined based on principles as confirmed by the literature review (cf. Chapter 1, section 1.8). As public health ethics can be grouped within the domain of applied ethics, ethical challenges within public health contribute towards enlarging the understanding of public health ethics. It is for this reason that in the literature review, following the principle-based approach, the working definition presented for public health was presented as: *Public health ethics is the ethical principles, decisions, and behaviour to improve a community or population's health and well-being.*

As applied ethics, the following working definition was offered: *Public health ethics is the application of ethical principles through decisions and professional behaviour to improve the community's health and well-being.*

From the ranking of statements and the consideration of care ethics and professional ethics, the following refined definition for public health ethics was offered: *Public health ethics is the application of ethical principles through a professional ethic resulting in care and relationship building.*

The factor analysis assisted with a broader view on ethics. The **seventh factor** portrayed that ethics is an individual matter and therefore influenced by personal orientation, and the **ninth** factor confirmed the perspective put forward in this study, namely that ethics is more than making a choice between what is right or wrong: it also adds value to a given situation and can be applied to real-life situations. The positive influence public health ethics can have on the geriatric community is confirmed by the **third factor.**

A central theme in this study was the influence of social determinants on the health and well-being of the geriatric community. The **second factor** confirmed that social determinants do influence the geriatric community, while the **eighth factor** outlined the influence of social determinants on the health of the geriatric community.

The **fourth factor** confirmed the value that public health is adding to the health of the geriatric community. This is only doable with the availability of systems, support and education, as identified by the **sixth factor**.

Regardless of the important role, availability and contribution of public health systems and

ethical support, the responsibility of the geriatric community towards their own health cannot be discharged, as confirmed by the **eighth factor.**

The **fourth observation** was that the participants had strong opinions when ranking the statements. In the Index on Social Determinants with 20 statements, six statements had only agree or strongly agree rankings (cf. Chapter 2, Table 2.3, Statements 3, 4, 6 & 7, & Table 2.4, Statements 9 & 10). Four of the statements elicited either disagreed or strongly disagreed from the majority of respondents (cf. Chapter 2, Table 2.4, Statement 13 & Table 2.5, Statements 15, 17 & 19). One statement had a high neutral ranking (36.4%) (cf. Chapter 2, Table 2.5, Statement 17). The matters ranked based on a strong opinion (either agree, strongly agree, disagree, strongly disagree) are linked to the influence of social determinants on the geriatric community's health, government's responsibility towards the geriatric community and systems available to support the geriatric community. These rankings contributed to the conclusion that the geriatric community is vulnerable and that this community requires sufficient support to maintain its health. This view is further informed by the disagree or strongly disagree statement that the geriatric community's healthcare needs are more important than those of other communities, while 36.4% of the rankings had a neutral view on this statement. The Index on Public Health Ethics with its 15 statements had two statements with an agree or strongly agree ranking only (cf. Chapter 3, Table 3.3, Statements 2 & 11). These rankings confirmed the general orientation of ethics, namely the interest of all people or situations (cf. Chapter 3, Table 3.3, Statement 2). The link between ethics and social determinants is noteworthy. This observation confirmed that social determinants can evoke ethical challenges (cf. Chapter 3, Table 3.3, Statement 11). The 22.7% neutral ranking of the statement on care and relationship building should not be interpreted as an opposing view but rather as unfamiliarity with this interpretation of public ethics (cf. Chapter 3, Table 3.3, Statement 12). The 15 statements of the Index of a Public Health Ethics Framework's ranking pattern supported the need for a public health ethics framework for the geriatric community (cf. Chapter 4, Table 4.3). These rankings contributed to the interpretation that public health ethics is regarded as important for the geriatric community and that it can contribute to maintaining the health of this community. Equally important is the observation that respondents are in agreement with having a public health ethics framework for the geriatric community, the role that such a framework can play in maintaining health, and the assistance that such a framework can make towards ethical judgements (cf. Chapter 4, section 4.5).

Based on the literature review presented in Chapter 1 and the interpretation of the ranking of statements in Chapters 2 and 3, Chapter 4 presented building blocks for a public health ethics framework for the geriatric community.

Table 5.3: Building blocks for a public health ethics framework

Building block	Focus of building block	Benefit of building block
Promote the core value of public health.	Communities and not an individual only.	Community centred within the promotion of health and prevention of disease.
Identify the principles for public health ethics.	Promotion of health, respect for life, dignity and vulnerability, quality of living and environment, and access to services.	Ethical awareness in public health for the geriatric community.
Recognise ethical challenges for agent and recipient of service.	Ethical challenges in the workplace and community.	Awareness of ethical challenges and vulnerability.
Advance ethics leadership.	The practice and promotion of ethics.	Ethical behaviour between healthcare provider and healthcare recipient.
Introduce ethics education.	Knowledge of ethics.	Preparedness to evaluate and deal with ethical challenges.
Promote social justice.	Equality of public health policies, programmes and interventions.	Equity and equality in public health.
Develop ethical expertise.	Practice-oriented understanding of ethics in public health.	Professional behaviour.
Practice care ethics.	Relationship building.	Avoid power domination towards vulnerable groups.

The next section attends to how these building blocks can be integrated into a public health ethics framework.

5.5 INTEGRATION OF BUILDING BLOCKS IN THE DEVELOPMENT OF A PUBLIC HEALTH ETHICS FRAMEWORK FOR THE GERIATRIC COMMUNITY

Building blocks for a public health ethics framework were presented in Chapter 4. It was emphasised that the core of what public health is, must be found in a public health ethics framework (cf. Chapter 4, section 4.5). This comment was made, based on a similar argument discussed in Chapter 3 (cf. section 3.5).

The building blocks for this framework, identified in Chapter 4 (cf. Table 4.4) and reflected in Table 5.3 above, suggest a multi-faceted approach to such a framework. The eight

building blocks represent a multi-layered approach to developing this framework.

Building Block 1 [Promote the core values of public health] emphasises a basic requirement for this framework, namely the understanding what public health is. This requirement is well articulated by Kass' (2001:1776) comment that "Public health seeks to ensure societal conditions under which people can lead healthier lives, minimizing threats to our health…" A first accent contained in this building block is that in public health the focus is not the individual but the community. A second accent is quality of health and well-being.

For **Building Block 2** [Identifying the principles for public health ethics], a triangular approach to public health ethics is suggested, namely (a) *applied ethics* as it addresses the application of principles in service delivery and provision; (b) *professional ethics* as it calls on the behaviour towards vulnerable groups; and (c) *social ethics* as it concerns itself with communities. For the latter a care ethics approach is suggested (cf. Chapter 3, sections 3.4 & 3.5). This building block is defined by (a) the integration of the *prima facie* bioethics principles formulated by Beauchamp and Childress (2013), namely respect for beneficence, non-maleficence, autonomy and justice; (b) the "four principles plus scope" approach suggested by Gillon (1994); (c) the principles relevant to public health ethics; and (d) the contribution that applied ethics can make towards the scope and space for public health ethics.

The intertwined view on public health ethics resonates well with **Building Block 3** [Recognise ethical challenges for agent and recipient of service] that ethical principles for the geriatric community's healthcare, apply to the network relevant for caregiving and care receiving. Comments by Vanlaere, Burggraeve and Lategan (2019), Carter *et al.* (2012), and Krebs (2008) substantiate individual or group and systems' responsibility. It is especially the systems' responsibility that has attracted attention. The design and implementation of healthcare systems should be ethical too. Chapter 2 suggests that failure in delivering quality healthcare creates ethical dilemmas.

Building Block 4 [Advance ethics leadership] cannot be delinked from leadership. As public health is linked to government's responsibility to promote the health of its citizenry, the actions from government or delegated to its agencies cannot go without assessment. A good example may be a utilitarian approach to weigh the benefit that an intervention or policy has for a group (Carter *et al.,* 2012:103). Krebs (2008:579) rightly identifies one of

public health's ethical focuses to be the role of government in delivering public health. Within the South African context, the realisation of public health may not be possible without constructive partners. The roll-out of vaccinations during COVID-19 calls for such partnerships (RSA, 2021). Although partnership development can contribute to the realisation of quality public health, the emphasis for this building block remains leadership as action to promote ethics. In fact, one of the major challenges of the current vaccination programme is a leadership challenge.

Building Block 5 [Introduce ethics education] should be grounded in critical cross-field outcomes. Within the context of cross-field outcomes there are critical and developmental outcomes. These outcomes can address the comment recorded in Chapter 4 (cf. section 4.5) that healthcare workers seldom talk about ethical challenges. As Carter *et al.* (2012:102), point out, the decisions made in public health are joint and not individual decisions. The value of the critical cross-field outcomes is well illustrated through, for example, systems thinking as part of critical outcomes and responsible participation as part of the developmental outcomes (Academy of Science of South Africa [ASSAf], 2018:133).

Building Block 6 [Promoting social justice] reports inequalities and its social determinants in South African healthcare caused by socio-economic reasons are not new. Omotoso and Koch (2018) use national representative data from the 2004, 2010 and 2014 General Household Surveys (GHSs) to confirm this observation. They use ill-health and disability as health indicators, and their results confirm that a wide range of social factors should be used to address this problem. Although their research confirms that the growth in non-contributory old age pension and child grants has increased, a large group of black Africans and Coloured people are still recipients of healthcare that may not meet their needs. Building on the population age of black Africans and Coloureds, the deduction is that a large percentage of geriatric people in these population groups are suffering from poor healthcare delivery. Kelly, Mrengqwa and Geffen (2019) confirm the role that financial means plays in geriatric healthcare. The sample size of their research concludes that the environment within which geriatric people live, adds to their health status. Although no confirmed statistics could be identified, the assumption is that this matter is even worse in rural and under-serviced communities. This commentary confirms the importance of social justice in healthcare but at the same time opens the ethical challenge between the compromised public healthcare system and private healthcare. Carter *et al.* (2012:102), rightly present the "publicness" of public health. They follow Dawson and Verweij who have two meanings for "public", namely the collective, community or population and the collective action led by

government. Social justice is therefore primary in healthcare matters.

Building Block 7 [Developing ethical expertise] accommodates the argument in favour of the professional ethics in public health as outlined in section 5 above. What can be added to professional ethics is the expected competence (broad-base understanding of public health) and competency (ability to do a specific assignment) in professional ethics (ASSAf, 2018:132).

Building Block 8 [practising care ethics] reflects on care ethics that is presented as the ethics of every day's care. In care ethics (a) the person is central, (b) relationship development between the network of caregivers and care-receivers is the primary focus, and (c) addressing vulnerability is the aim.

These building blocks have been used to present an integrated public health ethics framework.

5.6 A PUBLIC HEALTH ETHICS FRAMEWORK FOR THE GERIATRIC COMMUNITY

The perspectives presented in the literature review (cf. Chapter 1) and the perspectives developed on social determinants impacting the geriatric community (cf. Chapters 1 & 2), together with the ranking of statements (cf. Chapters 2 - 4), contributed to the development of a public health ethics framework. Based on the ranking of statements, building blocks were identified (cf. Chapter 4, Table 4.4 & Chapter 5, Table 5.3) that contributed to the public health ethics framework for the geriatric community.

The following commentary is added to interpret this framework:

- A foundational understanding of ethics is the choice between right and wrong. Applied to public health ethics, this means the choice between right and wrong in the promotion of a population's health and well-being. **Building Block 1** represents the core of public health <health and well-being>. Public health focuses on the <community> and is driven by <social justice>. The geriatric community's health is influenced by <social determinants>. Social determinants, together with social justice, require <quality of service>. This building block is interlinked with the population it serves (the geriatric community), what impacts on the core of public health (social determinants), and the

obligation of quality of services as part of social justice. Public health workers should always ask what the core of their activity is, and should be mindful of what impacts on the core activity.

- Four questions can be associated with ethics. These questions can assist with alignment of the other seven building blocks to Building Block 1. The questions are:

    - Are we doing things right?
    - Are we doing the right thing?
    - How can the common good be promoted?
    - What benefit is there?

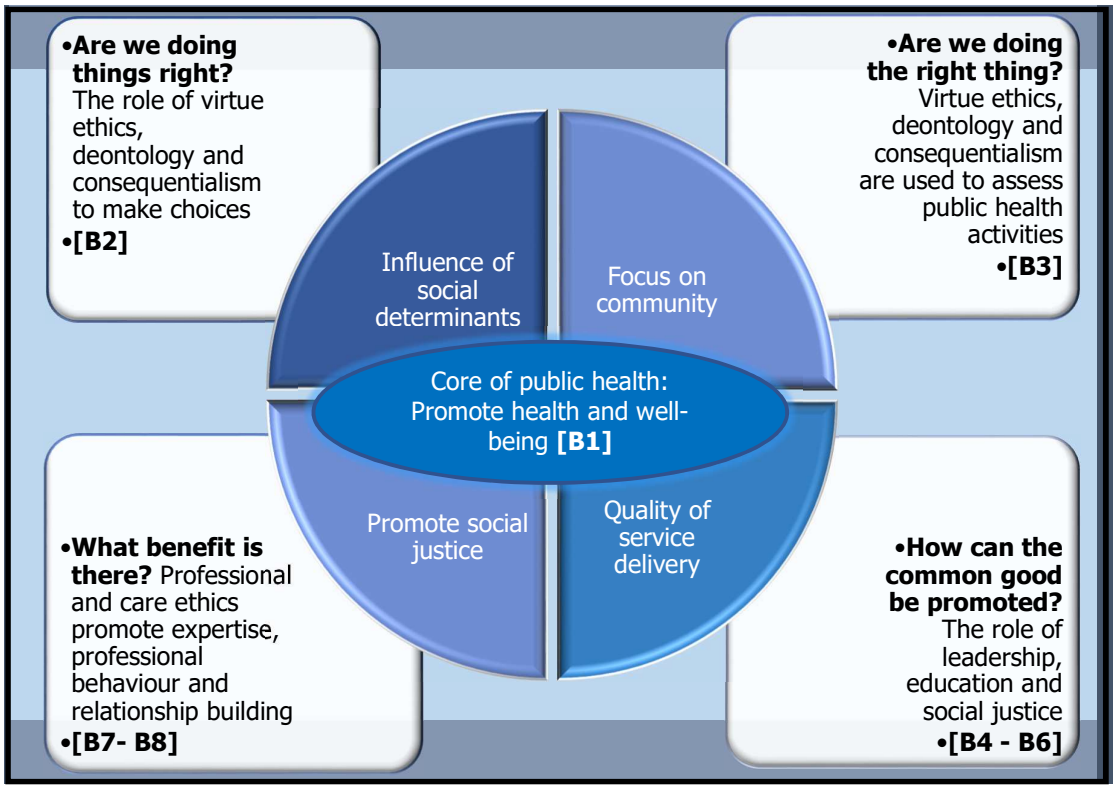
- The geriatric community is vulnerable due to the factors impacting on public health. The growing elderly community and the demand on the public health system give rise to ethical challenges. To deal with such challenges the question is, are we doing things right? This question identifies the principles required for dealing with the geriatric community. **Building Block 2** fits in here as it resonates with the choice between right and wrong. The three schools of ethics will provide guidance in making this choice. The questions to ask are: What is the motive for the action? (Virtue ethics). What are the obligations to do the activity? (Deontology). What will be the result of the action? (Consequentialism).

- **Building Block 3** engages with the healthcare worker and/or geriatric community to evaluate whether the best ethics decision has been taken. The question is whether the public health activity will be in the best interest of the geriatric community. The three schools of ethics can be used to identify if the best ethical decision has been taken. The questions to ask are: Whose interest was served? (Virtue ethics). How was the activity approached? (Deontology). What outcome will the activity have? (Consequentialism).

- **Building Blocks 4 – 6** promote the common good in public health. Leadership, education, and social justice support public health actions by making the right choices and promoting equity and equality (social justice) in healthcare.

- **Building Blocks 7 – 8** advance the benefit of ethics. Professional ethics and care ethics will be adding value to public health.

Figure 5.1 presents the public health ethics framework visual.



Legend: B = Building Block

Figure 5.1: A public health ethics framework for the geriatric community

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CONCLUSION

In his comment on public health ethics, Krebs (2008:579), identifies three important aspects:

(a) the role of government in public health,
(b) the fact that bioethics cannot deal sufficiently with public health challenges, and
(c) the world-wide significance of ethics for health and public health.

His comment is complemented by Chan (2017), outgoing Director-General of the World Health Organization (WHO), in her statement that ethics are important in securing equitable public health. The importance of ethical guidelines is emphasised by a growing elderly community across the world. Ageing populations will put a strain on public health resources. Consequently, applicable ethical guidelines, amongst other things, will be required for public health.

Although public health ethics is a new field compared to medical ethics and bioethics, there has been a growing body of literature on public health ethics since the new millennium. Unfortunately, there is only a limited contribution from a South African perspective to this body of knowledge. Even if ethics are universal, context remains important to develop ethical perspectives or to apply ethical guidelines to a situation. The South African health system is characterised by a public and a private healthcare system, unequal access to, and benefits from, a public health system, social justice discrepancies in receiving healthcare based on economic and social factors and current and past political systems. Even though nobody, nor any institution, denies the importance of ethics for public health, this matter does not seem to be high on the agenda of the National Health Department, in terms of developing ethical guidelines for public health. The implications of the lack of a public health ethics narrative cannot be ignored, as warranted by the growing ageing society and therefore the geriatric community, as delineated as scope for this study.

The **first conclusion** drawn from the study is that the need for a public health ethic is more a global discussion than a South African discussion. In South Africa, a comprehensive public health focus on geriatric care and the possible ethical challenges associated with geriatric communities are mainly absent. This observation does not mean that geriatric communities are not important in public health. A fair conclusion is that the need for a public health ethic exists and the importance is recognised, but it remains largely an

unattended need. This study is intentionally making a contribution to address this need.

Ethics can be grouped into meta-ethics (dealing with foundational ethical questions), normative ethics (providing principles) and applied ethics (application to situation). Of interest to this study were the principles identified for public health ethics and the application of these principles to public health. The *bona fide* principles for bioethics can be regarded as a backbone for public health ethics, but not as the conclusive principles. The normative approach to public health ethics has resulted in an abstract definition: *public health ethics is defined as the ethical principles, decisions, and behaviour to improve a community or population's health and well-being.* The rankings in Chapter 3 confirm the need for a more user-friendly description of what public health ethics is. The applied ethics approach, based on the ranking of statements, presents *public health ethics as the ethical principles, decisions, and behaviour to improve a community or population's health and well-being.* The integration of care ethics and professional ethics into public health ethics offers the following refined definition: *Public health ethics is the application of ethical principles through a professional ethic resulting in care and relationship building.*

The ranking of statements further suggests that public health ethics can be framed in professional ethics and care ethics.

From the ethical scope for public health, it is evident that (a) the ethical focus is people-centred, and (b) it involves professional service delivery to uphold the responsibility of government towards its citizens. Furthermore, (c) the care ethics perspective facilitates multi-diversity and addresses ethical challenges as they emerge.

The **second conclusion** is that an applied approach to public health ethics as professional ethic may be more user friendly than a normative approach to ethics.

The **third conclusion** is that care ethics can facilitate the fostering of a relationship between public health (government and its agencies) and community that can bridge the multi-diversity of South African society.

In South Africa healthcare is delivered through a public system (primarily nurses providing basic care) as well as a private one (doctor-driven). Socio-economic and political factors contribute to an unequal and resource-limited healthcare system. Although public health has the promotion of health and well-being of the community as focus, this focus is

evidently challenged through quality of service and available resources as confirmed by the National Department of Health's Strategic Plan, 2020-2025 (RSA, 2020a) and the South African Lancet Study on the Quality of South African healthcare (2018). Despite the difficulty in delivering uncompromised services to the public, this does not mean that there are no services available. The negative impact of social determinants on healthcare delivery cannot be ignored. Again, attention is on improving the impact of social determinants, however, the absence of a confirmed plan to address the current needs of geriatric communities and the future elderly communities is largely absent.

The **fourth conclusion** is that public health for the geriatric community needs more focused attention. Here, too, the focus will be the promotion of health and prevention of disease. This should contribute to the healthy ageing and well-being of the geriatric community.

The **fifth conclusion** is that the negative consequences of social determinants on the geriatric community place more expectations on public health delivery, which is already challenged by limited resources resulting in poor service delivery. This, in return, results in social determinants that can also give rise to ethical challenges.

Three indexes, namely the Index of Social Determinants, the Index of Public Health Ethics and the Index of a Public Health Ethics Framework contributed to the development of a public health ethics framework for the geriatric community. The Q-methodology was used to rank the statements to support the development of a public health ethics framework. The ranking of statements resulted in identifying eight building blocks for such a framework.

The **sixth conclusion** is that a public health ethics framework has been developed to assist public health workers to assess the ethical implications of what they are doing. The framework is based on the primary focus of ethics, *do no harm*, making right decisions and contributing towards the common good. This framework can fit into the three groupings of ethics, namely meta-ethics, normative ethics, and applied ethics. The framework is also reflective of the three schools of thought in ethics, that is virtue ethics, deontology, and consequentialism.

This study's contribution to a public health ethics framework is from a South African perspective. Economically marginalised provinces (Free State, Northern Cape & Northwest provinces) with a total of 30% of geriatric people (older than 60 years) were identified for

the study (RSA, 2020b). Within these provinces rural geriatric facilities were identified to rank the statements. This selection of provinces and facilities was made in order to collect information from provinces and facilities that are not mainstreamed in economic activities and which are not normally invited to be part of public health studies. Although this sample may not be representative of the whole of South African society, their opinions are not less important. Based on available South African literature, the opinion of this sample is also not different in terms of the impact of social determinants on health and well-being or the need for a framework to facilitate public health ethics. The comment on representation of opinion should be interpreted within the broader context of absence of quality data that will give evidence to public health performance as confirmed by the South African Lancet Study on South African healthcare (2018).

The **seventh conclusion** is that reliable data on the delivery of public health services for geriatric communities is required to arrive at reliable conclusions on this matter.

This study emerged in 2017, sparked by the advice offered by four African scholars, A. Githeko, B. Mash, K. Daniels and T. Mwangi, to the newly-elected Director-General of the WHO, Dr Tedros Ghebreyesus, regarding what the public health needs are in Africa. They identified a "toolbox" to heal health ills, namely (a) funding and supportive resources to address communicable diseases; (b) attendance to neglected primary care matters such as hypertension and diabetes; (c) improvement of healthcare systems and the introduction of enabling healthcare policies; (d) research to find evidence-based solutions; and (e) training to deal with these problems. This study's origin was to contribute to items (c) – (e) above.

What was not foreseen at that point was the COVID-19 pandemic and the effect this would have on the geriatric community. Looking back, this may have influenced the approach to this study. This pandemic emphasised the vulnerability of the geriatric community not only because of a nearing end of life. It was a lesson in ethics too: healthcare systems are used by governments for transformative reasons without asking the fundamental ethical question: *are we making the right decisions?*

The **eighth conclusion** is that a public health ethic should not only act as gatekeeper for how public health policies, programmes and interventions are implemented but should also question the reasons for these policies, programmes and interventions.

In summary: the conclusions confirmed the absence of a public health ethics framework for the geriatric community in South Africa – both at conceptual level and implementation level. Although limited information on the geriatric community's needs is available, contributed the ranking of statements to profiling a framework for the South African geriatric community. The existing bodies of knowledge and information on this topic, although limited, added to the interpretation of the data to make the framework relevant for the South African context. This framework addressed a specific need within the geriatric community. It is anticipated that this framework can be relevant at a conceptual and implementation level in other health systems too as the need to be ethical towards the geriatric community is not limited to the South African situation only.

The conclusions offered in this study confirm that the research questions have been answered and the objectives of the study met.

The conclusions above have also contributed to a policy statement. The drafting of a policy statement should be viewed as part of "research uptake": research uptake can be defined as the purposeful outcomes of a research project (Lategan, 2019). Three activities are associated with research uptake namely:

- Public dissemination of research results
- Innovation
- Policy statement

Apart from the public dissemination of research results as published articles and commentaries, the public health ethics framework is presented as a new service. This is part of social innovation.

POLICY STATEMENT

The intention of the policy on public health ethics for geriatric communities is to promote ethic-driven engagement with geriatric communities, as part of vulnerable communities, characterised by integrity, common good, social benefit and care, through securing physical and social access to quality but affordable healthcare services based on relevant policies, programmes and interventions to develop an equitable healthcare system in South Africa.

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APPENDICES

Appendix 1:

Questionnaire

UFS·UV
UNIVERSITY OF THE FREE STATE
UNIVERSITEIT VAN DIE VRYSTAAT
YUNIVESITHI YA FREISTATA

QUESTIONAIRE

A PUBLIC HEALTH ETHICS FRAMEWORK FOR GERIATRIC PEOPLE: A SOUTH AFRICAN PERSPECTIVE

Laetus OK Lategan

A. General information

Please provide the following information. The information will remain confidential. The purpose of the information is to establish the potential influence of biographic information and context on ranking statements.

Please provide the following information by clicking one box with the **x** symbol per information category:

Information Category		Answer
Gender		
	▪ Male	
	▪ Female	
Age		
	▪ 20-30 years	
	▪ 31-45 years	
	▪ 46-60 years	
	▪ 61-65 years	
	▪ 66-70 years	
	▪ 71 years and older	
Highest education level		
	▪ Grade 12	
	▪ Post-school education	
	▪ University education	
Professional registration		
	▪ Yes	
	▪ No	
Profession		
	▪ Medical doctor	
	▪ Registered sister	
	▪ Nurse	
	▪ Therapist	
	▪ Manager	
	▪ Administrative staff	
	▪ Social worker	
	▪ Chairperson of board old age facility	

▪ Other Please specify:	
Facility	
▪ Urban	
▪ Rural	
Number of years working in geriatric care environment	
▪ 0-5 years	
▪ 6-10 years	
▪ 11-15 years	
▪ 16-20 years	
▪ 21-30 years	
▪ 31 years and longer	

B. <u>Statements around social determinants</u>

The World Health Organisation (WHO) is clear on the fact that health is influenced by more factors than physical illness only. Factors such as living conditions, food and water, social interaction and availability of healthcare influence general health. These influences on health are referred to as **social determinants**.

This section deals with

(a) the meaning of public health,
(b) those social determinants influencing the health of geriatric people and
(c) which social determinants may cause ethical challenges.

In this study an old age or geriatric person is defined as 60 years and older.
Please rank the following statements by ticking one box per statement using the following scale: strongly disagree, disagree, neutral, agree, strongly agree. Insert **x** in a box representing your choice.

STATEMENT	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
1. Public health is about prevention and not treatment.					
2. Public health is about collaboration between government, healthcare facilities and communities.					
3. Health is influenced by more than physical challenges or illness only.					
4. Social factors such as low income, little and substandard education, limited employment options, high levels of unemployment and poor living and working conditions influence the health of all people.					
5. Lifestyle influences health.					
6. Poor service delivery influences healthcare.					
7. The poor management of healthcare influences health.					
8. Lack of finances influences *access* to and *quality* of healthcare.					
9. Geriatric people's health is influenced by access to healthcare, whether financial, area (location of healthcare facility), language or mobility.					
10. Geriatric people's health is influenced by living conditions such as accommodation / housing, food, nutrition, electricity, water, sanitation and the general environment.					

11. Geriatric people's health is influenced by social factors such as the role in the family (for example caring for grant children), isolation from peers and / or children.					
12. Geriatric people's health is influenced by public health preparedness to prevent disease and create good living conditions.					
13. Geriatric people have the *responsibility* to care for themselves.					
14. Geriatric people need to be *educated on how to care for themselves*.					
15. Government has only a financial responsibility to promote the health of geriatric people.					
16. Geriatric people have *different needs* from other population age groups.					
17. Geriatric people's *interest* is more important that the *communities' interest*.					
18. Differences in the availability of healthcare support systems is geriatric people's biggest challenge.					
19. There are *enough healthcare support* systems available to support geriatric people.					
20. The healthcare of geriatric people is poorly managed.					

C. Statements around public health ethics

This section deals with what public health ethics is. Ethics is normally understood as the choice between what is right and what is wrong. In the context of public health ethics, ethics will refer to choosing what is best to promote the health of a population. The absence of ethical behaviour towards geriatric people or the delivery of healthcare to geriatric people also influences the health of geriatric people. Public health ethics for geriatric people not only deals with geriatric people, but also with those who care for geriatric people or the support systems of geriatric people.

Please rank the following statements by ticking one box per statement using the following scale: strongly disagree, disagree, neutral, agree, strongly agree. Insert **x** in a box representing your choice.

STATEMENT	**Strongly disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly agree**
21. Ethics can be explained as the choice between what is good and what is bad.					
22. Ethics is about having the best interest of a person and/or situation at heart.					
23. Ethics is not about the needs of the other only, but also the self.					
24. Ethics is about dealing with the *vulnerability* of the self, other people, systems and the immediate situation.					
25. Ethics is to know what you need to do right to prevent harm to the self, other people, systems and the immediate situation.					
26. Ethics is influenced by own understanding of what is good for the self, other people, systems or a situation.					
27. Ethics is influenced by one's likes or dislikes of other people or systems.					
28. Ethics is not only about people but also about systems, practices, processes and application.					

29. Public health ethics for geriatric people is about what is best to promote the health of this population group.					
30. There are not enough ethical guidelines available to support healthy living conditions for geriatric people.					
31. Public health ethics can play a role in the prevention of poor health.					
32. Public health ethics for geriatric people is about *care* and *relationship-building* between various stakeholders and geriatric people.					
33. Public health ethics for geriatric people should make healthcare practitioners more sensitive towards the vulnerability of geriatric people.					
34. Public health ethics for geriatric people deals with the fairness of how geriatric programmes are implemented.					
35. Public health ethics for geriatric people should change behaviour towards elderly communities.					

D. <u>Statements around a public health ethics framework</u>

This section deals with the design of a public health ethics framework for geriatric people. Sections B and C's statements claim that public health concerns itself with prevention of illness and the promotion of health and living conditions through making the right ethical choices when dealing with geriatric people's health. The framework will assist in applying ethics to the promotion of geriatric people's health and living conditions.

Please rank the following statements by ticking one box per statement using the following scale: strongly disagree, disagree, neutral, agree, strongly agree. Insert **x** in a box representing your choice.

STATEMENT	**Strongly disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly agree**
36. Ethical decision making is to address the ethical dilemma in hand.					
37. Ethics is about making a choice, implementation of the choice and evaluation of the outcome of the choice.					
38. Ethics decision making can have future consequences.					
39. Relationship building is important in ethics.					
40. Healthcare practitioners need a practical guide to assist them in ethical behaviour and decision making.					
41. Healthcare facilities / institutions and healthcare practitioners seldom talk about ethical challenges.					
42. Ethical success depends on participation around a common goal.					
43. Ethics is not about who is right or wrong but about what one can do to prevent or address a moral dilemma.					
44. Public health policymakers do not know what the ethical needs of elderly people are.					
45. Healthcare practitioners need ethical education.					
46. Leadership and management should promote ethical behaviour.					
47. Public health ethics must promote human rights in geriatric care (medical justice)					

48. Public health ethics must protect the vulnerability of geriatric people and healthcare practitioners.					
49. Public health ethics must promote decision making capacity.					
50. Ethics should be integrated in the public health ethics value chain.					

When completed, please return in the envelope provided to:

Prof. Laetus OK Lategan
65 Dan Pienaar Drive
Bloemfontein
Cell: 071 894 8834

Appendix 2:

Invitation Letters to Participate in Research

UFS·UV
UNIVERSITY OF THE FREE STATE
UNIVERSITEIT VAN DIE VRYSTAAT
YUNIVESITHI YA FREISTATA

[Date]

[NAME, INAME OF INSTITUTION, ADDRESS]

Dear

PARTICIPATION IN A STUDY TO DESIGN A PUBLIC HEALTH ETHICS FRAMEWORK FOR GERIATRIC PEOPLE

I, the undersigned researcher, Laetus Oscar Kotzè Lategan, is an enrolled doctoral student in the Department of Community Health in the Faculty of Health Sciences at the University of the Free State.

The title of the study is: A public health ethics framework for geriatric people.
The approved ethical clearance number is: UFS-HSD2019/0471/2502

My study focuses on the design of a public health ethics framework for geriatric people. The background to this study is the growing aging population that will have a very specific impact on the public health needs of the country. Ethical challenges can be linked to the public health needs of a country. Typical examples will be access to medical facilities, basic healthcare, liveable environments, food security, personal safety, end of life support and affordability of healthcare. Although the challenges are not new to geriatric care, an ethics informed framework that can deal with these ethical challenges is still absent. This study wants to address this shortcoming as it is my informed opinion that such ethical framework can add to the health and well-being of geriatric people.

The voluntary participation of the doctors, healthcare practitioners (professional nurses, nurses, caretakers) and healthcare policymakers, managers and administrators is kindly requested. The purpose your participation is to rank statements on what cause ethical challenges in public health and what should form part of a public ethics framework for geriatric people. If needed, can a group discussion be organised to explain the background of the study.

The participation is voluntary. The participants do not have to pay any cost for participating in the study. There will also be no honorarium or remuneration paid to the participants. The confidentiality of the participants will be guaranteed as far as legally possible. They can withdraw at any time from the discussion. No patient will be involved in this study. As this is a non-therapeutic research study and no medicines will be used, there will be no harm or risk to the geriatric patient, the participant, institution, environment or management practices of the institution. The participants will not be identified individually in the study. The feedback that will be captured, is to inform the usefulness of the planned framework. The participation in this research will be based on informed consent. Feedback will be given to the participants within two months after the engagements. A participant can withdraw at any time. The institution will also be acknowledged in the study and research publications or if preferred, treated anonymous.

The added value of your participation is by sensitising your staff as to public health ethics challenges in the caring of geriatric people.

Should you agreed to this, then a suitable time will be confirmed with you by [Date] to finalise your participation. The engagement, potential discussions and feedback will be via electronic platforms due to COVID-19 restrictions. You will also be requested to assist identifying appropriate participants for this study.

Following the capturing of information from participating institutions, a summative workshop will be convened to give overall feedback on this framework. You will be invited to this workshop after all the information has been captured from the participating institutions. Should this not be possible due to COVID-19 restrictions, then the summative workshop will be presented online.
Your favourable consideration of this request will be highly appreciated.

May I please receive feedback by [Date]. Additional communications will follow to prepare for the sessions. This will include the signing of the consent forms and data collection on your institution (example number of staff and patients, existence of ethical framework and training and identified ethical challenges by staff and / or management).

For your consideration please.

Kind regards

[Insert electronic signature]

Prof. Laetus O.K. Lategan

Appendix 3:

Ethical clearance

UNIVERSITY OF THE FREE STATE
UNIVERSITEIT VAN DIE VRYSTAAT
YUNIVESITHI YA FREISTATA

UFS·UV
HEALTH SCIENCES
GESONDHEIDSWETENSKAPPE

Health Sciences Research Ethics Committee

28-May-2021

Dear **Prof Laetus Lategan**

Ethics Number: UFS-HSD2019/0471/2502-0001

Ethics Clearance: **A PUBLIC HEALTH ETHICS FRAMEWORK FOR GERIATRIC PEOPLE: A SOUTH AFRICAN PERSPECTIVE**

Principal Investigator: **Prof Laetus Lategan**

Department: **Community Health Department (Bloemfontein Campus)**

Submission Page

SUBSEQUENT SUBMISSION APPROVED

With reference to your recent submission for ethical clearance from the Health Sciences Research Ethics Committee. I am pleased to inform you on behalf of the HSREC that you have been granted ethical clearance for your request as stipulated below:

Continuation report: The ethical clearance of this project is extended until 27 May 2022.

The HSREC functions in compliance with, but not limited to, the following documents and guidelines: The SA National Health Act. No. 61 of 2003; Ethics in Health Research: Principles, Structures and Processes (2015); SA GCP(2006); Declaration of Helsinki; The Belmont Report; The US Office of Human Research Protections 45 CFR 461 (for non-exempt research with human participants conducted or supported by the US Department of Health and Human Services- (HHS), 21 CFR 50, 21 CFR 56; CIOMS; ICH-GCP-E6 Sections 1-4; International Council for Harmonisation (ICH) Harmonised Guideline, Integrated Addendum to ICH E6(R1), Guideline for Good Clinical Practice (GCP) E6(R2), 2016, SAHPRA Guidelines as well as Laws and Regulations with regard to the Control of Medicines, Constitution of the HSREC of the Faculty of Health Sciences.

For any questions or concerns, please feel free to contact HSREC Administration: 051-4017794/5 or email EthicsFHS@ufs.ac.za.

Thank you for submitting this request for ethical clearance and we wish you continued success with your research.

Yours Sincerely

Prof. A. Sherriff
Chairperson : Health Sciences Research Ethics Committee

Health Sciences Research Ethics Committee
Office of the Dean: Health Sciences
T: +27 (0)51 401 7795/7794 | E: ethicsfhs@ufs.ac.za
IRB 00011992; REC 230408-011; IORG 0010096; FWA 00027947
Block D, Dean's Division, Room D104 | P.O. Box/Posbus 339 (Internal Post Box G40) | Bloemfontein 9300 | South Africa
www.ufs.ac.za

UNIVERSITY OF THE FREE STATE
UNIVERSITEIT VAN DIE VRYSTAAT
YUNIVESITHI YA FREISTATA

UFS·UV
HEALTH SCIENCES
GESONDHEIDSWETENSKAPPE

Health Sciences Research Ethics Committee

31-Jan-2020

Dear **Prof Laetus Lategan**

Ethics Clearance: **A PUBLIC HEALTH ETHICS FRAMEWORK FOR GERIATRIC PEOPLE: A SOUTH AFRICAN PERSPECTIVE**

Principal Investigator: **Prof Laetus Lategan**

Department: **Community Health Department (Bloemfontein Campus)**

APPLICATION APPROVED

Please ensure that you read the whole document

With reference to your application for ethical clearance with the Faculty of Health Sciences, I am pleased to inform you on behalf of the Health Sciences Research Ethics Committee that you have been granted ethical clearance for your project.

Your ethical clearance number, to be used in all correspondence is: **UFS-HSD2019/0471/2502**

The ethical clearance number is valid for research conducted for one year from issuance. Should you require more time to complete this research, please apply for an extension.

We request that any changes that may take place during the course of your research project be submitted to the HSREC for approval to ensure we are kept up to date with your progress and any ethical implications that may arise. This includes any serious adverse events and/or termination of the study.

A progress report should be submitted within one year of approval, and annually for long term studies. A final report should be submitted at the completion of the study.

The HSREC functions in compliance with, but not limited to, the following documents and guidelines: The SA National Health Act. No. 61 of 2003; Ethics in Health Research: Principles, Structures and Processes (2015); SA GCP(2006); Declaration of Helsinki; The Belmont Report; The US Office of Human Research Protections 45 CFR 461 (for non-exempt research with human participants conducted or supported by the US Department of Health and Human Services- (HHS), 21 CFR 50, 21 CFR 56; CIOMS; ICH-GCP-E6 Sections 1-4; The International Conference on Harmonization and Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH Tripartite), Guidelines of the SA Medicines Control Council as well as Laws and Regulations with regard to the Control of Medicines, Constitution of the HSREC of the Faculty of Health Sciences.

For any questions or concerns, please feel free to contact HSREC Administration: 051-4017794/5 or email EthicsFHS@ufs.ac.za.

Thank you for submitting this proposal for ethical clearance and we wish you every success with your research.

Yours Sincerely

Dr. SM Le Grange
Chair : Health Sciences Research Ethics Committee

Health Sciences Research Ethics Committee
Office of the Dean: Health Sciences
T: +27 (0)51 401 7795/7794 | E: ethicsfhs@ufs.ac.za
IRB 00011992; REC 230408-011; IORG 0010096; FWA 00027947
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Appendix 4:

Protocol

A PUBLIC HEALTH ETHICS FRAMEWORK FOR GERIATRIC PEOPLE: A SOUTH AFRICAN PERSPECTIVE

Student: Laetus O.K. Lategan

Student Number: 1984298982

PhD in Community Health (by article route)

Promoter: Prof. Gert J. van Zyl

Co-promotor: Prof. Willem H. Kruger

26 February 2019

Contents

Abstract

This study has as objective the development of a public health ethics framework for geriatric people. The need for such a framework arises from the growing reality of an aging population which will have an impact on the provision of healthcare and the securing of quality of health and living of geriatric people. Although an aging population is evidence of an increase in life expectancy due to an improved healthcare system, it poses ethical challenges associated with various aspects of healthcare, and more so in a resource-limited environment. The need is further highlighted by the absence of sufficient reflection on what the ethical challenges of a public healthcare system may be. The research is informed by a qualitative approach to ethics in healthcare for geriatric people. An evidence-based analysis of what public health and ethics are, provides the basis of a definition of public health for geriatric people as the improvement of the quality of health and well-being of geriatric people. Ethics can be defined as the identification of values for a situation and subsequently value-driven decision-making and behaviour. Public health ethics can therefore be defined as value identification and subsequently value-driven decisions and behaviour in support of quality of health and well-being. The focus is on geriatric people and the context is South Africa. As a result of the conceptual analysis, a framework will be proposed to deal with ethical challenges in public health delivery to geriatric people.

1. INTRODUCTION

From World Health Organisation (WHO) studies and profile documents it is evident that, around the world, the number of geriatric people is growing. It is estimated that by 2050, 16% of the global population will be aged people. Aged people are identified as 65 years and older. It is further estimated that in less developed countries the increase will be 250% compared to the 71% in developed countries (National Institute on Aging and the World Health Organization 2011:4). The World Health Organisation's Report on Aging and Health (2018) projects that the world's population older than 60 years will nearly double by 2050 from 12% - 22%. This means a growth from 900 million people in 2015 to 2 billion people by 2050. Although there will be improvement in health, these improvements are not without their challenges. An example is non-communicable diseases. A changing world characterised by globalization, economic meltdown and technological developments also impact on healthy aging. An example is family life which tends to have more families living on their own than together (World Health Organisation, 2018).

The South African situation is not lagging behind in regard to this phenomenon (World Health Organisation, 2015: 48; Statistics South Africa, 2011). Based on 2017 statistics there are 8.1% of the population older than 60 years (Statistics South Africa, 2017: 3). The increase in life expectancy is generally due to improvement in health and living conditions, increased access to healthcare services, improved healthcare delivery, better policies and (relatively) supportive budgets. Statistics South Africa (2017: 3) comments that the growing number of elderly people will increase social, health and financial demands.

In addition, the World Health Organisation's report on long term care in Africa (World Health Organisation, 2017: ix-x, 1, 2, 6) predicts a growing need for long term care to be consistent with people's basic rights, fundamental freedoms and human dignity. The irony is that the geriatric people are very often cared by people who lack support and guidance on what might be the best care and how it should be rolled-out. As a result, the elderly may not receive the best care that is available, can even be abused or neglected or the care givers themselves can be vulnerable and therefore not in the best position to provide care to others. To top these challenges is the growing phenomenon of dementia which further challenges care for the elderly as facilities and resources are declining (Zikali, 2018). Here too, is it a matter of not having enough expertise and support systems available to care for the elderly.

Although an increase in life expectancy is generally regarded as a positive development, the unintended consequences of this development can evidently not be ignored. In her report as outgoing Director General of the World Health Organisation, Chan (2017:108) comments that aging is now a universal trend. By the middle of this century, people aged 65 and above will outnumber children for the first time in history. A general conclusion is that aging will challenge existing healthcare resources, practices and perceptions. Although money is the first thing that comes to

mind, the World Health Organisation (2015:17) convincingly shows that there are more benefits than disadvantages.

These developments call for a relook at geriatric care and ethical practices associated with healthcare such as access to healthcare, affordability of healthcare and end-of-life challenges.

The 2015 World Report on Aging and Health states that stereotypical thinking prevents the comprehension of old age in a way that does not limit new realities. Outdated stereotypes of old age hinder an understanding of the present-day realities and needs of older people (World Health Organisation 2015:10). This affects all countries at all levels of development in every region of the world (Chan 2017:112). The World Health Organisation has developed a new narrative for ageing that is framed around the *functioning* of the older person (Chan, 2017:113). The World Health Organisation's global strategy and action plan on ageing and health (2016-2020), adopted by World Health Assembly in 2016, maximises functional ability and establishes partnerships to support healthy ageing (Chan 2017:113,114).

This development creates challenges beyond clinical interventions only. Social determinants will have a defining influence on how to deal with the healthcare challenges of geriatric people. In the South African context, four specific observations give support to this statement (World Health Organisation 2015:12,216; Booker, 2016; Coovadia, Jewkes, Barron, Sanders & McIntyre, 2009; Mayosi, Lawn, Van Niekerk, Bradshaw, Karim & Coovadia, 2009; Chopra, Lawn, Sanders, Barron, Bradshaw, Jewkes, Karim, Fisher, Mayosi, Tollman, Churchyard & Coovadia, 2009; De Maeseneer, 2009):

- firstly, the implementation of a responsive basic healthcare system, especially to address matters of inequality;
- secondly, the new sociological role of aging people to care for children due to the mortality of parents caused by, amongst others, HIV Aids;
- thirdly, the impact of healthcare determinants such as food security, housing, access to healthcare, and poverty due to vast inequalities in society; and
- fourthly, the lack of participation in and integration with a public healthcare system due to social cohesion.

What comes as a surprise is Kalula (2013:1) who expresses his concern with regard to the preparedness of South Africa "to meet the challenges of providing adequate and appropriate healthcare to the older population in future." Sigasana (2017) correctly asked if the elderly in South Africa are invisible? Zikali (2018) cites Potonick (2018) who adds to this concern. He says that South Africa is one of the fastest aging countries in Africa. He expresses concern on how elderly people with mental problems are cared for. The inability of the South African healthcare system to deal with the aging population is further problematised by the difficulty in finding a working definition of an older person in Africa. It is evident that a single definition such as chronological age or social/cultural/functional markers cannot be used due to demographics, economic activity and cultural practice. Hence, a combination of chronological, functional and social definitions is proposed. Subsequently geriatrics in Africa cannot be understood in the same way as, or treated similarly to, other geriatric programmes around the world (World Health Organisation, 2002, 2015). This comment is contextualised by Mhaka-Mutepfa, Hunter, Mpofu and Cumming (2016:51) who argue that due to the HIV Aids pandemic, grandparents in sub-Saharan Africa increasingly take on the role of carer for grandchildren. A small case study based on lived experience methodology in Zimbabwe has shown that this has an impact on the health and well-being of the grandparents (Mhaka-Mutepfa *et al*., 2016:52). The result of this impact is not always ill health. There are very often social factors involved, as presented by Mhaka-Mutepfa *et al*. (2016:59). Consequently, there are not enough personal and social resources available to assist (Mhaka-Mutepfa *et al*., 2016:53,57). This means that geriatric people live in highly stressful environments without resources or protective factors and need specific support programmes (Mhaka-Mutepfa *et al*., 2016:59,61).

Apart from the fact that (South) Africa is apparently not ready to deal with a growing aging population and related matters, there is another challenge: although there may be an assumption that sufficient ethical guidelines are in place to deal with geriatric challenges, this is evidently not the case. This observation is based on the studies discussed below.

The Lancet studies in 2007 and again in 2012 on health in South Africa acknowledge the existence of specific policy and programmes for the so-called "colliding epidemics" or "quadruple burden of disease" namely HIV and tuberculosis; chronic illness and mental health; injury and violence; and maternal, neonatal and child health. Although positive changes such as leadership, affirmative responses to the colliding epidemics, health insurance and consensus about health issues are observable, major challenges such as social determinants and racial disparities, health systems integration, information capturing, and innovations in healthcare are nevertheless evident (Mayosi *et al*., 2012). Coovadia *et al.* (2009) criticise the lack of stewardship, leadership and management of the health system. Despite good policies, limited attention has been given to the implementation of these policies. Coovadia *et al.* (2009:831) comment: "The lack of stewardship and leadership has been evident in the highly variable quality of care delivered within the public sector". Chopra *et al.* (2009:1030) make a similar comment: "A continuing engagement across government is needed to tackle these broad social determinants of health and encourage all sectors to review their policies from a health perspective." Even though these challenges all presuppose an ethical basis, no specific guideline informs this basis.

A more optimistic view is presented by Ezeh, Sewankambo and Piot (2017), based on a Lancet-commissioned report on the prospects of health in sub-Saharan Africa. It is believed that Africa should have the same opportunities to secure a long and quality life based on new technologies, well-functioning health systems and good governance. Twelve strategic directions are offered for all sub-Saharan countries. Of importance is the role of higher education (leading to better job opportunities), research (to deal with diseases) and healthcare systems (the effective roll-out of the management of healthcare). This is complemented by the Sustainable Development Goals of the United Nations (Goal 3 – Good health and well-being). Goal 3 has as aim healthy lives and to promote well-being at all ages.

The conclusions are therefore clear:

- firstly, there is an undeniable need to address geriatric healthcare in the context of the basic healthcare of a population growing due to improved life expectancy;
- secondly, there is an assumed expectation that ethics cannot be absent when dealing with this matter;
- thirdly, there is a need for geriatric care but an obvious absence of accompanying ethical guidelines; and
- fourthly, although the need for an ethical framework exists, there is an assumption that everyone will share a common framework.

This study will concern itself with a public health ethics framework for geriatric people.

2. WHY A PUBLIC HEALTH APPROACH?

The general understanding of public health is that it comprises of *preventative* actions directed at groups and communities to improve the quality of health and not necessarily on individuals.

Kass (2001:1776) describes it well by commenting: "Public health is the societal approach to protecting and promoting health. Generally, through social, rather than individual actions, public health seeks to improve the well-being of communities … Public health seeks to ensure societal conditions under which people can lead healthier lives, minimizing threats to our health…"

Horn (2015:26) contextualises this for developing countries by commenting that "Public health is about the health of societies and communities rather than the health of individuals, and it involves all spheres of health, where collective action by governments and other organizations can make a positive impact."

The Constitution of the World Health Organisation (adopted and signed in 1946, as amended) includes nine principles. Health is defined "as a state of complete physical, mental and social well-being and not merely the absence of the disease or infirmity." The Constitution identifies the enjoyment of health as a fundamental human right and it acknowledges health's contribution to the attainment of peace and security. With regard to the public health agenda, the Constitution states

that "Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of people." The role of government is confirmed through the provision of adequate health and social measures.

Based on these comments, public health can be defined as the *strategies and preventions to promote, secure and sustain quality of health and well-being based on a public health value chain.*

The importance of a public health value chain lies in the identification of those factors influencing quality of health and well-being and how these factors fit together to secure an integrated approach to quality of health and well-being.

A public health approach is therefore taken in this study as this will secure a comprehensive understanding of promoting quality of health and well-being of geriatric people.

3. THE 'LOCAL' FOCUS TO THIS DISCUSSION

Dywer-Lindgren (2017) argues in The Lancet Editorial [Lancet, 2(9), September 2017] in favour of a "local" approach to public health. She comments that it has now become a global phenomenon for cities (thus the local approach) to deal with those challenges that pose a risk to citizens' health. Although this approach does not suggest that the "global" approach to healthcare it not valuable, it simply advises that the "local" condition should be understood to deal with health issues more comprehensively. It further offers advice that in understanding the local condition, social determinants are necessary to address healthcare issues. The Lancet editorial reacts favourably to this approach as it can increase greater precision in public healthcare: "Public health science is now reaching a degree of precision that could provide us with street-level health outcomes and determinants of health. New disciplines, such as urban health, offer new opportunities for research and potential interventions. With cities and local communities becoming the new unit of public health, it is time to think and act much more locally" (Dwyer-Lindgren 2017:2).

This approach is particularly true of geriatric people in South Africa. In the absence of a specific list of challenges, the following can be listed as priorities: income, accommodation, safety and security, food and diet, access to healthcare, cost of healthcare and the role as a second parent (Statistics South Africa, 2011; World Health Organisation, 2015:27,216; Lategan, 2017:126-127; Kalula, 2013; SIFAR, 2018; De Maeseneer, 2009).

4. SCOPE OF STUDY

What should be evident from the above discussion is that (a) the growing aging population will have a very specific impact on the public health needs of the country; (b) these specific needs are sparked by context-specific social determinants; and (c) although the ethical dictum of *primum non nocere* (first, do no harm) is well enshrined in the South African Constitution and international bioethics codes (such as the Helsinki code), a specific ethics framework to deal with ethical challenges is still required. The advocacy of such a framework is to use it in training, managing and promoting the well-being of geriatric people. The promotion of a public health ethics framework for geriatric people is because of the demand for more responsive health aging but the simultaneous absence of such a framework to guide responsive health aging.

From a literature review, three observations can be presented:

4.1 What are the South African social determinants for geriatric people?

On a global level reminds Chan (2017) of the growing role of social determinants and their impact on public health. Berridge (2016:72-98) also identifies the crucial role of social determinants in healthcare. The World Health Organisation (2015:14) echoes the universal human right of geriatric people to the highest standard of attainable health. For this to happen favourable socio-economic factors are important to secure a healthy life, as well as underlying determinants such as nutrition, housing, sanitation and a healthy environment. Access to health facilities and keeping up with standards of medical ethics are equally important. To this observation it must be added that a new way of thinking is important, to move away from focusing on the cost of elderly care and rather to

focus on the contribution that elderly people are making towards society (World Health Organisation 2015:16).

No authoritative report could be identified on what the social determinants of the geriatric community in South Africa are. To address this matter, an approach was first taken to identify universal needs of the geriatric communities. Vanlaere and Gastmans (2010) identify five themes in geriatric care. These themes relate to (a) dignity and respect for the person, (b) physical care, (c) intimacy and sexuality of patients with dementia, (d) withdrawal of activities to sustain life, and (e) euthanasia (active ending of life).

Secondly, factors influencing quality of health and living were identified, based on qualitative research (cf. paragraph 1). These factors range from resources available to support geriatric people, livelihoods, food safety and security, communication and integration in a family structure and human rights violations.

Following from the above approach three major social determinants were identified:

- The lack of resources to support quality of health and well-being.
- Isolation from family and community structures.
- The conflicting roles of being on retirement but having to earn an income to make ends meet, being a grandparent and substitute parent at the same time, and being vulnerable but with limited support from social and personal communities.

The appropriateness of these social determinants for South Africa must still be confirmed.

An important consequence of identification is that these determinants call for ethical guidelines which needs to be further developed.

The next section considers the important role of public health ethics dealing with geriatric people.

4.2 What can be defined as public health ethics?

The question now is what can be defined as public health ethics?

Ethics is derived from the Greek word "ethos". This embodies the meaning of a set of beliefs or ideas on what the accepted behaviour is towards other people, structures, nature and society.

The general explanation is that ethics deals with those factors, either external (for example the influence of a group or a community) or internal (one's own attitude or belief system) that guide a person to act in a particular manner. The generally accepted definition of ethics is that it deals with the identification of principles and norms and their application to a situation (Ten Have, Ter Meulen & Van Leeuwen 2013:8ff).

For the purpose of this study, ethics will be defined as (a) the *identification* of the values for the situation, (b) the value-driven *decision* made about a situation and (c) the value-driven *behaviour* in a situation. Building on this explanation of ethics, and on the definition given for public health, public health ethics may be defined as (a) the identified values for, (b) the value-driven decisions made and (c) behaviour to improve and secure quality of health and well-being. Public health ethics for geriatric people may then be defined as the identification of values applied through value-driven decisions in support of and the behaviour shown in respect to geriatric people' quality of health and well-being. The identification of the values, value-driven decisions taken for the situation and the behaviour based on the decisions form the basis of ethics. If ethics is an integration of decisions and behaviour based on identified values, then public health ethics is informed by those values, decisions and behaviour that will improve the quality of health and well-being.

This approach needs further exploration, however. The comments below should be taken into consideration.

Decision making and behaviour presuppose a response to a given situation, and therefore imply

action. Any decision making and behaviour are based on values. These values need to be identified for the situation. The values for medical ethics and bioethics are well represented in the so-called Georgetown mantra (Ten Have 2011:27) as identified by Beauchamp and Childress (2013). They refer to *respect for individuals and their autonomy, non-maleficence (no-harm), beneficence* (well-being) and *justice*. These principles will guide the discussion on a public health ethics that can be used in geriatric care.

What should be evident is that ethics is also *praxis*: ethics as science is applied to a given activity – in this case, public health. Broadly speaking, if public health is preventive in nature, has no clinical intervention and is directed at the group, then *utilitarianism* as an ethical approach cannot be ignored. Utilitarianism can best be explained as the consequences of an action and/or decision. Such an approach should be linked to *social justice*. The link to social justice is well explained by Horn and Mwaluko (2014:100-102) who refer to the balance contest between individual rights and those of the group. An appropriate example is found in the debate on healthcare for elderly people. The question is often raised as to the affordability and justification of (expensive) healthcare for the elderly (Annemans, 2016; Berridge, 2016; Williams & Evans, 2017). The debate moves between the need of a group competing with other groups for resources, and the question of whether (expensive) treatment should be made available, when calculated against economic input and participation.

Although the group is prominent in the context of social justice, *growth* as an outcome of ethical engagement can never be ignored. Justification of this approach may be found in Burggraeve's explanation of growth. Burggraeve, in the tradition of the French philosopher Emmanuel Levinas, defines the purpose of ethics as not only to identify and apply the best value for a situation but also to add to the initial resolving of the ethical dilemma of the situation. Growth refers to a number of important aspects in ethical decision making. Firstly, because ethics deals with dilemmas, it is suggested almost by default that a decision taken in a situation may be the best possible option available, yet it may not always be the best solution to deal with a particular matter. Secondly, ethics should always direct one towards the best possible solution. Thirdly, ethics is never without salvation, redemption and liberation, and creating a meaningful life. Such an interpretation is looking for new meanings and new interpretations in a situation. Ethics should never be scaled down to the respect for autonomy and the no-harm principle only. Ethics can never be limited to the mechanical application of principles. This will result in "narrow" or "negative" ethics. Ideally speaking, should one strive towards deepening the quality of action, and towards making ethics a lived experience searching for gradations of perfection and meaning. This may be referred to as "broader" or "positive" or "quality" ethics. These perspectives fit with Burggraeve's advocacy of an ethics of mercy. He argues that there are not only restrictions but also opportunities. It is in this context that people have to grow and live as meaningfully as possible (Burggraeve 2016:79-81;105ff,138-139). Schotmans (2012:141) echoes the same sentiment by saying that ethics is guiding, orientating and looking forward to taking up responsibility and making human-centred decisions.

What cannot be ignored is ethics as service, and also the stewardship role of ethics. Schotmans (2012:17-22) refers to the *service* character of ethics. This means that there should be an outreach and an engagement with, in the context of this study, the geriatric community. Stewardship ethics supposes a responsibility towards the other as if one were taking care of oneself (Le Roux & Lategan, 2010). This approach can further be contextualised in the framework of an engagement ethics. Lategan, Burggraeve and Vanlaere (2015) developed this framework to indicate that both patient and healthcare practitioner should be met in their specific context to care optimally and to address each group's (patients and healthcare practitioners) vulnerability.

In the design of an ethics framework for public health, Kass (2001:1776) provides valuable directives. To her, two ethical challenges should be considered constantly: Firstly, the appropriate extent of its reach, and secondly whether public health activities are not infringing on individual rights. Given the basic focus of public health, namely improving the health and living of populations, the question is always: How can individual liberties be maximised and how can social justice be promoted? The scope of public health therefore relates to reducing morbidity, data collection that will show progress in dealing with mortality, and the implementation of programmes to deal with combating mortality. These objectives relate very much to monitoring and evaluation. Failure to secure good health is not a management issue only, but very much also an ethical one. This means that the importance of empirical ethics cannot be overlooked. Although associated with the ethical consequences of data,

Parker (2009) adds another useful perspective to empirical ethics. She says that next to the normative value of ethics, ethics is also based on evidence that supports or substantiates a matter. Progress with ethics should also be evaluated and monitored.

The advocacy of these perspectives on ethics are well related to Kenny's (2017) calling for a paradigm shift in patient care. She compares care to an assembly line and argues that humans cannot be assembled like cars. The challenge is that due to organisational structures, as well as focus and cost of care, personal care and compassion have taken a back seat. She remarks: "In today's framework this viewpoint is quite frequently missing and healthcare is undergoing a crisis where compassion is scarce" (Kenny 2017:28). In training the emphasis is more on disease processes than on the healing process. Kenny believes that it should be all about the quality of care. Vanlaere and Burggraeve (2017:46-47) echo this too, with their comment that the quality of care lies in the relationship with the patient.

The ethical guidelines proposed in this section are based on ethics as value identification, value-driven decisions and behaviour to address ethical dilemmas in a situation. These values are aimed at addressing the quality of service and relationship in geriatric care. Since public health ethics deals, in this case, with geriatric communities, quality of health and living is a manifesto of social justice. As vulnerable people are at risk, the quality of mercy can never be removed from the ethical engagement with elderly people. As the focus is on geriatric people, the healthcare practitioner cannot be removed from this caring relationship. Ethics always has growth as a positive outcome from an ethical dilemma. Since the provision of healthcare can never be delinked from management (monitoring and evaluation), management can never be detached from ethical practices.

The next section will use these guidelines to propose an ethics framework to address the challenges of geriatric people.

4.3 Framework based on literature review

Based on a literature review, public health ethics can be identified as value identification, value-driven decision making and behaviour in response to the need for improvement in the quality of health and well-being. Applied to geriatric people, it will mean the value-driven improvement in the quality of their health and well-being.

From the literature review the following outline for a public health ethics framework for geriatric people can be identified. This framework will be further developed based on the identified research design (cf. paragraph 5).

Social determinants	Levels of engagements	Managerial engagement	Ethical actions
Public health ethics as value identification, value-driven decisions and behaviour	**Level 1**: The multi-phased needs of geriatric people (ranging from physical, socio-economical, environmental and socio-cultural to life expectancy). These needs can be explained as being ecological in nature. The ecological metaphor refers to the encompassing needs of geriatric people that can be grouped in five categories with personal as the core of these categories: resources (human, physical and financial), activities (integration in and contribution to community), social networks (family life) and healthcare (to address fragility). Following on the identification of these needs, the ethical dilemmas and challenges can be identified.	Creation of a value chain to transfer inputs to outputs, to align these needs and to create a value-adding approach to them.	Value-based decisions and behaviour based on identified guidelines (mercy, growth, social justice, service, stewardship, care and compassion, protection of vulnerability).

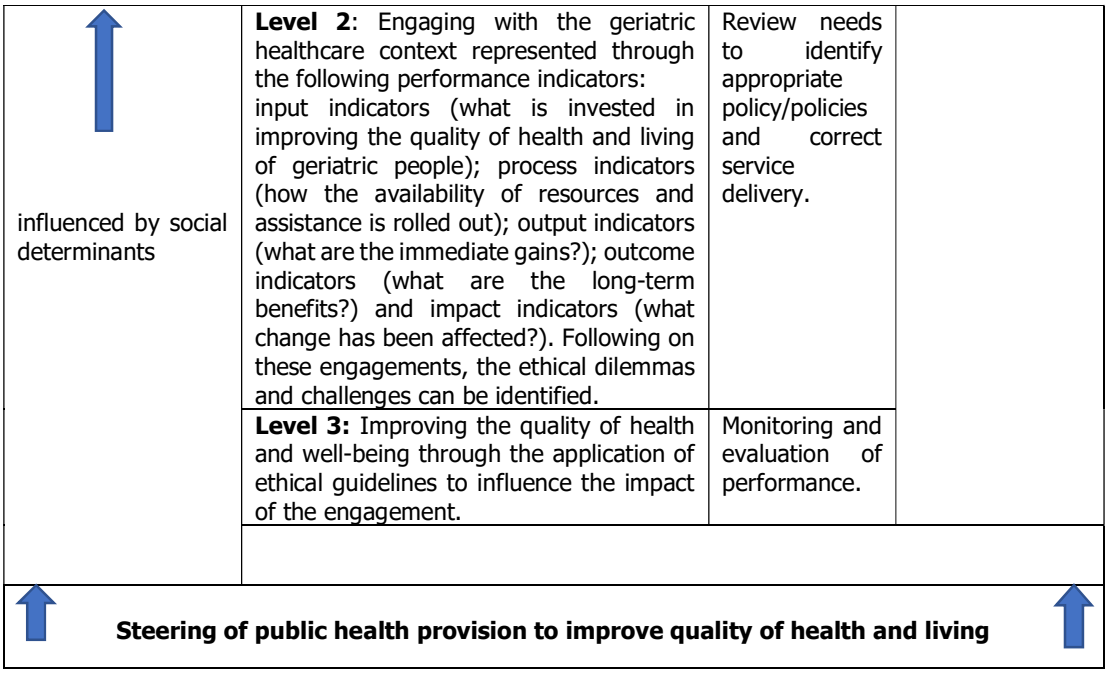

Figure 1: Public health ethics applied to geriatric people

This framework suggests the following major observations:

- Dealing with public health ethics for geriatric people presupposes an integrated approach – from *understanding* the context of geriatric care to ethical *engagement* with the context to *steering* and *influencing* the public health system to *optimise* quality of health and well-being through addressing ethical dilemmas.
- Public health ethics is characterised by many dimensions and processes. Public health ethics is broader than life and death issues. It includes all aspects of the geriatric people's existence and needs.
- Public health ethics draws on the management of the public health system and necessitates the monitoring and evaluation of the public health system. The implementation and meaning of ethics guidelines should be managed through monitoring and evaluation.
- Public health ethics influences not only an individual or group dilemma but also the context, engagement with the context and response to the context.
- Public health ethics cannot be limited to the responsibility of doctors and/or healthcare practitioners only. This becomes a joint responsibility of all who are formally engaging with geriatric people. Such a perspective also breaks the perception that public health ethics is limited to bio-ethical and medical-ethical dilemmas only. The breakthrough is also in holding public health officers responsible for taking ethical responsibility for geriatric people.
- Public health ethics has a triangular responsibility (public health officials, healthcare practitioners and doctors). To this can be added the "public" as the beneficiaries of a health society but also as co-owner of a healthy society.
- Based on this logic, decision-making about ethics can never be removed from the joint responsibility of the public.

5. RESEARCH DESIGN

5.1 Problem statement

From the literature study is this evident that there is growing elderly community. Social determinants identified ethical challenges that geriatric people can experience in the context of public health delivery.

These are:

- The lack of resources to support quality of health and well-being.
- Isolation from family and community structures.
- The conflicting roles of being on retirement but having to earn an income to make ends meet, being a grandparent and substitute parent at the same time, and being vulnerable but with limited support from social and personal communities.

The problem statement of the study is based on a comment by Thomas, Sage, Dillenberg and Guillory (2002:1057) that ensuring and protecting the health of the public (in this case geriatric people) is inherently a moral obligation. This obligation was originally implicitly assumed but is now explicitly stated. For the mentioned authors, public health principles include principles that concern individuals, institutions and groups.

The literature study confirmed the absence of a public health ethics framework for geriatric people. The problem statement for this study is the absence of a public health ethics framework for geriatric people.

5.2 Aim of study

The aim of this study is to draft a public health ethics framework for geriatric people. The anticipated framework will be drafted based on the results of the qualitative research. This can be supplemented by the *statement of purpose,* namely the identification of a public health ethics framework for geriatric people.

5.3 Research question

The research question is: *What is public health ethics for geriatric people in the South African context?*
The *research question* may be labelled as an *exploratory research question* (Jansen 2008:11) namely "*What is public health ethics for geriatric people in the South African context?"*

The exploratory research question is supported by an *explanatory question*, *"What is the added value of public health ethics for geriatric people despite the existence of medical, bioethical and healthcare ethics, protocols and statements?"* (Jansen 2008:10).

5.4 Research objectives

From the research question, three research objectives can be identified:

- To determine/identify the South African social determinants that present ethical challenges for geriatric people (Qualitative research performed through scholarly review and Q- methodology – cf. paragraph 5.5).
- To define public health ethics for geriatric people (Qualitative research performed through scholarly review and Q-methodology – cf. paragraph 5.5).
- To develop a public health ethics framework for geriatric people (Qualitative research performed through scholarly review and Q-methodology and post Q summative workshop).

5.5 Research method and methodology

This study will be based on a literature review as part of a qualitative method and the Q-Methodology which is qualitative in its information collection and data sampling but that can be quantitative based on the method of analysis.

5.5.1 Characteristics of qualitative research

The research method for this study is grounded within the broader domain of a *qualitative study*, characterised by validity, practicality and effectiveness (Maree & Van der Westhuizen, 2008:38).

According to Silverman (2006:282-291) this method is very much descriptive (non-experimental). Silverman (2006:43) remarks: "The main strength of qualitative research is its ability to study phenomena which are simply unavailable elsewhere." Following Hammersley (1992), he continues by stating that the value of qualitative research is that it is flexible and reflects on what people are doing. Qualitative research studies reflect on *process and outcomes, meaning* and *causes.* The application value of the research problem is the meaning it brings to practitioners and administrators. Qualitative research is therefore applicable to real life situations (Silverman 2006:349-351). It is seen as a valid description of a phenomenon or activity and that it can be applied to practice.

The approach that will be followed in qualitative research is based on *epistemology* (how knowledge is viewed), *ontology* (views on being/existence), *axiology* (views on what is right/good and wrong/bad) and *methodology* (views on how to do research).

5.5.2 Scope of qualitative approach

Two techniques within the qualitative methodology will be used:

- the literature review to analyse and assess the debate on ethics in public health, and
- the Q-methodology (as part of a qualitative method) to identify (a) which social determinants present ethical challenges in public health and (b) what should be part of a public health ethics framework addressing these challenges.

5.5.3 The literature review as a scholarly review

Based on Trafford and Leshem's (2012:68-74) idea of literature, a literature and document review can be defined as "a specific body of knowledge … that is recognised by its respective users", it is identified by the researcher, yet it has a "recognisable identity when someone explains its corpus" and is explained through the researcher's lexicon and paradigms. The literature review can therefore not be isolated from the broader knowledge base: it has to engage with what is available on a topic and the analysis and reflection have to contribute to deepening the knowledge base. Tilley (2016:58) confirms that documents that contribute towards historical and/or contextual knowledge, are "useful data".

Preference goes to Mouton (2001:78), however, who refers to a scholarly review rather than a literature review. The scholarly review refers to how other researchers have interpreted and dealt with a particular research problem within a body of knowledge. The literature review, on the other hand, is influenced by personal orientations and perspectives (formed by scientific traditions, evidence-based research and world and life view).

This study will build on Mouton's (1996:10) approach of the "three worlds": *meta-science* (critical interest – to understand the world of science), *world of science* (epistemic interest – to understand reality), and the *world of everyday life* and *lay knowledge* (pragmatic interest).

Through the literature review, themes in the knowledge base will be identified. Identifying themes will assist to understand what are the mainline ethical challenges facing geriatric people in the context of public health.

A multi-disciplinary approach will be followed in this study. Multi-disciplinary refers to the interaction between two or more distinct disciplines to formulate a new perspective (Kokt, Lategan & Orkin 2012:141). The reason for choosing such an approach is that public health ethics straddles the broad disciplinary bases of healthcare and ethics.

The literature review will *reflect* on what is available in the literature and not merely *share* the existing knowledge base. Inclusion criteria will include research published in South African and international publication article bases such as Science Direct, Proquest, Tailor and Francis, Sabinet African Journal Collection and will include journal articles, conference proceedings, books / chapters in books, legislation, policies and public communications on the topic. Exclusion criteria are that literature will not be older than ten years, excluding seminal publications, legislation and policies.

5.5.4 Q-methodology

The Q-methodology originates from and is developed by William Stephenson (1902-1989). He focuses on the subjective or first-person viewpoints of his participants.

The Q-methodology will be used to contribute towards drafting the envisaged framework. This technique will be used to identify (a) which social determinants create ethical challenges in public health and (b) what comprises a public health ethics framework to address these challenges.

According to Alderson, Roy, Bryant, Ahmed & House (2018) is the Q-methodology particularly useful in understanding stakeholders' / participants' viewpoints. (This is known as inter-rater comparisons.) This method assists to understand how a matter is viewed and what impact these views may have during implementation. This is part of a qualitative approach to the study.

Mason (2018) associates the Q-methodology with two main stages: (a) Developing the statements and sorting them and (b) analysis and interpretation of the ranked statements.

Du Plessis (2005) unpacks the Q-methodology in five stages, which correlates with the above two stages. These stages are collecting of information from the discourse, sampling, sorting of statements, factor analysis and interpretation. As the overall focus of stages correlates, Mason's more streamlined approach will be used.

The Q-methodology outlines both consensus and deviation (Alderson *et al.*, 2018). This is based on ranking predefined statements relevant to the research question of the study. These statements addressing the research question derive from the literature review as scholarly review. Participants ranked these statements that were formulated as a result of the literature review as a scholarly review. The rankings are part of the participants' subjective view on a topic. Through the sampling of different viewpoints, possible barriers and levers in implementing the envisaged framework can be anticipated.

The *advantage* of this method is that it narrows many viewpoints down to a few which can be regarded as shared way of thinking. An additional advantage is that it can include a small group (even one participant) to a large group.

Fischer (2018) assigns a positive outcome of this methodology. She says that an objective or scientific understanding is given to subjective opinions.

5.5.5 Application of Q-methodology

5.5.5.1 Identifying the population and sampling of information

The target population will exclude geriatric people and focus on those who work in the domain of public health for geriatric people namely doctors, healthcare practitioners (nurses, therapists, caretakers) and healthcare policy makers, managers and administrators. The reason for the exclusion criteria is that the framework is a public health ethics framework for doctors, healthcare practitioners and healthcare policymakers, managers and administrators to use the anticipated framework as a guideline in their engagement with geriatric people.

The participants will be selected from at least one geriatric institution and / or facility in the Free State, Southern Northern Cape and North-West provinces in South Africa. These provinces represent geographically central South Africa. The geriatric institutions and / or facilities will be identified on the basis of Marshall's (1996) grouping of *convenience sampling* (most accessible environment), *judgement/purposeful* (most productive example) and *theoretical sampling* (building interpretative theories) as sample strategies.

5.5.5.2 Information sampling and data collection

The primary purpose of information sampling is to explore complex human issues, it contributes to trustworthiness and constitute transferability of results. The overarching aim of qualitative sampling

is to understand the complexity of an activity (here the drafting of a public health ethics framework for geriatric people) and hence the *implementation* thereof and not the *generalisation* of results (Marshall 1996:524).

The information sampling will take place on the basis of the ranking of statements. The target audience or respondents (called the P-set), represented by the identified population group, will rank the statements (Q-set) during a group meeting where the process will first be explained to the audience, whereafter the P-set will have the opportunity to rank the Q-set (Shabila, Al-Tawil, Al-Hadithi & Sondorp, 2014). Representatives from the identified population as well as diversity in location will secure the diversity in participation.

The statements will be defined on the basis of the literature review. Two sets of statements will be ranked. Firstly, to indicate which social determinants creates ethical challenges in public health and secondly what should be part of public health ethics framework for geriatric people. Fischer (2018) observes that existing material (such as literature or previous surveys) can assist with the development of the concourse, that is the documented full extent of opinions and viewpoints on the topics.

On recommendation by Fischer (2018) the statements identified for ranking by the Q-set can be extended in the Q-sort by adding additional qualitative inputs such as open-ended comments.

During the group meeting questions may be raised with regard to the research topic. These questions and / or comments will be informed by the outcomes of the ranking (Fischer, 2018).

The ranking of statements contributes to data collection. The purpose of data collection is to elicit subjective viewpoints and identify shared patterns amongst individuals (Shabila, Al-Tawil, Al-Hadithi & Sondorp, 2014).

The ranking will be based on presenting the statements by means of a five-point Likert-scale questionnaire where the raking will take place on the basis of least important (1 point) to cannot do without this (5 point). The ranking of statements can fit the two extremes of the Likert-scale namely either agree or disagree with a moderate or neutral point of indecisive. Using the Likert-scale can represent a quantitative approach within the Q-methodology.

As the information will be collected from more than one geriatric institution and / or facility and in three provinces in South Africa, the impact of demographics and their intersectionality can be assed too (see Fischer, 2018). The demographic variables will be either *categorical* (age, gender, marital status) or *continuous* (age, years of education, family size). Although not the purpose of the ranking it can also point out what communalities or differences exist between the participants.

Should it not be possible to secure at least one representative from each of identified population groups, (a) person(s) will be identified and the request for ranking sent electronically or presented on a personal basis.

The ideal P-set is a total of 40-60 participants, thus 15-20 participants per geriatric institution or facility. The number is based on shared viewpoints and not generality of viewpoints. The recommend Q-sort is 40-80 statements as it provides a wide range of topics to rank (Fischer, 2018; Watts & Stenner, 2005). Shabila *et al*. (2014:2), say that as the Q-methodology is not designed for hypothesis testing, therefore it is not subjected to sample size estimation.

5.5.5.3 Analysis of results

The SPSS statistical support software will be used to analyse the ranking captured by means of the Likert-scale.

The analysis will assist to understand which social determinants create ethical challenges in public health and what should be part of a public health ethics framework.

Fischer (2018) further recommends that the data analysis is done by means of a Non-Q *by-variable*

analysis (feedback per participant) and Q-methodology *by person* analysis (feedback per statement).

5.5.6 Sharing of results

After the different opinions have been included in the framework, a summative workshop will be convened in Bloemfontein during which more discussions will be held on the outcomes of the research. This is known as the post-Q discussions. A total population of at least 50 participants from the participating regions will be invited to the workshop. The target audience will be directed at doctors, healthcare practitioners and healthcare policy makers, managers and administrators. This will include doctors (representative of cure), healthcare practitioners (representative of care), healthcare administrators and managers (representative of control) and elderly people, family and relatives (representative of community). The target audience will be invited from more institutions than those that have participated in the Q-set. This will be a three-hour event during which feedback on the research and the results will be shared and reflections on the feedback will be captured. These results from the post-Q discussions will be captured in the research report. Where views are significantly different from those based on the analysis of the rankings, it will be reflected in drafting the final framework.

A scribe will take down the notes during the post-Q discussion sessions to assure optimum attention of the facilitator during the discussions.

5.5.7 Summary of the qualitative method and Q-methodology used

The research method and methodology used in this study can be summarised as follows:

- Start: Literature review as scholarly review
- Concourse of statements from a scholarly review
- Prioritisation of statements
- Information sampling
- Data collection
- Q-data analysis
- Additional data analysis
- Post Q discussions

5.5.8 Outcome

Three conceptual papers will be drafted. These conceptual papers are:

- Why a public health ethics framework for geriatric communities? (Working title.)
- What is public health ethics for geriatric communities? (Working title.)
- A public health ethics framework for geriatric people. (Working title.)

5.6 Research uptake

Research uptake can be defined as what are the purposeful outcomes of a research project. Three activities are associated with research uptake namely:

- Public dissemination of research results
- Innovation
- Policy statement

The following uptake is envisaged:

- Three journal papers will be presented for publication.
- Research results will be presented at a conference.
- The public health ethics framework will present a new service. This is part of social innovations.
- A policy statement will be drafted to advocate the inclusion of such a framework in policy.

6. RESEARCH ETHICS AND INTEGRITY CONSIDERATIONS

Internationally accepted research ethics and integrity guidelines will be followed in this study [see Lategan, Sempe, & Tilley (2017) for a discussion of these principles]. The following research ethics and integrity guidelines will be implemented in this study:

- **Paradigmatic choices:** Although researchers should be free to select the paradigm for their academic work and to phrase their own findings and conclusions, these findings and conclusions should be available for scrutiny and criticism. At no time should any paradigmatic choice leads to discrimination and violence. Respectful conduct should be the basis for all research work. As healthcare staff will be involved in this study through the Q-methodology, respectful conduct will guide the engagement with the participants. After Tilley (2016:17) is respectful research defined as the researchers' knowledge, methodological choices, research focus and participants' involvement in the research process.
- **Dictum of doing no harm**: Researchers should commit themselves to the ethical dictum of "doing no harm" in all their research activities. Through the research no intentional harm will be caused to geriatric communities, healthcare practitioners, the environment, culture or social structures. The dignity of the participants will be upheld at all times.
- **Relevance of research**: Research activities should be informed, relevant and contribute towards implementable and useful knowledge. Researchers should avoid "research waste" by bad design, poor or no reporting or the recycling of existing knowledge. The intention of the research is to formulate a framework that can be used in the caring of geriatric people. The value of this research is that it can protect the vulnerability of geriatric people.
- **Avoid power relationships:** Research activities should be free from any form of power play, harassment and the misuse of any professional relationship for personal gain and benefit. When the Q-methodology will be implemented, no power play will be performed in the facilitation of the discussion.
- **Integrity of information:** The integrity of the information collected through the group discussions will be reported accurately and will not include fabricated information or falsified results in any report, assignment or publication. In the collection, management and use of information, the researcher is committed to safeguard the privacy of participants and to ensure that personal information remain confidential. Informed consent letters will be signed. The information will be captured on the work-based computer of the researcher who is subjected to the privacy policies of his university. The researcher is also informed as to the requirements of the Protection of Personal Information Act 4, 2013 (commonly known as the POPI Act) and will use these guidelines as basis.
- **Authorship**: The researcher accepts responsibility for the validity of the whole manuscript. Authorship will be limited to individuals who have made a significant contribution to the research. The ICMJE authorship guidelines and the ASSAf Code in Scholarly Publishing (2018) will be followed.
- **Risk:** There is no risk associated with the research that can endanger the lives of the research subject or do harm to the environment.
- **Conflict of interest:** Any potential conflict of interest will be declared. The researcher is committed that there will be no conflict of interest that can derail the project or harm the trust of the public in the performance of the research, engagement with healthcare practitioners or framework developed.
- **Informed Consent**: Written approval from the authorities of the participating geriatric institutions and facilities and the voluntary participation of the participants will first be obtained before any interviews and collection of information will take place (cf. Appendix 1, 2 & 3 as examples of such letters seeking approval and informed consent). The objectivity of the participation will further be enhanced through the emphasis on no payment / remuneration for participating in this activity. Mindful of the developmental state agenda, this activity will contribute to the participants' skills development.
- **Quality:** The research will meet the integrity guidelines captured in the Singapore Statement on Research Integrity. The emphasis is on honesty, accountability, professional courtesy and fairness and good stewardship when doing research. The research will meet the minimum standard associated with research.
- **Trustworthy**: The research will be trustworthy – ranging from the doing of research (credibility and dependability), the management and administration (confirmability) thereof and the impact

research has on society (transferability).

- **Skill and Competency:** The Researcher's competence and expertise is supported by two completed doctoral studies in various aspects of ethics. The researcher also published several papers in the area of ethics.

7. CONTENTS AND FORMAT of STUDY

The study is designed around three stages:

Preparatory phase (Semester 1 – 5):

- Initial literature review: Reading and orientation towards study.
- Development of protocol for Evaluation Committee (September 2018 / February 2019) and subsequent ethical approval (March 2019).

Research phase [Semester 5 – 6 (following ethical approval)]:

- Literature review as scholarly review
- Formulation of statements based on scholarly review
- Rankings of statement based on the Q-methodology
- Development of public ethics framework for geriatric people

Portfolio of evidence phase (Semester 6):

- Completion of research to be ready for summative assessment
- Summative assessment: Assessment of study and update, where required.

The study will have the following content and format. Anticipated progress is also indicated.

Activity	Title	Format	Time frame
Preparatory reading	Public health	Research Notes	February 2017-May 2018
Protocol	Aim, objectives, problem statement, methodology and ethical considerations	Research document	June 2018 – January 2019
Approval	Evaluation Committee	Research document	February 2019
Approval	Submission to Ethics Committee	Research document	March 2019
Scholarly review	Extended review of literature to address research problem	Research document	March – May 2019
Data Collection	Data collection via Q-methodology	Rankings	June – July 2019
Papers	Writing of papers: 1. Why a public health ethics framework for geriatric people? 2. What is public health ethics for geriatric communities? 3. The design of a public health ethics framework for geriatric communities	Journal article Paper 3 will be drafted on the basis of the information collected through the Q-methodology Technique.	August – October 2019

Portfolio of evidence	Integration of research outputs into a portfolio of evidence	Thesis format	November 2019
Conclusion	Summative overview of study	Thesis format	November 2019
Technical preparation of study for assessment	Language editing, technical requirements such as lay-out of study	Thesis format	December 2019
Summative assessment	Summative assessment	Assessment Report	December 2019

* The UFS requirements are three publishable / published papers.

The study will contribute towards the critical outcomes as identified by the NQF Level 10:

- Critical thinking
- Science writing
- Science communication
- Supervision skills

8. BUDGET

The following budget will support the research:

Item	**Amount**	**Comment**
Tuition fees	-	Paid by researcher's home university
Qualitative study	R 10 000	Funded by researchers' own research funding
Data collection (travel, material, workshop venue)	R 35 000	Funded by researchers' own research funding
Statistical support	R 20 000	Funded by researchers' own research funding
Page fees for journal articles	R 15 000	Funded by researchers' own research funding
Language editing	R 10 000	Funded by researchers' own research funding
Technical lay-out, binding and copying of study	R 10 000	Funded by researchers' own research funding
Total	**R 100 000**	

9. CONCLUSION

This study identified a need for an ethical framework for public health delivery to geriatric people. The central argument is that due to an aging population and therefore an increase in life expectancy, there are many (new) ethical challenges that require, as a consequence, an integrated framework that will deal with (a) understanding the influence of and demands by social determinants on public health delivery; (b) the levels of ethical engagement that are required on the basis of public health ethics as value-driven decision making and behaviour; (c) how these engagements should be

managed to secure optimal quality of health and living; and (d) how an ecological approach to geriatric healthcare can be implemented that will promote an ethical framework. As an indented outcome of the research a policy statement will be drafted for public use.

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Appendix 1
Information Leaflet

1. TITLE OF THE STUDY

A public health ethics framework for geriatric people.

2. STATUS OF STUDY

Academic status
This is an academic study in the Department of Community Health in the Faculty of Health Sciences at the University of the Free State towards a PhD Degree.

Researcher
The researcher is Prof. Laetus O.K. Lategan with student number 1984298982.
His academic background is a PhD in Philosophy and DTh in Systematic Theology.

His contact details are:
Prof. Laetus O.K. Lategan
Senior Director: Research Development & Postgraduate Studies
Central University of Technology, Free State
1 Park Road
Bloemfontein
Tel: 0515073279

Promotors
The promotors for this study are:
- Promoter: Prof. Gert J. van Zyl
- Co-promotor: Prof. Willem H. Kruger

3. PURPOSE OF THE STUDY

This study identified a need for an ethical framework for public health delivery to geriatric people. The central argument is that due to an aging population and therefore an increase in life expectancy, there are many (new) ethical challenges that require, as a consequence, an integrated framework that will deal with

(a) understanding the influence of and demands by social determinants on public health delivery;
(b) the levels of ethical engagement that are required on the basis of public health ethics as value identification and subsequently value-driven decision making and behaviour;
(c) how these engagements should be managed to secure optimal quality of health and living; and
(d) how an integrated approach to geriatric healthcare can be implemented that will promote an ethical framework.

The research of this study will provide the policy framework to the study that will also be the researcher's own contribution to the topic.

This study has as objective the development of a public health ethics framework for geriatric people. The need for such a framework arises from the growing reality of an aging population which will have an impact on the provision of healthcare and the securing of quality of health and living of

geriatric people. Although an aging population is evidence of an increase in life expectancy due to an improved healthcare system, it poses ethical challenges associated with various aspects of healthcare, and more so in a resource-limited environment. The need is further highlighted by the absence of sufficient reflection on what the ethical challenges of a public healthcare system should be.

The research is informed by a qualitative approach to ethics in healthcare for geriatric people. An evidence-based analysis of what public health and ethics are, provides the basis of a definition of public health for geriatric people as the improvement of the quality of health and well-being of geriatric people.

Ethics can be defined as value identification and subsequently value-driven decision-making and behaviour. Public health ethics can therefore be defined as value identification and subsequently value-driven decisions and behaviour in support of quality of health and well-being.

The focus is on geriatric people and the context is South Africa.

The research question for this study is: *What is public health ethics for geriatric people in the South African context?*

4. POTENTIAL ADVANTAGES OF THE STUDY

The advantage of this study is the drafting of a public health ethics framework for geriatric people. Although ethics is evident in public health, it can be regarded as an emerging focus in promoting public health as field of study (on a scientific basis) as well as the practice of public health (as a policy intervention). This study will close this gap in the knowledge basis.

As a result of the conceptual analysis, a framework is proposed to deal with ethical challenges in public health delivery to geriatric people.

What should be evident from the above discussion is that (a) the growing aging population will have a very specific impact on the public health needs of the country; (b) these specific needs are sparked by context-specific social determinants; and (c) although the ethical dictum of *first, do no harm*, is well enshrined in the South African Constitution and international bioethics codes (such as the Helsinki code), a specific ethics framework to deal with ethical challenges is still required.

The advocacy of such a framework is to use it in training, managing and promoting the well-being of geriatric people.

5. MODE OF DATA COLLECTION

The participants will be selected from at least one geriatric institution and / or facility in the Free State, Southern Northern Cape and North-West provinces in South Africa.

The target audience will exclude patients and focus on doctors, healthcare practitioners, healthcare policymakers, managers and administrators.

A ninety minute sessions will be conducted with each identified institution or facility. The target audience will be the doctors, healthcare practitioners and healthcare policy makers, managers and administrators working at these geriatric institutions or facilities. The researcher will be the facilitator of these discussions. The participants will be asked to ranked statements to identify what social determinants present ethical challenges in public health and what should be part of a public health ethics framework addressing these challenges.

The discussion will be based on an informed consent and voluntary participation basis and feedback will be given to the participants within one month after the engagements.

The feedback that will be captured, is to inform the usefulness of the planned framework. A scribe will take down the notes to assure optimum attention of the facilitator during the discussions.

6. RISK

The researcher lives by the dictum of "*first, no harm*" and international accepted principles for medical ethics and bioethics research namely *respect for individuals and their autonomy, beneficence* (well-being) and *justice*.

These principles will guide the discussion on a public health ethics framework that can be used in geriatric care.

No patients will be involved in the study.

There is no risk associated with the research that can endanger the lives of the research subject or do harm to the environment.

Through the research no harm will be caused to the participants, geriatric people, the environment, culture or social structures.

7. VOLUNTARY PARTICIPATION

The participation is voluntary.

Approval from the participating old age institutions and facilities and the voluntary participation of the participants will first be obtained before any discussions and collection of information will take place. The objectivity of the participation will further be enhanced through the emphasis on no payment / remuneration for participating in this activity. Mindful of the developmental state agenda, this activity will contribute to the participants' skills development.

8. PARTICIPANT WITHDRAWAL

A participant can withdraw at any time.

9. INTEGRITY AND CONFIDENTIALITY OF INFORMATION

The integrity of the information collected through the group discussions will be reported accurately and will not include fabricated information or falsified results in any report, assignment or publication.

In the collection, management and use of information, the researcher is committed to safeguard the privacy of participants and to ensure that personal information remain confidential. Informed consent letters will be signed.

The information will be captured on the work-based computer of the researcher who is subjected to the privacy policies of his university. The researcher is also informed as to the requirements of the Protection of Personal Information Act (Act 4 of 2013, commonly known as the Popi Act) and will use these guidelines as basis.

10. NO COST TO PARTICIPATE IN RESEARCH

The participants in this project do not have to pay for their participation.

Their participation will be during their working hours as arranged with their employer.

The summative feedback of information will be during an organised workshop. Invitations will be extended to an organisation and not the individual. Hence there should be no cost to the participants.

11. NO REMUNERATION FOR PARTICIPANTS

No honorarium or remuneration will be payable to any participant.

12. INFORMED CONSENT

This is a non-therapeutic study. The information sampling and data collection will be through the Q-methodology. This method is used to capture individuals' views and perceptions on a matter.

As this is a non-therapeutic study there are no reversible or irreversible side-effects.

Informed consent letters will be signed by participants. Each page will be initialled by the participants. The letters will be in English. Each letter will outline the purpose of the study, the independency of participation and the voluntary consent to participate in this study. Where language is a challenge, an interpreter will assist, where possible.

13. RESEARCH UPTAKE

Research uptake can be defined as what are the purposeful outcomes of a research project. Three activities are associated with research uptake namely:

- Public dissemination of research results
- Innovation
- Policy statement

The following uptake is envisaged:

- Three journal papers will be presented for publication.
- Research results will be presented at a conference.
- The public health ethics framework will present a new service. This is part of social innovations.
- A policy statement will be drafted to advocate the inclusion of such a framework in policy.

14. DURATION of STUDY

This study is designed around three stages and will run over six semesters (three academic years).

Preparatory phase (Semester 1 – 5):
- Initial literature review: Reading and orientation towards study.
- Development of protocol for Evaluation Committee.
- Ethical approval.

Research phase [Semester 5 – 6 (following ethical approval)]:
- Literature review as scholarly review
- Formulation of statements based on scholarly review
- Ratings based on the Q-methodology
- Development of public ethics framework for geriatric people

Portfolio of evidence phase (Semester 6):
- Completion of research to be ready for summative assessment
- Summative assessment: Assessment of study and update, where required.

15. COMPLAINTS

All complaints can be directed to the UFS Medical Ethical Committee. The contact details are:
The Secretariat of the Health Sciences Research Ethics Committee

Faculty of Health Sciences
University of the Free State
PO Box 339
Bloemfontein
Tel: 051 4017794/5

Appendix 2

Consent to participate in research

[date]

Dear Participant

You have been asked to participate in a research study.

You have been informed about the study by [name of the supervisor of the participating geriatric institution or facility will be included after permission has been obtained to participate in this study]

To confirm your participation in the study, the following:

1. Your participation in this research is voluntary, and you will not be penalised or lose benefits if you refuse to participate or decide to terminate participation.
2. Since your participation is based on a discussion, there is no harm or risk to you, geriatric people or the environment.

Contact information

You may contact Prof. Laetus O.K. Lategan at 051-5073336 any time if you have questions about the research or if you are injured as a result of the research.

You may contact the Secretariat of the Health Sciences Research Ethics Committee, University of the Free State at telephone number (051) 4017794/5 if you have questions about your rights as a research subject.

If you agree to participate, you will be given a signed copy of this document as well as the participant information sheet, which is a written summary of the research.

Confirmation

The research study, including the above information has been verbally described to me. I understand what my involvement in the study means and I voluntarily agree to participate.

_____ _____
Signature of Participant Date

_____ _____
Signature of Witness Date
(Where applicable)

_____ _____
Signature of Translator Date
(Where applicable)

INFORMATION DOCUMENT

Study title: A public health ethics framework for geriatric people.
Student: Prof. Laetus O.K. Lategan

Dear Participant
My study focuses on the design of a public health ethics framework for geriatric people.

The **background** to this study is the growing aging population that will have a very specific impact on the public health needs of the country. These needs will invite a number of ethical challenges in the public health delivery of elderly people. Typical examples will be access to medical facilities, basic healthcare, liveable environments, food security, personal safety, end of life support and affordability of healthcare. Although the challenges are not new to geriatric care, a public health ethics informed framework that can deal with these ethical challenges is still absent. This study wants to address this shortcoming as it is my informed opinion that such ethical framework can add to the health and well-being of geriatric people.

Your voluntary participation in a ninety minutes' session is kindly requested. The purpose of this session is to identify and to rank statements. discussion is to obtain consensus on the public ethics framework envisaged for geriatric people.

Your participation is voluntary. You do not have to pay any cost for participating in the discussion. There will also be no honorarium or remuneration paid for participating in this study.

Participants can withdraw at any time from the discussion. No patient will be involved in this study. No medicines will be used. There is therefore no harm or risk to you, the geriatric patient, environment or management practices of the institution. As participant you will not be identified individually in the study.

The objective of the session to identify what social determinants present ethical challenges in public health and what should be part of a public health ethics framework addressing these challenges.

The added value of your participation is your sensitisation of public health ethical challenges in the caring of geriatric people.

Efforts will be made to keep personal information confidential. Absolute confidentiality cannot be guaranteed. Personal information may be disclosed if required by law. If results are published, chances of individual/cohort identification are very low.

Prof. Laetus O.K. Lategan

Appendix 3

Example of letter that will be sent to the participating geriatric institutions

[Date]

[NAME, INAME OF INSTITUTION, ADDRESS]

PARTICIPATION IN A STUDY TO DESIGN A PUBLIC HEALTH ETHICS FRAMEWORK FOR GERIATRIC PEOPLE

I, the undersigned researcher, Laetus Oscar Kotzè Lategan, is an enrolled doctoral student in the Department of Community Health in the Faculty of Health Sciences at the University of the Free State. Please find enclosed a copy of the ethical approved status of this project.

My study focuses on the design of a public health ethics framework for geriatric people. The background to this study is the growing aging population that will have a very specific impact on the public health needs of the country. Ethical challenges can be linked to the public health needs of a country. Typical examples will be access to medical facilities, basic healthcare, liveable environments, food security, personal safety, end of life support and affordability of healthcare. Although the challenges are not new to geriatric care, an ethics informed framework that can deal with these ethical challenges is still absent. This study wants to address this shortcoming as it is my informed opinion that such ethical framework can add to the health and well-being of geriatric people.

The voluntary participation of the doctors, healthcare practitioners (professional nurses, nurses, caretakers) and healthcare policymakers, managers and administrators in a ninety minutes' session is kindly requested. The purpose of this session is to rank statement on what causes ethical challenges in public health and what should form part of a public ethics framework for geriatric people.

The participation is voluntary. The participants do not have to pay any cost for participating in the discussion. There will also be no honorarium or remuneration paid to the participants. The confidentiality of the participants will be guaranteed as far as legally possible. They can withdraw at any time from the discussion. No patient will be involved in this study. As this is a non-therapeutic research study and no medicines will be used, there will be no harm or risk to the geriatric patient, the participant, institution, environment or management practices of the institution. The participants will not be identified individually in the study. The feedback that will be captured is to inform the usefulness of the planned framework. The participation in this discussion will be based on informed consent. Feedback will be given to the participants within two months after the engagements. The participation is voluntary and a participant can withdraw at any time. The institution will also be acknowledged in the study and research publications or if preferred treated anonymous.

The added value of your participation is by sensitising your staff as to public health ethics challenges in the caring of geriatric people.

Should you agreed to this, then a suitable time will be confirmed with you during **[date in 2019]**. You will also be requested to identify [xx] appropriate doctor(s) and staff to participate in this study.

Following the capturing of information from participating institutions, a summative workshop will be convened to give overall feedback on this framework. You will be invited to this workshop after all the information has been captured from the participating institutions.

Cost for your venue, if applicable, will be paid on the basis of your procurement and facilities policy. Light refreshments will be provided during the discussion.

Your favourable consideration of this request will be highly appreciated.

May I please receive feedback by [date]. Follow-up communications will follow to prepare for the sessions. This will include the signing of the consent forms and data collection on your institution (example number of staff and patients, existence of ethical framework and training and identified ethical challenges by staff and / or management).

Kind regards

Insert electronic signature

Prof. Laetus O.K. Lategan

Appendix 4

POSSIBLE RANGE OF STATEMENTS FOR THE PUBLIC ETHICS FRAMEWORK FOR GERIATRIC PEOPLE

Although the framework still has to be completed, a preliminary literature review suggests the following five sets of statements that can be ranked for purposes of the framework:

- Public health ethics as applied ethics – public health ethics should identify values to address moral problems related to community health.
- Public health ethics must advocate values that can inform and direct the public health value chain. This should lead to the improvement of community health and social justice.
- Public health ethics should educate skilled workers that will have the knowledge and skill to deal with dilemmas in the public health agenda.
- Public health ethics cannot be removed from professional behaviour – professionals have to act in a virtuous way.
- Public health ethics should promote safety and security, individual interest and responsibility, and economic freedom through integrating ethical values with the public health agenda.

The emerging discussion will be around the framework.

Appendix 5:

Frequency Tables

FREQUENCY TABLE

Respondents' gender

	Frequency	Percent	Valid Percent	Cumulative Percent
Male	6	27.3	27.3	27.3
Female	16	72.7	72.7	100.0
Total	22	100.0	100.0	

Respondents' age

	Frequency	Percent	Valid Percent	Cumulative Percent
31 - 45 years	3	13.6	13.6	13.6
46 - 60 years	8	36.4	36.4	50.0
61 - 65 years	2	9.1	9.1	59.1
66 - 70 years	3	13.6	13.6	72.7
71 years or older	6	27.3	27.3	100.0
Total	22	100.0	100.0	

Respondents' highest educational level

	Frequency	Percent	Valid Percent	Cumulative Percent
Grade 12	6	27.3	27.3	27.3
Post-school education	4	18.2	18.2	45.5
University education	12	54.5	54.5	100.0
Total	22	100.0	100.0	

Respondents' professional registration

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	11	50.0	61.1	61.1
No	7	31.8	38.9	100.0
Total	18	81.8	100.0	
Missing System	4	18.2		
Total	22	100.0		

Respondents' profession

	Frequency	Percent	Valid Percent	Cumulative Percent
Medical doctor	2	9.1	9.1	9.1
Registered sister	7	31.8	31.8	40.9
Nurse	1	4.5	4.5	45.5
Manager	5	22.7	22.7	68.2
Administrative Staff	5	22.7	22.7	90.9
Chairperson of board of old age facility	1	4.5	4.5	95.5
Health Care Worker	1	4.5	4.5	100.0
Total	22	100.0	100.0	

Respondents' facility

	Frequency	Percent	Valid Percent	Cumulative Percent
Urban	11	50.0	50.0	50.0
Rural	11	50.0	50.0	100.0
Total	22	100.0	100.0	

Respondents' geriatric work experience

	Frequency	Percent	Valid Percent	Cumulative Percent
0-5 years	8	36.4	36.4	36.4
6-10 years	2	9.1	9.1	45.5
11-15 years	1	4.5	4.5	50.0
16-20 years	3	13.6	13.6	63.6
21-30 years	4	18.2	18.2	81.8
31 years and longer	4	18.2	18.2	100.0
Total	22	100.0	100.0	

Respondents' education level

	Frequency	Percent	Valid Percent	Cumulative Percent
Not university education	10	45.5	45.5	45.5
University education	12	54.5	54.5	100.0
Total	22	100.0	100.0	

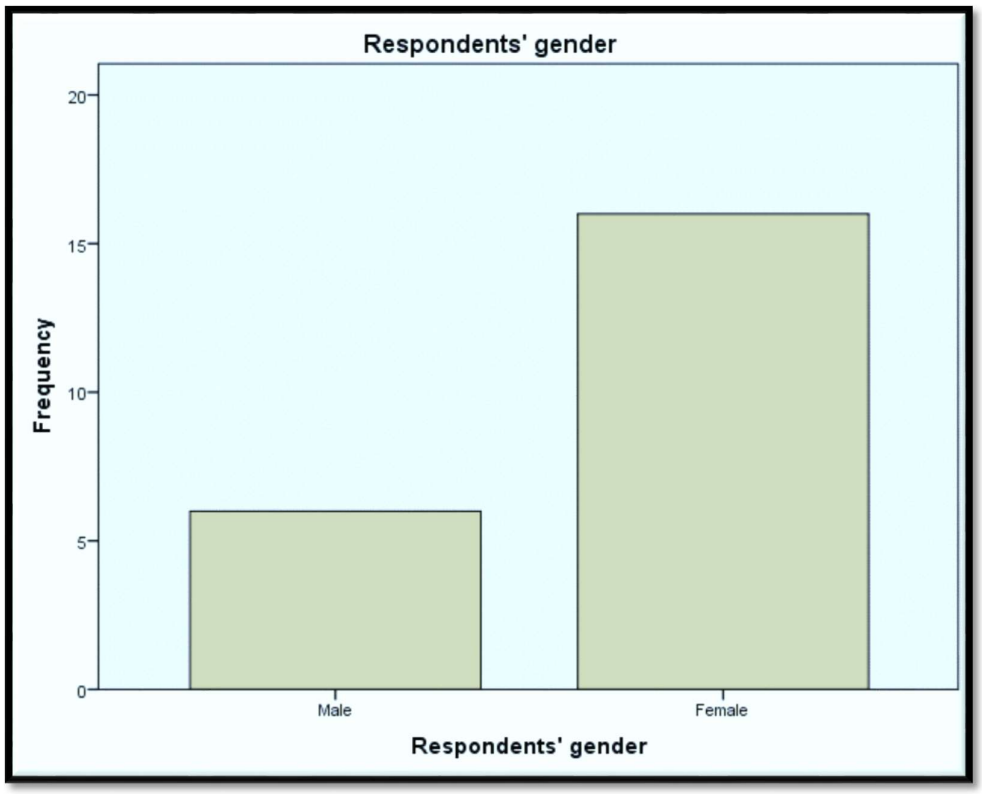
Respondents' side

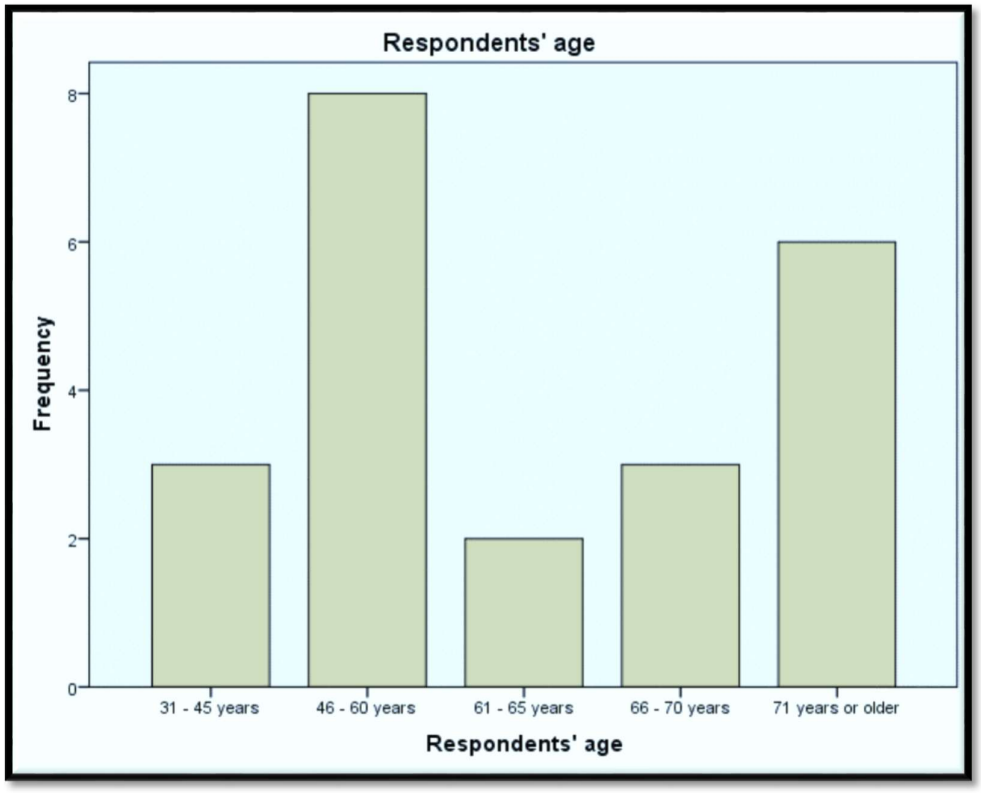
	Frequency	Percent	Valid Percent	Cumulative Percent
Caretaker	11	50.0	50.0	50.0
Admin	11	50.0	50.0	100.0
Total	22	100.0	100.0	

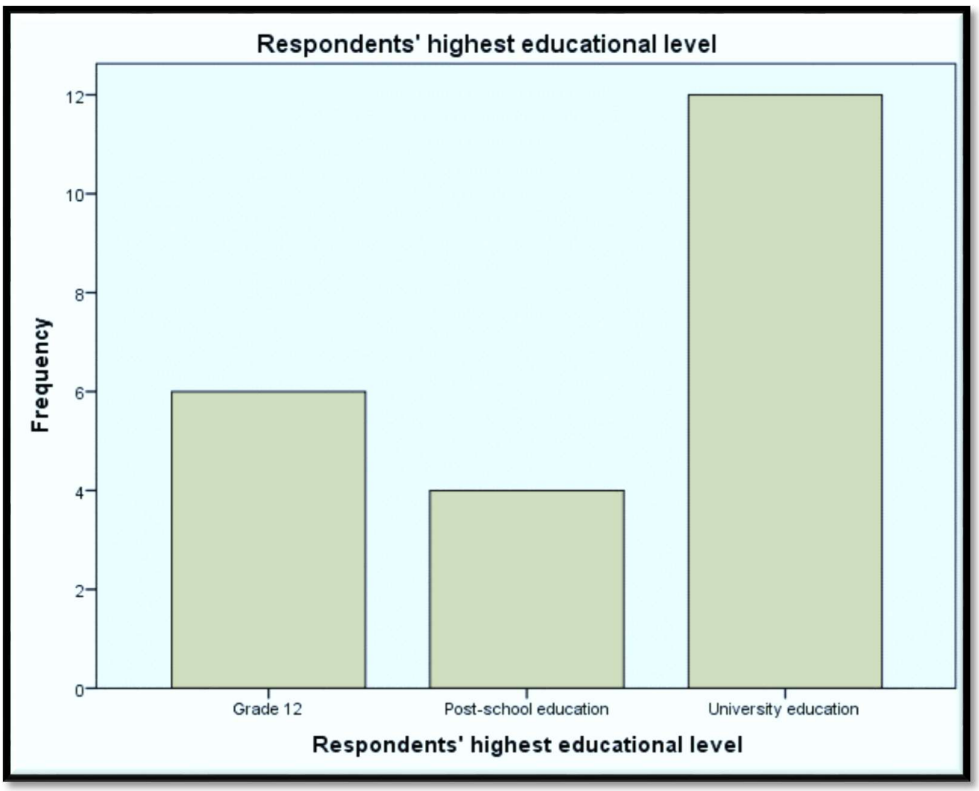
Geriatric work experience (new grouping)

	Frequency	Percent	Valid Percent	Cumulative Percent
0-5	8	36.4	36.4	36.4
6-20	6	27.3	27.3	63.6
21 or more	8	36.4	36.4	100.0
Total	22	100.0	100.0	

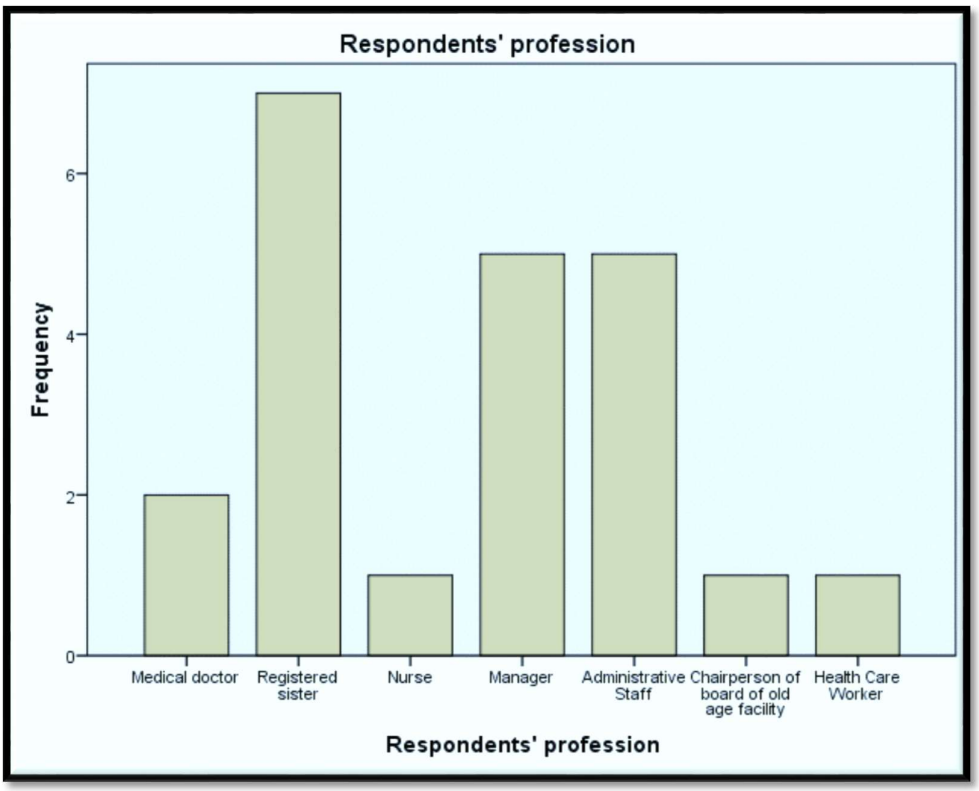
BAR CHART

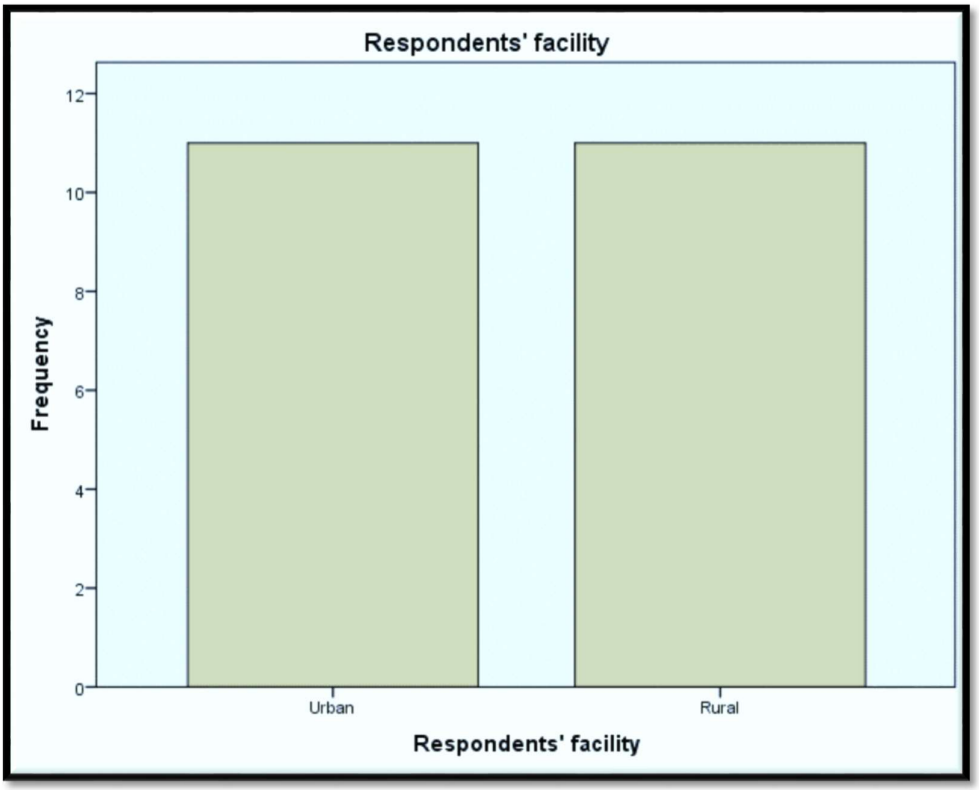

Respondents' gender
Frequency
20
15
10
5
0
Male
Female
Respondents' gender

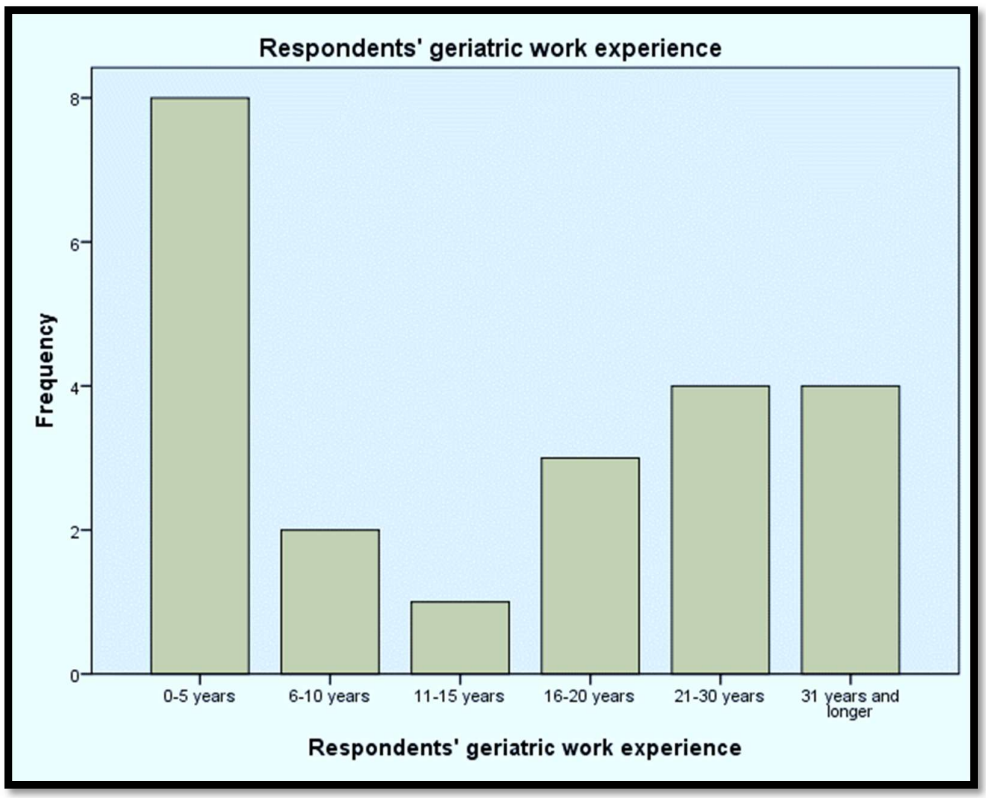

Respondents' age
Frequency
8
6
4
2
0
31 - 45 years
46 - 60 years
61 - 65 years
66 - 70 years
71 years or older
Respondents' age

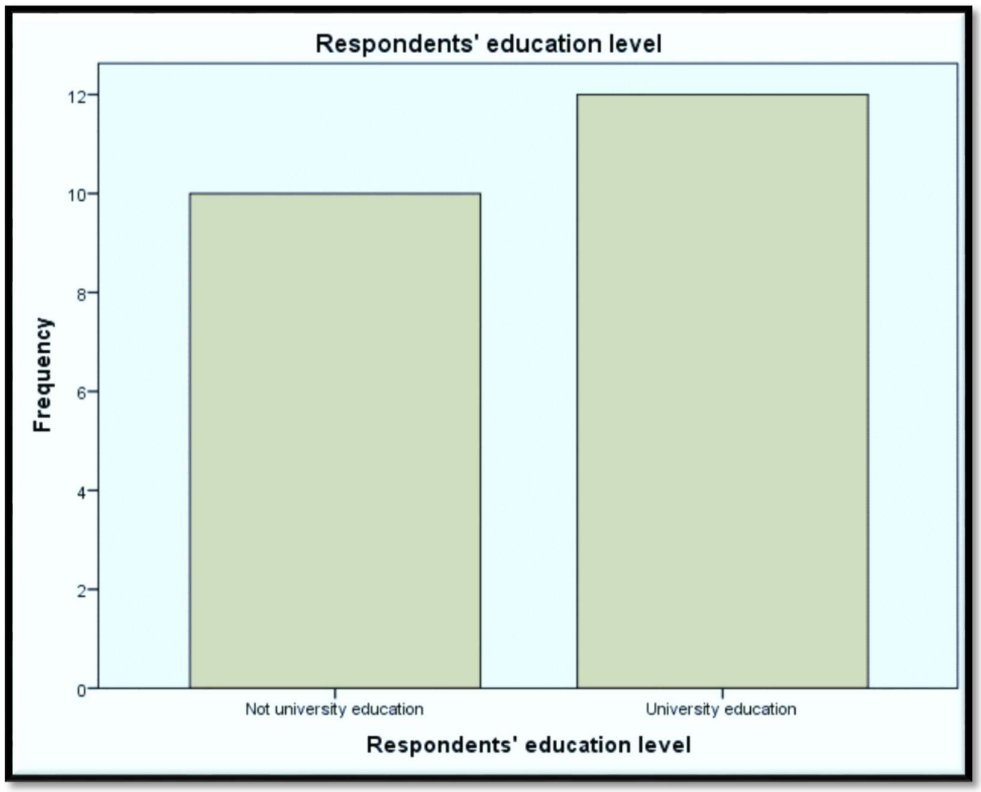

Respondents' highest educational level
Frequency
0
2
4
6
8
10
12
Grade 12
Post-school education
University education
Respondents' highest educational level

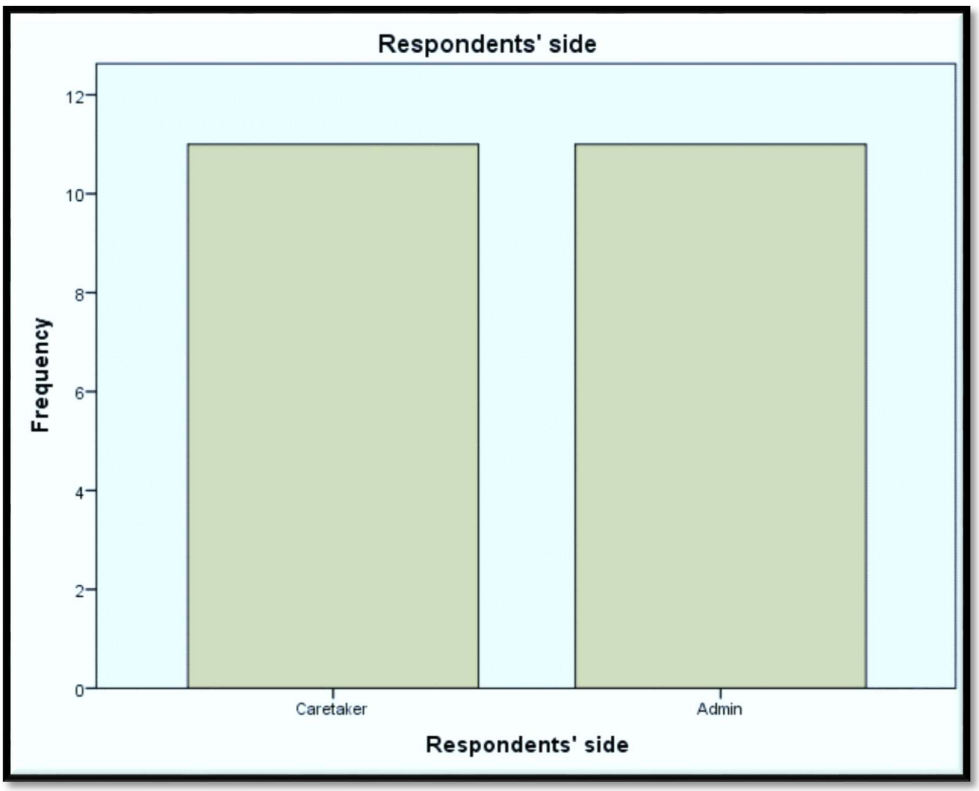

Respondents' professional registration
Frequency
0
2
4
6
8
10
12
Yes
No
Respondents' professional registration

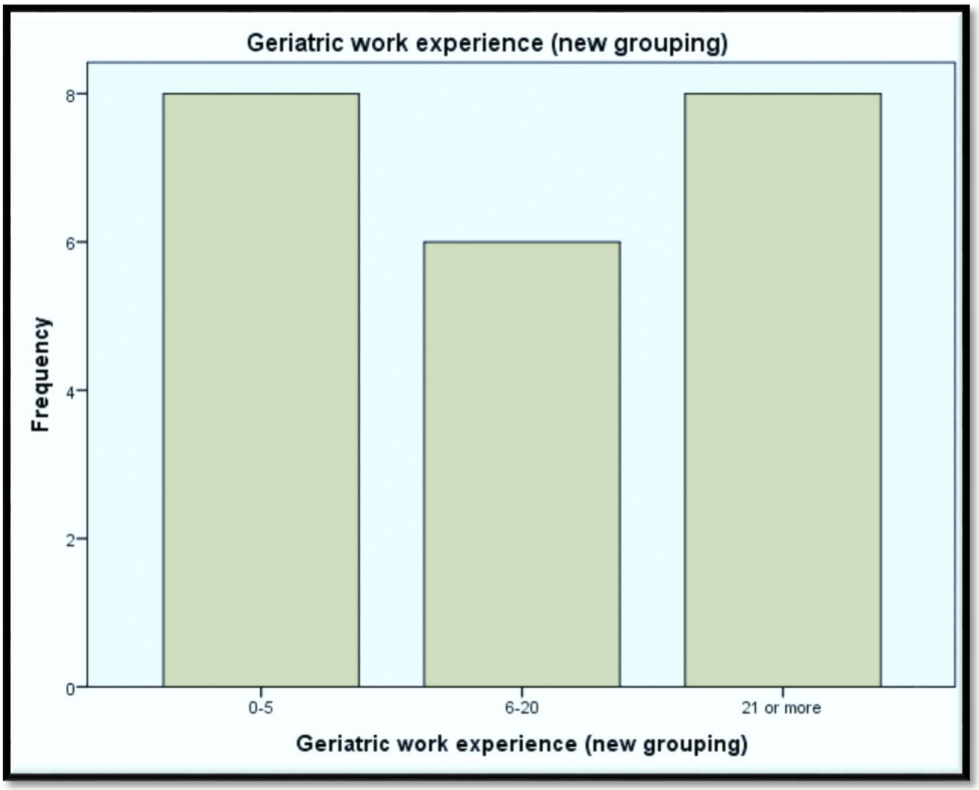

Respondents' profession
Frequency
0
2
4
6
Medical doctor
Registered sister
Nurse
Manager
Administrative Staff
Chairperson of board of old age facility
Health Care Worker
Respondents' profession


Respondents' facility
Frequency
0
2
4
6
8
10
12
Urban
Rural
Respondents' facility


Respondents' geriatric work experience
Frequency
0
2
4
6
8
0-5 years
6-10 years
11-15 years
16-20 years
21-30 years
31 years and longer
Respondents' geriatric work experience


Respondents' education level
Frequency
0
2
4
6
8
10
12
Not university education
University education
Respondents' education level


Respondents' side
Frequency
12
10
8
6
4
2
0
Caretaker
Admin
Respondents' side


Geriatric work experience (new grouping)
Frequency
8
6
4
2
0
0-5
6-20
21 or more
Geriatric work experience (new grouping)

Respondents' ratings of statements around social determinants

	Strongly disagree		Disagree		Neutral		Agree		Strongly agree	
	Count	%	Count	%	Count	%	Count	%	Count	%
Public health is about prevention and not treatment.	3	14.3%	4	19.0%	0	0.0%	13	61.9%	1	4.8%
Public health is about collaboration between government, healthcare facilities and communities.	0	0.0%	0	0.0%	1	4.5%	15	68.2%	6	27.3%
Health is influenced by more than physical challenges or illness only.	0	0.0%	0	0.0%	0	0.0%	11	52.4%	10	47.6%
Social factors such as low income, little and substandard education, limited employment options, high levels of unemployment and poor living and working conditions influence the health of all people.	0	0.0%	0	0.0%	0	0.0%	8	36.4%	14	63.6%
Lifestyle influences health.	0	0.0%	1	4.5%	0	0.0%	11	50.0%	10	45.5%
Poor service delivery influences healthcare.	0	0.0%	0	0.0%	0	0.0%	8	36.4%	14	63.6%
The poor management of healthcare influences health.	0	0.0%	0	0.0%	0	0.0%	8	38.1%	13	61.9%
Lack of finances influences access to and quality of healthcare.	0	0.0%	1	4.5%	0	0.0%	9	40.9%	12	54.5%
Geriatric people's health is influenced by access to healthcare, whether financial, area (location of healthcare facility), language or mobility.	0	0.0%	0	0.0%	0	0.0%	11	50.0%	11	50.0%
Geriatric people's health is influenced by living conditions such as accommodation / housing, food, nutrition, electricity, water, sanitation and the general environment.	0	0.0%	0	0.0%	0	0.0%	9	40.9%	13	59.1%
Geriatric people's health is influenced by social factors such as the role in the family (for example caring for grant children), isolation from peers and / or children.	0	0.0%	0	0.0%	1	4.5%	14	63.6%	7	31.8%
Geriatric people's health is influenced by public health preparedness to prevent disease and create good living conditions.	0	0.0%	0	0.0%	1	4.5%	17	77.3%	4	18.2%
Geriatric people have the responsibility to care for themselves.	2	9.1%	8	36.4%	5	22.7%	5	22.7%	2	9.1%
Geriatric people need to be educated on how to care for themselves.	1	4.8%	4	19.0%	4	19.0%	10	47.6%	2	9.5%
Government has only a financial responsibility to promote the health of geriatric people.	9	42.9%	11	52.4%	0	0.0%	0	0.0%	1	4.8%
Geriatric people have different needs from other population age groups.	0	0.0%	2	9.1%	2	9.1%	11	50.0%	7	31.8%

Geriatric people's interest is more important that the communities' interest.	3	13.6%	8	36.4%	8	36.4%	2	9.1%	1	4.5%
Differences in the availability of healthcare support systems is geriatric people's biggest challenge.	1	4.8%	1	4.8%	4	19.0%	10	47.6%	5	23.8%
There are enough healthcare support systems available to support geriatric people.	7	31.8%	14	63.6%	0	0.0%	0	0.0%	1	4.5%
The healthcare of geriatric people is poorly managed.	0	0.0%	2	9.1%	3	13.6%	14	63.6%	3	13.6%

Respondents' ratings of statements around public health ethics

	Strongly disagree		Disagree		Neutral		Agree		Strongly agree	
	Count	%	Count	%	Count	%	Count	%	Count	%
Ethics can be explained as the choice between what is good and what is bad.	0	0.0%	0	0.0%	1	4.5%	15	68.2%	6	27.3%
Ethics is about having the best interest of a person and/or situation at heart.	0	0.0%	0	0.0%	0	0.0%	13	65.0%	7	35.0%
Ethics is not about the needs of the other only, but also the self.	0	0.0%	1	4.8%	2	9.5%	13	61.9%	5	23.8%
Ethics is about dealing with the vulnerability of the self, other people, systems and the immediate situation.	0	0.0%	0	0.0%	1	4.8%	12	57.1%	8	38.1%
Ethics is to know what you need to do right to prevent harm to the self, other people, systems and the immediate situation.	0	0.0%	0	0.0%	1	4.5%	12	54.5%	9	40.9%
Ethics is influenced by own understanding of what is good for the self, other people, systems or a situation.	0	0.0%	1	4.5%	0	0.0%	14	63.6%	7	31.8%
Ethics is influenced by one's likes or dislikes of other people or systems.	3	13.6%	3	13.6%	4	18.2%	9	40.9%	3	13.6%
Ethics is not only about people but also about systems, practices, processes and application.	0	0.0%	0	0.0%	1	4.5%	14	63.6%	7	31.8%
Public health ethics for geriatric people is about what is best to promote the health of this population group.	1	4.5%	0	0.0%	1	4.5%	12	54.5%	8	36.4%
There are not enough ethical guidelines available to support healthy living conditions for geriatric people.	0	0.0%	1	4.5%	4	18.2%	13	59.1%	4	18.2%
Public health ethics can play a role in the prevention of poor health.	0	0.0%	0	0.0%	0	0.0%	14	63.6%	8	36.4%
Public health ethics for geriatric people is about care and relationship-building between various stakeholders and geriatric people.	0	0.0%	0	0.0%	5	22.7%	11	50.0%	6	27.3%

Public health ethics for geriatric people should make healthcare practitioners more sensitive towards the vulnerability of geriatric people.	0	0.0%	0	0.0%	1	4.5%	13	59.1%	8	36.4%
Public health ethics for geriatric people deals with the fairness of how geriatric programmes are implemented.	0	0.0%	0	0.0%	2	9.1%	19	86.4%	1	4.5%
Public health ethics for geriatric people should change behaviour towards elderly communities.	0	0.0%	0	0.0%	2	9.1%	16	72.7%	4	18.2%

Respondents' ratings of statements around a public health ethics framework

	Strongly disagree		Disagree		Neutral		Agree		Strongly agree	
	Count	%	Count	%	Count	%	Count	%	Count	%
Ethical decision making is to address the ethical dilemma in hand.	0	0.0%	0	0.0%	1	4.5%	15	68.2%	6	27.3%
Ethics is about making a choice, implementation of the choice and evaluation of the outcome of the choice.	0	0.0%	0	0.0%	0	0.0%	15	68.2%	7	31.8%
Ethics decision making can have future consequences.	0	0.0%	0	0.0%	0	0.0%	12	54.5%	10	45.5%
Relationship building is important in ethics.	0	0.0%	0	0.0%	2	9.1%	12	54.5%	8	36.4%
Healthcare practitioners need a practical guide to assist them in ethical behaviour and decision making.	0	0.0%	0	0.0%	0	0.0%	13	59.1%	9	40.9%
Healthcare facilities / institutions and healthcare practitioners seldom talk about ethical challenges.	1	4.5%	1	4.5%	7	31.8%	13	59.1%	0	0.0%
Ethical success depends on participation around a common goal.	0	0.0%	0	0.0%	4	19.0%	11	52.4%	6	28.6%
Ethics is not about who is right or wrong but about what one can do to prevent or address a moral dilemma.	0	0.0%	0	0.0%	1	4.5%	14	63.6%	7	31.8%
Public health policymakers do not know what the ethical needs of elderly people are.	0	0.0%	0	0.0%	6	27.3%	9	40.9%	7	31.8%
Healthcare practitioners need ethical education.	0	0.0%	0	0.0%	3	13.6%	14	63.6%	5	22.7%
Leadership and management should promote ethical behaviour.	0	0.0%	0	0.0%	0	0.0%	12	57.1%	9	42.9%
Public health ethics must promote human rights in geriatric care (medical justice).	0	0.0%	0	0.0%	2	9.1%	11	50.0%	9	40.9%
Public health ethics must protect the vulnerability of geriatric people and healthcare practitioners.	0	0.0%	0	0.0%	1	4.5%	11	50.0%	10	45.5%
Public health ethics must promote decision making capacity.	0	0.0%	0	0.0%	2	9.1%	12	54.5%	8	36.4%
Ethics should be integrated in the public health ethics value chain.	0	0.0%	0	0.0%	0	0.0%	12	54.5%	10	45.5%