AGING AND THE FUTURE OF THE HUMAN BEING*

M.S. GORE

The demographic trend is that more and more people will live to older ages. An extended life span makes demands not only on the elderly individual and the medical profession, but also on the society, of which the two are a part. The society must be a caring one, one which promotes the physical, social and economic autonomy of the individual.

Dr. M.S. Gore was Director of Tata Institute of Social Sciences till 1982, Vice-Chancellor of Bombay University till 1986 and currently, National Fellow, Indian Council of Social Science Research, New Delhi.

From the demographic point of view, one striking fact of the twentieth century has been the world-wide growth of elderly populations. As David Macfadyen (1990:V) of the World Health Organization puts it, "Every month, the net balance of the world population aged 55 years or over increases by 1.2 million persons". What is more, "More than 80 per cent of the monthly increase, a gain of nearly one million persons, occurs in developing countries". This is a consequence of the generally improved standards of public health even in developing countries, the improved standards of public health in developed countries, and the consequent falls in infant mortality at one end and postponement of adult mortality at the other. For the world as a whole, life expectancy at birth has increased from less than 50 years in 1950-55 to over 60 years in 1991. It is expected to approach 70 years by the year 2000. There is a difference of approximately 10 years in life expectancy between populations of the more developed and less developed regions (Siegel, 1982).

In the developing world, the higher expectancy of life at birth has been largely a consequence of relative lowering of infant mortality through public health measures of improved sanitation, protected water supply, immunisation campaigns and a consequent control of diseases in epidemic form. Improved nutrition — qualitatively as well as quantitatively — seems to be the next important step needed to prevent morbidity and to achieve improved positive health. Improved clinical medicine has, probably, played a greater role in the urban areas and in the developed world, especially in the management of illness and in coping with crisis situations. It appears that clinical medicine will have an increasingly important role to play in reducing mortality and adding years towards the end of the life span.

But even at this end, the life-style of the individual, his/her avoidance of known risk factors associated with coronary disease, hypertension and cancer will play an important role in reducing the risks of morbidity and mortality.

In the developing countries, where birth rates still continue to be high while the death rates have fallen, the age structure of the populations has not changed materially and the elderly populations still constitute only around 6 to 8 per cent of the total and the below 15 year populations, as high as 35 to 40 per cent of the total. In the developed countries the fertility levels have declined and the below 15 year populations are around 12 to 15 percent. In some cases the elderly are over 20 per cent of the country's population, as for example, in Sweden. The net dependency ratio, made up of the young plus the elderly segments of the population in the developed and the developing countries is probably

* Text of talk prepared for The 4th Asia/Oceania Regional Congress on Gerontology, October-November, 1991.

not very different in 1990, though in 1960 and 1980 the total dependent population was a higher percentage in the developing countries than in the developed countries (Siegel, 1982 : 10). But the age-structure of the two sets of countries is very different. The developed countries have older populations with more adult and aged individuals in the population whereas, the developing countries have younger populations with more young and younger individuals in the population.

The present trends are that more and more people will live to older ages. Even now in the developing countries, once a child has survived to the age of 5, his/her life expectancy increases appreciably and the lowering of the below-five-mortality rate is considered the best indicator of development of a country. Is there a natural limit to the expansion of the human life span? Some scientists think that there may be a natural genetic limit to the expansion of the average span of human life, say, upto 85 years; but, there is no conclusive proof that this is so. In fact, other scientists believe that this span may be expandable to as much as 115 years. The only point of agreement seems to be that human beings cannot attain a state of immortality (Kane, 1990: 30-49).

One presumes that the differentials between the developed and the developing countries will continue for some years, though it is expected that, at some point the differences in the demographic patterns in the developed and the developing countries will be narrower than at present.

Apart from the expansion of the total span of human life, there seems to be a fair possibility that the span of 'active' years for the elderly can also be extended. We know that there is an appreciable difference between the average life expectancy at birth in the developed and the developing countries: one expects this is parallelled by a difference in the average 'active' life available to individuals beyond the age of, say, 60 years. The point for the onset of heightened morbidity, disability and/or impairment beyond the formal onset of chronological 'old' age is critically important for the elderly and for society. The longer this period, the more 'desirable' the prolongation of life, both for the individual and for society.

The extension of the average life span of human beings should be a matter of gratification because, men in all cultures have aspired to live long — maybe to the biblical age of three score and ten or to the Hindu desired norm of living to see a hundred autumns. Will this longer life be in fact an enjoyable experience? One expects that this would depend in good measure on their continuing to be in a state of good health, possessed/assured of a measure of economic security and their continuing to be involved in meaningful social and psychological relationships. The fulfilment of these conditions cannot be taken for granted and it calls for conscious effort on the part of the elderly and the creation of a supportive environment in the society, of which they are a part. The future of the human being in the context of an extended life span depends on how (s)he expects to fill this additional slot of time.

The World Health Organization defines health as a complex state of physical, mental and social well-being. Medical opinion is increasingly veering to the view that there is no necessitous relationship between chronological aging and decline in physical or mental abilities of an individual. Much of what was once considered as the inevitable decline of aging is now seen as capable of being prevented, checked and even remedied. It is difficult to identify diseases which are specifically 'age related' as different from life-style related or environment and contagion related. Disabilities normally associated with aging may in fact be related to disease.

This does not mean that the elderly can look forward to lead a life totally free of disease or disability, but it does mean that what needs to be treated is disease and not aging, and that, because a person

is aged, one need not expect him/her to be 'naturally' predisposed to disease or less capable of benefitting from appropriate treatment. Further, it also means that if the aging individual takes appropriate care in the form of nutrition, exercise and avoidance of known risks, (s)he can expect to reduce morbidity and to cope with it better, than if (s)he neglected himself/herself and began to accept decreased ability and decreased resistance to disease as inevitable. Grimely Evans (1990:50-68) makes an important point when he says that a poor prognosis on the part of the doctor often becomes a self fulfilling prophesy. Because, if the elderly are expected to do badly, they are likely to do badly since they will tend to be given poor care. One may add that, a poor prognosis may also weaken the will of the elderly to fight and overcome morbidity.

Coping with problems of health of the elderly requires a change of attitude both on the part of the elderly individual as also his doctor. Neither must regard morbidity to be 'natural' or something to be borne patiently by the elderly with the help of alleviatory or pain management drugs. But such a change in attitude will not come about or become evident in old age unless it has been a part of the attitude to health and disease at earlier periods of life. It calls not only for a generally positive attitude of mind, but also for discipline and a resolve to inculcate a life-style conducive to health at earlier stages of life, when the spectre of disease and death are only distant possibilities. It also means the negation of a fatalistic attitude which would regard disease as god-ordained or as a retribution for unknown, earlier, moral or religious transgressions. Morbidity and disease may well be retributions, but usually only for known, avoidable risk-embracing behaviour.

An extended life span makes demands not only on the elderly individual and the medical profession, but also on the society, of which the two are a part. This society must be a *caring* society and one which promotes the physical, social and economic autonomy of the individual.

It is as a representative of such a society that the medical profession first helps in preventing morbidity through development of appropriate public health and preventive medical practices and later, where morbidity occurs, by focusing on clinical care to cure the disease, to reduce disability or impairment, and to restore the individual to a state of maximum functioning. But, beyond the provision of medical help for physical or psychological illness, the society must adopt policies and programmes which promote the social and economic well-being of the individual. In fact, physical and psychological well-being and social and economic well-being are mutually interactive and one cannot be ensured without the other. A physically ill person who is exposed to the risk of psychological depression is likely to suffer in familial and social status and to find his illness a drag on his own or family's economic resources. Also, low income or poverty is likely to deprive a person of adequate nutrition and medication, and worsen the ills of age in a physical sense.

An extended life span is, today, a fact to which human societies have to respond. It has resulted from advances in health sciences which help to reduce morbidity and postpone mortality. It has also resulted from greater productivity which makes higher standards of nutrition, better clothing, and better public health possible, at least, in some countries of the world and in some sections of the populations of all countries. But now it calls for other adjustments and creative responses at the level of the individual and society.

At the level of the individual, the question is: What does he do with the additional years? If he has been self-employed and continues to be physically able, he can continue to practice his occupation — shop-keeper, farmer or professional. This will give him a continued source of income, provide work to occupy his time and assure him of his status in society. But if he is not self-employed, then, he is faced

with a situation where the formal employment structure declares him to be a superannuated person, who must leave his employment at the age of 55 to 60 or 65. In fact these varying ages of retirement have been a response to the fact of an extended life span, but these extensions are not available in all types of occupations. Jobs which require greater physical exertion have earlier ages of retirement. Also, in countries where the population is still young, *i.e.,* where persons below the age of 14 are still 30 to 40 per cent of the total population, and those above 60 are still less than 10 per cent, there is a pressure from the young aspirants to gain an entry into the job market and governments are under pressure not to raise the age of superannuation. In a few states in India, the government lowered the retirement age from 58 years to 55 years.

Extended life spans will make this issue of the age of retirement critical in the developing world where the age structure of the population is still young and, yet, where the proportion of those who live beyond the age of superannuation and who are still physically active, is increasing. The age of retirement cannot be extended, but there is a growing number of individuals who are suddenly faced with the prospect of having nothing to do. After a short period of leisure and relaxation, the urban, middle-class retiree faces this problem of what to do, where to spend his 'day'. In homes with limited accommodation an adult male with nothing to do is very much in the way and disturbs the work schedule and the tenor of life of the rest of the household, made up primarily of women and children. Comparatively speaking, an elderly female does not face this problem of how to occupy her time. She may continue in her housewife role for a longer period, until she is physically infirm, or in a joint-household, the daughter-in-law tactfully nudges her out of it. But then there is the option of her spending more time with the grandchildren. At any rate, a woman who has been a housewife has developed ways of occupying herself during periods of 'inactivity'. But the male is normally less equipped to cope with it.

If the problem of the idle, elderly male is not a pressing one in developing countries it is because most of the employment is still in the unorganised sector or in agriculture, where there is no fixed age of retirement, and where, lower levels of productivity and/or under-employment are still acceptable.

But retirement or loss of employment is not only a problem of loss of something to do, it is also a problem of reduced or no income. How does the retiree meet his financial needs? If he is from the middle class he may have some savings, a life insurance policy, a provident fund; he may receive a gratuity and, if he was a government servant, he may be eligible for a life pension. These sources usually yield incomes lower than the monthly salary, and are, in any case, not adequate to meet increases in cost of living resulting from inflation and from increased expenses on medicines, doctor's fees or hospitalisation. To a greater or lesser degree, the retired individual becomes dependent on the younger generation — first for his life's needs and then for physical care. The extent of dependence and the period of such dependence varies from individual to individual. But, generally, with extended life expectancy, the period has tended to increase. Also, with increasing shift of employment from unorganised to the organised sector, with greater urbanisation and inter-generational migration, the family tends to be a less easily available and a less secure source of support for the elderly.

This is where the need for a better planned social response to the needs of the elderly becomes important. It calls for various measures of social insurance, social security and public assistance to ensure income maintenance, health services and social support. The presently developing societies have generally smaller percentages of the elderly to support, their family support systems are relatively in better shape to care for the aged, but their resources are meagre and the elderly dependents are, in a way, competing with the young dependents for the available meagre resources,

whether of the family or of the State. The developed societies have more resources, their young dependents are smaller than the elderly dependents, but the elderly dependents probably consume proportionately more of the social and economic resources than the corresponding young dependents, and they have little to offer the family or society in the future. Besides, the developed societies also seem to face the prospect of a decreasing percentage of the adult, the working, and the wealth producing age-group in the population. One response to this situation would be to extend the age of retirement, so that, persons beyond the age of 60 or 65 continue to be economically productive. Further, it is possible that automation may reduce the number and proportion of people that need to work at any given time to be able to support a dependent population of young plus elderly persons.

In the social-psychological sphere, the problems are complicated for the elderly by the changing family relationships in which the acceptance of support and services from one's own children seems less and less right even to the elderly. This is not merely a question of accepting the legitimacy of the economic burden of supporting one's parents. A question of attitudes is involved. Because, even though the legitimacy of supporting one's children is more willingly accepted, increasingly fewer women are willing to set aside years of their life for pregnancy, child birth and child rearing. The fertility rates have fallen because young couples do not or cannot spare the time for child rearing; they are preoccupied with the personal and the present, not overtly worried about the past or the future. Individuals rarely act in terms of what may be in the interest of society in the long term. The modern, adult individual is probably *no more* selfish than individuals in past ages *or* in traditional societies, but (s)he is in all likelihood more self-preoccupied. (S)He thinks of the larger society in the abstract and is responsive to social and world causes, but his/her immediate social world of close relationships is narrower and (s)he does not welcome close personal involvements stretching over long periods of time. This is likely to be true not only of those who are young today, but also of their parents who are in their sixties or seventies. This accentuates, in a psychological sense, the problems of a longer life span. Just as there is the problem of the loss of a work role and the loss of economic security, there is the problem of atrophy of meaningful relationships — relationships where exchanges can take place without a sense of obliging or being obliged, with an assured sense of continuity in time.

In most societies of south and east Asia where agriculture was the main occupation and laws of heredity strengthened the father-son ties, filial obligations were routinely accepted and the aged parents had a sense of living in their own homes, with the grown up sons accepting a subordinate status in the family status hierarchy. Usually, the active years of the father faded out as the mature, active years of the son or sons unfolded. The father maintained a formal position as head, but the eldest son assumed increasing authority. Extension of the life span and the active years will raise new questions of relationships and authority in such households.

In the urban areas with occupational change from father to son, and with the involvement of both in the formal, monetised economy, there is no common property base for reinforcing the filial tie and obligation. The houses are small, the new found sense of social privacy makes the house seem even smaller. Will the institution of the family be able to contain three generation households and meet the care and support needs of the elderly?

In the West, for a time, institutionalisation of the elderly dependents was seen as a solution. Nursing and medical care, it was thought, could be more adequately provided in this setting. That still holds true for the non-ambient or physically disabled elderly. But, generally, the trend has changed and increasingly efforts are made to help the elderly to live in the community with state income support

and domiciliary health services. Will the elderly in the developing societies go through the same sequence of care or will these societies shore up family and community support systems without having to go through the institutionalisation phase? This would call for a policy of financial subsidy and special housing design to enable the adult children to take care of the elderly parents. The policy followed by a few state governments in India requiring the elderly to show themselves as poor and without children to support them before they qualify for state support, Is self-defeating, because a really 'poor' elderly person can hardly sustain himself on the paltry state pension.

In India the law (Section 125 of the Criminal Procedure Code) requires every person, having sufficient means, to maintain his/her parents if the latter is unable to support himself/herself. But apart from the law, the responsibility of the son for the support and care of his parents has been emphasised by cultural tradition and social custom. In most cases, sons accept this responsibility as a matter of course — willingly or at times complainingly. Tradition had exempted the daughter from this responsibility, except in rare cases.

In Western societies, where the state provides some form of financial support, the caring role seems often to be taken by the daughter than by the son or son's wife. Studies done among working class families in London suggested that daughters, on marrying, often preferred to live within a street or two of an aging mother or father. Even where the elderly live alone or in institutions, the maintenance of links with relatives has been found valuable for their health and adjustment to life in an institution.

It seems important to identify 'caring' as a distinct function, different from 'providing'. Increasingly, where elderly individuals have no resources of their own, the function of 'providing' material support tends to be assumed by the State in the developed countries, but the 'caring' function which requires individuation of the elderly person and meeting his/her emotional needs cannot be effectively met by a formal agency. Mid-day clubs, home help, meals on wheels are all necessary services and volunteers often provide them conscientiously, but they cannot meet the legitimate dependency needs of the elderly. With advancing years and growing helplessness, the need increases for someone who will listen to your grumblings and tolerate occasional cussedness and still keep the channels of care and communication functioning. In its absence the institutionalized elderly may adopt a conforming behaviour pattern and become easy to manage, but he will gradually lose his individuality.

One of the needs of later old age, the period after cessation of economic, occupational activity, is to find a meaningful social role. This is not a new problem. It exists even at stages and in societies where the expectancy of life is low, because there is usually a gap between the cessation of economic activity of the individual associated with advanced age and the death of a person. How does one fill his/her time during this period of enforced inactivity? The traditional three generation family in some cultures recognised the role of an elder individual as the head of the family and the decision maker, albeit, often in a formal sense. The important thing was that the elderly individual — male or female — had a socially recognised role.

In Indian philosophy there is also the concept of the third stage of life — *vanaprastha* — wherein the person voluntarily withdraws from the concerns of daily life and assumes the role of an 'elder' in the larger kingroup and in the village community. By this age the individual was expected to try to attain an equanimity of mind and be able to look at life's issues dispassionately and give 'sage' advice where it was sought. The major preoccupation at this stage of life was to seek the attainment of the culturally recognised state of a mind at peace with itself. It is possible that other cultures will look upon

this goal as characteristic of a 'passivity' — what Schweitzer considered the Nay-saying proclivity of the Hindu mind. But the goal of equanimity of mind prescribed for the elderly individual had a social context and function. It also fitted in well with the religio-philosophical goal of withdrawal from worldly pre-occupations and dedication to other-worldly, spiritual goals.

The modern mind finds it difficult to accept this goal both because of its generally activist orientation as also because science and reason have shaken the foundations of transcendental goals and philosophies. But that fact has not reduced the significance of the question: What for life? or its variant, what for longevity? The expanded life span with an increasing number of 'active' years for the elderly has made this question all the more relevant.

It is true that most of us live and wish to continue to live, even struggle to live, from year to year because that is our nature in common with every life species. We do not always live for a purpose, and mostly, our purposes are proximate *e.g.,* earning a livelihood, supporting a family, educating our children, helping them settle in life. Some of us may have occupational and professional goals or ambitions of making a distinctive contribution in our fields, may be, of making a name. But for most persons, occupational goals cease to be meaningful at various stages between 55 and 70 years of chronological age. As the average life span extends to 80 or 90, new roles, new activities, new socially recognised 'purposes' will have to be identified to suit individual abilities and inclinations. In their absence, the mind will be dulled or will be haunted by restlessness.

One way in which we try to evade this challenge of extended old age is by advising the elderly to do nothing but relax and enjoy. This is what we do with young children as well, when they tend to interfere with whatever we may be doing. We put them in a pen and surround them with toys. We do something similar by providing the elders with a television set, a cable T.V. facility or a games room facility. There is nothing wrong with either set of activities if the children or the elderly are themselves motivated to play or relax. But the less an elderly person uses his mind or his limbs, the more is he likely to lose the facility in using them. Involvement in life, learning new skills and practising them is important for the elderly. The capacity of the elderly will eventually decline, but the longer the decline is postponed, the longer will the elderly individual be able to live a self-reliant life. Hopefully, it will also be a more meaningful life.

From this point of view, it would be best if the elderly were themselves to emerge as an identifiable interest group and decide what they would like to do for themselves, what they can do for the community and what they expect from it to enable them to give meaning to their added years.

In the Don Juan sequence of the play *Man and Superman,* Bernard Shaw presents the dual possibilities of his concept of heaven and hell. In his view, the two are only metaphorically separated. Hell is full of pleasurable pre-occupations and heaven is painted as peopled by dull and serious people. With a typically Shavian twist, Shaw shows Don Juan to be bored with the pleasures of hell and in search of the contemplative solitude of heaven, whereas the erstwhile upright and chivalrous knight, father of one of Don Juan's loves — Ana — is bored with heaven and makes frequent visits to the more lively vicissitudes of hell. What has caused the change is the prospect of a life of eternity, the freedom of their ethereal bodies from the urges of hunger and sex, and the impossibility as well as the needlessness of their having to live up to other people's expectations for an eternity. Hypocrisy is difficult to sustain except over finite periods. Don Juan was not a hypocrite in life and his love of pleasure was satiated.

The additional years of the elderly on earth will not quite add up to an eternity nor will the elderly be free of their aging earthly bodies, but a relative freedom from occupational compulsions and social obligations could still help them find creativity in things they had wanted to do, but could not do in their active years. Yet, they would need a socially and psychologically supportive environment and enough economic support for adequate nutrition, medical care and housing.

It would seem that the future of the human being depends on medical science in so far as it relates to physical health and longevity, but his/her happiness depends upon the readiness and the ability of the individual to make continuing adjustments to new social situations, since a long span of life would inevitably mean his being witness to more social changes, changes not only in the individual's immediate family but in the ways of life of the larger society. Will the elderly individual with a still expanding life span be able to make these adjustments in his/her ideas of right and wrong, of appropriate behaviour, of what (s)he should expect of others and of what is expected of him.

An important question arises here. Will the human being who is willing, in fact, pleading for medical science to do something to ensure his/her bodily health and to add years to his/her life span be willing to let medicine do something to his/her psyche? Would (s)he be willing to have his/her mind strengthened — innured(?) — against unpleasant experiences? Would (s)he be willing to have his/her temperament made more flexible, more pliable? The question is not far-fetched. We are already living in a world where medicines can serve as mood-changers. Would we accept personality changers? We speak seriously of the advances in genetic engineering. Would we accept with equal enthusiasm, human genetic engineering?

In much of our discussion of the progress of medicine, we speak of what medicine is doing for mankind, we do not ask or think of what medicine may be doing to mankind. When we think of the progress in medical science we assume that when our bodies are subjected to medicinal and surgical interventions our identity as persons is not affected. We think we are making the decision as to what will be done to our body. When it comes to medicines of the mind we lose that certainty. Will the person who has been subjected to mood changers or, in course of time, trait changers, be still the same person?

These questions are generally important and not specific to a consideration of the problems of aging. Their special relevance here arises because of a tendency, not too rare, of treating the elderly as objects for whom or to whom something has to be done. This violates the basic value of the autonomy of the individual.

The prospect of the expansion of the human life span will seem less attractive unless it ensures both extended physical well-being and continuance of the sense of psychic integrity and autonomy of the individual. Rightly or wrongly, we attach great significance to the notion of freedom of will. Had it not been so, we need not have been frightened of Aldous Huxley's scenario of the *Brave New World.* Somehow we do not like to consider ourselves to have been created or manipulated into being an *alpha, beta, gamma,* or *theta.* With human genetic engineering there is always this possibility of someone making these decisions of who will live how long and to what purpose. With mood changers there is the possibility of elderly persons living an extended life span of mindless pleasure. We do not like either of these possibilities.

We like to believe that despite limitations, we as human beings are gaining greater control over our lives. We do not like decisions regarding our individual lives to be made by others. We do not like the

prospect of our area of choice being reduced. We do not like the scenario of human beings living a programmed existence.

One cannot really speak about the future of the human being except in terms of speculative philosophy. On the other hand, one can make relatively plausible statements about the implications of an aging population at the level of the society and the implications of aging in an aging society at the level of the individual. This is what I have attempted.

Recapitulating the main points, it is possible to say that, with the decline in mortality rates, nearly all societies in the world are going to experience an increase in the proportion of the elderly in their respective populations. For some time, in the developing societies this may not show itself in a higher proportion of the elderly dependents and a decrease in the proportion of young dependents, but by the end of the next 20 to 30 years, this aging of the population may become apparent in most countries. This may mean a net increase in the proportion of dependents — young plus old — in relation to the working population.

The reduced rate of addition to the labour force will initially not cause concern because it will be compensated by a reduced demand for labour as a consequence of technological development and labour-saving devices. It may also mean an extended work span for the individual who is well past his/her 'adult' stage. This might also help reduce the dependency of the elders on social resources — whether institutional or familial — by a few years. Also, with fewer children to bring up, the elderly individuals may have somewhat more personal savings to fall back upon in a situation of high fertility.

Despite the compensatory changes resulting in improved health and longer work life spans, it is still uncertain whether the net period of elderly morbidity — the period between loss of meaningful work and social participation and death — will be substantially reduced. The hope is that it will be. But until then, the proportion of the helpless and dependent elderly will call for more and newer social innovations beyond the institutionalization phase, to 'provide' and to 'care' for the elderly.

The familial support pattern may change, but it seems unlikely that it will ever become unnecessary or can be completely replaced by services in the larger society. At the same time, it is likely that dependence of the elderly will partly be transferred from the younger members of the individual family to the younger cohorts in the country's population as a whole (Ryder, 1988).

The implications of aging at the level of the individual can also be anticipated with some measure of clarity. The increased period of health and activity will challenge individuals to find and continue in work roles and in other meaningful social roles and relationships. The link between health and continuing social involvement will be found to be mutually supportive. The longer one continues to work and is socially involved, the longer may be the span of life in general and the consciousness of health.

There will still be periods of decreasing physical ability and dependence. Just as the individual will be challenged to discover meaningful roles during the extended active period of aging, he will need to discover 'this-worldly' or 'other-worldly' philosophical sources of sustenance which will minimise self-pity and pre-occupation with morbidity. On this ability of the elderly individual to live creatively, with his cerebral abilities intact, will depend the worthwhileness of adding years to the life of the elderly.

Many issues which are just beginning to emerge — the morality of keeping individuals alive on a medical support system, the moral implications of euthanesia, the remote and yet not totally unlikely possibility of society's deciding upon an 'optimum' life span for individuals — will occupy centre stage and will inevitably raise new debates on older issues, such as the meaning and purpose of life. Earlier, these issues arose in response to suffering born of paucity of resources: they can also arise in the midst of plenty.

REFERENCES

Evans, J. Grimely 1990 — "How are the Elderly Different" in Robert L. Kane *et al.,* (ed.) *Improving the Health of Older People,* Oxford : WHO and Oxford University Press.

Kane, Robert L. *et. al.,* 1990 — "Compression of Morbidity: Issues and Irrelevancies" in Robert L. Kane, *et al.* (ed.) *Improving the Health of Older People,* Oxford: WHO and Oxford University Press.

Macfadyen, David 1990 — "Foreword" to Robert L. Kane *et al.,* (ed.) *Improving the Health of Older People,* Oxford: WHO and Oxford University Press, 1990 p. v.

Ryder, Norman B. 1988 — "Effects on Family of Changes in the Age Distribution" in *Economic and Social Implications of Population Aging,* New York: United Nations, ST/ESA/SER-R 185, 1988.

Siegel, Jacob S. 1982 — *Demographic Aspects of the Health of the Elderly to the Year 2000 and* Beyond, WHO/AGE/82.3