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Feature Interview with Dr. John Beard

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Feature Interview with Dr. John Beard<sup>☆</sup>

John Roland Beard's career has been dedicated to international and national policy development in the area of population ageing. As the current Director of Ageing and Life Course for the World Health Organization (WHO), he works with all levels of government and academia in the 194 WHO member states, including heads of state, ministers, and other key decision makers.

As lead editor and author of the World Report on Ageing and Health, he helped to frame a global public health response to population ageing by reconceptualizing "healthy ageing." Since the report's release in late 2015, it has had a significant global impact with more than 350,000 copies downloaded in full. Beard also led the team that drafted the Global Strategy and Action Plan on Ageing and Health that was adopted by the 2016 World Health Assembly. In 2012, he established the WHO Global Network of Age-friendly Cities and Communities, which now links municipalities covering more than 200 million people in more than 40 countries. He is past chair of the World Economic Forum's Global Agenda Council on Ageing and a member of its Global Future Council on Human Enhancement.

Throughout his career, Beard's research has focused on the impact

of physical and social environments on a wide range of outcomes across the life course. Much of this work has explored the influence of individual- and neighborhood-level socioeconomic determinants. More recently, he has focused on defining, following, and identifying the determinants of life-course trajectories of healthy ageing and developing comprehensive, evidence-informed societal responses to the demographic transition to older populations. He received his PhD in medicine/epidemiology from the University of Sydney in Australia.

**Challenges of population ageing**

**The World Health Organization includes ageing and the life course among its priority areas of work. As the leader of the WHO's response to global ageing-related issues, why do you think ageing should be a priority? What exactly does prioritizing ageing mean, and what are this effort's key goals?**

There are multiple reasons for prioritizing ageing. Sustainable development requires creating fair, cohesive, and equitable societies that can adapt to demographic and social change. Because populations around the world are ageing rapidly, considering the interplay between this shift and future development is essential. Moreover, no matter how many older people there are, they still have fundamental rights enshrined in international law, such as to the best possible health and wellbeing. But, of course, this doesn't pit one generation's needs against another. We frame ageing within the life course and try to identify the interventions at different stages of life that have the maximum impact on people's longevity and healthy life expectancy. Identification as a priority means the WHO understands this demographic trend's importance, creating opportunities to advocate strongly for intervention, frame a formal global public health response, and free the resources to achieve this.

**What are the most salient social impacts of population ageing, and which of these impacts will need to be addressed through policy?**

Population ageing will impact on almost every aspect of society. Unfortunately, the political discourse often starts by considering this trend's potential negative economic impacts. However, older populations are also a wonderful, and often neglected, human resource. The goal of action should be to foster older people's abilities and thus ensure they have the opportunity to contribute to, and not be left behind by, development. Perhaps the most fundamental shift required is to reframe the way society views ageing and older people. In particular, we need to shift from outdated stereotypes that assume such a thing as a "typical" older person and form new societal responses. One of the hallmarks of

<sup>☆</sup> This interview was conducted and edited by co-editors David Bloom and Uwe Sunde.

older age is great diversity, and we need to understand that every older person is different and respond with policies that embrace this diversity.

**To what extent are you concerned about population ageing's fiscal implications and its impacts on workforce participation, savings, and economic growth? How do these challenges differ between rich and poor countries?**

I believe political concerns about population ageing's fiscal implications are overplayed and often just an excuse for other political imperatives. Societies can adapt to very large demographic shifts. For example, Germany's population is older than that of the United States, yet it has outstripped the United States in per capita gross domestic product growth over the past 15 years. So appropriate policy responses can certainly address ageing's macroeconomic impacts. However, that is not to say that we can ignore the potential impacts demographic change will have on health services, social services, and pensions. But we need to think about how we can use this change to bolster the economy in innovative ways, rather than simply think about systems as they are and cut expenditures. A saying is that the rich world grew rich before it grew old, while the poor world is growing old before it grows rich. I'm not sure I agree with this perspective. I think population ageing is intimately entwined with socioeconomic development, and countries actually grow rich as they grow old, which gives the developing world the opportunity to invest in appropriate systems. In this regard, the south is often in the fortunate position that they do not have the same entrenched and rigid self-interests that are embedded in systems in the north.

**Do you think that increasing statutory retirement ages will ultimately be necessary in response to these pressures? You've previously advocated for awarding old-age benefits on the basis of functionality and socioeconomic status, rather than on chronological age. Can you describe what this transition might entail and why it's important?**

First, I'd like to question the whole notion of retirement: why we have it, what it means, and how we should enable it. Chronologically based pension systems are inevitably inequitable because the rich tend to live longer and are likely to benefit from them over a longer period of time. Raising the chronological age at which somebody can access a pension also disadvantages the poor because they are much less likely to have flexible employment opportunities and more likely to experience significantly poorer health. We need to rethink how to ensure financial security in older age equitably, and to do that we need to move away from models based on chronological age. New models could instead consider a person's capacity, employability, and financial status. But again, we need to reconsider the purpose of retirement and invest in maintaining the health of all before we automatically frame a financing mechanism.

### **Promoting healthy ageing**

**The challenge of ageing depends critically on older adults' health. Although life expectancy is increasing for most populations, not entirely clear is whether adults today are actually healthier than previous cohorts of same-aged individuals. Do current trends point to an expansion or compression of morbidity in the years ahead?**

The evidence on whether health expectancy is keeping up with or exceeding increases in life expectancy is very mixed. Significant gains in health expectancy certainly seem to have occurred as resource-poor settings experience socioeconomic development and people are less likely to die in infancy or early adulthood. However, in the rich world, most of the current gains in life expectancy have resulted from increasing life expectancy at older ages. That this is a consequence of health services allowing people to live longer while experiencing significant disability is quite possible. For example, recent research from the United Kingdom suggests that of the 4.1 extra years of life

expectancy women gained between 1991 and 2011, only a tiny proportion was experienced in good health. However, this need not be the case. If we invest in appropriate health systems and encourage appropriate behaviors, health expectancies can increase significantly, even in the rich world.

**Can you articulate what "healthy ageing" entails in this context? How are we falling short of this goal at present, and what does your vision of success two decades from now look like?**

People often consider healthy ageing from the perspective of the absence of disease. Yet we know that most people over the age of 65 experience multiple morbidities even though many of them report being in good health. The WHO therefore adopted a capabilities approach to frame healthy ageing as building and maintaining an older person's ability to be and to do the things they have reason to value. Not only do the personal attributes of the individual determine this ability, but so do the environment they inhabit and their interaction with it. Each of these provides opportunities for interventions at different stages of the life course.

Success in two decades would comprise a comprehensive societal response that has not only raised average healthy ageing trajectories, but has also reduced the inequalities that often become most obvious in older age. This would require action to create enabling environments, align health systems, build systems of long-term care, establish healthy ageing monitoring systems, and fill multiple knowledge gaps. And, of course, this societal response would need to be integrated.

**What would be the consequences of a failure to adapt current "business-as-usual" approaches to supporting older adults and healthy ageing?**

In some advanced countries we are already seeing life expectancies, and possibly health expectancies, starting to decline, certainly in some subpopulations. Unless we invest in appropriate systems and services, we are likely to reach a plateau and not reap the full reward of the demographic shift to older populations.

**What are the most important challenges, barriers, and congestion points in reaching the "success" scenario you describe?**

Several areas present barriers, but these are also opportunities for intervention. Perhaps the most fundamental challenge is the pervasive ageism that undermines effective societal response and directly affects individual older people. We need to shift from stereotyping older people and telling them what they should be doing to enabling them to invent their own futures.

We must also realign health services to the older populations they increasingly serve. This means shifting from providing ongoing care for multiple conditions independently to services that are oriented around the older person in a more holistic way. It would also mean a shift from provider-driven services to services oriented to people's needs and capacity. Many entrenched interests, particularly in high-income settings, are likely to resist this.

Furthermore, we must also ensure that older people who are experiencing significant capacity losses have access to appropriate long-term care, even in the poorest settings. This will require a change in the political perspective that this is an undesirable drain on society to an understanding that care economies can reinforce socioeconomic development and benefit everyone.

And finally we need to fill many knowledge gaps on quite fundamental issues such as your previous question on the compression of morbidity. We need to reach a consensus on the terms that we use, and we need to establish appropriate surveillance and monitoring systems. At the moment, some surveillance systems (for example in relation to HIV or health behaviors) actively exclude older people. This is just not acceptable.

**Who is responsible for taking on these challenges? Are these issues fundamentally local, national, or global in nature?**

Everyone is responsible. Global leadership is required, but so is stewardship at the global, national, and local levels.

**What are the most important steps for these actors to take to**

**promote health, functionality, and economic security in old age? How much would you emphasize universal healthcare here versus prevention, early detection, and treatment?**

Universal health coverage is essential, but we need to move on from the idea that the matter is simply one of universal health insurance and better access to the same services. To have a meaningful impact, we must completely redesign available services. Prevention is also important, but relates more to the prevention of functional declines than the prevention of disease, which requires a shift in thinking. For example, aerobic physical activity is particularly important in younger ages, but as people age, resistance training becomes equally important. This is counterintuitive to many people, and the evidence needs to be communicated effectively.

**With respect to prevention, how do immunization programs for older adults (such as pneumococcal, herpes zoster, and influenza vaccination) figure in to the WHO's strategy to address population ageing?**

Immunization programs are important, and new vaccines, such as for herpes zoster, create exciting opportunities. Unfortunately, immune response tends to wane with age, which has to date limited some vaccines' effectiveness. In low-resource settings in particular, minor infections, such as cytomegalo virus, may be more prevalent and have significant subsequent negative effects in older age. We need to consider whether opportunities exist earlier in the life course to influence the immune senescence that occurs after the age of around 20.

**Are any other ageing-related programs or policy initiatives particularly vital to promoting healthy ageing? Which countries, systems, or programs would you point to as models worth imitating?**

From a healthy ageing perspective the role of the environment is very important. The environment can encourage healthy behaviors and thus prevent disease or slow declines of capacity. But it also creates many opportunities to help people compensate for, or adapt to, losses of capacity. More than 570 municipalities are currently participating in the WHO's global network of age-friendly cities, and they are doing some exciting concrete work on the ground. The WHO encourages them to share these practices, enabling them to learn from one another. For people who are interested, [agefriendlyworld.org](http://agefriendlyworld.org) has some further information.

In general, no country has yet got it all right, but some are much more advanced on specific issues. For example, Germany, Japan, the Netherlands, and South Korea have mandatory long-term care insurance. Many European countries have effective models of health care. Japan is trying some interesting approaches to integrated care, and China is taking the issue very seriously and exploring options to ensure access to both health and long-term care.

**How will population ageing influence the political process? Will this affect implementation of the policy measures you propose?**

As populations age, the political influence of older age groups is likely to increase. I hope this will help decision makers realize the importance of some of the measures I have outlined, but political responses have to date been inconsistent and often reinforce some of the negative policies that prevent older people from experiencing healthy ageing.

### The role of intergovernmental organizations

**What are the biggest challenges you face in directing the WHO's Programme on Ageing and pursuing your vision of healthy ageing more broadly? Is recruiting talent to the field or mobilizing resources to support that talent difficult?**

Raising resources is very difficult. Most governments I talk to understand the importance of healthy ageing, but are not yet willing to

invest in global action. Another major problem is a lack of trained people on the ground. Ageing is a universal experience. For this reason, decision makers often assume that this personal experience means they know everything to know about the topic. However, ageing is an incredibly complex area, and the opportunities will come from transforming current systems, not revising the past. We urgently need to build decision makers' skills and knowledge to realize this. Increasingly, emerging talent is recognizing that this is a fantastic field to get involved in, and these days recruiting talent centrally poses little difficulty. However, this was not always the case.

**How would you situate the role of the WHO in raising awareness about ageing-related issues compared with other major intergovernmental organizations, such as the World Bank, the United Nations Population Fund, and the United Nations Development Programme? Is any single organization particularly well poised to champion the issues of the older adults worldwide?**

Of all the international organizations, the WHO is very well placed in this area. Ageing clearly relates to the WHO's health mandate, and the organization has invested significantly in moving the agenda forward. However, much of the action required needs to happen outside our traditional constituency of health ministries. Crucially, every international organization must provide leadership on this issue, and I have seen a greater enthusiasm for that over the last few years.

**Do the Sustainable Development Goals adequately highlight concerns related to population ageing?**

The Sustainable Development Goals have created the opening for action on ageing, and the WHO's Global Strategy and Action Plan on Ageing and Health provides a framework for action that fills in what the SDGs don't say explicitly. However, globally, many stakeholders do not yet seem to accept that sustainable development requires understanding demographic change.

**Looking forward, what would constitute an ideal system of global governance to articulate and defend the rights of the elderly against abuse, insecurity, and vulnerability? Would a convention on the human rights of older people advance these efforts? Why or why not?**

Our work is rights based, and mechanisms must exist to ensure that older people's rights are respected. This requires clearer elucidation of these rights and their enshrinement in international law. Either a convention or revamping existing instruments could achieve this. I would personally be happy with either. What is unacceptable is pretending that current protection is adequate. Whatever approach is used, we must ensure it does not reinforce prevalent stereotypes of all older people being vulnerable and a burden.

### Economic research on ageing

**What is the WHO doing in the realm of ageing research? What role does economic research have in supporting the WHO's ageing-related objectives, such as promoting healthy ageing, better integrating care for older adults, and addressing ageism?**

The WHO is doing significant research in many areas, including the global burden of poor health; ageism; the construct, measurement, and implications of intrinsic capacity; and models of care. Economic research is crucial, yet the bulk of economic output seems stuck in outdated paradigms. A better understanding of the output of economic research on the impacts of population ageing and the economic benefits of various interventions is essential.

**What is the broader role of academic research on the economics of ageing? Throughout your career, which types of economic analysis have you tended to rely on most often?**

We need a much more nuanced understanding of the true costs and contributions of older populations. This needs to account for their diversity in health state and circumstance and not assume that older

people are either “dependent” (whatever that means) or work avoidant.

**In general, does the economic research conducted on ageing match the needs of policymakers and other stakeholders?**

No.

**What are the most crucial ways in which this research is lacking? What would you identify as major limitations and barriers in the literature?**

I am repeatedly surprised at just how poorly developed this field is, particularly at a macroeconomic level. A classic example is the persistence of outdated concepts such as the dependency ratio. Concepts like this are values driven, rather than based on evidence, and their continued use reinforces ageist stereotypes and leads to poor decision making. Economists must do better. A key problem is the common failure to consider older populations’ diversity; another is failing to account for older people’s various contributions (for example, through taxes, volunteering, caregiving, consumption, etc.). When considering the impact on health services, the research often overlooks the impact of time to death, and too much modeling seems to make a simplistic assessment of the relationship between age and health care utilization. Little account seems to be made of the impact of different systems of health care. For example, the relationship between age and health care costs appears to be quite different in the United Kingdom compared with the United States. Why? What is the economic impact of long-term care systems, both on families and for society? Indeed, how about properly valuing the contributions of caregivers and their opportunity costs in providing care?

Some of these problems arise because the data are lacking, but academic researchers have a responsibility to point this out and insist on better. Of course, I am being a bit provocative, and I know good research is also being done. But political responses often start with economic analyses, and from where I sit these too often reinforce outdated stereotypes and social models. If the economic analysis focuses primarily on population ageing’s costs, then the natural policy response is to cut these expenditures. However, if the other side of the coin can be quantified, people will realize that these expenditures are actually investments that we can expect a return on. For example, health care expenditure is an investment in health that benefits individuals and enables their social contributions to the benefit of all.

**Part of your work with the WHO focuses on building global consensus on ageing terms and metrics. Where is the terminology incongruent, and how has this obstructed effective research and policy?**

This is absolutely critical, and we are working to shift and clarify language. Our Healthy Ageing paradigm includes the distinct concepts of intrinsic capacity and functional ability, and we consider the trajectories of these over time. We are working to build a consensus on the use of these and other terms, how to structure them, and how best to measure them. And this measurement must be conceptually consistent at both individual and population levels.

In general we tend to be very sloppy with our use of language in this area. For example, consider the widely used terms older/old person, elderly (and so on). What do we mean when we use them? Why can we simply not be accurate and describe who we are talking about? If we are talking about a population over a certain chronological age, then we should say, for example, 60 and above—although I would challenge the usefulness of such an aggregation of very different people. If we mean frail people, we should say that. If we mean people who are accessing publicly funded pensions, we should say that (and note that self-funded retirees should not be included in this pool).

Dependency is another frequently misused term that also reflects certain values. Many societies value interdependency, yet in the west the term is often negatively framed. But more importantly, attributing a characteristic like this to a heterogeneous group of people defined by chronological age is quite misleading. In the rich world many retirees

are self-funded and contribute significantly to society. Bill Gates is over 60, is he dependent? I also see dependency ratios given for low-income countries when I know most older people there likely remain in the workforce. Indeed, the average age of a smallholder farmer in Kenya is 60 years, so older people in Africa are important for food security. Within families, cash transfers flow from old to young until people are well into their eighties. We just need to be much more accurate in how we use this kind of language. The WHO does use the term care-dependent, but it is based on an individual’s capacity (defining when people require others’ support to perform the basic tasks of daily life), not an assumption of their social role.

Another confusing concept is retirement. First, this is not necessarily the same as the age at which a person can access a pension, yet these are often conflated. Second, what is retirement age anyway? We often assume it is a given when it is a mutable social construct.

I could go on, but the basic message is that we need to be specific and accurate in the language we use and avoid value-laden terms.

**If you had a \$100 million budget for research on the economics of ageing, how would you allocate it among data collection and analysis and basic and applied research, and which topics of study would you prioritize? Could any novel research endeavors be highly beneficial in promoting healthy ageing?**

A simple transparent integrated macro model that combines demography (disaggregated), various social determinants, and health would be nice. This would require adequate representative data collection at an individual level. Using this to get a global picture with meaningful comparisons among different systems and approaches would be good.

A more nuanced assessment of pension schemes would also be nice. Who benefits the most from and who is affected by increasing retirement ages? Many of our societal responses may simply reinforce the cumulative impact of disadvantage that some people have experienced throughout their lives.

I have probably already spent my \$100 million, but health economics analyses based on capacity, not disease, would be really helpful. In fact, this presents great opportunities for further research. What is the relationship between capacity and productivity, what are the total costs of losses of capacity (to the individual, their family, and society)? What impact do interventions have on capacity and ability, and what are the related cost-benefit analyses?

### Career background and advice

**I’d like to close the interview by talking a little bit about how you got to where you are today. How have your training and professional experiences influenced your interest in ageing and shaped your career progression?**

My career path has been quite eclectic—an unusual mix of clinician, academic, and policy maker. I started as a clinician, but realized I was more interested in the health of populations than that of individuals and undertook a PhD in epidemiology. I have always been fascinated by the impact of the physical and social environment on health. Over the years my research interest shifted from pesticide exposure to socio-economic determinants of health and then naturally to older people. I worked as a public health director in Australia (I was actually Manager of Public Health for the Sydney 2000 Olympics) and then headed an academic center for rural health before moving to the Center for Urban Epidemiologic Studies at the New York Academy of Medicine. This may seem a strange jump, but our research approaches and way of considering the world were very similar. Somehow I landed at the WHO.

So my career progression was unplanned to say the least. But one of the most exciting things about the field of ageing is how it impacts on almost every aspect of society. Maybe this kind of diverse background is necessary to really grasp it.

**What advice would you offer to young professionals who may be interested in work on ageing? What skills and professional profiles are most needed in the field, and how do the career paths available compare with those for other population issues?**

This is such an exciting area, and so many fields are relevant. More important, much of the field remains unexplored, and opportunities exist to make major advances. Of all the major issues confronting

humanity in the 21st century, this is one we know will happen and where the evidence base is weak. My advice would be to ignore those who look to the past to invent the future. Build the broad competencies that can allow you to join the dots and then push deep into whatever field excites you. Invent the future that the academics of today have not been able to imagine.