

Special Issue: Successful Aging: Theoretical or Methodological Article

# Toward a More Comprehensive Concept of Successful Aging: Disability and Care Needs

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## Abstract

Rowe and Kahn's model of Successful Aging 2.0 argues that changing environmental settings, societal policies, and individual life styles will lead to a significant extension of healthy life years. Recent epidemiological research, however, confirms the dilemma that the ongoing extension of life expectancy prolongs not only the years in good health but also those in poor health. We see it as a major limitation that Rowe and Kahn's model is not able to cover the emerging linkage between increasing life expectation and aging with disability and care needs. Therefore, we suggest a set of propositions towards a more comprehensive model of successful aging which captures desirable living situations including for those who grow old with disabilities and care needs. We describe individual, environmental, and care related strategies and resources for autonomy and quality of life when facing disabilities and care needs in late life, putting emphasis on inter-individual differences and social inequality. We argue that expanding the traditional concept of successful aging to aging with disabilities and care needs serves not to undermine, but rather to anchor the concept in aging science and in public perception.

**Keywords:** Extension of aging with disability—Extension of life expectancy—Rowe & Kahn's model of successful aging—Strategies—Interindividual differences—Social inequality—Visionary component of aging

## The Promise of Successful Aging 2.0 Seen in the Light of Aging With Disability and Care Needs

The concept of successful aging strived from its inception to identify protective factors and to develop effective intervention strategies for promoting the highest possible quality of life in old age. This has been and remains an important step forward in aging research and practice, particularly in research on health behavior in old age (McKee & Schüz, 2015). The most influential model of successful aging so far was proposed by Rowe and Kahn (1987; 1998). Their concept is based on three components, that is, (a) low probability of disease and related disability; (b) high cognitive and physical functioning; and (c) active engagement with life. In contrast to “normal aging,” successful aging

addresses what would be possible if latent reserve capacities (Baltes, Lindenberger, & Staudinger, 2006) and healthy lifestyles (Fries, Bruce, & Chakravarty, 2011) have optimal opportunities to evolve. More than a quarter of a century after the publication of the original model, Rowe and Kahn call for research on successfully aging societies—societies which are capable of dealing with the risks and benefits of demographic change, foster productivity, cohesion, resilience, and sustainability of aging societies, and “facilitate successful aging at the level of the individual” (Rowe & Kahn, 2015, p. 2).

In contrast to these optimistic expectations, it could be argued from the perspective of population science that aging in the future is likely to face a fundamental dilemma in that longer lives will go along with years in good health

and years in poor health. Hence, we claim that, when considering full-blown aging trajectories covering the third and fourth age, it is necessary to integrate the idea of “successful aging with care needs” into the traditional concept of successful aging.

We are well aware that we are not the first to address the issue of successful aging and aging with disability and care needs. As has already been demonstrated in previous work, Rowe and Kahn’s model excludes disability and physical impairment from successful aging (Cosco, Prina, Perales, Stephan, & Brayne, 2014; Depp & Jeste, 2006). In a recent review on critiques of successful aging models, four groups of critical arguments were distinguished (Martinson & Berridge, 2015). A first group of critical arguments points out that traditional models of successful aging contain too few dimensions to characterize aging processes sufficiently. Hence, traditional models should be expanded by including a number of other dimensions such as different variants of psychological well-being (see also Ryff, 1989). Secondly, some models of successful aging disregard older adults’ subjective constructions of what it means to age well. These subjective and often culturally diverse constructions should be added to models of successful aging (see also Bowling & Dieppe, 2005). A third group of critical comments argues that traditional models of successful aging do not capture essential features of old age. As a consequence, alternative ideals that take in age related losses and spiritual qualities of meaning and identity should replace the current models of successful aging. A fourth and final group of critical arguments suggests that models of successful aging should be abandoned altogether as these models could create stigma and discrimination as they exclude older adults with disabilities and functional impairment (Von Faber et al., 2001). Moreover, the traditional concept of successful aging might possibly only fit the “happy few,” neglecting the importance of social inequality up to old age (Hank, 2011).

Against this background, we argue against abandoning the concept of successful aging and advocate embracing its visionary component: Individual and societal interventions are needed for creating desirable living situations in old age which are characterized by autonomy and quality of life. Contrary to Rowe & Kahn, we argue, however, that interventions for healthy aging will not eliminate care needs at the end of life, but will entail more years in good health and years with care needs. Because healthy aging and aging with care needs are—for many—consecutive phases within the life course, they should not be treated as separate categories. As a consequence, we need a more comprehensive concept of successful aging: The concept of successful aging should be expanded to capture desirable living situations for those who grow old in good health and for those who grow old with care needs. Autonomy and well-being are important aspects of desirable living situations in old age. Focusing on successful aging with disability and care needs, we describe effective strategies and resources on three levels: Individual, environmental, and care related strategies

and resources. We are convinced that expanding the traditional concept to aging with disabilities and care needs serves not to undermine, but rather to anchor the concept of successful aging in aging science as well as in the public perception. We have summarized our argument in seven propositions (Table 1), and will explicate these propositions in the following sections.

### Proposition 1: Stable and Substantial Prevalence of Disability and Care Needs

Rowe and Kahn’s model of Successful Aging 2.0 as outlined above strongly hinges on the idea of compression of morbidity. Fries and Crapo (1981) started to promote the idea that—by means of health promotion and prevention—individuals can to a large extent control their health outcomes over their life course. Consequently, morbidity may become increasingly compressed at the end of life across an anticipated positive cohort flow over the next 50 years or so (see also Fries, Bruce, & Chakravarty, 2011). If life expectancies remain fixed and stable, compression of morbidity occurs if morbidity onset happens later in life. However, in most populations all over the world a steady increase in life expectancy has been observed over the past century (Oeppen & Vaupel, 2002). In the case of growing life expectancy, (relative) compression of morbidity is indicated if gains in years in good health are larger than gains in total life expectancy.

In an international study comparing no less than 187 countries worldwide (and using disability as health indicator), evidence was found for the opposite of compression—expansion of disability in late life (Salomon et al., 2013). Between 1990 and 2010, worldwide total life expectancy increased faster than healthy life expectancy, with each 1-year increase in life expectancy at birth associated with a 0.8-year increase in healthy life expectancy. The correlation between increase in life expectancy and increase in years with disability was *positive and high* (larger than .80, Salomon et al., 2013, p. 2156). Although there are, as to be expected, differences between countries, the overall trend of disability expansion could be observed in most countries. For instance, in the United States, life expectancy in poor health increased for women from 10.5 years in 1990 to 11.0 years in 2010; for men the increase was even larger (from 8.7 years in 1990 to 9.7 years in 2010; Salomon et al., 2013, p. 2152). This study provides evidence that morbidity has not been compressed in absolute terms, but years gained in good health may have been accompanied by additional years in poor health.

However, the evidence is not as clear cut as this large international study might suggest. Depending on the definition of morbidity, studies have come to different conclusions in regard to compression of morbidity (evidence for compression of disability: Manton, Gu, & Lowrimore, 2008; evidence for compression of poor

**Table 1.** Propositions Towards Conceptualizing Successful Aging as Both Aging in Good Health and Aging With Care Needs

Core of proposition	Content of proposition
1. Stable and substantial prevalence of disability and care needs	Individual and societal strategies toward healthy aging will probably not eliminate disability and care needs at the end of life, but will go along with both extended years in good health and extended years with care needs. Hence, the prevalence of older people with care needs will remain stable and substantial in modern societies.
2. Aging in good health and with care needs as consecutive phases in the life course	Healthy aging and aging with disability and care needs cannot be treated as separate categories ("Two-World" argument of aging), but should be considered as consecutive phases within the life course.
3. Expanding the concept of successful aging toward aging with disability and care needs	Because of Propositions 1 and 2, the traditional concept of successful aging should be expanded to capture desirable living situations (autonomy, well-being) and to consider effective strategies and resources for aging in good health and aging with disability and care needs (individual, environmental, and care related strategies and resources).
4. Individual strategies and resources for successful aging	Individual strategies and resources for coping with care needs involve the ability to maintain autonomy and well-being (e.g., through secondary control, goal selection) in a situation with disability and care needs.
5. Environmental strategies and resources for successful aging	Environmental strategies and resources for coping with care needs consist of the use of compensatory and optimizing devices to maintain autonomy and well-being (e.g., adequate housing, mobility and other technology).
6. Care related strategies and resources for successful aging	Care related strategies and resources consist of interaction and negotiation between caregiver and care receiver in order to maintain the care receiver's autonomy and well-being. Both care receiver and caregiver provide in many instances the context for successful aging with care needs.
7. Visionary component for successful aging	Both more traditional understandings of successful aging as well as extensions toward including aging with care needs should operate with a strong visionary view of aging.

self-rated health: [Doblhammer & Kytir, 2001](#); evidence for expansion of both disability and morbidity: [Crimmins & Beltrán-Sánchez, 2011](#); evidence for expansion of morbidity: [Perenboom, van Hertem, Boshuizen, & van Den Bos, 2005](#)). It has been suggested that disability related measures of morbidity tend to support the hypothesis of morbidity compression, whereas disease related measures of morbidity tend to support the hypothesis of morbidity expansion ([Chatterji, Byles, Cutler, Seeman, & Verdes, 2015](#), p. 570).

In addition, the affect of social inequality on life expectancy and morbidity in late life has to be acknowledged. Educational, racial and income disparities in life expectancy have been stable or rising over the last decades ([Olshansky et al., 2012](#)). Whenever compression of morbidity was found, there seems to be a strong influence of socioeconomic status, favoring individuals with a higher status (e.g., [Brown et al., 2012](#); [House, Lantz, & Herd, 2005](#)). If interventions for successful aging are more effective in higher SES groups, this might not lead to compression of morbidity for all members of a society, but to increased health inequalities in later life.

**Proposition 1:** Individual and societal strategies toward healthy aging will probably not eliminate disability and care needs at the end of life, but will entail both extended years in good health *and* extended years with care needs. Hence, the prevalence of older people with care needs will remain stable and substantial in modern societies.

### Proposition 2: Aging in Good Health and Aging With Care Needs as Consecutive Phases in the Life Course

[Robine and Michel \(2004\)](#) have argued that health promotion, prevention, diagnosis and treatment have different, even antagonistic consequences for population aging. Improvement in health promotion and prevention in new cohorts of older people could lead to compression of both morbidity and disability. In contrast, improvement in diagnosis and treatment of severe diseases as well as better management of chronic diseases might lead to increased survival with morbidity and, hence, extension of morbidity. Finally, both improved health promotion as well as better treatment might foster the emergence of very old and frail populations and, hence, an extension of morbidity and disability. These trends coexist and superimpose upon each other, leading to the complex empirical situation described above ([Robine & Michel, 2004](#)).

This brings us to a fundamental conceptual question concerning Rowe and Kahn's approach: its underlying "Two-World" argument. Implicit in the traditional concept of successful aging is the assumption that there are two distinct classes (or worlds) of aging trajectories, namely "healthy aging trajectories" on the one hand, and "aging with multimorbidity, frailty and care needs" on the other hand. One might illustrate this "Two-World" argument with the analogy of two pathways branching off a fork at a road, running in different directions and never crossing again. One pathway may be labeled as successful

aging (representing good health and engagement in old age), whereas the other would represent the pathway of unsuccessful aging (representing multimorbidity, frailty, and care needs).

We consider such a “Two-World” argument building on a dichotomy between successful and unsuccessful aging misleading. Instead, backed by [Robine and Michel \(2004\)](#), we assume that individual and societal interventions toward successful aging are likely to have mixed, time-delayed, and antagonistic effects. Early stages of old age profit from societal and individual interventions based on Rowe and Kahn’s model of successful aging (improving individual and population health), but the same interventions may also contribute to longer life expectancy and, consequently, to increased rates of disability and care needs during the last years of life. Thus, Rowe and Kahn’s recommendations for successful aging will probably not eliminate multimorbidity, frailty, and care needs altogether, but postpone them to a later phase in life, that is, the fourth age. Hence, it is very likely that both facets of aging (aging in good health and aging with care needs) are consecutive segments in the *same* course of life. Individual exceptions (trajectories in good health until the end of life) may be possible, but these exceptions should not be used for defining successful aging.

Going further, it has to be acknowledged that inter-individual differences are large and might even increase with age. The cumulative advantage/disadvantage theory has pointed out that late life diversity and inequality may stem from different starting conditions early in life ([Ferraro & Shippee, 2009](#)). Research on the relationship between early childhood and successful aging has shown that, independent of concurrent age-related influences, childhood conditions affect individuals’ chances to age well ([Pruchno, Wilson-Genderson, Rose, & Cartwright, 2010](#)). In the light of these results, Rowe and Kahn’s concept of successful aging might only capture the continuation of favorable conditions over the life course into old age. Individuals accumulating advantages over the life span tend to be healthier also in late life, whereas individuals accumulating disadvantages over the life span are more likely to experience disabilities and care needs in old age. Hence, social inequality seems to regulate access to the world of healthy aging to a significant extent.

Proposition 2: Healthy aging and aging with disability and care needs cannot be treated as separate categories (“Two-World” argument of aging), but should be considered as consecutive phases within the life course.

### Proposition 3: Expanding the Concept of Successful Aging Toward Aging With Disability and Care Needs

Because interventions for healthy aging will probably not eliminate frailty in old age in the foreseeable future (Proposition 1) and because aging in good health and aging

with care needs will—for many—be consecutive periods in their life course (Proposition 2), the term “successful aging” should not be used exclusively for those segments in old age with good health, high cognitive functioning, and active societal engagement. Instead, the concept of successful aging should be expanded in order to capture desirable living situations for both aging in good health and aging with disabilities and care needs.

Rowe and Kahn’s definition of successful aging mainly focuses on individual resources and capacities (low probability of disease and illness, high cognitive and functional functioning). These resources, as desirable as they may be, should be regarded as the means (for reaching goals), rather goals in themselves. Based on different traditions in gerontological discourse, we propose autonomy and quality of life as endpoints (goals) of successful aging. Autonomy can be defined as a person’s ability to make his or her own decisions, even in the face of disability and need for care (e.g., [Baltes, 1996](#)). Quality of life can be defined as (objective) welfare and (subjective) well-being of individuals across the life course (e.g., [Power, Quinn, & Schmidt, 2005](#)).

Good health and functioning are highly relevant resources for individual autonomy and quality of life (over the life course and, especially, in old age). Emergent disabilities and the need for care may jeopardize autonomy and quality in life in old age. Good health and functioning are important, but not necessary conditions for maintaining autonomy and quality of life in the face of aging with disabilities and care needs. Aging with disability and care needs challenges the individual, the environment and the social context. We believe that there are effective strategies and resources for aging with care needs which support autonomy and quality of life in old age and, hence, foster successful aging with care needs. In the following sections we will examine three facets of strategies and resources: Individual, environmental, and care related strategies and resources for successful aging with care needs.

Proposition 3: Because of Propositions 1 and 2, the traditional concept of successful aging should be expanded to capture desirable living situations (autonomy, well-being) and to consider effective strategies and resources for aging in good health and aging with disability and care needs (individual, environmental, and care related strategies and resources).

### Proposition 4: Individual Strategies and Resources for Successful Aging When Facing Disability and Care Needs

Considering successful aging with disabilities and care needs calls for a life-span developmental perspective on the individual level. More and more aging individuals experience both the third and fourth age as part of their lives. This has led



developmental theorists to describe the specific challenges of the fourth age. Joan Erikson, for instance, stated that “old age in one’s 80s and 90s brings with it new demands, reevaluations, and daily difficulties” (Erikson, 1998, p. 105). Consequently, she added a ninth stage of developmental tasks to the eight stages already described by Erik Erikson. Solving the developmental tasks of the ninth stage successfully and coping with disabilities and care needs in late life requires individual coping strategies and resources.

Models of developmental regulation over the life course analyze different ways to deal with age related challenges—on the one hand trying to prevent, slow down or reverse age related losses, and on the other hand adapting to changed circumstances (e.g., Baltes & Baltes’ model of selective optimization with compensation, Baltes & Baltes, 1990; Brandstädter’s dual process model of developmental regulation, Brandstädter, 2009; and Heckhausen & Schulz’ model of primary and secondary control, Heckhausen, Wrosch, & Schulz, 2010). Central to these models is the assumption that effective orchestration of coping strategies is possible when the need for a transition arises. Balancing tenacious goal pursuit and flexible goal adjustment means that a person should neither give up too early nor too late when coping with increasingly irreversible losses. Empirical research has shown that the prevalence of adaptive strategies increases with advancing age (Brandstädter, 2009). Although it is highly relevant to offer guidance in the care transition process (see Levine, Halper, Peist, & Gould, 2010, with respect to counseling family members in this transition), models of developmental regulation have been rarely used for systematically counseling older individuals in order to help them experience the care transition process successfully (see also Heckhausen, Wrosch, & Schulz, 2013).

Coping resources and strategies might be differentially available to individuals, but overall they are efficient means to cope with disability and care needs (Gignac, Cott, & Badley, 2000). Inter-individual differences may, however, result in differential access to and use of coping strategies and resources. For example, due to personality differences, some individuals might be more predisposed to adaptive responses when facing disabilities and care needs in old age than others (Carver & Connor-Smith, 2010). In addition, social inequality, based on unequally distributed material and immaterial resources (e.g., income, wealth, education, social status), can influence access, use and affect of coping resources and strategies as well. It has been shown, for instance, that—depending on an individual’s income and/or education—coping resources like optimistic self-beliefs and social support can have different effects on outcomes such as functional health (Schöllgen, Huxhold, Schüz, & Tesch-Römer, 2011).

Proposition 4: Individual strategies and resources for coping with care needs involve the ability to maintain autonomy and well-being (e.g., through secondary control, goal selection) in a situation of disability and care needs.

### Proposition 5: Environmental Strategies and Resources for Successful Aging When Facing Disability and Care Needs

Models of disability take a relational stance in defining what it means to successfully master life challenges. According to disability models, ability and disability have to be analyzed by looking at individuals embedded in environmental conditions (Goodley, Hughes, & Davis, 2012). Central to disability models is the distinction between impairment and disability. Although impairment refers to the damage or deficiency of an individual body, disability refers to environmental barriers which are (at least partially) constructed by society. Based on the consideration of health conditions, functional impairments and disability, the International Classification of Functioning, Disability and Health (ICF; WHO, 2001) focuses on those individual and environmental factors which enable an individual to take part in activities and societal participation. Similarly, the Ecological Theory of Aging (ETA; Lawton, 1982; Wahl & Oswald, 2016) refers to the capacity to adapt behaviorally to existing physical-environmental pressure. According to ETA, older individuals need to react to environmental pressure in order to remain as independent as possible and feel well. An important implication of the ETA is that environmental optimization and respective interventions are critical for older adults with disabilities (Wahl, Fänge, Oswald, Gitlin, & Iwarsson, 2009).

Successful aging with disability and care needs depends, to a large extent, on environmental factors: Housing, technological equipment, provision of services as well as infrastructure of the neighborhood. Housing solutions for older adults with disabilities may be regarded as a highly critical context for successful aging with care needs. Importantly, a full range of environmental solutions is meanwhile available for older adults and the long-term care industry (e.g., Day, Calkins, Bechtel, & Churchman, 2002, with respect to dementia). For example, assisted living arrangements in the intermediate sphere between “normal” housing and nursing homes have been found which support autonomy and quality of life. New housing solutions offered, for instance, in the Scandinavian countries can potentially reduce the affect of aging with disability and care needs on autonomy and quality of life (Regnier, 2003). Environmental conditions influence the quality of life of older people and may also increase their resilience and capacity for successful aging (Golant, 2015).

Despite the fact that environmental resources can support autonomy and quality of life effectively when facing disabilities and care needs in late life, there are disparities in the availability of and access to environmental resources. Regional disparities can be seen, for instance, in the differential access to modern technology like high-speed internet in urban and rural areas (Czaja, *in press*). Additionally, income inequality may restrict access and use of technologies, which can be highly supportive, but may be too costly for many who would profit from these environmental

resources (Czaja, *in press*). Hence, in addition to the development of environmental resources and strategies for successful aging with care needs, attention to the availability, access, and use of these resources is urgently needed.

Proposition 5: Environmental strategies and resources for coping with care needs consist of the use of compensatory and optimizing devices to maintain autonomy and well-being (e.g., adequate housing, mobility and other technology).

### Proposition 6: Care Related Strategies and Resources for Successful Aging When Facing Disability and Care Needs

When an older person experiences the transition into a situation of frailty, this is for the traditional notion of successful aging, the opposite of success. Not only the scientific discourse, but also everyday and political discourse on frailty and need of care have been characterized by the concept of burden: Being in need of care is seen as a burden to the person, caring as a burden on informal and formal caregivers (Pinquart & Sørensen, 2003), and funding long-term care as a burden on society (Gaugler, 2015). The preconditions for successful aging in long-term care have been rarely analyzed (Baltes, Wahl, & Reichert, 1991).

Broadening the perspective and taking theories on care and nursing into account might change this perception. When looking at the concept of care—the provision of support which is necessary for someone’s protection, health, and welfare—it is crucial that care always implies a relationship between a care recipient and a care provider. Theories of care (e.g., Orem & Taylor, 2011; Peplau, 1997; Roy, 2011) differ in their focus, but they converge in emphasizing the relevance of the relationship between care provider and care recipient who interact in supporting self-determination and well-being of the care recipient. As a consequence, successful aging might not only describe an individual achievement (maintaining one’s health, functioning, and participation into old age) but also a joint endeavor of a care receiver and a care provider, striving to maintain self-determination and quality of life of an older person with care needs.

Similarly, care ethics—a moral philosophy strongly anchored in a feminist tradition—starts with the observation that interrelatedness and dependency are universals in human development (Tronto, 2014). The needs and preferences of both caregivers and care receivers have to be respected when caring for individuals with disabilities and care needs. For aging individuals with care needs, successful aging could be seen as the outcome of a joint process of caregiver and care recipient based on a process in which caregivers provide care in an attentive, responsible, and competent manner and care receivers respond to these acts of support. This even applies to end-of-life care: Protecting autonomy, dignity and well-being while caring for a dying person

is essential in psychosocial approaches to care (Gott & Ingleton, 2011). It may indeed be seen as *the* societal litmus test of successful aging. In this sense, “successful dying” is not an oxymoron, but a necessary element of successful aging (cf. Jeong, Higgins, & McMillan, 2010).

Long-term care comprises more than the relationship between caregiver and care recipient. Care takes place in different settings (community based and residential care; care provided by informal or formal caregivers) and is based on diverse forms of funding and welfare state regulation (Leichsenring, Billings, & Nies, 2013). Although long-term care has changed over the last decades, and a variety of innovations have transformed the field (Gaugler, 2015), there is no doubt that quality of care differs between and within settings. Achieving high quality in long-term care has been a long-standing issue in aging research (e.g., Yee-Melichar, Flores, & Cabigao, 2014). In addition, access to high-quality care is unequally distributed because of income, education, race, and ethnicity (e.g., Fennell, Feng, Clark, & Mor, 2010; Howard et al., 2002). The reality of long-term care has to be improved to the extent that high-quality care is delivered to everybody in need and across different settings. We believe that an extended concept of successful aging with care needs could help to change the organization and practice of long-term care and contribute to a change in the culture of care in long-term care settings (Ronch & Weiner, 2003).

Proposition 6: Care related strategies and resources consist of interaction and negotiation between caregiver and care receiver in order to maintain the care receiver’s autonomy and well-being. Both care receiver and caregiver provide in many instances the context for successful aging with care needs.

### Proposition 7: Visionary Component for Successful Aging Including Individuals with Disability and Care Needs

If individual, environmental, and societal conditions are to be optimized in any given direction in the future, concepts of successful aging must contain a visionary component of what is possible late in life. This proposition takes up the idea of the latent reserve capacities in aging which need additional effort to become fully utilized. It also corresponds with the idea of Rowe and Kahn (e.g., Rowe & Kahn, 1998) that “successful” aging reflects forms of aging still not normative and hence containing innovative potentials. Such a visionary argument must take into account that aging is a dynamic process characterized by changes and transitions. The goals of health interventions may change from recovery and even gains in fitness to keeping functional abilities stable to slow down losses. In addition, the visionary component of successful aging has to take into account that—for many older adults—there will

be a transition into frailty and dependency. Hence, visions for successfully aging with care needs are required as well. For example, new developments such as technology use and new and creative housing solutions may be critical in challenging situations such as long-term care needs (Wahl, Iwarsson, & Oswald, 2012).

Successful aging depends not only on interventions at the individual and organizational level, but also in the larger societal and political context. Indeed, such a view accords well with the argument to be found in Rowe and Kahn's Successful Aging 2.0 that social policy and environmental settings must be considered in any discussion of successful aging. Support and care for older people with disabilities and care needs is often delivered in settings regulated by the welfare state (Geissler & Pfau-Effinger, 2005). Welfare state policies regarding long-term care can help to secure autonomy and well-being in old age even when facing disabilities and frailty. Hence, successful aging is not only a challenge for aging individuals, but also a task for society at large. The "European Charter of the Rights and Responsibilities of Older People in Need of Long-Term Care and Assistance" might be seen as an example for this approach (AGE Platform Europe, 2010). Welfare states should provide long-term services which are accessible and affordable, providing high-quality care for older people with disability and care needs, focusing also on the needs of those who are vulnerable and at risk of being socially excluded (Leichsenring et al., 2013).

Proposition 7: Both more traditional concepts of successful aging as well as definitions broadened to include aging with care needs should operate with a strong visionary view of aging.

## Outlook

Since the early contributions of Rowe and Kahn, the discussion on successful aging has been driven by an overly optimistic hope for the feasibility of shaping a disease-free phase of old age. In Successful Aging 2.0, this hope now has become an explicit element. Based on international epidemiological data, we argue that this hope might be, at least in part, wishful thinking, because future aging is faced with the extension of both disability-free and disability-prone years. That said, we believe that functional loss, frailty, dying and death belong to the "conditio humana" and must therefore be considered in any concept of successful aging. Doing so will not blur but enhance the understanding of successful aging, open avenues for intervention, and prevent an elitist view of aging successfully. Seeing aging also through the lenses of disability and care helps avoid overlooking those with twisted, bended, and "unsuccessful" biographies. A more comprehensive concept of successful aging could also enhance gerontological thinking with the addition of compassionate ideas on the important role of social cohesion and solidarity for aging societies.

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## Conflict of Interest

We certify that we have *no* affiliations with or involvement in any organization or entity with any financial interest (such as honoraria; educational grants; participation in speakers' bureaus; membership, employment, consultancies, stock ownership, or other equity interest; and expert testimony or patent-licensing arrangements), or non-financial interest (such as personal or professional relationships, affiliations, knowledge or beliefs) in the subject matter or materials discussed in this manuscript.

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